# SB

# 206

<TARGET><BILL>SB 206</BILL><SUBJECT>SB
206</SUBJECT><COMM>SFIN29</COMM></TARGET>

STATE CAPITOL
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Juneau, AK 99811-0001
907-465-3500
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# Governor Bill Walker
STATE OF ALASKA

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March 24, 2016

The Honorable Kevin Meyer
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Meyer:

Under the authority of Article III, Section 18 of the Alaska Constitution, I am transmitting a bill relating to residents who are high risk and to the state health insurance plan.

The bill would make changes to the Alaska Insurance Code (code) for assessments made under a reinsurance program established to reinsure "residents who are high risks." As the code is currently written, a member of the reinsurance program may offset 50 percent of the amount of the assessment made under the reinsurance program (and other state health insurance programs) as a premium tax credit. The bill would remove the assessments made in relation to the high risk reinsurance program from the offset provision. The bill also would amend the definition of "residents who are high risks." These changes are intended to provide a mechanism to help insurers spread the risk of high-cost claims in the individual health insurance market.

The bill also would authorize legislation to allow the State to seek a waiver of certain requirements under the Affordable Care Act in order to implement innovations with respect to the provision of health insurance coverage in the state. This would give the State the ability to restructure the approach to health insurance reform by waiving and proposing alternatives to applicable provisions of the Affordable Care Act.

I urge your prompt and favorable action on this measure.

Sincerely,

Bill Walker
Governor

Enclosure

**Department of Commerce, Community, and Economic Development**

DIVISION OF INSURANCE

P.O. Box 110805
Juneau, AK 99811-0805
Main: 907.465.2515
Fax: 907.465.3422

**SB 206 – Reinsurance Program; Health Insurance Waivers**
**Sectional Analysis**

**Section 1. AS 21.55.220(c)** is amended to allocate the assessment necessary to fund the reinsurance losses on the basis of enrollment. The current structure of ACHIA provides for the assessments on a percentage of premium basis; meaning that those insurers writing more premium pay the larger assessments regardless of the number of covered lives they may have. Conversely, an insurer, particularly an insurer writing only stop-loss insurance, may have very little premium but a large number of covered lives. The intent of this subsection amendment is to distribute the assessment on an equal basis to all insureds on a per member/per month basis.

**Sec 2. AS 21.55.220(f)** is amended to clarify that any assessment made against an ACHIA member (as defined in AS 21.55.010) by ACHIA (to fund the reinsurance losses from the reinsurance program established by regulation for reinsuring residents who are high risks) will not be subject to an offset of 50 percent that otherwise would have applied against the member's premium tax. Unlike the current high risk pool, where members are allowed to offset 50 percent of their ACHIA assessment when remitting their premium tax, the reinsurance assessments would not be eligible for the premium tax credit. While a premium tax credit was a benefit to the ACHIA members to support ACHIA when it was created to provide the only means for Alaskans to gain access to healthcare insurance at the time, the premium tax credit is not being proposed to be extended to the reinsurance assessments due to the economic outlook of the State of Alaska at this point in time.

**Sec. 3. AS 21.55.500 (20)** amends the definition of "residents who are high risks" by deleting the requirement that the person be unable to obtain insurance coverage substantially similar to that which may be obtained by a person who is considered a standard risk. Under the ACA, an insurer is no longer allowed to deny coverage to a person based on a pre-existing condition making this part of statute a moot point. Deleting this language enables the creation of the reinsurance program and provides the director of insurance with the flexibility needed in designing the program by authorizing the director to supplement the definition of "residents who are high risk".

**Sec 4. AS 21.55.500** provides a definition of "covered lives" which is based on the definition that currently exists in Title 23.

**Sec. 5. AS 21.96** is amended by adding a new section to allow for a waiver for state innovation. Under the ACA, states may submit an application to the Secretary of the United States Department of Health and Human Services requesting a waiver from certain provisions of the Act. In order to receive this waiver, the state must have enabling legislation and Sec. AS 21.96.120 provides that the director of the Division of Insurance may apply for a waiver and, if granted, implement a state plan meeting the waiver requirements in a manner consistent with state and federal law.

