WISCONSIN HOSPITAL ASSOCIATION, INC.

July 12, 2017

Thomas E. Price, Secretary
Department of Health and Human Services

Seema Verma, Administrator
Centers for Medicare & Medicaid Services

ATTN: CMS-9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9928-NC, Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients.

Dear Dr. Price and Ms. Verma,

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 130 Wisconsin hospital and health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing world class care, research, and training. On behalf of our members, we are providing comments in response to CMS' Request for Information, *CMS 9928-NC*

Wisconsin has maintained a very low uninsured rate for many years and annually ranks at or near the top nationally in health care quality. Moreover, Wisconsin has one of the most competitive health insurance markets in the country. Wisconsin's hospitals and health systems support efforts that recognize and preserve the strengths of our current system while focusing on continuing challenges related to health care cost, quality, and coverage in ways that do not jeopardize access. WHA supports a health care market that:

- Strengthens Wisconsin's pluralistic private sector based coverage options;
- Encourages value strategies, such as maximizing competition and choice, minimizing administrative costs and adverse selection, and rewarding quality without using rate setting or price controls as a cost containment tool;
- Fosters broad access to a choice of providers able to provide true continuity of care;
- Makes personal responsibility and prudent use of health care services a top priority.

Hospitals and health systems are on the front line of providing care, and serving all who come to their emergency room doors regardless of coverage. It is from this lens, and with the above principles in mind, that Wisconsin Hospital Association is providing comments to the following topic areas as outlined in your request for comments:

1. Empowering patients and promoting consumer choice.
2. Stabilizing the individual market
3. Enhancing affordability
4. Affirming the traditional regulatory authority of states in regulating the business of health insurance.

1. Empowering patients and promoting consumer choice.

Enrollment in coverage is a multi-step process that includes awareness of the coverage options, determination of eligibility, plan selection and enrollment, and maintenance of coverage. WHA has long advocated for effective outreach and enrollment processes to help maximize coverage. Hospitals truly are the safety net, serving anyone who comes through their emergency room doors regardless of coverage. As there has been great uncertainty over the past year, and as insurers have begun to exit the market, there is a need to ensure that consumers have the information they need to make informed and educated decisions about enrollment.

Enrolling in a health plan requires further information about the provider network for that plan. WHA has long advocated that while strong network adequacy provisions are important, review of provider networks and enforcement of network adequacy standards are critical. Under the prior Administration, enforcement of adequate provider networks was needed.

We appreciate that under your Administration, CMS has earlier this year allowed states greater authority for reviewing provider networks. However, we also have experienced that federal requirements, such as those for essential community providers, may not be well understood at the state level. Network adequacy requirements can ensure access to quality, affordable health care, but they are only as valuable as the enforcement and monitoring mechanisms behind them.

We encourage CMS to work on enforcement and monitoring provisions, in partnership with states, so that consumers and providers can be assured of adequate networks.

Recommendation: We encourage CMS to provide leadership, funding and technical resources to states for monitoring network adequacy and for education and enrollment efforts.

2. Stabilizing the individual market

We appreciate your interest in changes that would bring stability to the individual market risk pool, and reducing uncertainty and volatility in the markets. WHA recommends CMS focus on supporting high risk pools as a long term solution.

A. Support High Risk Pools

There are several reasons why the individual market has historically been unstable, largely related to the size of the pool and the risk of individuals in the pool. There is generally no employer contribution in the individual market to offset premium costs for enrollees, and the market tends to be comprised of "older" individuals who have more health care needs. This is because many young healthy below the age of 26 remain covered on their parents' policies, and incenting the young and healthy to sign up for coverage has historically been extremely challenging.

