Affordable Care Act
Repeal and Replace:

Proposals to Aid the Transition to a
more Sustainable, Value-Driven System

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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AFFORDABLE CARE ACT REPEAL AND REPLACE:
PROPOSALS TO AID THE TRANSITION TO A MORE SUSTAINABLE, VALUE-DRIVEN SYSTEM

Why Health Care Reforms Must Emphasize Market Stabilization And Cost Containment Solutions

The Council for Affordable Health Coverage (CAHC) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, biopharmaceutical manufacturers, insurers, brokers and agents, patient groups, and physician organizations.

The following proposals address the need for insurance market stabilization and longer-term health care reform and are intended to facilitate further discussion and policy development. These comments reflect the proposals and positions of CAHC, but may not necessarily reflect the individual views of our members.

Executive Summary

The Patient Protection and Affordable Care Act (ACA) made massive changes to health markets – some positive and some negative. It created new consumer protections, corrected some market imbalances, and reduced the number of uninsured Americans to historic lows. The program has been rife with political controversy and programmatic challenges, however. While many Americans with significant health needs or lower incomes have greater access to coverage now, the reality is that for millions of others, health coverage is less affordable and more out of reach than when the ACA was enacted seven years ago. Overregulation, mandates, taxes and fees have contributed to high and growing health insurance premiums, marked by average double-digit price increases for exchange plans. Because of these problems, insurers are exiting marketplaces throughout the country, reducing competition and contributing to a seriously unbalanced and expensive risk pool where consumers have fewer choices. This is leading to a vicious cycle causing healthy consumers to abandon the exchange markets where they are desperately needed to hold coverage costs down over the long-term.

For the second time in less than a decade, Americans now face a major fight over health care reform. President Donald J. Trump and Republican congressional leaders have pledged to immediately work to repeal President Barack Obama's controversial health system overhaul and replace it with a more flexible, market-driven approach. This holds great promise to correct mistakes in the law that have led to market instability and higher costs. If replacement efforts are not coupled with immediate stabilization efforts, however, markets will continue to deteriorate and the loss of coverage for millions of enrollees will be severe.

CAHC supports efforts to create a more sustainable health system through reforms that will help increase competition, improve access, foster and expand informed consumer choice, promote value, and empower consumers. Congress and the Administration should work aggressively to stabilize and improve risk pools, expand and enhance competition and consumer choice, and reduce statutory and regulatory burdens. Perhaps most importantly, decision makers should heed the threat posed by rising health costs. We support long-term policies that will rein in the growth of health costs to meet that of general wage growth, so that working Americans can again afford their health coverage.

The following proposals will help meet these goals:

- ***Stabilize markets.*** The ACA risk pools are unbalanced and reflect the higher costs of care for people who were not able to purchase coverage prior to enactment of the law. While there are many policies that can help improve risk pools, there is a strong need in both the short- and long-term to provide funding to states that will help mitigate risk posed by the highest cost enrollees. Additionally, Congress must fund any mandates imposed on insurers, such as subsidizing cost sharing for lower income individuals (via Cost-Sharing Reduction (CSR) requirements) or there will be more market withdrawals and significantly greater premium increases in 2018 and beyond. These resources should be made available as soon as possible in 2017.

- ***Cultivate healthy risk pools.*** Younger, healthier consumers have lower enrollment rates than expected because they often find exchange plans to be too expensive compared to the benefits they provide. The resulting older, sicker risk pool has caused premiums to skyrocket, further dissuading younger, healthier consumers from enrolling in coverage. Congress and the Administration should enact policies to reverse this trend, including:
    - ***Creating strong continuous coverage incentives.***
    - ***Expanding age rating bands.***
    - ***Expanding avenues for enrollment.***
    - ***Allowing insurers on the individual market to provide incentives for healthy behavior.***
- ***Empower consumers.*** The ACA and many of the rules regarding it have both dramatically increased cost-sharing requirements and hampered the use of consumer-driven health products (CDHPs), including Health Savings Accounts (HSAs)and Flexible Spending Accounts (FSAs), which consumers rely on to manage out-of-pocket costs. In addition, the ACA created a monopoly on where consumers can buy coverage with their subsidies. The ACA further mandates the types of products available for purchase that are laden with requirements, which drive up costs. Consumers should be free to use their subsidies off exchanges and for products they want and need, including account-based plans. Tools to enable transparent markets that foster informed decision-making should be widely available for the evaluation of plan and provider choices.
- ***Reduce, reform, and eliminate regulatory burdens.*** The overly restrictive requirements for qualified health plans limit the number of tools available to keep premiums low and cost sharing manageable. This is stifling innovation and prevents insurers from tailoring plans to meet diverse consumer needs. Special enrollment periods (SEPs), grace periods for premium payment, and allowing third parties to pay premiums have all destabilized the market. Additionally, numerous taxes, fees, and regulations are leading to higher costs for consumers – both individuals and employers. These policies can and should be reversed quickly.
- ***Enable state decision-making and flexibility.*** Congress and the Administration should allow for more state flexibility and innovation when it comes to designing their health care markets. This can be accomplished through expanding and reforming the use of waivers in regards to the ACA and other programs, as well as reverting insurance regulation back to state rather than federal control.
- ***Support the employer market.*** Employers serve as the largest purchasers of health care services and coverage in this country, and they are leading the way in innovation and the shift toward value in the private market. The ACA saddled employers with regulatory burdens and new taxes. Policy makers should, first and foremost, "do no harm" by protecting aspects of the market that are working well and leading to innovation in coverage and cost-containment, but they should rescind policies that undermine the system and hamper innovation.

At a much more fundamental level, Congress and the Administration should shift focus to addressing the growing long-term challenge of rising health costs. During President Obama's eight years in office, the cost for coverage of a typical family of four is estimated to have ballooned by 54 percent, far outpacing increases in average wages.[1] [2] The typical worker thus spends more and more of each paycheck on health care, taking home less and less. Failure to address this issue will lead to ever-increasing premiums and out-of-pocket costs for Americans and will likely result in continued upheaval and political discord around health policy.

While the policies presented here by no means represent a comprehensive set of solutions, they will help to stabilize and improve markets in the short- and medium-term while shifting the long-term focus of health reform appropriately toward cost-containment and a more sustainable future.

Introduction

CAHC is concerned that health costs are too high and rising too fast. In fact, costs continue to rise faster than the economy, while premiums are increasing significantly faster than wages.[3] Thus, even with substantial financial assistance and new marketplace protections, recent reports show that many exchange enrollees are devoting 25 percent of their incomes to health costs and one in five individuals with qualified health plans still can't afford their medical bills.[4] [5] This problem must be addressed.

If premiums and cost-sharing were decreasing or even stabilizing, support to repeal the ACA would be limited. The reality is the opposite, however, with average premiums and deductibles increasing by double-digits. While the ACA focused on coverage expansion and access, it failed to significantly address the key contributor to rising premiums – unsustainable medical costs. Should Congress once again fail to bring costs down, Republicans may pay the same political price Democrats have.

The 2016 elections gave control of both houses of Congress and the Presidency to Republicans – making repealing, reforming, and replacing major aspects of the ACA a very real possibility.

Congress and the Administration face a monumental task – they must retain and improve upon the ACA's successes, correct aspects that are leading to market deterioration, and make advances toward long-term sustainability. If reform and replacement policies are unable to meet these objectives, we predict continued widespread dissatisfaction and frustration from consumers. To avoid this, Congress and the Administration must work aggressively to stabilize and improve markets in the short- and medium-term and shift focus toward bending the medical cost curve over the long-term.

CAHC offers the following policies to assist in this process. We have focused on those changes that will create a more stable market and foster a more sustainable health system. The policies presented here do not represent a comprehensive set of reforms, but we believe these reforms can help to stabilize and improve markets, inject greater competition, choice, and value into the marketplace, and help lead us to a more sustainable system in the future.

