



February 22, 2022

The Honorable Kevin Hern
United States House of Representatives
1019 Longworth House Office Building
Washington, DC 20515

The Honorable Rick Allen
United States House of Representatives
570 Cannon House Office Building
Washington, DC 20515

The Honorable Victoria Spartz
United States House of Representatives
1523 Longworth House Office Building
Washington, DC 20515

Dear Representatives Hern, Allen, and Spartz:

Thank you for the opportunity to provide feedback to the Healthy Future Task Force's Affordability request for information. The 21 undersigned organizations are pleased to provide answers to several questions put forward by the Affordability subcommittee.

2017, our organizations agreed upon three principles that we use to help guide our work on health care to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.¹ These principles state that: (1) healthcare must be adequate, meaning that

¹ Healthcare reform principles. Available at: <https://www.lung.org/getmedia/24309f63-74e9-4670-8014-d59f21104cfd/092021-ppc-healthcare-principles-42-logos-final.pdf>.

healthcare coverage should cover treatments patients need; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to get, keep, and understand and not pose a barrier to care.

Our organizations would welcome you to come and speak to our coalition about your priorities related to increasing affordability in the coming months. If you have any questions or would like to schedule a time to speak with our groups, please contact Katie Berge, Director of Federal Government Affairs at the Leukemia & Lymphoma Society at katie.berge@lls.org, Jennifer Dexter, Director of Policy at the National Health Council at jdexter@nhcouncil.org, or Lauren Drew, Director of Congressional Relations at the National Kidney Foundation at lauren.drew@kidney.org.

Sincerely,

American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)

National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
United Way Worldwide

I. Improving Healthcare for America's Workers and Small Business Owners

1. On June 19, 2018, the Department of Labor finalized the Association Health Plan (AHP) rule, which allows small businesses, including the self-employed, to band together by geography or industry to obtain healthcare coverage as a single large employer. In addition, this Congress Rep. Walberg, Republican Leader Foxx, Rep. Allen, and Rep. Burgess introduced H.R. 4547, the Association Health Plans Act to codify association health plans.

a. Have geographic based AHPs been successful in creating additional insurance options for small businesses?

Our organizations are concerned that proposals to expand the availability of AHPs would harm the patient populations we represent. The track record of AHPs and Multiple Employer Welfare Arrangements (MEWAs) in reliably providing comprehensive coverage for consumers is poor. Furthermore, these entities have a long history of fraud and have engaged in other concerning practices. According to state insurance regulators, AHPs “have been notoriously prone to insolvencies.”² AHPs are not required to cover services included in the EHB package, may charge higher premiums based on occupation (a loophole that allows discrimination based on gender

² National Association of Insurance Commissioners. (2018, March 6). *NAIC Letter to Employee Benefits Security Administration, U.S. Department of Labor Definition of Employer—Small Business Health Plans RIN 1210-AB85-*. NAIC. https://www.naic.org/documents/index_health_reform_section_180306_comments_assoc_plan_nprm.pdf

and other factors as well³), and in the case of “Pathway 1” AHPs,⁴ health status. As a result, these plans expose enrollees to the financial and health risks inherent in substandard coverage. Meanwhile, the marketing of these products can be confusing or misleading and can cause individuals to enroll in plans that do not align with their medical needs or expectations.

AHPs pose risks to the many consumers who do not enroll in them, too. By leveraging the regulatory advantages they enjoy, compared to Affordable Care Act (ACA)-compliant individual and small group coverage, AHPs can siphon away healthy individuals from the broader market. This leaves the individual and small group markets smaller and with a larger proportion of individuals with pre-existing conditions than they would be otherwise, which leads to higher premiums and fewer plan choices for the people who depend on those markets to access comprehensive coverage.

b. Should Congress expand upon the Trump Administration rule to increase the number of entities eligible to form AHPs, such as by expanding the “commonality of interest” necessary to form an AHP?

Key provisions of the 2018 AHP rule were blocked by a federal court, a ruling which our organizations supported.⁵ While our organizations appreciate that the small group market has certain challenges providing affordable coverage, we believe that any solution to expanding affordable coverage should not sacrifice quality or allow entities to discriminate based on gender, age, or medical history. As a result, our organizations would not support a statutory or regulatory expansion of the 2018 rule.