**Sec. 6.** Provides for an immediate effective date.

SB206

Best Estimate Consumer Impacts

**Statistics Pulled from Division of Insurance 2015 Annual Report**

| *No. of Covered Lives* | *Market* |
|---|---|
| 17,216 | Single Employers 1-50 |
| 11,914 | Single Employers 51-100 |
| 18,133 | Single Employers 100+ |
| 7,617 | Med Supp |
| 150,652 | Stop Loss |
| 4,228 | MEWA |
| 316 | Other Groups |
| 820 | Associations in Individual Market |
| 22,105 | Direct Individual Market |
| 3,754 | Individual Med Supp |
| 24 | Trust |
| 236,779 | Total Covered Lives |

**Federal Reinsurance Program - Affordable Care Act**

| *Year* | *Annual Fee* | *Per Member/Per Month* |
|---|---|---|
| 2014 | $ 63.00 | $ 5.25 |
| 2015 | $ 44.00 | $ 3.67 |
| 2016 | $ 27.00 | $ 2.25 |

| | *Estimated Taxes* | Individual - Estimate *Per Member/Per Month* | Group - Estimate *Per Member/Per Month* |
|---|---|---|---|
| 2014 | 2.5% | $ 25.00 | $ 15.00 |
| 2015 | 2.5% | $ 25.00 | $ 15.00 |
| 2016 | 3% | $ 30.00 | $ 18.00 |

provided by DCCED

SB206

Best Estimate Consumer Impacts

**Possible Reinsurance Annual Limit**

| | Estimated Covered Lives | Estimated Market Impact |
|---|---|---|
| | **236,779** | |
| $ 10,000,000 | $ 42.23 | |
| Per Member/Per Month | $ 3.52 | |
| $ 25,000,000 | $ 105.58 | 8% Premium Impact |
| Per Member/Per Month | $ 8.80 | |
| $ 35,000,000 | $ 147.82 | |
| Per Member/Per Month | $ 12.32 | |
| $ 45,000,000 | $ 190.05 | |
| Per Member/Per Month | $ 15.84 | |
| $ 55,000,000 | $ 232.28 | 15%-18% Premium Impact |
| Per Member/Per Month | $ 19.36 | |
| $ 72,000,000 | $ 304.08 | 25% Premium Impact |
| Per Member/Per Month | $ 25.34 | |
| $ 81,000,000 | $ 342.09 | 27%-29% Premium Impact |
| Per Member/Per Month | $ 28.51 | |

**CC Set 1**

| | |
|---|---|
| Paid Claims | 237,774,342 |
| Claims Removed | 26,332,990 |
| Remaining Claims | 211,451,352 |
| Percentage Remaining | 88.9% |
| # Claimants | 29,869 |
| Claimants Removed | 196 |
| Remaining Claimants | 29,673 |
| Percentage Remaining | 99.3% |

| HCC # | HCC |
|---|---|
| 26 | Mucopolysaccharidosis |
| 70 | Sickle Cell Anemia (Hb-SS) |
| 112 | Quadriplegic Cerebral Palsy |
| 66 | Hemophilia |
| 75 | Coagulation Defects and Other Specified Hematological Disorders |
| 184 | End Stage Renal Disease |
| 118 | Multiple Sclerosis |
| 251 | Stem Cell, Including Bone Marrow, Transplant Status/Complications |

provided by DCCED

**CC Set 2**

| | |
|---|---|
| Paid Claims | 237,774,342 |
| Claims Removed | 53,872,151 |
| Remaining Claims | 185,845,858 |
| Percentage Remaining | 78.2% |
| # Claimants | 29,869 |
| Claimants Removed | 495 |
| Remaining Claimants | 29,374 |
| Percentage Remaining | 98.3% |

| HCC # | HCC |
|---|---|
| 26 | Mucopolysaccharidosis |
| 70 | Sickle Cell Anemia (Hb-SS) |
| 112 | Quadriplegic Cerebral Palsy |
| 66 | Hemophilia |
| 75 | Coagulation Defects and Other Specified Hematological Disorders |
| 184 | End Stage Renal Disease |
| 118 | Multiple Sclerosis |
| 251 | Stem Cell, Including Bone Marrow, Transplant Status/Complications |
| 115 | Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy |
| 10 | Non-Hodgkin's Lymphomas and Other Cancers and Tumors |
| 9 | Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia |
| 8 | Metastatic Cancer |
| 247 | Premature Newborns, Including Birthweight 2000-2499 Grams |