Current State of the Marketplace

The individual market is currently struggling and rapidly deteriorating rapidly. The ACA's major reforms targeted this market, which helped many Americans gain access to coverage. At the same time, these reforms have contributed to millions of consumers facing higher costs, reduced choices, and uncertain coverage. Separately, the ACA imposed policies that negatively impact the employer market and should be reversed with additional flexibility added in to ensure that the vast majority of non-elderly Americans maintain appropriate coverage and access to care as the following statistics illustrate:

Individual Market

- For 2017, average premiums for the subsidy-benchmarked Silver plans will increase by 25 percent for the 39 states using HealthCare.gov as their marketplace.[6] In many areas around the country, premiums are going up by much more. For example, Arizona has seen a 116 percent increase in premiums for these plans.[7]
- Deductibles, copayments, and coinsurance are also rising by double-digits. Silver plan deductibles are increasing by 15 percent on average for 2017.[8] Families enrolled in these plans will have average deductibles of nearly $7,500 while families enrolled in Bronze plans will face average deductibles of an eye-popping $12,393.[9] This means that Bronze level deductibles equal nearly a quarter of a typical family's income.[10]
- Plan choice and competition have declined. Insurers' losses in the individual market eclipsed gains by $5.2 billion in 2015, more than twice the 2014 deficit of $2.2 billion.[11] While some larger companies may be able to sustain such losses for a short time, this is not sustainable over the long-term and does not bode well for the future viability of exchange markets. This is evident in the collapse of nearly all the CO-OPs over the past two years and the withdrawal of 83 issuers in markets across the country.[12] As a result, approximately 21 percent of consumers will only have one health issuer to "choose" from next year.[13]

- The exchange risk pools are ailing.
  - Total ACA insurance exchange enrollment is projected to be approximately 10 million by the end of 2016, which is less than half of the original estimations from the Congressional Budget Office (CBO) at the time of enactment. [14] [15]
  - Roughly half of exchange enrollees were originally projected to be under age 35, but only 37 percent of 2016 enrollees are in that age bracket.[16] The exchanges have only around 65 percent of the number of individuals aged 18-34 needed to keep markets healthy.[17] [18]

Employer Market

While premiums in the employer market (where the vast majority of non-elderly people receive their coverage) have remained relatively stable compared to the individual market, costs are still rising more than twice as fast as wages. [19] [20] [21] This is largely due to rapid increases in the cost for medical services. In fact, these rising costs are a primary contributor to premium growth, and as costs continue to outpace economic growth, it makes coverage less affordable and more out of reach for millions of Americans.[22]

The ACA massively accelerated cost-shifting toward employees and their families largely due to the 40 percent excise tax on cost plans. This tax was meant to disincentivize what Congress decided were overly generous plans. This inflexible, blunt instrument – also known as the "Cadillac Tax" – has a myriad of problems in its design and implementation.

The Cadillac Tax is currently designed so that 68 percent of large employers, where most working age adults are employed and receive coverage, would offer at least one plan that would be subject to the tax.[23] To prevent running up against the excise tax's threshold, employers have been forced to shift costs onto employees and provide skimpier coverage.[24] While this cost-shifting can help avoid the excise tax, it has done little to reduce overall costs for coverage.[25]

The tax also unfairly targets employers that operate in areas of the country with higher medical costs, a higher number of workers with chronic or serious conditions, those with larger families, or those who operate in fields with higher medical expenses such as manufacturing. The excise tax further erroneously inhibits the use of tools to help contain costs (*e.g.* HSAs) and maintain health (*e.g.* employee wellness programs).

Put simply, the current insurance marketplace is in peril, and consumers face significant uncertainty and insecurity in their coverage. Immediate action must be taken to stabilize markets and improve them in future years.

Longer-term system reforms should be paired with short-term stabilization and relief policies in early 2017 or the employer market will further weaken and the individual market may largely cease to exist entirely. Both Congress and the Administration can and should take immediate steps to avoid this looming disaster.

Policy Proposals

CAHC advocates for Congress and the Administration to enact the following reforms to stabilize markets, cultivate healthy risk pools, empower consumers, reduce regulatory burdens, enable state flexibility, and support the employer market. Enacting such reforms will help meet diverse consumer needs while also putting the health system on a more sustainable path.

STABILIZE AND IMPROVE RISK POOLS

Premiums and cost-sharing have increased significantly for plans available through the insurance exchanges as the enrollee risk pool has turned out to be smaller, sicker, and older than initially expected. One of the most effective ways to lower premiums is by broadening and improving the risk pool. Only about half of those eligible have enrolled in ACA exchange plans, reflecting a lack of consumer enthusiasm for the plans found there.[26] Greater participation rates – particularly by younger, healthier enrollees – would lower average costs for everyone by spreading risk across a larger population.

Preserving and improving the integrity of the risk pool while incentivizing targeted outreach efforts to better attract greater participation in marketplaces is essential to longer-term market reforms, insurer participation, and consumer options.

Legislative

a. ***Appropriate funding for CSR subsidies***. The ACA reduces cost-sharing expenses that would otherwise be imposed by insurers through a subsidy program to people making less than 250 percent of the Federal Poverty Level. The ACA requires insurers to provide coverage with reduced cost-sharing for eligible enrollees, and then stipulates that the Department of Health and Human Services (HHS) will make periodic and timely payments to insurers equal to the value of the reductions. Importantly, the ACA does not designate a source of funds, nor does it specifically appropriate money for CSRs. Congress has never appropriated these funds, and insurers are now facing an unfunded mandate that is not sustainable.

   Insurers priced plans and entered markets based on an understanding that CSR payments will be made. In thinking through whether to participate in 2018 markets, plans are looking to Congress to provide relief from or fund CSR requirements. If this does not in happen 2017, considerably more plans will withdraw from markets. Those who remain will increase premiums to cover the costs of the missing CSR payments. Rising premiums will increase taxpayer costs and further dissuade consumers from the market, making it less likely that a robust and thriving market will be able to handle additional reforms in 2019 and beyond. **To support long-term sustainability, Congress should fund CSR payments at around $4 billion annually early in 2017 as part of the transition to a more competitive market.**[27]

b. ***Protect cost, sick enrollees through risk stabilization pools.*** Starting in 2017, adequate funding for states should be provided to establish pools to help stabilize markets and ensure that high-cost consumers can continue to access affordable and appropriate coverage. Health care utilization and spending is highly concentrated among a small percentage of individuals, which skews risk pools dramatically when large numbers of healthy individuals forego coverage. Nationally, just one percent of individuals generate nearly a quarter of all health expenditures while five percent generate around 50 percent.[28] There is an immediate and long-term need to shore up risk pools through such stabilization pools by mitigating the impact of the relatively few who need the most care.

   States should have flexibility in how funding for these pools is used. For example, states could choose to provide assistance seamlessly to carriers to help mitigate risks associated with covering cost enrollees. Consumers would experience no disruption or change in their coverage with such a policy, as the pool funding would take place on the back end. Alaska adopted such a model using state funds to prevent the collapse of its exchange market where just 2.1 percent of the 23,000 exchange enrollees accounted for $53 million in annual health costs.[29] This means that nearly a third of 2016 exchange enrollees would have to pay a full year's worth of benchmark premiums without incurring medical claims to cover the costs of the 2.1 percent of cost enrollees.[30] Rates in the state stabilized because of the program. Premium increases in 2017 were seven percent compared to the estimated 43 percent increase without it.[31] **This type of program could be quickly established across the country for plan year 2018.**

   States could also elect to establish a separate pool administered by private insurers for consumers whose health needs meet a certain risk profile (as identified by providers). Such a pool could be designed for consumers with major medical issues and could help them to maintain access to appropriate care, manage their conditions, and prevent complications. Additionally, this type of pool could also serve as a back-stop for any areas where a plan might not be available. Segregating high risk can improve the relative risk of other insurance pools in a state, leading to lower premiums and higher enrollment.