3. On June 20, 2019, the Trump Administration finalized the Individual Coverage Health Reimbursement Arrangement (ICHRA) rule, which allows employers to make tax-advantaged, defined contributions for employees to purchase their own health insurance or pay for medical expenses. ICHRAs became available to employers January 1, 2020.

b. What barriers are employers having to participating in ICHRAs?

Our organizations agree that patients and consumers who receive coverage through midsize and small employers should have access to high quality, affordable coverage. However, as costs have increased for employers, so too have they increased for patient employees. In recent years, employers have dramatically increased health insurance plan deductibles, adding to the total spending required by employees before their health plan begins to cover even the most essential treatments.

Tax advantaged accounts and other mechanisms used to defray costs for employers, such as high-deductible health plans (HDHP) and health reimbursement arrangements (HRAs), can often simply exacerbate the cost pressures faced by employees. Our organizations are concerned that the expansion of these types of accounts may result in inappropriate and excessive cost shifting from employers to consumers, thereby making care less affordable.

³ Patient Groups Comments on RIN 1210-AB85; Definition of “Employer” Under Section 3(5) of ERISA— Association Health Plans (2018, August 22). <https://www.heart.org/-/media/files/get-involved/advocacy/regulatory-comments-and-correspondence-letters/access/030618-coalition-ahp-comments--final.pdf>

⁴ Ibid.

⁵ *State of New York, et al. v. U.S. Department of Labor*. (March 28, 2019). U.S. District Court for the District of Columbia. [Case 1:18-cv-01747-JDB](https://www.courtlistener.com/docket/11111111/state-of-new-york-et-al-v-us-department-of-labor/).

Federal rules effective January 1, 2020, permit employers to offer individual coverage HRAs (ICHRA) instead of traditional job-based group health coverage. Employers may fund ICHRA to cover premium and out-of-pocket costs for employees to purchase individual market coverage. The rules also allow employers to offer some employees a group health plan and others an ICHRA, but their coverage decisions must be based on designated employment classifications (e.g., full-time status, or work location). ICHRA must also comply with the ACA employer responsibility rules for affordable coverage but don't necessarily have to comply with other ACA quality standards.

While the long-term impacts of the 2019 rule are still not well understood, expanding access to ICHRA could also have knock-on effects for the employer sponsored insurance market. ICHRA have the potential to lead to a decoupling of coverage from employment. This may present opportunities to enhance the affordability of coverage in some circumstances. In particular, low wage employees offered skinny coverage may be better off if they qualify for marketplace coverage with substantial premium and cost-sharing subsidies, but some employees may be made worse off. In addition, greater use of ICHRA would represent a fundamental shift to defined contribution coverage, shifting risk for high out-of-pocket costs onto employees with serious or chronic medical conditions, including those we represent. We are also concerned that the 2019 rule's safeguards will be inadequate to prevent employers using ICHRA to send older and more costly employee groups to the marketplace. The proposed 2023 payment parameter rule would require insurers to report use of ICHRA with their risk adjustment data, which would allow for analysis of the risk associated with ICHRA users compared to other marketplace enrollees. The impacts of ICHRA and existing regulations related to their operation need to be updated and carefully crafted to ensure patients - and their ability to access high quality coverage - are not negatively impacted. At a minimum, we urge policymakers to use the risk adjustment data to inform any future amendments to the ICHRA law and regulations.

Recognizing the Healthy Futures Task Force aims to improve overall affordability for employer sponsored coverage, our groups recommend updating the federal employer sponsored coverage affordability standards to allow employees to access subsidized individual market coverage in cases in which their only employer-sponsored insurance option fails to offer comprehensive coverage. Furthermore, additional steps could be taken to update the cost inputs to federal ESI affordability standards to capture both premium and deductible costs in comparison with employee income. Policymakers should consider both employer and employee costs when crafting solutions aimed at addressing affordability and should not simply rely on expanded tax advantaged benefit structures to curb utilization or erode coverage quality.

II. Promoting Employer Programs to Lower Costs and Improve Care

2. Entities who participate or are planning to participate in programs such as direct contracting, high performance networks, and centers for excellence must determine how to measure value and health care outcomes. For those who participate in these types of private value-based programs please answer the following questions:

As a coalition, we embrace the principle that no matter how coverage is structured it must meet the basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost-sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans, and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26, and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

As the Task Force explores this question of different financing arrangements, we encourage you to commit to assuring meaningful coverage.

