



January 13, 2010

The Honorable Nancy Pelosi
Speaker
U. S. House of Representatives
Washington, DC 20515

Dear Madam Speaker:

The Alliance of Community Health Plans (ACHP) appreciates your leadership on health care reform. As a group of non-profit, community-based and regional health plans or subsidiaries of non-profit health systems that provide coverage and care for approximately 18 million Americans and 15 percent of Medicare Advantage enrollees, we share your view that all Americans should have health care coverage. In our view, the best way to achieve the goals of access and delivery system reform is through shared responsibility among individuals, employers, health plans, and government.

ACHP member organizations predominantly serve individuals purchasing insurance and small and mid-sized businesses. You will find among the signatories below many of the high-performing health plans cited by the President and Congressional leaders as models of coordinated care or integrated delivery systems. We share longstanding commitments to our communities, close partnerships with providers, and substantial investments in the infrastructure necessary to provide coordinated, affordable, and high quality care.

As you consider final legislation, we wanted to bring to your attention three significant issues and ask that you consider the cumulative impact of these provisions on community-based health plans. Each provision separately raises substantial financial concerns. Taken together, the financial impact of these provisions, along with the potential competitive disadvantage they engender, could threaten the stability of these health plans that often are discussed as models of what a reformed delivery system should look like. The three provisions, which we will address in turn, are:

- Annual fee on health insurance providers
- Medicare Advantage payment and quality provisions
- Multi-state plans

Annual fee on health insurance providers

Section 9010 of the Senate bill as further amended by Section 10905 would impose a tax on the premium revenue of health plans. We have previously written to you about this tax and a copy of that letter is attached. While any tax imposes certain burdens, this provision is particularly burdensome because it would be assessed on a narrow base: the tax would apply **only** to fully insured health coverage. Fully insured coverage is common to the individual and small or mid-sized employer market – but not to self-insured coverage, which accounts for more than half of

MAKING HEALTH CARE BETTER

coverage nationwide and is the predominant mechanism for coverage in the large employer market. For this reason, the Joint Committee on Taxation has noted that much of the proposed tax will be passed through to individual purchasers of insurance and small and mid-sized businesses – exactly those groups for whom Congress is trying to make coverage more affordable.

For many of our plans, the combined taxes equal or exceed current margins. As non-profit plans or subsidiaries of non-profit health systems, our operating margins are used solely to meet the needs of enrollees and to maintain state-mandated funding requirements; we will have no other option but to pass through the costs in higher premiums, higher cost-sharing, and lower benefits.

We urge you not to include this annual tax on fully-insured business in final health care reform legislation. The tax undermines health reform’s goals of greater affordability, relief for individuals and small business, and delivery system changes that should ultimately move our health care system away from the volume-increasing incentives of fee-for-service payment and toward more coordinated approaches to care.

Medicare Advantage Payment and Quality

There are significant differences between the House and Senate bills on the issues of Medicare Advantage (MA) payment and quality, but both bills would reduce the benchmarks that determine payments to MA plans. Ultimately, the impact of these reductions will be felt by beneficiaries who will face higher premiums, greater cost-sharing requirements, and reductions in benefits – and, in some areas, the loss of coverage options as plans are unable to continue offering Medicare Advantage plans. Further, unless there is a strong value-based purchasing provision in the legislation, these payment reductions will be implemented without regard to the quality of care provided in a community.

That many Medicare beneficiaries will lose their opportunity to choose an MA plan under both the House and Senate bills is supported by the CMS Office of the Actuary, which has estimated that *enrollment in Medicare Advantage under the House bill would decline by about 64 percent* or more than 8 million beneficiaries compared to more than 13 million who would have been in the program in 2014 if current enrollment trends continued. Under the Senate bill, the comparable projection is a loss of 33 percent or 4.5 million beneficiaries by 2015 (Office of the Chief Actuary, memoranda 11/13/09 and 12/10/09).

