Making Health Care Work for Every American:

Solutions to Deliver More Competition, Market Stability & Affordable Coverage

Americans deserve affordable health care coverage that works. Whether it's through their employer or on their own, through Medicare or Medicaid, our commitment is to deliver affordable coverage that improves individual health and offers financial protection.

The Affordable Care Act (ACA) will see significant changes. Those changes can either begin a stable transition to a better approach, or they can bring about even more uncertainty and instability.

Everyone wants an individual market that works. That's why we should all work together to find solutions that deliver both short-term stability and long-term improvement.

Health plans have the experience, expertise, and understanding to accomplish this goal. We know how health insurance truly works and what doesn't work. We know what changes can improve markets. We know the timing and processes needed to design and develop effective coverage options. We know which rules are effective – and which rules simply create red tape.

As policymakers begin the process of improving the individual market, there are key principles that, if followed, will help ensure a stable, competitive market that delivers real choice, high quality, and affordable care:

- **Make a strong commitment to continuous coverage.** Millions of Americans depend on their current care and coverage. The immediate repeal of federal support, particularly for programs such as cost-sharing reductions (CSR) and Medicaid expansion, will jeopardize both. We can ensure a stable transition with smart solutions that protect both consumers and taxpayers.

- **Deliver affordable coverage for every American.** Tools such as tax credits can help low-income individuals and families get the coverage they need – but must be effective enough to make coverage truly affordable. For Americans with complex medical needs, solutions like high-risk pools can mitigate the risk of adverse selection and deliver effective coverage.

- **Protect hardworking taxpayers.** More consumer choice and more consumer control, through solutions like tax credits and Health Savings Accounts, will deliver efficient, effective solutions that control costs for both consumers and taxpayers.

- **Give states the flexibility to develop effective solutions that work best for their citizens.** Every consumer is different – and every state is different. States can decide what's best for their people, and let the people decide what's best for themselves.

Looking ahead to 2017:

Today there are many more questions than answers, from timing and sequencing to what stays and what goes. What is clear is that the foundation of an effective individual insurance market is continuous coverage for everyone – those who utilize their coverage to get quality care AND those who are healthy

but have insurance to protect them in case they get sick. The individual mandate will be changed, but the challenge of encouraging everyone to purchase coverage will remain. Finding effective incentives for continuous coverage is essential to avoid even higher premiums and fewer choices for everyone. Other priorities and specific solutions include:

- **Ensure that people's coverage – and lives – are not disrupted.** Millions of Americans are selecting and purchasing individual health plans now – and will continue to do so through January 2017. Millions more have enrolled in Medicaid. Making sudden, significant changes now or mid-year will jeopardize the coverage they depend on.

- **Send strong signals that Congress and the new Administration are committed to market stability and consumer choice – in both 2017 and 2018.** The strongest signals would be to fund temporary, transitional programs, including cost-sharing reductions and reinsurance, through at least January 1, 2019. These programs reduce costs for those who need financial help and provide coverage for high-need patients. Eliminating funding, such as CSR, would do the opposite.

- **Make reinsurance payments for 2016 as originally intended.** This will help protect consumers against dramatic premiums increases and reduce the likelihood of significantly fewer coverage options in 2018.

- **Reduce premium growth across the board** by eliminating the Health Insurance Tax and PCORI tax.

- **Implement effective pre-enrollment verification for consumers who sign up for coverage during special enrollment periods.** Ensuring accountability and fairness in getting and keeping people covered will control costs for everyone.

- **Protect people who are eligible for public programs from being inappropriately steered into the commercial insurance market.** People should receive support from the programs that are designed for them. Inappropriate steering and third-party payments increases costs for all consumers.

- **Develop effective solutions to incentivize continuous coverage.** Replacing the individual mandate with strong, effective incentives, such as late enrollment penalties and waiting periods, can help expand coverage and lower costs for everyone.

- **Maintain sufficient funding in Medicaid to avoid a sudden and significant impact on state budgets** and jeopardizing insurance coverage for enrollees.

<u>Looking Ahead to 2018:</u>

Health plans are already developing plans and designing coverage options for 2018 – and the experience of 2017 significantly factors into the design, development, and cost of 2018 plans. To ensure a stable transition to a new approach, policymakers should consider these improvements:

- **Extend the timelines that health plans must meet.** Under current federal rules, health plans must file exchange products for the 2018 marketplace by May 2017. This timetable could be extended into the summer. Uncertainty in early 2017 may discourage plans from submitting bids for 2018 – which could mean most people have no pathway to purchase the coverage they need.

- **Consider actuarially sound methods for funding high-risk pools** or other risk mitigation arrangements.

- **Reduce rules, regulations, and red tape** in the areas of network adequacy, quality reporting, benefit offering requirements, grace periods, RADV, rate review, Summary of Benefits and Coverage, Renewal Notices and language taglines.

Looking Ahead to 2019 and Beyond:

The individual health insurance market has always been challenging. It was before the ACA and continues to be today. We have an opportunity to deliver long-term improvements where individuals and small businesses have effective, affordable coverage:

- **Allow time to develop new products for a reformed individual market.** To satisfy existing regulatory requirements, plans need at least 18 months to create and file products with state regulators.

- **Consider whether new rules are needed.** New rules will require time for draft rulemaking notices, comment periods, final rulemaking and timing for implementation.

- **Consider whether states may need to repeal current statutes** tied to current federal law, and enact any necessary changes.