   Financing the high risk pools via premium surcharges would undermine the market structures and drive up premiums. We discourage their use. Further, there will likely be an ongoing need for risk stabilization. **CAHC believes such programs should have dedicated and continued funding streams after the initial transition period. Congress should make federal funds available for these efforts as soon as possible. Funding must be maintained at an adequate level to make the pools workable. CAHC estimates that $30 billion in federal funds over three years will be need to both fund these stabilization pools.**[32]

c. ***Shorten grace periods.*** Some evidence suggests that a number of consumers are gaming the system by stopping premium payments without losing coverage.[33] This drives up costs for everyone else. Under the ACA, enrollees using subsidies to obtain coverage have a 90-day grace period where coverage cannot be rescinded for failure to pay premiums as long as coverage was initially effectuated. A disproportionate number of enrollees are halting premium payments toward the end of the year, yet a majority of individuals who cease to pay premiums enroll in coverage during the new open enrollment period.[34] The current policy is highly problematic for both insurers and providers for obvious reasons.

The current 90-day grace period is problematic because it allows some enrollees to game the system. Enrollees can stop paying their monthly premiums for 90 days without being held liable for claims while insurers are only responsible for claims for the first 30 days – even if enrollees continue to obtain care throughout the 90-day period. **Beginning in 2017, CAHC believes the grace period timeframe should be shortened to 30 days and enrollees should be required to pay any outstanding premiums before they can enroll in coverage for another plan year.**

d. ***Incentivize and make viable continuous health coverage.*** Republicans policy makers have indicated that the individual mandate is a top target of repeal efforts while guaranteed issue and community rating are likely to remain. The rationale behind instituting a mandate is that major medical insurance comes with significant annual costs while healthy people generally utilize few medical services, making it highly likely that in a guaranteed issue world, healthy people would forego coverage until they get sick. Without strong incentives to obtain and maintain coverage, individuals would also be incentivized to enroll in and drop coverage based on their fluctuating individual care needs. This severely harms risk pools and drives up costs.

New York provides a case study where market rules similar to those found in the ACA (guaranteed issue, community rating, and a standardized benefit package) were instituted without incentives to obtain or maintain coverage. As a result, premiums tripled from 2001-2010 and fewer people were enrolled in coverage after enactment of the reforms.[35] Kentucky and Washington enacted similar policies in the 1990s but had to reverse them as insurers fled the individual market.[36]

Even with the individual mandate, enrollment of young and healthy individuals has been much lower than what is needed for a healthy risk pool. If the mandate is repealed, however, the current state of the market will drastically worsen. In light of this, **Congress must create stronger incentives and avenues for obtaining and maintaining coverage to prevent severe and rapid deterioration of the individual market. There are two critical primary features that should be included in any coverage incentive:**

1. **Strong incentives for continuous coverage.** Insurers should be required to extend coverage on a guaranteed issue and community rated basis to consumers who have responsibly maintained coverage. **Insurers should be granted the flexibility to impose waiting periods, increase premiums, restrict benefit options, and temporarily limit coverage of preexisting conditions for those who have not maintained continuous coverage.**

2. **Long-term risk stabilization.** The cost to acquire health insurance must be low enough for generally healthy individuals to justify purchasing it. This is difficult to do without large subsidization, adjustments for health status, or long-term risk mitigation mechanisms.

   Health costs are highly concentrated among a small number of individuals that utilize a disproportionate amount of care. The cost of this care is excessive, and there are few tools to curtail it since many, if not most, of these individuals reach their out-of-pocket maximums in any given year. This is an untenable situation. Without at least partially shielding the broader population from the health costs of those requiring the most care, premiums may never be justifiable for some of the youngest and healthiest – particularly since they often have lower incomes.

   There is a clear need to rely on market forces to foster efficiencies and quality in the system, but there is also a strong role for government to help distribute risk for the small number of individuals who incur exorbitant costs in any given year. **Short- and long-term risk stabilization pools are needed to foster a well-functioning market.**

These policies are fundamental to incentivize and make possible for individuals. **There are additional policies that Congress should consider, however. This include enacting a mix of penalties and rewards to provide adequate incentives for continuous coverage**, including through:

- Allowing insurers to impose late enrollment penalties (as in Medicare Part B and Part D) on enrollees who have not maintained continuous coverage. The penalties could be phased out over two to three years so long as the individual maintains coverage.
- Allowing plans to provide premium discounts or cost-sharing assistance for individuals who maintain continuous coverage over a set period-of-time.
- Shortening open enrollment periods to align more closely with those in the Medicare program.
- Increasing the time between open enrollment periods to occur every two (or more) years and couple them with similar plan-year cycles. Only individuals prospectively qualifying for an SEP could enroll in coverage outside the enrollment periods.

When considering continuous coverage options, CAHC advises that a balance must be struck between providing strong incentives for continuous coverage for healthy individuals and avoiding sticks so strong that they keep people out of markets – particularly those that could improve the risk pool over time.

CAHC urges Congress to adopt continuous coverage provisions prior to any removal or relaxation of the individual mandate.

e. ***Make coverage more affordable for younger enrollees while maintaining access for everyone.*** Exchange marketplaces have failed to attract the number of younger individuals needed for risk pool stability. This is primarily due to the cost of premiums on the exchanges. Young adults are highly cost sensitive when it comes to insurance, since they tend to have lower incomes compared with older adults while facing fewer medical costs. By and large, younger people do not find exchange plans to be worth the cost even when they are eligible for subsidies and face a tax penalty for forgoing coverage. In fact, nearly half of the younger uninsured said they did not see value in health insurance while two-thirds cited cost concerns as their rationale for foregoing care.[37]

Part of the reason younger people find exchange plans unaffordable is due to strict rating bands favoring older enrollees. The ACA imposes a 3:1 rating band, even though 64-year-olds use, on average, six times as much health care as 19-year-olds. This limited band forces most young enrollees to pay considerably more than the cost of their own care, increasing premiums for enrollees aged 21-29 by 42 percent.[38] [39] This policy has heavily impacted enrollment as only 37% of the pool includes enrollees under age 35. If all eligible individuals enrolled in coverage, those under 35 would make up roughly half of the individual market.[40]

In 2016, the House Energy and Commerce Committee held a hearing on legislation to provide states with the flexibility to decide the rating ratio (where 42 states used a 5:1 or greater age-rating band prior to enactment of the ACA) or, if a state failed to make a determination, default to a 5:1 ratio.[41] **CAHC supports this measure and calls for its adoption in 2017, as it would significantly lower premiums for younger enrollees, which could help improve the risk pool and lower premiums for all consumers in the long-run.** At the same time, policy makers must help older enrollees obtain needed care when other coverage options are not available.

CAHC strongly believes advanceable subsidies should continue to be available to assist individuals in obtaining coverage on the individual market. Policy makers have suggested a variety of forms subsidies could take, including basing tax credits on income or age or by providing a flat dollar subsidy. **CAHC could support many different subsidy structures, but it is vital that Congress meets the following criteria in any design:**

- **Provide sufficient subsidies to attract the requisite number of individuals in the under 35 age bracket to enroll in coverage, creating a healthy and sustainable risk pool;**
- **Ensure that subsidy levels are adequate for older enrollees to access coverage; and**
- **Be relatively simple to administer and easy for consumers to use and understand.**

The existing federal data hub, which cross-index applications and consumer information with data from multiple governmental agencies as a mechanism to help determine eligibility for subsidies, provides a vital tool for the implementation of any subsidy mechanism. **CAHC strongly urges Congress and the Administration to maintain this system.** Further, Congress should retain and improve the effectiveness of the federal data hub as a resource for all states, private payers, public and private insurance exchanges, and web-broker entities (WBEs) to verify eligibility and prevent fraud and abuse of taxpayer premium subsidies and other governmental resources.

If subsidy amounts are pegged and designed correctly, CAHC believes that coupling this structure with a 5:1 age-rating band could offer optimal conditions to attract younger consumers while still providing necessary assistance for older enrollees who likely need more care. This could help lower premiums for everyone without sacrificing access.

We further support administrative simplicity as a glide path toward subsidy portability. Finally, we believe a structure that is easier to understand and predict on the part of consumers would help promote enrollment. CAHC would be supportive of any subsidy structure striking such a balance.

