



**American Hospital
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July 12, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including nearly 90 that offer health plans, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on ways to empower patients and promote consumer choice, stabilize the Health Insurance Marketplaces, enhance affordability, and support states in regulating their health insurance markets.

The Health Insurance Marketplaces continue to face challenges related to plan pricing and participation, putting consumer coverage and choice of health plan at risk. The AHA has long advocated for measures to stabilize the marketplaces and protect this vital source of coverage for millions of Americans. The most effective way to stabilize the marketplaces and ensure that affordable coverage options remain available to consumers is to maximize enrollment of eligible individuals. Robust enrollment will attract insurer participation and drive down costs for consumers by improving the risk pool and enabling insurers to spread costs across a larger population. Significant opportunity for enrollment gains exists: many of the nearly 30 million remaining uninsured are likely eligible to purchase coverage through the marketplaces, and, in some states, tens of thousands of individuals remain enrolled in transitional health plans (i.e., “grandmothered” health plans).



Despite these opportunities, we are deeply concerned that marketplace enrollment is threatened by increasing uncertainty on both the part of consumers and insurers about the future of the marketplaces. While we include a more comprehensive set of recommendations below, we urge CMS to, first, commit to fund the cost-sharing reductions (CSRs).

Unless CMS continues to fund the CSRs, consumers will have less choice in 2018 and face higher premiums for those plans that remain. Uncertainty already has contributed to double-digit premium increases in some markets. While subsidized consumers are largely protected from these price increases, Americans earning more than 400 percent of the poverty level who do not receive subsidies may be priced out of coverage. In some markets, consumers may not have any options at all.

More information on the CSRs as well as our other recommendations on how to improve consumer choice, health plan affordability and marketplace stability follow.

AHA RECOMMENDATIONS

- **Fund the CSRs.** Without a commitment by either CMS or Congress to fund the CSRs, insurers face approximately \$7 to \$10 billion annually in unreimbursed costs. Without this funding, insurers likely would have to choose between exiting the marketplaces – reducing consumer coverage options – or significantly increasing premium rates to cover these costs – potentially making coverage unaffordable for many consumers. A recent analysis by the Kaiser Family Foundation estimated that insurance premiums would increase on average 19 percent to account for uncertainty related to the CSRs, with that amount varying from 9 to 27 percent in individual states.¹ Indeed, BlueCross BlueShield of North Carolina announced that 14 percentage points of its proposed 22.9 percent proposed rate increase is to account for the loss of the CSR payments.²
- **Enforce the individual mandate.** Without the individual mandate or another mechanism to incentivize enrollment, millions of individuals would likely opt not to enroll in coverage. The most likely consumers to forgo coverage are the healthiest individuals who expect to have minimal health care needs. Without these healthier individuals in the market, rates will rise as the risk pools worsen and there are fewer individuals to share costs. Indeed, insurers already are proposing higher rates as a result of uncertainty around whether the individual mandate will be enforced. Covered California, California’s marketplace, estimated that failure to

¹ Kaiser Family Foundation, “Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies,” April 6, 2017. Accessed at: <http://www.kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/>

² BlueCross BlueShield of North Carolina, “Premiums to Rise in 2018 for Affordable Care Act Plans,” May 25, 2017. Accessed at: <http://blog.bcbsnc.com/2017/05/premiums-rise-2018-affordable-care-act-plans/>

enforce the mandate could result in premium increases of more than 28 percent (and loss of coverage for 350,000 Californians).³

- **Expand federal outreach and enrollment efforts.** Enrollment in coverage is a multi-step process that first includes awareness that coverage options exist, determination of eligibility for coverage and subsidies, and plan selection/enrollment. Currently, many consumers rely on navigators, agents and brokers, and other assisters to assess their coverage options and apply for coverage. Given the amount of change this year, particularly due to the shortened open enrollment period, we urge CMS to devote more resources to federal outreach efforts and enrollment support. We particularly encourage CMS to increase its investment in television, radio and other advertisements to increase consumer awareness, and to increase resources for in-person eligibility and enrollment assistance.
- **Reinstitute a reinsurance program.** The temporary reinsurance program, which was funded by a fee on health plans, successfully provided additional financial protection to plans over the initial three-year period of the marketplaces to account for unexpected high-cost claims. The program helped lower marketplace premiums because it was funded by plans both inside and outside of the marketplaces. Such a program is critical to both attracting insurer participation and achieving affordable rates, and we urge CMS to work with Congress to reinstitute the federally administered program. As an alternative, we encourage CMS to continue working with states to develop and finance state-level reinsurance programs.
- **Continue evaluation and refinement of the risk-adjustment program.** The risk-adjustment program is an important tool to ensure appropriate reimbursement for health plans. We are concerned, however, that the program may unintentionally harm smaller, newer insurers. This has the impact of disincentivizing these insurers from entering and staying in the individual and small group markets, therefore reducing consumer choice. We encourage CMS to continue analysis of the risk-adjustment model to determine if modifications are necessary to ensure fair treatment of all insurers.
- **Fully phase out transitional health plans.** Since the marketplaces have been in operation, the federal government has allowed states to permit insurers to continue selling non-Affordable Care Act (ACA) compliant plans to those individuals continuously enrolled in such products. While many states have chosen to phase out these plans, those that have not have less healthy risk pools, which drive up the cost of coverage and are less appealing for insurers. The Kaiser Family Foundation found that, in 2015, the average risk score of the marketplace population was significantly higher – 8 percent – in states that both allowed these plans to continue and opted not to expand Medicaid, as compared to states that