We appreciate that both the House and Senate bills would, for the first time, recognize and reward high-performing health plans through quality incentive provisions. This is an important step in promoting value-based purchasing in Medicare and throughout the health system, and one which ACHP has supported for many years. The House provision, however, has limited impact because it would apply only in counties that have high rates of Medicare Advantage participation and are among the lowest in fee-for-service spending. Neither of these factors is related to the quality of care provided by a health plan. We believe that value-based purchasing should be considered as a separate issue from the underlying payment methodology and **we urge you to adopt the stronger Senate quality bonus provision which does not include geographic limitations.**

Multi-State Plans

The Senate bill authorizes the Office of Personnel Management (OPM) to enter into contracts with at least two multi-state plans, which would eventually be offered in all 50 states. These plans would have to meet a number of the same requirements as Qualified Health Plans which would be offered through health insurance exchanges – offering essential benefits, meeting age rating requirements, and so on. However, there is a major exception to these rules which creates an unlevel playing field. Under the Senate bill, if OPM contracts with a multi-state plan, that plan is deemed to be certified for participation in all state or sub-state exchanges. In other words, the OPM approval process creates for the multi-state plans *a single and automatic entry point* to state exchanges. In contrast, other plans have to apply to each exchange in which they want to offer coverage and, even if they meet certification requirements spelled out in the legislation, the exchange may exclude them on the vaguely worded grounds that the health plan is not “in the interests of qualified individuals and qualified employers in the State...” These provisions taken together – the deemed certification process through OPM, differences in how certification requirements may be applied between OPM and the state exchanges and among state exchanges, and the quoted exclusion language –are likely to put community-based and regional health plans at a competitive disadvantage.

In general, all health plans should have equal access to the exchanges. This would best be accomplished by requiring exchanges to allow all plans meeting certification requirements as Qualified Health Plans to offer coverage through the exchanges. In addition, it is important that all plans offering coverage, including multi-state plans, be subject to the same federal and state taxes and assessments as plans entering directly through the state exchanges. Finally, we suggest that health plans should be allowed to participate in multi-state plans through contractual arrangements.

ACHP members have been in the forefront of coordinated care and innovation, but we accept the challenge to drive further changes in the delivery system in order to reduce costs and improve quality. We also recognize that health plans have a responsibility to contribute federal budgetary savings to help finance coverage expansion. We ask you to consider, however, that the provisions identified in this letter, when taken together, impose an unfair and counterproductive burden that will have substantial negative impact on individuals and small and mid-sized businesses served by our health plans. They also undermine that goal of reforming the delivery system by moving towards coordinated and integrated care such as that delivered by high-performing, community-based health plans.

We would be happy to discuss our concerns with you and provide further information. Patricia Smith, ACHP President and CEO, would be happy to facilitate those conversations. She can be reached at 202-785-2247 or psmith@achp.org.

Thank you for your leadership and consideration of these issues.

Sincerely,

John D. Bennett, MD, FACC
 President and CEO
 Capital District Physicians' Health Plan
 Albany, NY

John M. Hogan
 President and CEO
 Capital Health Plan
 Tallahassee, FL

David E. Ford
 President and CEO
 CareOregon
 Portland, OR

Anthony Watson
 Chairman and CEO
 EmblemHealth
 New York, NY

Eric H. Schultz
 President and CEO
 Fallon Community Health Plan
 Worcester, MA

Jean Haynes
 President and CEO
 Geisinger Health Plan
 Danville, PA

Scott Armstrong
 President and CEO
 Group Health Cooperative
 Seattle, WA

Larry Zanoni
 Executive Director
 Group Health Cooperative of
 South Central Wisconsin
 Madison, WI

Mary K. Brainerd
 President and CEO
 HealthPartners
 Bloomington, MN

Michael W. Cropp, MD
 President and CEO
 Independent Health
 Buffalo, NY

George C. Halvorson
 Chairman and CEO
 Kaiser Foundation Health Plan and Hospitals
 Oakland, CA

David H. Howes, MD
 President and CEO

Martin's Point Health Care
 Portland, ME

David Kibbe
 Chief Executive Officer
 New West Health Plan
 Helena, MT

John H. Cochran, MD, FACS
 Executive Director
 The Permanente Federation
 Oakland, CA

Dennis A. Batey, MD
 President
 Presbyterian Health Plan
 Albuquerque, NM

Kimberly Horn
 President and CEO
 Priority Health Plan
 Grand Rapids, MI

Allan Einboden
 Executive Director
 Scott & White Health Plan
 Temple, TX

Steven R. Youso
 Chief Administrative Officer
 Security Health Plan
 Marshfield, WI

James Roosevelt, Jr.
 President and CEO
 Tufts Health Plan
 Watertown, MA

Nancy Feldman
 President and CEO
 UCare
 Minneapolis, MN

Diane Holder
 President
 UPMC Health Plan
 Pittsburgh, PA