May 12, 2017

Hon. Mitch McConnell
United States Senate Majority Leader
S-230, The Capitol
Washington, DC 20510

Hon. Charles Schumer
United States Senate Minority Leader
S-221 The Capitol
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

As the Senate turns its attention to health care reform, I am writing to you on behalf of the Alliance of Community Health Plans (ACHP). Our non-profit, community-based health insurance plans covering more than 18 million Americans in 27 states and the District of Columbia, are dedicated to providing health care coverage in the most affordable, effective and high quality ways possible. We are encouraged that the Senate intends to thoughtfully address challenges in the current system while maintaining stable, affordable insurance markets for working Americans.

ACHP member plans partner with their states, communities and the federal government to make the regions in which we operate healthier. It is in that spirit that we hope to work with you on an approach to health reform which ensures the millions of people who have gained coverage continue to be protected.

As leaders in delivering affordable, high-quality care, we understand and endorse efforts to reduce costs and wish to offer ideas on how to do that without jeopardizing coverage gains or local economies. ACHP member plans have adopted many effective strategies, including:

- Value-based insurance design
- Provider payment models that emphasize quality over quantity
- Extensive care management and coordination of services across providers and settings
- Aligned incentives between health plans and providers in integrated delivery systems
- Recognizing and addressing the social determinants that affect health status
- Prescription drug utilization strategies to manage escalating and unsustainable pharmacy costs

As long time health care innovators, ACHP plans are eager to work with you to ensure sufficient financial assistance is available to Americans to purchase coverage. It is our experience that absent these measures, people will forgo care and cost the system far more over the long-term. If tax credits are used, ACHP recommends adjusting for income and geographic cost variation in addition to age. We also recommend both indexing to keep pace with the growth of health care costs and the importance of supports to assist low-and moderate-income enrollees, such as cost-sharing reductions, to manage out-of-pocket expenses including deductibles and co-pays.

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ACHP plans work closely with their states to develop new insurance products that best serve their local populations. We appreciate the need to increase state flexibility, particularly if it is connected to the appropriate levels of financing and achieves the best care for chronically ill Americans. There is little evidence, however, that high risk pools achieve the goal of providing high quality care for chronically ill individuals; historically, high risk pools have been subject to funding shortfalls and even waiting lists and not served their populations well.

Medicaid is a vital safety net program, and essential in the lives of working families. We encourage the Senate to maintain the important gains that states have made in the health of their communities and their local economies. We also recommend that Medicaid reform have a sustained and clear focus on paying for quality at both the state and federal levels. Our plans are leading the way in delivering efficiencies in both care and cost, and experience tells us that capping payments to states and removing $880 billion in Medicaid financing does not take into account pressures on Medicaid spending at the state level including an aging population, changes to Medicare cost-sharing affecting dual enrollees, public health epidemics or the exponential growth in prescription drug prices. By focusing on quality and providing new flexibility, states can set actuarially sound and sufficient capitation rates to ensure beneficiary access to the full range of health care services.

ACHP member plans have achieved important progress in behavioral health and substance abuse treatment. Given the opioid epidemic afflicting every corner of our nation, reducing coverage for people enrolled in Medicaid is of great concern and jeopardizes the progress being made to combat this threat.

About 1.3 million Americans obtain treatment for mental health and substance abuse disorders under the Medicaid expansion. We believe the best way to reduce costs to the government is to utilize the full resources of managed care plans to help these individuals get well and return to the workforce.

Below, please find three position statements approved by our Board. They include:

- Stabilizing the Individual Market to Assure a Smooth Transition
- Recommendations on Health Care Reforms
- Our Position Statement on Medicaid

Our plans stand ready to work with you and Senators of both parties to develop market-tested solutions based on our many years of real-world experience improving the health of communities across the nation and the American health care system as a whole.

In the coming days and weeks, our chief lobbyist, Andrew Schwab, will be reaching out to Senate offices to further discuss our recommendations. As always, if you or your staff have any questions, please do not hesitate to contact me at cconnolly@achp.org or 202-785-2247.

Sincerely,

Ceci Connolly

Ceci Connolly
President & CEO

Cc: Honorable Members of the United States Senate

Stabilizing the Individual Market to Assure a Smooth Transition

Stability and predictability are critical to maintaining a well-functioning insurance market during the transition. Coverage options and rates were filed in May, 2016 for the 2017 plan year. Given the already difficult challenges of the individual market and continuing losses of many health plans on their individual business, significant changes in the basic parameters of coverage or funding for 2017 or 2018 would be extraordinarily destabilizing for insurers and consumers alike and likely lead to withdrawal from many markets.

Plans to repeal major elements of the ACA, with a transition period to be determined and replacement legislation to be developed at a later date raise a key question: Will this plan of action create such great uncertainty in the market that it will trigger large withdrawals even before a replacement bill is enacted, and put coverage for millions of people in jeopardy? Health plans and state regulatory agencies must soon make decisions on policies and rates for 2018 and need to know what operating rules and funding will be in place for that year. Consumers and caregivers also need clear expectations and information about available options; changes can be extremely disruptive if not communicated clearly and well in advance.

