



## **Alliance of Community Health Plans Recommendations on Health Care Reforms, March 2017**

As policymakers consider changes to the Affordable Care Act (ACA), the Alliance of Community Health Plans (ACHP) will be guided by the following principles:

- ACHP reaffirms that all Americans should have the opportunity to attain high-quality, affordable coverage and care. The millions of people who have gained coverage should not lose that protection.
- Americans deserve the right care at the right time in the right place. Premiums must be affordable. Affordability, in turn depends on bringing as many people as possible from the broadest range of health status into the risk pool, providers and pharmaceutical companies reducing costs including waste and unwarranted variation in treatment, insurers delivering care and coverage efficiently, and consumers making informed decisions.
- Given varying personal and financial circumstances and preferences for health coverage and care, federal and state policy and the health system as a whole must recognize and enhance consumer choices.
- Public policy and private payer initiatives should continue to promote financing models that move the delivery system towards greater quality and value-based care.
- The most effective way to provide coverage is a public/private partnership. That partnership should be grounded in the recognition that health care is provided locally and community-based plans are best positioned to develop relationships with providers in meeting the immediate needs and improving the long-term health of their communities.
- Because insurance premiums are driven by the total cost of care, public policy must address both the cost and utilization of medical services and the underlying social determinants that affect health status. New approaches are necessary, in particular, to restrain unwarranted increases in the cost of prescription drugs.

ACHP supports the following recommendations for reform of the individual market consistent with these principles:

1. Continue adequate **federal financial support**. Without this financing, most individuals would not be able to afford health insurance and health plans would be unable to continue offering individual coverage. Such assistance may be provided through a variety of mechanisms, but the support must

be both practical and sufficient for individuals and families to purchase coverage. If tax credits are used, they should be adjusted for age and income and payable both to those who do and do not pay taxes.

2. Maintain **insurance reforms**, including: guaranteed issue, prohibition of exclusions for pre-existing conditions, elimination of annual and life-time limits, gender-neutral rating and family coverage for children to age 26.
3. Recognizing different market circumstances and policy preferences across states, we recommend that states should have more **flexibility in determining coverage options**. States are best positioned to develop approaches that will encourage healthy, competitive markets. At the same time, it is important that benefit packages and other coverage requirements meet minimum standards to ensure that plans continue to manage the health risks of the population and accept all enrollees who maintain continuous coverage.
4. Ensure **continuous coverage**. Insurance cannot work if individuals move in and out of coverage depending on their need for services. If people make the choice to forego coverage, absent extenuating circumstances, there should be penalties for enrollment after initial eligibility. These could be financial as in Medicare Part B (e.g., higher premium) and coverage-related, (e.g., late enrollee limited to bronze plan). We recommend codifying the narrowing of special enrollment exceptions and effective verification of eligibility for special enrollment periods. In addition, further steps are necessary to shorten and reduce gaming of grace periods, non-payment of premiums, and cancellations/re-enrollments.
5. Expand efforts to **strengthen enrollment**. Especially in the absence of an individual mandate, health plans should be allowed to offer incentives for enrollment. Greater outreach and assistance in understanding options and enrolling remain important components of an enrollment strategy.
6. Given that “opt-out” models can raise participation, we support **automatic enrollment** options modeled on 401(k) automatic enrollment, with states assigning individuals receiving financial assistance to a plan.
7. States should have the option to establish **risk mitigation programs** such as high-cost risk pools and reinsurance, depending on the needs of the market. These programs require robust and broad-based funding which is an appropriate role for the federal government. If high-cost risk pools are used, they should not exclude patients for pre-existing conditions or impose waiting periods except as necessary to prevent gaming. Federal obligations under the current reinsurance program should be fully paid for 2016 and the program extended until alternative mechanisms are established.
8. While there are no easy choices in establishing **age rating bands**, the current 3:1 ratio has made coverage for younger enrollees more expensive than it should be. States should have flexibility to define the bands within their market.
9. Reconsider the **risk adjustment** model. The current budget neutral approach creates enormous uncertainty for health plans, forcing them to price accordingly. Non-budget neutral adjustments to account for the costs of enrollees with significantly higher than average health needs may be necessary. In addition, current methodology requires risk scores to be calculated on a statewide risk pool rather than on the basis of each market area. This can adversely affect plans based solely on geography rather than their relative ability to manage health risks. We recommend that states have

the option of establishing a statewide v. market area risk pool for the individual and small group markets.

10. Allow states to extend **non-compliant plans** during the transition in order to avoid market disruption. These plans have provided flexibility for individuals to choose benefits that meet their needs.
11. Permanently repeal the **premium or health insurance tax** in order to help constrain costs and encourage employers to offer coverage. The tax on high-cost plans (“Cadillac tax”) should be repealed or revised to be more equitable. If revised, it should not discriminate against plans that are efficient but have broader coverage and it should account for costs that are higher in certain regions and for groups that are smaller or have older workers.
12. Maintain current state authority to regulate the **sale of insurance**. States currently have the option of allowing out-of-state carriers to offer coverage under a “health care choice compact” that establishes an agreed upon regulatory structure. In contrast, unregulated selling across state lines would likely lead to unstable and segmented risk pools in which plans operating in states with fewer regulatory requirements could aggressively select the healthiest risk in a state with more requirements. New proposals to sell across state lines also raise serious doubts about the availability of adequate provider networks.