Administrative

a. ***Implement pre-enrollment verification for SEPs.*** Determination of eligibility for a SEP is currently retroactive since individuals can obtain coverage before they have proven their eligibility. As a result, ineligible individuals have been able to generate significant claims costs before HHS completes the verification process to determine whether coverage was appropriately obtained through the SEP. This is concerning because claims costs for SEP enrollees are higher, on average. According to the Blue Cross and Blue Shield Association, "individuals enrolled through SEPs are utilizing up to 55 percent more services than their open enrollment counterparts."[42] Furthermore, in their first month of coverage alone, SEP enrollees were much more likely to generate large claims in 2015 than traditional enrollees.[43] As a result, plans can be exposed to millions of dollars in inappropriate claims. Once claims are paid for an individual, it is both unlikely and costly to recoup those funds, even if consumer ineligibility or fraud is determined later. Due to HHS rules, legitimate premium-paying customers bear the costs for ineligible SEP enrollees.

   Rather than retroactive determination of eligibility, applicants should have prospective eligibility determinations before they are allowed to enroll via SEPs. Since consumer access may be a concern in regards to prospective enrollment, plans should be required to retroactively cover claims for eligible individuals dating back to the SEP application. This change should happen in 2017.

b. ***Prohibit third-party payments by providers or other entities to help consumers enroll in coverage.*** Hospitals and other healthcare providers, as well as additional commercial entities, frequently support premium payments for consumers receiving their care. Many enrollees receiving this assistance have high health care needs. There are significant concerns (even from HHS) that this could skew risk pools and further contribute to unbalanced marketplaces. Insurers have cited third-party payments as a reason for losses on exchanges, which has contributed to market exits.

   HHS has long recognized this as a problem. Former Centers for Medicare and Medicaid Services Administrator, Andy Slavitt, has said, "These actions can limit benefits for those who need them, potentially result in greater costs to patients, and ultimately increase the cost of marketplace coverage for everyone."[44] **While HHS has asked for requests for comment on the practice, discouraged its use, and considered curtailing the practice, it has not prohibited it. CAHC encourages them to do so immediately.**

c. ***Create additional pathways for consumer enrollment.*** Consumers face numerous decisions and complexities when determining coverage needs and evaluating available options. Consumers who use an agent, broker, or issuer learn about options and help with coverage decisions in an online format – also known as web-broker entities WBEs – are currently required to leave the WBE site, complete an eligibility determination on the Federally-Facilitated Exchange (FFE), and then return to the agent or broker's site to complete the enrollment process. This so-called "double redirect" serves no consumer-focused purpose and results in significant enrollment attrition. The confusing and convoluted process may also lead many consumers to believe they have completed enrollment even if they have not. Case studies have estimated that 69 percent of consumers facing the double redirect fail to complete eligibility determination and enrollment.[45]

Prior to March 2016, agents and brokers could enroll consumers in coverage on their websites using the Direct Enrollment Pathway (DEP) where consumers could complete the standard, uniform FFE eligibility application directly on the WBE's site. This process could take place at consumers' convenience and on their own computers. The DEP was developed as an alternative to the Marketplace Pathway (through which an agent or broker assists consumers while they directly log onto the consumer's account on HealthCare.gov), which generally must be done in-person. The risks of incorrectly completing an application through a DEP are no greater than those faced by consumers solely using HealthCare.gov since the DEP requires the use of language identical to that found on the FFE application.[46] However, recent HHS guidance has effectively eliminated the DEP as an online enrollment option by prohibiting WBEs from utilizing eligibility applications on their websites, however.[47]

The next plan year would be positively impacted by the reinstatement of the DEP as enrollment rates through these avenues would likely considerably increase. The ruling prohibiting the DEP should be reversed immediately, and WBEs should be able enroll consumers and host eligibility applications on their websites without the double redirect. The increased enrollment likely to result from this change can help to shore up risk pools.

EXPAND AND ENHANCE COMPETITION AND CONSUMER CHOICE

Plan choice and competition have declined under the ACA. Estimates indicate that more than one-third of consumers have just one issuer option on exchanges.[48] The ACA has significantly limited the types of plans available to consumers by restricting plan design and limiting subsidies to plans sold on public exchange markets. Some states have further reduced choices by disallowing any plan design variation and/or prohibiting the sale of plans outside public exchanges. Overly restricting plan design flexibility and choice limits the pool of consumers who may want to purchase coverage. It also hinders efforts to negotiate provider payment rates to lower costs for consumers. CBO has estimated that the essential health benefits (EHB), actuarial value (AV), and guaranteed issue requirements, alone, drive up costs by 27 to 30 percent.[49]

Both premiums and out-of-pocket costs are on the rise, and the ACA has tied consumers' hands in their ability to utilize tax-preferred health accounts to cover these costs. This problem is confounded by the fact that in the current market, tools are inconsistently available to assist consumers in their decision-making about quality, cost, and coverage. At the same time, data that could power tools to provide consumers with information about lower cost or higher quality providers is largely inaccessible. This suppresses enrollment and leads to suboptimal plan selection, inhibiting access to care.

This lack of information and consumer tools can harm consumers in the current environment. If such tools and information are made available, they hold promise for helping to bend the cost curve over time as consumers become empowered to make informed decisions about health care utilization.

Policies that seek to curb rising costs primarily through shifting these costs to patients and one-size fits all designs without added consumer tools will be ineffective. Innovations in benefit design and delivery have immense potential to bend the cost curve by shifting our system to one based on value rather than volume and by changing the way we pay for and provide care.

Innovative benefit designs include benefit or payment structures that vary by patient condition, efficacy, or provider quality as well as incentives to encourage healthy behaviors. While there has been some early adoption and experimentation with these designs, particularly in the employer market, they remain widely underutilized, largely due to a hostile statutory and regulatory environment that inhibits, rather than fosters innovation.

More flexibility and informed choice will help lower costs through expanded competition. Facilitating the development of and access to innovative products and tools that allow consumers to make better, more informed choices about health coverage and care will do more to lower costs and improve access than adding additional restrictions and requirements. Governmental policies that prevent the proliferation of and access to innovation in benefit design and delivery should be reformed or rescinded.

Legislative

a. *Provide subsidy portability.* Consumers can only access tax subsidies and credits for insurance coverage through publicly run exchanges even though on- and off-exchange markets must have a unified risk pool for premium setting. This policy not only distorts the markets and limits consumer choice, but it also prevents innovative practices in the private sector from reaching many consumers.

Total reliance on public exchanges and enrollment efforts have proven to be insufficient. The government has clearly struggled to build consistently functioning sites that both inform and ease the plan selection process. Despite the more than $5 billion spent to establish and maintain public exchanges, most have been operating below the state of the art in consumer accessibility and decision-support tools even though these tools are often found in the private sector.[50] [51] Consumers should have more and better options.

Instead of focusing on building websites, the government should concentrate efforts toward building and maintaining the infrastructure to support back-end functionality to link governmental databases with private sector enrollment platforms and insurers. These platforms can help increase enrollment, improve risk pools, and benefit consumer plan selection.

In all states, qualified private exchanges, issuers, and brokers should be able to supplement public exchange alternatives. To do this, Congress should enable all beneficiaries to take their tax credits and subsidies off the exchanges for the purchase of state-approved insurance products. This could spur innovation in the private sector to attract consumers that the current system is missing. It would also mean that marketing decisions and funding would be based, not on political or ideological decisions, but on market-based decisions to spur enrollment. This has the potential to accelerate access and development of innovative tools to aid decision-making, better target and engage consumers, and lower costs for taxpayers.

CAHC urges Congress to remove the on- and off-exchange designation in any replacement efforts to allow both individuals and states to benefit from additional choices and private sector competition and innovation.

b. ***Enable individual market insurers to incentivize healthy behavior.*** Rising rates of disease and disability are driving much of the growth in health spending. This spending is highly concentrated among patients with chronic illnesses – conditions that are long in duration and have no definite cure. About half of all American adults have one or more chronic illness.[52] In 2009, those with chronic conditions accounted for more than 75 percent of the $2.5 trillion spent annually on health care.[53] Most of these conditions can be prevented and improved through lifestyle choices and common preventive measures.