**CC Set 3**

| | |
|---|---|
| Paid Claims | 237,774,342 |
| Claims Removed | 70,911,323 |
| Remaining Claims | 169,030,235 |
| Percentage Remaining | 71.1% |
| # Claimants | 29,869 |
| Claimants Removed | 874 |
| Remaining Claimants | 28,995 |
| Percentage Remaining | 97.1% |

| HCC # | HCC |
|---|---|
| 26 | Mucopolysaccharidosis |
| 70 | Sickle Cell Anemia (Hb-SS) |
| 112 | Quadriplegic Cerebral Palsy |
| 66 | Hemophilia |
| 75 | Coagulation Defects and Other Specified Hematological Disorders |
| 184 | End Stage Renal Disease |
| 118 | Multiple Sclerosis |
| 251 | Stem Cell, Including Bone Marrow, Transplant Status/Complications |
| 115 | Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy |
| 10 | Non-Hodgkin's Lymphomas and Other Cancers and Tumors |
| 9 | Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia |
| 8 | Metastatic Cancer |
| 247 | Premature Newborns, Including Birthweight 2000-2499 Grams |
| 109 | Paraplegia |
| 94 | Anorexia/Bulimia Nervosa |
| 254 | Amputation Status, Lower Limb/Amputation Complications |
| 48 | Inflammatory Bowel Disease |
| 2 | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock |
| 159 | Cystic Fibrosis |
| 45 | Intestinal Obstruction |
| 29 | Amyloidosis, Porphyria, and Other Metabolic Disorders |
| 111 | Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease |
| 1 | HIV/AIDS |

**CC Set 4**

| | |
|---|---|
| Paid Claims | 237,774,342 |
| Claims Removed | 78,486,590 |
| Remaining Claims | 160,827,834 |
| Percentage Remaining | 67.6% |
| # Claimants | 29,869 |
| Claimants Removed | 1,291 |
| Remaining Claimants | 28,578 |
| Percentage Remaining | 95.7% |

| HCC # | HCC |
|---|---|
| 26 | Mucopolysaccharidosis |
| 70 | Sickle Cell Anemia (Hb-SS) |
| 112 | Quadriplegic Cerebral Palsy |
| 66 | Hemophilia |
| 75 | Coagulation Defects and Other Specified Hematological Disorders |
| 184 | End Stage Renal Disease |
| 118 | Multiple Sclerosis |
| 251 | Stem Cell, Including Bone Marrow, Transplant Status/Complications |
| 115 | Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy |
| 10 | Non-Hodgkin's Lymphomas and Other Cancers and Tumors |
| 9 | Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia |
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| 247 | Premature Newborns, Including Birthweight 2000-2499 Grams |
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| 254 | Amputation Status, Lower Limb/Amputation Complications |
| 48 | Inflammatory Bowel Disease |
| 2 | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock |
| 159 | Cystic Fibrosis |
| 45 | Intestinal Obstruction |
| 29 | Amyloidosis, Porphyria, and Other Metabolic Disorders |
| 111 | Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease |
| 1 | HIV/AIDS |
| 56 | Rheumatoid Arthritis and Specified Autoimmune Disorders |
| 38 | Acute Liver Failure/Disease, Including Neonatal Hepatitis |
| 37 | Chronic Hepatitis |
| 119 | Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders |
| 35 | End-Stage Liver Disease |
| 69 | Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn |
| 113 | Cerebral Palsy, Except Quadriplegic |
| 71 | Thalassemia Major |
| 27 | Lipidoses and Glycogenosis |
| 46 | Chronic Pancreatitis |