³ Covered California, “Analysis of Impact to California’s Individual Market If Federal Policy Changes Are Implemented: Effect on Premiums, Enrollment and Coverage in 2018,” April 27, 2017. Accessed at: [http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20\(1\).pdf](http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20(1).pdf)

disallowed such plans and expanded Medicaid (no states disallowed transitional plans but expanded Medicaid, therefore the two are evaluated jointly).⁴

The continuation of transitional health plans results in a less healthy risk pool for compliant products because they remove healthier individuals from the pool. These are exactly the individuals who, if included, would help stabilize the marketplaces. For example, in Iowa, while approximately 80,000 individuals are enrolled in ACA-compliant coverage in the single risk pool, between 90,000 and 120,000 individuals are in non-compliant coverage.⁵ Bringing these individuals into compliant coverage could significantly improve the marketplace risk score. We urge CMS to require that all individuals in non-compliant coverage be transitioned to ACA-compliant coverage in 2018.

- **Expedite review of state-level approaches to marketplace stabilization.** A number of states are exploring ways to stabilize their marketplaces, including through implementing state-level reinsurance programs (Alaska, Minnesota) and requiring that insurers participating in the state's Medicaid managed care program also sell a minimum number of products on the marketplace (Nevada, New York). We are encouraged that CMS reiterated its support of states exploring such approaches in its March 2017 letter to governors.⁶ We urge the agency to prioritize review of any state applications for innovative solutions, and encourage the agency to consider developing templates for common approaches that will help reduce the burden on states interested in pursuing such solutions.
- **Retain important patient protections.** Affordability is a critical issue for consumers and, if not achieved, could impact our efforts to maximize enrollment in coverage. We are very concerned, however, that certain approaches to reduce the cost of coverage also significantly reduce the value of a health plan. In many instances, such changes could render coverage meaningless when consumers need it most – when they are seeking care. For example, high-deductible health plans may appeal to consumers initially because of lower premiums. However, patients often find that they cannot afford the care they need when they are still within the deductible range. Similarly, any changes to the essential health benefits (EHBs), cost-sharing limits, and prohibitions on annual and lifetime limits may reduce health care spending in the short-term, but also have a longer-term, and far more detrimental, impact on the ability of patients to access care, ultimately driving up health care spending when conditions are exacerbated. Consumers often cannot assess what care they will need in a given year – an unexpected trauma, initial onset of a chronic condition, a cancer diagnosis – and, therefore, these minimum coverage standards offer important health and financial protections.

⁴ Kaiser Family Foundation, “Data Note: Effect of State Decisions on State Risk Scores,” Oct 07, 2016. Accessed at: <http://www.kff.org/health-reform/issue-brief/data-note-effect-of-state-decisions-on-state-risk-scores/>

⁵ Gaba, Charles for ACASignUps.net. Accessed June 17, 2017 at <http://acassignups.net/16/08/30/iowa-approved-2017-avg-rate-hikes-301-some-rare-transitional-plan-data>

⁶ Centers for Medicare & Medicaid Services Letter to Governors March 13, 2017. Accessed at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf

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In order to address affordability, we encourage CMS to instead focus on ways to improve the functioning of the health care system by supporting and promoting the development of care delivery and value-based payment models that seek to improve the quality of care and health outcomes while reducing waste and inefficiencies. We also continue to urge CMS to find ways to reduce provider costs associated with regulatory burden, and we point you to our [June 13 letter to the agency](#) for such recommendations. These reforms will help address the underlying challenges impacting health care affordability while retaining critical patient protections.

Thank you for the opportunity to provide input on the important issues of consumer choice, affordability of health coverage and marketplace stability. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, vice president for coverage and state issues forum, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President