Many factors are driving up health care expenditures, including unhealthy behaviors and non-adherence to treatment. Smoking, use of alcohol, and over-eating, can increase the likelihood that an individual will develop a long list of chronic health conditions, such as heart disease, cancer, stroke, obesity, and diabetes. Similarly, suboptimal or non-adherence to treatment for these conditions leads to worsening health status and expensive complications. This, in turn, increases premiums and costs for the entire system.

Providing rewards to people for engaging in healthy behaviors, meeting health goals, participating in preventive activities, and adhering to treatment regimens (particularly for those at risk of or who currently have a chronic condition) can improve outcomes and lower health costs. This should be encouraged.

Employers have been increasing their investment in these programs for years, with 70 percent of employers offering wellness benefits in 2015.[54] While allowed in the group market, it is against the law, in most instances, for insurers to provide wellness incentives, such as rebates, for individuals who pay for their own health insurance in the individual market. This policy should be reversed. **Congress should grant individual market insurers the ability to reward enrollees for engaging in healthy behavior and for managing their conditions with help from the plan and its network providers.**

CAHC also supports policies that improve treatment adherence to help patients improve outcomes while lowering systemic costs by avoiding unnecessary, expensive hospitalizations and emergency room visits. Poor treatment adherence results in 33 percent to 69 percent of medication-related hospital admissions in our health care system, at a cost of roughly $100 billion per year.[55] **Targeted outreach programs and benefit structures for people with chronic conditions should be permitted in the individual market.**

c. ***Improve and expand the use of consumer-driven health products.*** Congress created these products, like HSAs and FSAs, partly to generate more awareness and control in health consumption while maintaining access to care.

HSAs are savings accounts used to pay for health services and products and available to individuals who are enrolled in high-deductible health plans (HDHPs). With HDHPs, consumers are covered for catastrophic expenses but can utilize tax-free dollars to cover more routine care or accumulate funds to finance infrequent or expensive episodes of care. These mechanisms are likely to lower unnecessary health care utilization without negatively impacting quality or access.[56] In fact, premiums are typically lowest among coverage options for workers.[57] Despite these positive attributes, CHDP use has been hampered by restrictions.

The ACA limited ways that HSAs can be used, which can drive up costs for consumers. The following legislative changes should be made to give consumers greater control over their health care:

- The ACA prohibits individuals from using any remaining premium tax credit for the purchase of qualified health plans to be placed into an HSA. This creates powerful disincentives for consumers to choose lower-cost plans and place any left-over credit into an account for later use. **Congress should allow consumers to use any remaining subsidy credits for HSA contributions.**

- The ACA prohibited the use of HSAs, FSAs, Archer Medical Savings Accounts, and Health Reimbursement Arrangements to purchase or be reimbursed for the purchase of over-the-counter (OTC) medications without a prescription. There are many lower-cost alternatives to prescription drugs available OTC, but the law requires patients who would like to use these tax-preferred mechanisms to either go to their physician for a prescription (where the visit would have to be reimbursed) for the OTC drug or get a prescription for a similar drug covered by insurance. Either scenario drives up costs for the insurer and the patient. **Congress should reverse this policy, and allow patients to use consumer-driven health products for OTC medications.**

- **More flexibility should be given to the types of plans eligible for HSAs to meet more diverse consumer needs.** Anyone facing a chronic condition will likely use all or most of their HSA funds annually with little or no funds to roll over to cover large medical expenses that may be incurred later. CAHC believes that legislative action needs to be taken to allow for broader use of HSAs by individuals facing chronic conditions. Allowing HSA-eligible plans to provide first-dollar coverage for targeted treatments and preventive services that are clinically proven to improve health outcomes and prevent chronic disease progression would maintain appropriate access to necessary care. For example, such a plan could provide diabetic patient with pre-deductible access to test strips, insulin, and diabetic eye exams. This type of health plan design could help improve health, create greater efficiencies, and reduce medical expenses, like hospitalizations or amputations. Reforming these rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits for many enrollees while also potentially reducing costs.

- Cost-sharing generates more awareness of health consumption, which can positively influence consumer behavior. To maintain access to care, lower-income individuals should have access to assistance to cover these obligations, however. Congress should place cost-sharing assistance subsidies directly in the hands of consumers, where they will be empowered to make wiser decisions on their health care utilization.

Administrative

a. *Enhance plan flexibility and consumer choices.* The ACA requires plans to provide guaranteed issue to all eligible consumers while maintaining strict AV and EHB requirements. Both HHS and Congress have contributed to the definition of AV and the metal tiers that plans must meet and that consumers must purchase. These tiers define the generosity of coverage for a particular plan type (all plans must cover the EHB but can cover varying portions of the benefit through cost-sharing) – Bronze, Silver, Gold, and Platinum – and are set at 60, 70, 80, and 90 percent AV, respectively. States have the flexibility to select a limited number of benchmark plans, which often include coverage outside the ten broad statutory EHB requirements. Generally, substitutions for benefits on these benchmark plans can only be made with those that are actuarially equivalent. In some states, all variation is prohibited. The CBO has estimated that these provisions along with guaranteed issue drive up premium costs by 27 to 30 percent[58] **HHS should help reduce the premium impact of these requirements by granting additional flexibility in benefit design.**

Currently, HHS allows a two percent variation in the plan's value around the metal tier AV percentage. For example, a Bronze plan can be as low as 58 percent or as high as 62 percent. To provide additional plan flexibility and consumer choices, **CAHC believes the new Administration should modify the AV requirements to allow greater variation in AV calculation by expanding the threshold of +/- two percent to +/- five percent. For AVs that are between the two five-percent thresholds, the plan would revert to the higher metal tier (e.g**. a plan with an AV calculation of 65 percent would be considered a Silver plan, a plan with an AV of 75 percent would be considered a Gold plan, etc.).

Additionally, greater leeway should be granted toward the design of EHB. The statutory definition of the EHB is narrow, but regulations have significantly increased mandates and restricted benefit design by, among other items, including all state benefit requirements imposed prior to enactment of the ACA in the EHB. These restrictions have limited the types of plans available to consumers and increased costs. **CAHC advocates for a narrower interpretation of the EHB benefit requirements while maintaining policies that prevent further expansion of state mandates.**

b. Encourage greater flexibility in benefit design to help manage conditions and meet diverse consumer needs. The Administration should allow for and incentivize the creation of specialized plans that target and improve care for patients with high-cost conditions such as diabetes, mental health, and other illnesses. Because the exchange population has been shown to have greater medical needs than the general population, specialized plans can help insurers keep enrollees with higher cost conditions healthier, which can lower costs and premiums in a unified risk pool.[59] Current non-discrimination rules may make it difficult for plans to offer such coverage, however. Additionally, these types of plans are not available to consumers in states such as California that prohibit variation from rigid standardized benefit designs. CAHC is extremely concerned that HHS' introduction of standardized plans will also make it more difficult for enrollees to be aware of and access these innovative plans. **CAHC urges the Administration to reform or repeal any policies impeding innovative benefit design.**

c. *Encourage creativity in network design.* Networks have grown increasingly narrow as a key measure to contain costs. This is particularly true in areas where there is an imbalance in market share between insurers and providers. This has become progressively more common as provider networks consolidate and drive up rates. Rural areas are particularly impacted as these areas contain fewer providers, making it difficult to both meet network adequacy standards and to negotiate competitive rates. This results in higher premiums and fewer options for everyone, but particularly for rural consumers.