**Annualized Adjustment Estimate**

| | |
|---|---|
| 2015 Adjusted Claims | 197,993,163 |
| Medical Trend Factor (2 years at 12%) | 1.254 |
| 2017 Claim Estimate | 248,362,624 |
| 2017 Premium Estimate | 285,514,814 |

| | **Condition Set 1** | **Condition Set 2** | **Condition Set 3** | **Condition Set 4** |
|---|---|---|---|---|
| 2017 Claim Estimate | 248,362,624 | 248,362,624 | 248,362,624 | 248,362,624 |
| Estimated Percentage of Claims Remaining | 88.9% | 78.2% | 71.1% | 67.6% |
| Estimated Claims Remaining | 220,867,450 | 194,121,722 | 176,557,286 | 167,989,626 |
| Estimated Claims Ceded | 27,495,174 | 54,240,902 | 71,805,338 | 80,372,998 |
| Estimated Percentage of Claimants Remaining | 99.3% | 98.3% | 97.1% | 95.7% |
| *Estimated Percentage of Members Remaining* | *99.6%* | *98.9%* | *98.0%* | *97.0%* |
| Estimated Premium Ceded | 1,281,127 | 3,235,499 | 5,712,780 | 8,438,443 |
| Estimated Net Cost to Program | 26,214,047 | 51,005,403 | 66,092,558 | 71,934,555 |

**Testimony in Support of Senate Bill 206**
**Provided by**
**Kraig Anderson, SVP and Chief Actuary, Moda Health**
**April 13, 2016**

Co-Chair Kelly, Co-Chair MacKinnon, and members of the Senate Finance Committee,

My name is Kraig Anderson and I am a Senior Vice President and the Chief Actuary for Moda Health. Thank you for the opportunity to provide comments in support of **Senate Bill 206**, which will enable the establishment of a state reinsurance program for the Alaska individual health insurance market.

Moda Health has been offering individual health insurance coverage to Alaskans since 2007. With the implementation of the Affordable Care Act in 2014, we continued to participate in this market by offering policies both on and off of the Exchange. We remain one of only two insurance companies that provide individual health insurance coverage in Alaska. In spite of financial difficulties in the individual market these past two years, we continue to fulfill the commitments we've made to our individual policyholders.

Currently the Alaska individual market has 23,000 people, or about 4% of the population. With the expansion of individual coverage through Federally Facilitated Exchange, the number of people with individual coverage increased from approximately 13,000 people prior to 2014. The expansion of the individual market has been difficult nationally on many insurers because the health of the population is worse than what was expected, and Alaska is no exception. Part of the concern is the relatively small number of people in the Alaska individual market that are available to spread the risk.

We are supportive of this bill as a way of addressing the variability inherent in the Alaska individual market. Over the past few months, we have collaborated with the Alaska DOI, Premera and ACHIA on a reinsurance program aimed at helping to stabilize this market. Moda and Premera have provided detailed claims data through ACHIA to an actuarial consulting firm to model the impact of such a program. Our actuaries have been closely involved in reviewing the analysis and have provided feedback to ensure that the results are sound. We are supportive of Senate Bill 206 as this will help improve the predictability of the individual pool when setting future rates.

Thank you for considering my comments in support of **Senate Bill 206**. I want to emphasize that Moda is invested in the Alaska individual health insurance market and we are committed to working on the implementation of a state reinsurance program.

**Doniece Gott**

**From:** Sen. Anna MacKinnon
**Sent:** Wednesday, April 13, 2016 10:27 AM
**To:** Senate Finance Committee
**Subject:** FW: SB 206

**From:** Jerry Reinwand [mailto:reinwand@ptialaska.net]
**Sent:** Wednesday, April 13, 2016 10:26 AM
**To:** Sen. Anna MacKinnon <Sen.Anna.MacKinnon@akleg.gov>
**Cc:** Erin Shine <Erin.Shine@akleg.gov>
**Subject:** SB 206

Senator MacKinnon:

As you know, SB 206—legislation introduced by the Governor to address the crisis in the individual health insurance market—is up for a hearing today at 5:00 p.m. in Senate Finance. Here is the Readers Digest version of the problem that SB 206 is attempting to solve:

· The individual health insurance market in Alaska is in crisis

· With health reform, in 2014, the **major change** to the insurance market was **guaranteed issue** to all individuals without preexisting condition exclusions. This provided access to insurance for several thousands of individuals

– And, Premera and insurers priced products estimating the impact of the uninsured purchasing coverage for the first time

– We experienced a significant influx of new enrollees with very high medical costs , many leaving the high risk pool (which has shrunk by half) and the federal preexisting condition pool and Premera lost approximately $13 million in the individual market

· For 2015 and 2016, Premera had approximately 37% and 39% average rate increases for the individual metallic plans, but claims continue to exceed premiums.