High risk pools were operational throughout the country before the Affordable Care Act (ACA) was implemented. As Congress considers changes to the ACA, re-creating high risk pools has been discussed as a potential viable policy option. In our research, we conclude that high risk pools have potential to offer:

- ✓ Added medical management of chronic conditions

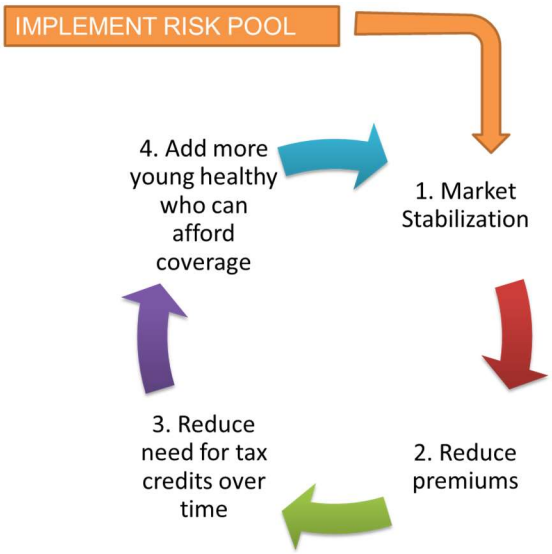
- ✓ State specific solutions with oversight and transparency to stabilize the individual market
- ✓ Relief in the form of premium reductions for the individual market

The experience of Wisconsin's former high risk pool – called the Health Insurance Risk Sharing Plan (HIRSP) – is an example of an efficiently run pool pre-ACA that addressed a critical need in the market.

Although the market dynamics have changed, and the purpose of a high risk pool now differs, risk pools that are properly structured and funded could be considered as a feasible policy option for stabilizing the market.

States need both funding and flexibility to implement effective risk pools. We encourage CMS to work with Congress to develop and help finance state-level risk pools.

An appropriately structured and subsidized high risk pool has the potential for stabilizing the individual market, thus leading to reduced premiums in the individual market. In 2011, an actuarial firm estimated that moving the high risk population pre-ACA into the individual market in Wisconsin would increase premiums in the individual market by 16%. Similarly, taking risk out of the market, should reduce overall premiums and help make the individual market more stable. Ultimately, as premiums are reduced, there should be less of a need for premium tax credits. Further, more young and healthy would find it attractive to participate in the market, reinforcing its stability. This is reflected in the following picture:



High risk pools could be structured in various ways. A "physical" pool similar to the former WI HIRSP program could be implemented, with individuals enrolled directly into the program. Alternatively, states might choose to establish a "virtual" risk pool, where individuals would remain enrolled in their commercial insurance plan while funding is used to offset risk for the insurers.

Both of these structures could have advantages and disadvantages, and states would need flexibility to determine the best structure for their state market dynamics.

Funding for states is critical to ensuring sustainability. However, state funding distributions often penalize states like Wisconsin that have a low level of uninsured, a competitive market, and have high quality health care. Funding included in the AHCA as passed by the House would do just that, for example, by distributing more funding to states that have a high level of uninsured or lack of competition in the insurance exchange, and that have high utilization. Further, funding should not be dependent on state contributions or state match.

We recommend that:

- ***CMS work with Congress and with states to develop and help finance risk pools.***
- ***Because risk pools could be structured in various ways, the specific structure should be left to the state to determine what would work best given their population, number of insured, number of insurers, and overall health care markets.***
- ***CMS work with federal actuaries to determine the amount of funding needed by states for high risk pools.***
- ***CMS use its authority to ensure funding for high risk pools is distributed in a manner that does not penalize states – and indeed rewards states – that have a low level of uninsured, that have a competitive market, and that have high quality health care.***

B. Incent Continuous Coverage in the Individual Market

Without younger and healthier individuals in the market, premiums will continue to rise and the market will continue to destabilize. The previous Administration estimated that in order to have a stable market, 40% of the enrollees needed to be under the age of 34. In 2016, only 28% of all enrollees were under the age 34. Although high risk pools have the potential to stabilize the market and reduce premiums, historically even with lower premiums and an individual mandate it has been challenging to incent the young and healthy to participate in the market. However, without the individual mandate, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimate higher premiums in the non-group market.

Most immediately, CMS can assure that the individual mandate will be enforced. This will have a short term stabilization effect. Longer term, as Congress seeks to eliminate the individual mandate, we encourage CMS to work with Congress to develop alternative options for incenting coverage. As an example, Medicare requires that anyone who does not sign up for Part B during the initial eligibility year, will have higher premiums for as long as they are enrolled in Part B. A strong incentive for signing up for coverage and maintaining coverage over time is critical to the long term stability of the market.