Over the last several years, state and federal regulators have held insurers to quantitative network design standards (such as time and distance). HealthCare.gov has even begun rating plans based on network breadth alone. This is highly problematic and contradictory to HHS' goal of moving from volume-based reimbursement to a value-based system. Such a rating would provide consumers with no information about the quality of networks and providers, implying that broad networks are better even if the network's providers are lower quality; this creates powerful incentives against innovative network designs. **The Administration should abandon the network breadth rating and develop a method that would inform consumers about network quality not just breadth.**

More flexibility should also be granted to plans in designing networks to meet consumer needs. For instance, we believe the Administration should create standards to include telemedicine services for appropriate provider types (such as behavioral health) as part of network adequacy qualifications. Such a policy could improve patient access, serve as a solution to current provider shortages, help patients stay adherent to treatment, and save costs.

d. ***Eliminate requirements related to standardized plan designs.*** Standardized designs can lead to reduced plan offerings, higher premiums and cost-sharing for certain consumers, and may influence suboptimal plan selection. Beginning in 2016, HHS designed plan offerings where a significant number of benefits were not subject to a deductible. HHS promoted these plans above others on HealthCare.gov, even though they may not have been the most appropriate plan designs for many enrollees. Such designs may unduly influence consumer behavior, further limit the number of tools available to insurers to hold down premiums, and force dramatic increases in cost-sharing for some services to meet maintain AV thresholds. These designs can lead to higher premiums and reductions in access to services for some enrollees.

For the 2018 plan year, the Administration should eliminate standard plans on the FFE as an anti-consumer, cost increasing regulatory measure. HHS should also change current regulations to prohibit state-based exchanges from either requiring plans to offer standardized plans or prohibiting plans that deviate from standard designs. Such policies not only lead to higher costs, but also remove consumer choice.

e. ***Remove the restrictions on short-term medical plans.*** HHS recently defined short-term medical plans as plans that only cover benefits for a period of three months and also prohibited their renewals. Previously, consumers could renew policies to fill in coverage gaps so long as they were enrolled in the plans for less than 12 months. The Administration should reverse the change of the definition of "short-term, limited duration insurance," which seeks to restrict this form of coverage in a misguided attempt to shore up exchange enrollment. Relatively few people enroll in these plans, so reducing enrollment will have minimal impacts on the exchange pool. If not restored, it will, however, take meaningful options away from consumers who rely on short-term coverage for a variety of reasons, which includes having lawful, non-resident immigrant status. Individuals who do not have resident alien status and do not pay taxes are not eligible for subsidies, and it frequently takes longer than three months for individuals seeking this status to achieve it. Additionally, because they cannot sign up for coverage on the individual market outside open enrollment periods, short-term plans may be the only viable option for these individuals to achieve coverage. **HHS should restore the short-term medical plan option for consumers who rely on this coverage and revert back to the previous, longstanding plan definition.** Issuers selling short-term plans should be required to provide clear, consumer-friendly explanations of the differences between major medical and short-term plans to avoid any consumer confusion.

f. ***Align requirements in individual market plans with those for consumer-driven health products.*** ACA implementation has restricted access to and undermined the usage of consumer-driven health products. Most exchange plans are not coupled with HSAs, including standardized plans being offered this year, even when their deductibles are higher than those in HDHPs. Additionally, ACA regulations have imposed new requirements in the market that are undermining HSA utilization.

   The Internal Revenue Service sets upper and lower out-of-pocket limits on HDHPs. Any health plan that has out-of-pocket limits outside this range cannot be coupled with an HSA. These requirements are not aligned with other ACA plan requirements, however, so the number of plans eligible for HSAs is dwindling. For example, out-of-pocket limits for standard individual Bronze and Silver plans for 2017 are $7,150, which is $600 above the $6,550 upper maximum out-of-pocket limit for HSA qualification.[60] [61] For 2017, average annual out-of-pocket maximums for Bronze plans were $6,940 with average deductibles of $6,092.[62] Because of the misalignment in thresholds, individuals enrolled in these polices do not have access to tax-preferred mechanisms that can help cover these high out-of-pocket costs. **CAHC firmly believes that consumers should be allowed to avail themselves of current tax-preferred mechanisms to help them maintain access to coverage in plans with high cost-sharing. The Administration should work to align any requirements for individual market policies with those in consumer-driven health products to facilitate their use.**

PROVIDE RELIEF FROM STATUTORY AND REGULATORY BURDENS

One of the chief shortcomings of the ACA is that it added an enormous layer of complexity to a system that was already too complex. Since enactment, the Administration has issued nearly 20,000 pages of ACA-related regulations in the *Federal Register* with an estimated cost of compliance of $51.7 billion dollars.[63] [64]

Insurance and employer markets have been the most impacted. For example, all plans sold in the individual and small group market are required to submit actuarially-certified justifications for premium increases above a certain threshold, including the portion of the premium increase attributable to each unique benefit category. Other regulations dictate the type and structure of benefit designs. Plans must generally submit duplicative information to both state and federal regulators and additional information is required for some state-based exchanges. Further, the level of profit and administrative expenses that a plan can incur is regulated as a defined percentage of premiums through the Medical Loss Ratio (MLR) – meaning that if administrative costs increase due to regulation, so do premiums.

At the same time, numerous taxes and fees are driving up out-of-pocket costs and premiums in all markets and employers are spending millions of dollars to meet regulatory reporting requirements.

The current system is cumbersome and inefficient and adds to premium growth and higher costs for employers and individuals and families. Congress and the Administration should make reducing the statutory and regulatory burden, streamlining processes, and allowing for more flexibility a high priority.

Legislative

a. ***Rescind taxes that lead to higher costs for consumers.*** There are numerous taxes and fees that are directly passed on to consumers, but provide little or no benefit to them. The ACA's health insurance tax increases premiums by another 2.5 percent or more for most markets with an estimated cost to consumers and taxpayers of $87 billion dollars between 2017 and 2020.[65] [66] Further, plans are assessed a 3.5 percent user fee to operate on HealthCare.gov. Plans who operate in states sold on State-Based Marketplaces using a Federal Platform also have to contribute user fees for HealthCare.gov's operation, and are frequently doubly assessed with their own state-based exchange user fees. All of this contributes to rising premiums.

   In the employer market, the 40 percent excise tax on employer-sponsored insurance is propelling cost-sharing increases.[67] It is estimated that 68 percent of large employers will offer at least one plan that would be subject to the tax.[68] To prevent running up against the excise tax's threshold, employers have been forced to shift costs onto employees and provide skimpier coverage.[69]

   Rescinding, limiting, and/or delaying these and other taxes would have an immediate, tangible impact on both premiums and cost-sharing. Congress should act as soon as possible.

b. ***Streamline reporting requirements.*** The ACA imposed significant new reporting requirements from employers. For instance, to verify compliance with the individual and employer mandates and administer subsidies, current regulations compel employers to collect their employees' and their dependents' personal information every month, including their dates of birth and social security numbers. This not only puts Americans' personally identifiable information at risk, but it has also necessitated millions of dollars of investments and work power.

   These requirements are needlessly complex and create undue burdens and confusion for employers and their employees, driving up the cost of doing business. Further, the reporting does not take place prior to exchange open enrollment, when it could provide more clarity on which individuals are eligible for tax credits. This puts individuals at risk for large tax penalties if they sign up for coverage using subsidies they may not be eligible for. **Congress and the Administration should work to immediately streamline and reduce the burden associated with these requirements and others like them. Further, any reforms to the current subsidy structure or other modifications that will require routine employer reporting should prioritize administrative simplicity and minimize potential employee confusion.**

Administrative

a. ***Delay or add flexibility to insurer filing deadlines and open enrollment for plan year 2018.*** Plans generally need to make decisions about market participation for the next plan year early (generally by February or March) in the current plan year. Because the Administration and Congress may be changing the insurance market rules at that time, **CAHC suggests delaying filing dates when possible and truncating the review process by allowing plans to submit rate and form filings by September 1, 2017, after Congress and the Administration has had more time to act. While states have individual filing deadlines, these are heavily influenced by federal action. We encourage the federal government to work with various states to create similar flexibility in their respective filing deadlines.**

   CAHC also advocates for a delay in the beginning of open enrollment for 2018 to match new deadlines for plan filings. We suggest pushing the start of open enrollment to December 1, 2017, at the earliest. The end of open enrollment could be extended further into 2018 if deemed necessary.