· To say it differently, Premera is taking in on average $713 in premium Per Month Per Member (PMPM) and paying claims at $919 PMPM, demonstrating the very high claims costs in the individual pool

· In a very small sized market like Alaska, **there are not enough healthy individual purchasers to offset the costs of enrollees with very high medical needs**

· Today-- Alaska's average benchmark plan premium is the highest in the country (over $700 per month; next highest state is $468)

· We are very concerned that premiums will continue to skyrocket due to the small size of the individual pool

– With fewer people to spread risk across, a small number of individuals with high cost conditions is destabilizing the pool and impacting costs dramatically

· One solution – is an approach other insurers already took- to exit the individual market; only two companies are currently writing policies in the individual market in Alaska: Premera and Moda

· Alternatively, Premera and Moda have been working collaboratively with the DOI to come up with a sustainable option for Alaskans—which is the reinsurance program administered by the state's high risk pool, ACHIA

· The reinsurance program would **spread the claims** from **highest cost medical conditions** across the entire insured market using the state's high risk pool-

– Paid for by an assessment on insured plans. Spreading costs across a broader base will help **lower the rate of increases for individual purchasers**

· This solution was implemented previously by the state's high risk pool (ACHIA) in 2013 to ensure that child-only health policies were available in the individual market

– Using ACHIA, a reinsurance program for the individual market could be implemented efficiently given ACHIA's experience and with minimal to no administrative costs, since the infrastructure already exists

· As an insurer that offers coverage to both individual and group purchasers (with around 45% marketshare in group business), **Premera supports a balanced assessment** that will not place undue burdens on the group market

· SB 206 will help mitigate the premium increases and on behalf of over 10,000 individuals that Premera covers, we ask for your support

If you have any questions regarding SB 206, please do not hesitate to contact me.

Jerry

**Alaska Chapter**
**Mission Statement**

*AAHU is a state chapter of the National Association of Health Underwriters. We provide professional development, promote high ethical standards of our members, advocate responsible legislation and proactively educate Alaskans on health and financial security needs.*

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**Executive Director**
***Kelli Lee***

**April 13, 2016**

**To: Alaska State Legislature**
**CC: Director Lori Wing-Heier, Division of Insurance**
**RE: Letter of Support for SB 206 & HB 374**

The Alaska individual health insurance market is unsustainable and in danger of collapsing due to the premiums for health insurance skyrocketing over the past three years. The individual health insurance premiums are set to increase at a dramatic rate again next year. We need to take action to guarantee the survival of the individual health insurance market and continue to have viable options for tens of thousands of Alaskans who are currently enrolled in individual health plans.

The Alaska Association of Health Underwriters is in full support of SB 206 & HB 374. This legislation would make changes to the Alaska Insurance Code to allow for a Reinsurance Program for Alaska residents who are high risks to the health insurance market. A Reinsurance Program will help to mitigate these drastic rate increases by stabilizing the market. It would spread certain high cost claims in the individual market across the broader insured market. Alaska Comprehensive Health Insurance Association (ACHIA) would administer the program.

In addition to the reinsurance program, the bill would also authorize the State to seek a 1332 State Innovation Waiver from the Affordable Care Act (ACA) in order to implement innovations which fit the Alaska marketplace. The 1332 Innovation Waiver would give the State the ability to restructure the approach to health insurance reform by waiving and proposing alternatives to applicable ACA provisions. The 1332 State Innovation Waiver program will allow Alaska to design a healthcare reform package that fits the State of Alaska.

We urge your prompt and favorable action on this measure.