- **Build enough time into the transition** to educate consumers on their options and inform them about changes to the purchasing process.

- **Ensure that any changes occur on January 1 of the transition year.** Mid-year changes to regulations creates unnecessary disruption for the consumers and businesses that plans serve. Plans need to be able to plan for a full year of premiums to ensure their options and pricing serve consumers and businesses well.

Medicaid

For Medicaid, if legislation creates a new system of Federal payments, potentially beginning as early as 2019, our priority is to ensure it is viable and actuarially sound. Medicaid health plans are fundamental to the operation of the Medicaid program, enrolling approximately 70 percent

of all Medicaid beneficiaries and providing integrated systems of care, health education outreach, disease management programs, and social services. To ensure a stable, competitive market, any new system must be sustainable, take into account state-specific circumstances, and provide a smooth transition from the current system, including for states that have expanded Medicaid.

2017

- **Limit new rules and regulations during the transition:** The Medicaid managed care final rule published in May 2016 has far-reaching changes. CMS and states will likely have new priorities and new/limited staff that will make it challenging to meet regulatory timeframes for issuing new guidance, modifying contracts, and changing processes. The Administration should work with stakeholders to identify necessary rule delays and other changes.

- **Build in appropriate timeframes:** To be effectively implemented in 2019, a new financing system would need to be developed far enough in advance to allow states and plans to analyze and budget for the reforms and to implement a variety of changes, including around rate setting, bidding and/or contracting. Any additional state flexibilities that are part of the changes need time for state development and any necessary CMS approvals.

- **Consider key issues for a viable system:** A new federal financing system should ensure states can have countercyclical protection during economic downturns as enrollment increases, and use formulas for calculating allotments that determine amounts that are sufficient for different categories of enrollees, are based on multi-year averages, and adequately account for the changing health of populations served.

2018

- **Fully repeal the HIT:** The HIT raises costs for states that use private sector health plans for their Medicaid programs.

- **Develop a transition for expansion states:** Roughly 12 million people have been covered through ACA expansion of Medicaid. If the expansion rules are changed, they should provide for a smooth transition that enables states to continue coverage if they choose while reducing Medicaid program costs, maximizing state flexibility and preparing enrollees for transitioning to other options like employer-sponsored coverage.

2019

- **Ensure actuarial soundness:** Under any new financing system, it will be critical for CMS to ensure on an ongoing basis there are strong, enforceable actuarial soundness requirements on states that allow continued access to benefits through Medicaid health plans.

- **Longer term considerations for Medicaid populations:** Potential new flexibilities for states and Medicaid health plans should include consideration of ways they can adopt innovations in concert with other changes outside the Medicaid program that can help address certain social determinants that are core drivers of health costs for Medicaid populations.

Medicare Advantage

Our most immediate priority is to ensure that the draft 2018 rate notice and call letter for Medicare Advantage and Part D plans will preserve and strengthen these important programs and put the Trump Administration in position to implement further improvements in the

future. Timelines for the new administration are short; the draft policies will be released by February 2, 2017, and the final guidelines are out by April 3, 2017. Below are several key issues for the February 2nd release.

2018 Priorities

Maintain stability: CMS is currently transitioning toward use of "encounter data" as the source of diagnosis for calculating risk scores, which are used to adjust Medicare Advantage plan payments. CMS began to adjust risk scores in 2016 based on these encounter data diagnoses, and has a schedule for moving toward full use of that data over the next several years. However, there are serious problems with the accuracy and reliability of the new system. Plans have significant concerns they effectively will receive a rate cut if CMS continues with its approach. The February 2nd draft rate notice should stop this policy and ensure plan risk scores are not reduced through this process. A similar approach was used when the Medicare Advantage program moved to risk adjustment payments.

Reduce burden: No new program requirements should be imposed on Medicare Advantage or Part D plans for 2018. This is necessary to avoid increased costs and burdens for beneficiaries, providers and plans. Changes should be included only if they reduce existing burdens and/or increase plan flexibility to offer innovative and high value benefits.

Reward quality: The industry has recommended numerous suggestions for improving the Star Rating System for Medicare Advantage and Part D plans. One suggestion we believe can be implemented in the short time frame is to stop the current CMS practice of using audit findings and compliance actions to adjust quality measures. This is critical to provide a more equal competitive environment, ensure the system accurately reflects the care beneficiaries actually receive, avoid duplicative penalties. We also suggest signaling that the Administration will consider using its regulatory authority to exclude quality bonus payments from a cap the ACA imposed on Medicare Advantage benchmark rates.

Signal willingness to increase engagement: Given the complexities of the Medicare Advantage and Part D programs, it is crucial that complex payment policies be developed through open and transparent processes that allow time and opportunity for industry analysis and engagement. CMS should indicate a willingness to provide, outside of the rate note and call letter process, significantly longer timelines and enhanced processes for input on complex changes to risk adjustment and other key areas of the program.

Background

The Medicare Advantage program has been a success despite major cuts in the ACA, frequent payment changes by CMS and an ever-increasing set of burdensome government requirements. Medicare Advantage plans cover over 17.5 million Americans, or 30% of all Medicare beneficiaries. The program has bipartisan support in Congress. Enrollee satisfaction is high. Research shows Medicare Advantage plans achieve better health outcomes than the government-run fee-for-service (FFS) program, and providers are adopting plan practices that "spill over" and reduce costs in FFS. Similarly, the Part D program has been stable and successful with more than 41 million enrollees and extremely high satisfaction rates.