b. ***Modify the MLR to eliminate disincentives to combat fraud and improve plan quality.*** The MLR requirement compels plans to pay out a percentage of every premium dollar in medical or quality costs or pay a rebate to consumers. Under current regulation, money recovered from fraud and abuse initiatives counts as a medical/quality component in an insurer's MLR calculation. While this provision appears to allow insurers to invest in fraud prevention and recovery activities, it creates potentially perverse incentives that run counter to fraud reduction. The current MLR regulation provides an incentive for health plans

to pay out more claims initially to get credit for their fraud detection and recovery activities rather than investing in preventing fraud on the front-end. This is inefficient and ineffective and drives up costs. **The Administration should revise the MLR rules to account for resources used for prospective fraud prevention.**

c. ***Reduce unnecessary regulatory burdens and uncertainty.*** The current regulatory certification process for health plans is cumbersome, complex, and expensive. Prior to enactment of the ACA, health plans were primarily regulated on the state level. Today, plans sold in the individual market are regulated at both the state and federal level, with some state-based exchanges requiring additional requirements and oversight. Duplicative information must often be approved by multiple regulatory bodies – which often provide conflicting guidance or requested changes – over the course of several months. Such a system is highly inefficient and costly with almost no benefit to consumers. Rising administrative costs lead to premium increases, particularly since the percentage of premiums that can go toward administrative expenses, which includes taxes and fees, is capped. **CAHC urges HHS to immediately shift more regulatory power to states by deferring benefit, rate, and network adequacy review.**

Uncertainty in the regulatory environment has also contributed to higher costs and instability in the market. Regulatory uncertainty has been a constant of ACA implementation with both final rule-making and subregulatory guidance changing the rules of the game after market decisions and rate determinations have already been made. This seriously undermines stability and makes it difficult to accurately evaluate markets.

Moreover, guidance concerning key policies that businesses must adapt to well in advance, like implementation of the Cadillac Tax or reporting requirements, has frequently lacked clarity and/or been delayed. This adds to business expenses and makes it difficult for employers to plan ahead.

CAHC urges the new Administration to release rules in a timely manner with adequate notice and opportunities for comment and stakeholder engagement. Additionally, states and issuers should be given sufficient time through the appropriate release of guidance to accommodate any major changes that could impact premiums or market participation.

d. ***Allow for greater state flexibility and innovation.*** The 1332 waiver process has the potential to create innovative pathways for greater efficiencies, cost-containment, and coverage expansion. Through the current statutory requirements, states can waive core provisions of the ACA and experiment with other reforms, including stabilization mechanisms, alterations or eliminations of exchanges, market rules innovation, and coverage maintenance inducements. The 1332 waivers could be used by states to pursue different avenues to improve and enhance their markets and tailor approaches to the unique attributes of each state. However, current regulatory requirements and processes are overly restrictive and significantly limit potential pathways states might otherwise consider.

More flexibility should be added to the 1332 waiver authority, including the potential to combine them with other programmatic waivers. We believe that when considering any reforms to these waivers or evaluating applications, the Administration and Congress must keep core principles and guidelines in mind to avoid unintended negative consequences, including:

- **Achieving a healthier, more balanced risk pool;**
- **Achieving long-term market stabilization;**
- **Expanding and enhancing competition and choice for consumers; and**
- **Reducing inefficiencies and unnecessary compliance burdens for both states and insurers.**

CALL FOR A LONG-TERM FOCUS ON OVERALL HEALTH COST CONTAINMENT

Reforming and stabilizing markets is only one aspect of needed reform for greater sustainability and choice in the future. The majority of premiums and out-of-pocket costs go directly toward medical claims and their associated expenses. We must, therefore, tackle the drivers contributing to increasing medical costs to achieve this goal. While the above policies have the potential to create more efficiencies, increase and enhance consumer choice, and add value, they, alone, will not fundamentally address the challenges currently facing the health care system.

One of the biggest mistakes of the ACA was to incorrectly assume that the market failures present in the health system and the difficulty many individuals and families had with accessing care was simply due to insurance design and practice rather than medical cost drivers. Premiums and cost-sharing have been rising at unsustainable trajectories for decades. While the ACA exacerbated many of the factors driving this trend, it did not cause them. The solution – as some have suggested – is not to simply increase subsidy levels for enrollees as a means of "making health care more affordable." This kind of solution is no solution at all. It will merely serve to shield consumers from cost growth in the short-term rather than addressing the underlying reasons driving the growth.

While there are certainly no easy answers or solutions to addressing cost growth, policy makers must shift the focus from playing around the margins of health care reform to addressing the factors leading to unsustainable cost growth and instability head on. If they are unable to do so, costs will continue to rise nearly four times faster than wages, making coverage less and less affordable for working Americans and cultivating greater political and economic turmoil in the health system.[70]

Numerous policies can help address the underlying factors impacting cost growth, but CAHC advises policy makers to focus on those that add true value to the system by promoting health, injecting real competition into health marketplaces, and empowering consumers – both individuals and employers – through enhanced and informed choice.

PROMOTE PREVENTION

Preventable diseases and complications account for an astronomical amount of health spending annually. According to the Centers for Disease Control and Prevention, more than 75 percent of our health spending is for patients with chronic conditions, which are often preventable.[71] Smoking-related illness in the United States costs more than $300 billion each year, including nearly $170 billion for direct medical care for adults and more than $156 billion in lost productivity.[72] Obesity also poses a serious problem. In fact, the annual medical costs of obesity may be as high as $147 billion.[73] People who are obese end up spending nearly $1,500 more per person per year on health care.[74] Additionally, decreasing rates of vaccination for serious but preventable diseases lead to unnecessary hospitalizations for patients across the county.[75]

CAHC strongly supports efforts and incentives to prevent chronic conditions and related complications, which will lead to lower costs and better quality of life for individuals and their families. We believe data can help provide evidenced-based pathways to advance these efforts. With this data, providers, insurers, employers, and government entities can determine what interventions produce the most effective results and provide the greatest value for their investment.

CAHC also supports additional policies that will help advance these efforts, including:

- **Utilizing telemedicine and store-and-forward technologies to help monitor and prevent disease progression.**
- **Changing budgetary analysis to account for cost savings from prevention efforts that may occur outside the 10-year budget window.**
- **Promoting comprehensive chronic care management for patients enrolled in both public and private insurance coverage.**
- **Supporting and advancing wellness incentives in the employer and individual markets.**

CULTIVATE COMPETITIVE MARKETS

Competition is at the root of the problem of cost increases and lagging quality, but it is also the solution.

CAHC opposes additional governmental restrictions on choice as a misguided mechanism to foster competition. Such policies merely inhibit competition further and serve to artificially choose new winners and losers; they do nothing to improve quality or efficiency. A solution includes enacting policies that facilitate informed consumer choice where consumers reward market participants for higher quality and efficiency.

Governmental policies, including those found in the ACA, have incentivized market consolidation across various health sectors. There is a wealth of evidence showing that excess consolidation and an imbalanced concentration of market power results in higher prices, lower quality, and less innovation.[76]

All plans sold in the individual and small group market are required to submit actuarially-certified justifications for premium increases, including the portion of the premium increase attributable to each unique benefit category. Recent analysis of rate filings for 2017 show that most of the largest contributor to premium increases are costs for hospital outpatient services (29.9 percent).[77] This data highlights a steady shift away from inpatient spending – and physician services to a lesser extent – toward outpatient hospital costs. This is largely due to the increasing acquisition of physician groups by hospitals, which is spurred by current Medicare payment structures. At the same time, many of these consolidating provider systems are creating their own health plans, which further deteriorates competition between major payers and providers in markets. **CAHC urges both Congress and the Administration to reverse current policies leading to greater consolidation in health markets and avoid enacting new ones.**

Rather than competition working to reduce overall costs and improve quality, as is seen in truly competitive markets, current market participants rarely compete based on value provided. Policy makers should facilitate competition based on the value provided by:

- ***Ensuring price and quality transparency.*** Variation in price and quality and inconsistent data and access limit decision-making ability for consumers, employers, and insurers. **Policy makers should create standards for this data and facilitate access to it.**
- ***Pegging reimbursement toward value provided.*** Achieving high value for consumers – not simply lowering costs – should be the overarching goal of any system, with value defined as the health outcomes achieved per dollar spent.[78] **Policy makers and the public should be willing to pay proportionally more for better value. At the same time, payments should be reduced or eliminated for services and products that provide little or no value.**
- ***Promote strategic alliances.*** While market consolidation can lead to increased costs through an imbalance in power, greater alliance and care coordination can improve patient outcomes and increase value and inefficiency without creating market imbalances and inhibiting competition. Strategic alliances formally bring together separate, independent parties in pursuit of a common goal. Many recent policies in the Medicare program promote such alliances in the form of alternative payment models. **Policies should encourage these arrangements both inside and outside the Medicare program.**

There is no one set path to achieving greater competition, but increasing innovation, choice, and transparency will be fundamental to any successful policies in this endeavor.