Jennifer Meyhoff
AAHU Legislative Chair
Jennifer.meyhoff@marshmc.com
907-257-6350

Jeff Ranf
AAHU Legislative Vice Chair
Jeff.ranf@usi.biz
907-334-4703

– Waivers – BACKUP ①

A Robert Wood Johnson Foundation program

# State Health Reform Assistance Network

## Charting the Road to Coverage

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# 1332 State Innovation Waivers: Getting off the Ground

**Manatt Health Solutions**

**July 2015**

# Agenda

- Getting Started with 1332 Waivers
- 1332 Waivers in HealthCare.Gov States
- Discussion of Future Topics
- Discussion

# Getting Started with 1332 Waivers

How many want a 1332 waiver?

Why do you need a 1332 waiver?

# 1332 Activity in the States

| State | Status | Description |
|---|---|---|
| **Arkansas** | Bill introduced but not enacted during 2015 session | Would have authorized several state agencies to apply for and to implement 1332 waivers on the state's behalf |
| **California** | Senate passed bill, Assembly considering | Requires the Secretary of the California Health and Human Services Agency to apply for a waiver to allow individuals who are not eligible for coverage because of their immigration status to obtain coverage |
| **Hawaii** | Legislation Signed by Governor | Narrows "the scope of work of the State Innovation Waiver Task Force to facilitate the development of an Affordable Care Act Waiver in a timely manner" |
| **Rhode Island** | Enacted budget | Authorizes Marketplace to pursue a 1332 waiver |
| **New Mexico** | Senate passed resolution | Establishes task force within Office of Superintendent of Insurance to study waivers |
| **Minnesota** | Legislation Signed by Governor | Governor charged with convening "Task Force on Health Care Financing" to consider, among other topics, using 1332 waivers to improve continuum of coverage and delivery system reform |



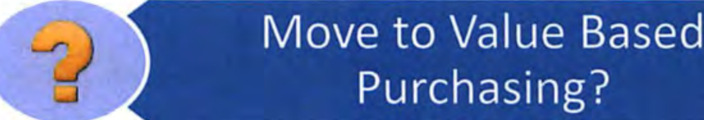
*Source:* Heather Howard and Galen Benshoof, *Section 1332 Waiver Activity Heating Up in States*, Health Affairs Blog, June 2015. *http://healthaffairs.org/blog/2015/06/24/section-1332-waiver-activity-heating-up-in-states/*

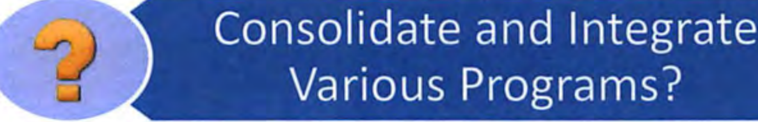
# Framework for Moving Forward

# Identify State Goals

**Important to Align Broad Goals and Targeted Objectives**

**Does the State Want to….**



# Identify Barriers and Strategies

| Potential Barriers | Strategies for Overcoming Barriers |
| --- | --- |
| Eligibility Standards Differ Across Programs | Align Eligibility Requirements |
| Participating Providers Change Based on Program | Align Standards Across QHPs and Medicaid MCOs |
| Large Cost Sharing Increases on Small Income Changes | Smooth the Cost Sharing Continuum |
| Disruption to Existing State Roles/Responsibilities | Convene Interagency Taskforce |

# Available Tools

1332 waiver to waive certain ACA provisions

1115 waiver to waive provisions of federal Medicaid law

Combine 1332 and 1115 Waivers

State legislation or regulation

Just do it!