Recommendation: We encourage CMS to enforce the individual mandate in the short term, and work with Congress to develop meaningful incentives for maintaining coverage over time.

3. Enhancing affordability

We appreciate HHS' interest in ensuring affordability for consumers. In Wisconsin, the exchange marketplace and Medicaid are inter-connected. Wisconsin chose to expand Medicaid for all who have income below the poverty line, while helping those with income above poverty to enroll in the exchange marketplace with affordable tax credits for both premiums and cost sharing reductions.

As described in more detail below, CMS can help enhance affordability by maximizing state flexibility and funding for states that expanded coverage to individuals at an income level below 138% FPL – in Wisconsin's case to individuals with income below 100% FPL. In Wisconsin, those funds could be used to help consumers offset their costs. Further, HHS can work with Congress to fund cost sharing reductions.

A. Funding Equity for States

Wisconsin took a unique path to providing coverage for childless adults with income below the poverty line. In doing so, the previous federal administration determined that Wisconsin's 'partial expansion' was ineligible for enhanced federal matching funds, even though Wisconsin clearly expanded coverage and has added about 130,000 childless adults to the Medicaid program under the Wisconsin model for coverage. Medicaid is a safety net and in Wisconsin all who have income below 100% FPL, those who are "in poverty", are covered by the program.

Wisconsin's approach has required an investment by the state which has significantly benefitted the federal Medicaid program but which has been inequitable because the previous federal Administration's interpretation of the ACA provisions were inflexible in meeting state objectives. With the principle of equity in mind, we encourage CMS to approve the enhanced match for the population of non-elderly, non-disabled childless adults in Wisconsin as an expansion population.

Wisconsin has been a model in avoiding gaps in coverage and could be a flagship state among those that want to focus adult coverage in Medicaid on those living in poverty with income below 100% FPL. Wisconsin can continue to serve that leadership role, but there needs to be equity in federal support. As states seek flexibility for their programs, including as expansion states seek ways to reform their programs and reduce costs for their Medicaid programs, the principle that Medicaid should be a safety net for all in poverty can resonate if states are assured of enhanced funding.

Recommendation: We encourage CMS to allow states to choose to expand eligibility for adults at any income level at or below 138% FPL (such as at or below 100% FPL), with enhanced federal participation to create funding equity.

B. Fund Cost Sharing Reductions

Cost sharing reductions have been extremely important not only in helping consumers afford coverage, but also in helping providers avoid uncompensated care. Now, the potential lack of CSR funding is having a destabilizing effect on the market. Without a commitment by either CMS or Congress to fund the CSRs, insurers face billions of dollars in unreimbursed costs. If CSRs are no longer funded, insurers would likely have to choose between exiting the markets or significantly increasing premium costs to cover the unfunded mandate. As coverage becomes unaffordable for some at higher incomes, providers face greater risk of uncompensated care.

Recommendation: We strongly encourage CMS to work with Congress to ensure funding for the CSRs is appropriated.

4. Affirming the traditional regulatory authority of states in regulating the business of health insurance.

Enrolling in a health plan requires further information about the provider network for that plan. WHA has long advocated that while strong network adequacy provisions are important, review of provider networks and enforcement of network adequacy standards are critical. Under the prior Administration, enforcement of adequate provider networks was needed.

We appreciate that under your Administration, CMS has earlier this year allowed states greater authority for reviewing provider networks. However, we also have experienced that federal requirements, such as those for essential community providers, may not be well understood at the state level. Network adequacy requirements can ensure access to quality, affordable health care, but they are only as valuable as the enforcement and monitoring mechanisms behind them.

We encourage CMS to work on enforcement and monitoring provisions, in partnership with states particularly in areas such as around essential community provider provisions, so that consumers and providers can be assured of adequate networks.

Recommendation: We encourage CMS to provide leadership, funding and technical resources to states for monitoring network adequacy and for education and enrollment efforts.

Conclusion

Thank you for the opportunity to comment on the Request for Information. If you have any questions, please contact Joanne Alig, Senior Vice President, Policy & Research at 608-274-1820, or jalig@wha.org.

Sincerely,

/s/

Eric Borgerding
President & CEO