SHIFT TO VALUE

To achieve cost containment, care delivery and reimbursement must transition to a value-based system. This is needed to create true competition in marketplaces and improve health quality and outcomes. CAHC is encouraged by progress toward this shift, but additional policies must be enacted to accelerate its progression.

Employer leadership in spurring innovation in the health system should be encouraged and supported. Dramatic gains in quality and efficiency can be achieved in coming years. Since employers serve as the largest purchasers of health care services and coverage in this country, they can and should lead efforts in the shift toward value in the private market. Policy makers should ensure that successes in this market are preserved and nurtured while focusing on removing barriers that hamper innovation in coverage and care.

In addition to providing the majority of Americans under 65 with health coverage, employers are leading the charge in the transition to value-based policies. Employers and employer-based plans are already implementing innovations such as care management and consumer engagement programs and creating value-based arrangements (VBAs) for health services. More innovation is taking place in this sector than in the individual market for several reasons, including better access to and control of plan data and exemptions from rules and regulations through the Employee Retirement Income Security Act (ERISA). **Current policies, like ERISA, that foster innovation should be protected, and additional policies should also be enacted or reformed to cultivate further advances.**

VBAs hold great promise for transitioning to a system that reimburses providers for helping to prevent illnesses or improve outcomes rather than simply providing services. These arrangements seek to align incentives across providers, employers, payers, and bio-pharmaceutical and life-science manufacturers to improve clinical outcomes and efficiencies. These arrangements often use mechanisms such as risk baring and shared savings (including for enrollees) to achieve this. For example, under a VBA, payers and pharmaceutical companies would increase the link between payment (a rough proxy for price) for a treatment to the medical outcome achieved. Employers could also reward employees for treatment adherence through shared savings. This move toward outcome-based payment, increase collaboration, and novel benefit design is driving innovation in how we pay for and deliver health care services.

Many barriers currently prohibit the rapid proliferation of VBAs, however. Such barriers include insufficient or misaligned data, which result in technical difficulties and governmental policies that deter further innovation. CAHC advises Congress and the Administration to work to address the barriers that stand in the way.

Some of the key reforms that should be factored into policy considerations concerning VBAs are outlined below:

- ***Revising Stark and anti-kickback rules.*** These rules are intended to prevent fraudulent and abusive practices by prohibiting arrangements where organizations or individuals could receive inappropriate payments and benefits to receive one product or service over another. While the intention of these rules is valuable, it has the unintended consequence of hampering the adoption of VBAs. For example, anti-kickback rules prevent plans from creating incentives structured around prescribing medications with high clinical efficacy or rewarding patients for adherence to such therapies. Similar problems arise if physicians refer patients to centers with high quality outcomes to treat conditions if the physician has any financial relationship with the center. For example, a physician who has a financial relationship would be prohibited from referring a patient to the center even though these centers often have better reported outcomes than others, particularly for certain conditions like cardiovascular disease.

- **Clear exceptions should be created to these rules allowing for more flexible VBAs and risk-sharing based on medical outcomes.** This could include a shared savings model in which providers and patients are incentivized through sharing in overall health savings, which are derived from prescribing and adhering to appropriate high-value treatments that have been shown to improve outcomes and reduce overall health service spending.

- ***Clarifying anti-discrimination provisions.*** Anti-discrimination laws may inhibit insurer ability to create value-based insurance designs (VBID). VBID is a mechanism for altering cost-sharing based on higher-value clinical treatments to enable and incentivize treatment adherence.

- For instance, biologic medications can vary widely in their effectiveness for different patients, and the benefit delivered by any given medication may vary markedly depending on the particularities surrounding its use and patient condition. VBID can align the use of these relatively expensive and complex specialty medications with appropriate patients by basing consumer cost-sharing on a treatment's clinical value not just negotiated rates.

- Current anti-discrimination rules are ambiguous as to whether these types of arrangements would be permitted. **CAHC encourages Congress and the Administration to create clear guidelines that support VBID arrangements while maintaining consumer protections.**

- ***Create safe-harbors for VBAs.*** Governmental pricing policies in regards to biopharmaceuticals create artificial price floors that inhibit VBAs in the private sector. Drug manufacturers are required to offer Medicaid programs the "best" price for a drug, regardless of what arrangements may have been made in other markets that are structured very differently from Medicaid. This inherently deters drug manufacturers from entering into more innovative, lower cost arrangements within other markets because the lowest or "best" price must be shared with all state Medicaid programs. A similar problem arises with Average Sales Price calculations in Medicare Part B. **These incentives must be aligned properly in order truly spur innovative value-based design. CAHC urges Congress to create safe harbors within these calculations for VBAs.**

When considering any reforms to the employer market, CAHC urges policy makers to first "do no harm" to areas in the market that are already functioning well. Policy makers should, however, add additional flexibility and pathways to innovation while avoiding any new policies that might compromise the size, composition, or integrity of the current employer-sponsored coverage markets. Most individuals and families rely on coverage from their employers; greater innovation for care and cost containment is found in this market more than any other.

ADVANCE COMPETITION AND THE SHIFT TO VALUE THROUGH INFORMATION

Transparency and readily understandable information is the foundation for competition. Choice is useless unless individuals have the necessary information to enable comparison. Unfortunately, vital information in the health system – particularly on pricing and quality outcomes – is difficult to access and understand. We have divergent reporting systems and information is rarely shared with the public, much less in an easily understood format. This makes informed decision-making difficult or impossible.

Patients should have access to relevant, meaningful, and actionable information so they can make informed decisions about their health care and coverage choices. Congress should require the broader availability and use of data to generate meaningful and accurate comparative tools and information on benefits and plan choices. This should be done in a way that supports market competition and does not disclose competitively sensitive information.

Similarly, lack of consistent and readily available information serves as a huge barrier to establishing VBAs, targeted treatment regimens, and other alternative payment arrangements and benefit structures. Strong standards should be created and promoted to align measures and methods of reporting with a focus on outcomes. **Data, metrics, and methodologies related to cost and quality from public programs such as Medicare and Medicaid should be made publicly available in accessible formats. Medicaid data should also be made standard across states and communicated to HHS. CAHC applauds work being done in this area, and we encourage HHS to continue and accelerate these efforts. CAHC further advises that standard metrics be developed for apples to apples comparisons between various payers and markets.**

These and other methods to promote standardization, access, and transparency in data can lower costs and improve quality in many ways. It can aid employers and payers in establishing VBAs, empower consumers to choose efficient and effective providers, and inform providers about the efficacy of various treatments. These are necessary steps in the shift toward value and cost containment.

CONCLUSION

Policy makers face a monumental task. They must begin the complex work of repairing a struggling system and replacing it with policies that will make coverage and care more broadly affordable in both the individual and employer markets. This will be an impossible task if immediate action is not taken to shore up and improve unstable markets during a chaotic and uncertain period.

Even if policy makers are successful in reform efforts, the reality is that without shifting the focus of health care reform to cost containment, premiums and out-of-pocket costs will continue to rise at an untenable rate and Americans are likely to find themselves in the midst of yet another reform effort a few years from now.

CAHC believes that with the policies outlined in this paper, Congress and the Administration can encourage innovation, greater choice, and transparency. This can empower consumers to make informed decisions about their health care and coverage, and we will begin to see the cost curve bend with the emergence of more competitive markets. This can help transform the system into a more sustainable, value-driven one – potentially faster than we can imagine.

CAHC stands ready and willing to serve as a resource in this endeavor.

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