III. Increasing Transparency and Marketplace Innovation

1. Hospitals in the United States typically have more than 20,000 items in their chargemaster files, making it very difficult for patients to compare the price of individual services across hospitals. On November 27, 2019, the Department of Health and Human Services finalized price transparency requirements that make hospitals publish a list of user-friendly, standard charges for certain items and services online.

Price transparency efforts must always include all potential out-of-pocket impacts for patients. Greater transparency of both the cost of care and available options is needed by patients. Patients need a clear understanding of what health care will cost them out of pocket when making health care decisions. In order to promote access to high-value care, as defined by patients, patients should be provided with adequate and transparent options for comprehensive and appropriate coverage and care.

Any efforts to encourage patients to “shop” for lower priced care, including high-deductible health plans, should be halted or rolled back until patients can actually receive estimates of what their care will cost. Price comparison shopping is impossible if the prices are hidden from the shopper.

3. Before the Affordable Care Act passed, states set the rules for what private health insurance needed to cover in that state, controlled who could and couldn’t offer health insurance, reviewed and set rules for rates, and handled consumer complaints. Now, the federal government is involved in all of these activities.

a. Are there ways to return some of this power to states that would increase affordability while protecting those with pre-existing conditions?

Prior to the ACA, Americans faced a patchwork of healthcare regulations that varied state to state, with no consistent protections or assurances that a pre-existing condition would be covered, let alone what even the definition of a pre-existing condition was. This posed a significant financial and economic hardship to many Americans and their families. Insurance companies could and did, deny claims after the fact for a whole host of reasons, including a pre-existing condition like cancer prior to it ever being diagnosed. One consequence was to significantly limit opportunities for job growth, as many workers were unable to leave jobs, for fear they could be locked out of coverage.

The ACA has not limited states’ ability to regulate their marketplaces. In fact, states do have ample authority to regulate their marketplace and respond to consumer and carrier needs. Despite this, some states have opted not to utilize that authority and prefer that the federal government manage their marketplace instead.

One clearly beneficial action available to Congress would be to permanently extend the enhancements to advance premium tax credits (APTCs) made in the American Rescue Plan Act (ARPA). According to CMS’ final enrollment snapshot for the 2022 plan year, a record 14.5 million Americans, including 3 million enrollees new to the Marketplaces, enrolled in coverage during this most recent open enrollment period, clearly demonstrating the impact that the ARPA-enhanced subsidies have had in helping individuals in all 50 states afford coverage (<https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period>).

report-final-national-snapshot). This builds on the success of the ACA in reducing uninsurance rates, medical debt, and bankruptcies due to medical debt, all of which have declined significantly since the ACA was implemented.

b. How can 1332 waiver authority be improved to help address affordability?

Section 1332 waivers allow states to innovate with policies that improve the affordability of comprehensive coverage while ensuring that the key protections of the Affordable Care Act are not jeopardized. The program includes crucial statutory guardrails. Federal law prohibits a waiver from being approved unless a state can demonstrate that, under its waiver program: coverage will be as affordable as it would be without the waiver; coverage will be as comprehensive as it would be without the waiver; a comparable number of people will be covered under the waiver as would be without it; and that the waiver will not add to the federal deficit.

Our organizations strongly opposed the 2018 guidance on Section 1332 waivers that significantly undermined quality and affordable healthcare for patients with pre-existing conditions. The guidance made it easier for states to use federal taxpayer dollars to promote sub-standard plans that do not provide comprehensive and affordable coverage, and it tipped the scales in favor of insurance products that are inadequate to meet the needs of the millions of patients and consumers our organizations represent. This policy was repealed in 2021, a decision that we strongly supported.

Within the current guidelines, states already have the ability to develop waivers that address the affordability of coverage. For example, many states (including Alaska, Colorado, Delaware, Georgia, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Pennsylvania, Rhode Island and Wisconsin) have applied and received approval for waivers establishing reinsurance programs. A recent report found that states with reinsurance waivers have experienced significantly lower individual market premiums than they would have otherwise and have seen gains in insurer participation.

c. Would removing the firewall between 1332 and 1115 waivers allow for state innovation to improve affordability?

Our organizations do not believe that any changes to the statutory language regarding Section 1332 waivers are needed at this time, including any changes to the firewall between Section 1332 and Section 1115 waivers. States can continue to pursue innovative policies to improve affordability without jeopardizing key patient protections, especially for individuals with pre-existing conditions, without any additional action by Congress in this area.