While there are multiple ways to alter the mechanisms for providing health coverage during a transition period, a guiding principle for reforms should be that individuals and families should not lose coverage. Early steps to adopt a "stabilization agenda" for the next several years could help to avoid large scale market withdrawal and loss of coverage. To stabilize the market in the short term and ensure a smooth transition period, legislation that repeals or modifies components of the ACA must include the following core elements:

- Adequate funding
- Stable risk pool
- Affordability

Adequate funding:

1. Continued funding of premium tax credits and cost-sharing reduction subsidies is key. Without this financial support, most individuals would not be able to afford health insurance and health plans would be unable to continue coverage. No step is more important in reducing market uncertainty than signaling that both subsidies will continue through a transition period.

2. Reinsurance is a well-established mechanism to protect against unanticipated losses and has worked effectively for exchange coverage and in other contexts. Reinsurance obligations for 2016 should be fully paid and the program should be extended for 2017 and beyond.

3. In addition, plans undertook coverage obligations in the understanding that no plans would gain excessive margins from exchange business nor suffer excessive losses; non-payment of the government's risk corridor obligations – again, a well-established mechanism used in Medicare Part D – cost plans millions or tens of millions of dollars. These obligations should be paid.

Stable risk pool:

1. Continuous coverage is critical – and plans have shown that individuals who maintain coverage show significant improvements in their risk profile in relatively short periods of time. Both expanded pre-enrollment verification of eligibility for special enrollment periods and further narrowing of special enrollment exemptions are warranted, as are steps to reduce gaming of grace periods, non-payment of premiums, and cancellations/re-enrollments.

2. If insurance reforms are maintained, as they should be, new steps to strengthen enrollment are necessary. Especially in the absence of a tax on individuals who do not enroll, health plans should be authorized to offer incentives for enrollment and those should be paired with 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).

3. Risk adjustment allows health plans to offer affordable coverage to more complex patients and also serves to level the playing field among plans. Current risk adjustment methodology requires risk scores to be calculated based on a statewide risk pool rather than on the basis of each market area. This can adversely affect plans offering coverage in only a portion of the state. States should have the option of establishing a statewide v. market area risk pool for the individual market and for the small group market.

4. Health plans should have greater flexibility in designing coverage, but any changes in benefit packages and other coverage requirements should be designed with the expectation that health plans will continue to manage risk and accept all enrollees.

5. States should have the option to extend non-compliant plans during the transition.

Affordability:

1. Higher taxes likely have discouraged employers from offering coverage and are a significant factor in raising out-of-pocket costs. The premium or health insurance tax should be repealed permanently and the tax on high-cost plans ("Cadillac tax") should be revised to be more equitable or repealed.

2. If high-cost risk pools or other risk mitigation strategies chosen by states are included in reforms, adequate and broad-based funding to meet needs is essential. High-cost risk pools should not exclude patients for pre-existing conditions or impose waiting periods except as necessary to prevent gaming. Premiums should be at standard market levels.

3. Government policy should encourage and support innovations in benefit design to encourage value-based treatment, patient-centered care, and use of telehealth-based services and other technologies that increase access and efficiency and meet patient expectations.

ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

Recommendations on Health Care Reforms

As policymakers consider changes to the Affordable Care Act (ACA), the Alliance of Community Health Plans 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 Financial Support

Without adequate federal financial support, 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

Congress should 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. Allow State Coverage Flexibility

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. 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. Authorize Automatic Enrollment

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. Allow Risk Mitigation Options

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. Revise Risk Adjustment Model

The current budget neutral approach to risk adjustment 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.

9. Maintain State Insurance Regulation

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.

The Medicaid Market in the United States

- Medicaid provides for the health care needs of one in five Americans or 74 million people, and more than 75 percent of them are enrolled in managed care plans.

- As leaders in delivering high quality, affordable coverage and care across 27 states and the District of Columbia, ACHP's member plans have a long record of improving the health of their communities. States that have expanded Medicaid are improving the delivery and financing of health care in measurable ways, and ACHP member plans are at the forefront of those innovations and improvements in care.

- ACHP supports the maintenance of fundamental, comprehensive benefits that are clinically informed and meet the needs of the population, including prenatal care, mental health services and substance abuse treatment.

  - Medicaid is a major payer of both behavioral health coverage and substance abuse treatment and prevention. This population requires extensive care coordination, which ACHP plans provide.
  - **Continuous Coverage is Cost Effective:** An average monthly medical expenditure for an adult enrolled in Medicaid for 12 months is approximately two-thirds the level of a person enrolled for six months and half the cost of a person enrolled for one month.

Medicaid Financing

- Financing of the Medicaid program must account for pressures on spending at the state level and payment rates to providers and plans must be actuarially sound and sufficient to ensure beneficiary access to the full range of health care services.
- Medicaid's rate of growth in spending per enrollee has been comparable to or lower than that of Medicare and private insurance since the early 1990s, and it is projected to be lower than that of Medicare and private insurance in the future.
- Per enrollee spending caps that limit growth to medical inflation will not account for state level spending challenges including:

  - The aging of the population
  - Changes to Medicare cost sharing for beneficiaries dually eligible for Medicare and Medicaid
  - Public health epidemics
  - The unsustainable rise in prescription drug prices

- Network adequacy rules must focus on access as well as timeliness, quality of care, clinical outcomes and patient satisfaction.

What This All Means: The Medicaid program needs a sustained and clear focus on paying for quality at both the state and federal levels. ACHP supports consistent and coordinated reporting requirements and the standardization of quality measures. Medicaid quality measures should be relevant to the Medicaid population and used by the Health Effectiveness Data and Information Set (HEDIS) or Consumer Assessment of Healthcare Providers and Systems (CAHPS).