# Minnesota's Health Care Task Force

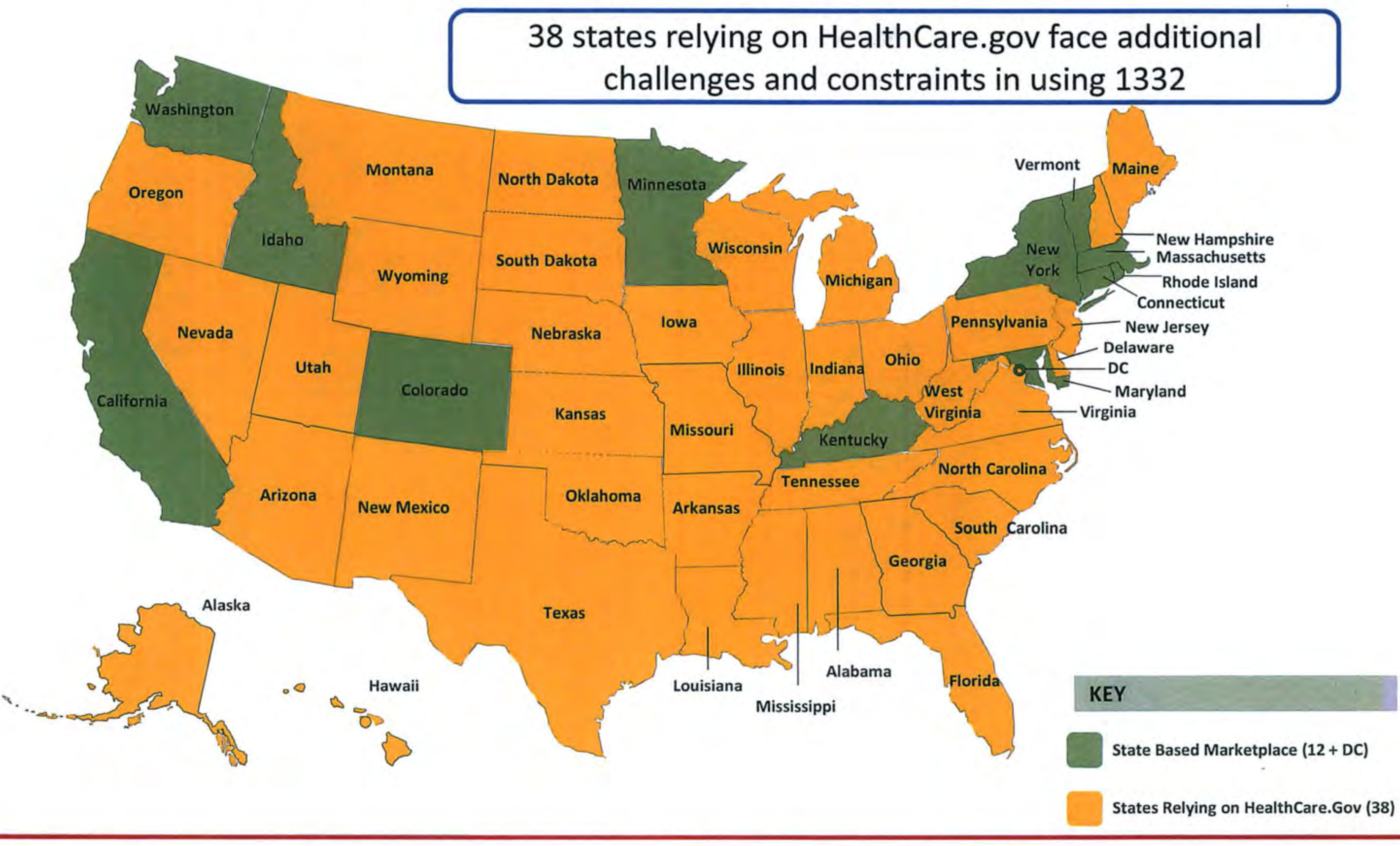
| Goal | Barrier | Strategy |
|---|---|---|
| **Align affordability programs eligibility and enrollment requirements** | Sharp differences in out-of-pocket costs as people move from one affordability program to another | Introduce gradual increases in cost-sharing for higher income enrollees to create a smoother transition from public programs to QHPs. 1332? 1115? Existing authority? |
| **Create multi-payer alignment in payment and delivery reform across affordability programs** | Providers not incentivized towards the same goals of quality and efficiency across insurance affordability programs | Increase payment for providing care to members based on performance that results in improved health outcomes 1332? 1115? Existing authority? |
| **Align coverage and contracting requirements** | As members move between programs, relationships with trusted providers and care delivery may be disrupted | Align network adequacy and quality incentives across payers to facilitate formation of ACOs that serve members across affordability programs. |



*Source:* Minnesota Department of Human Services, *2017 Innovation Waiver Report*, February 2015. *http://www.mn.gov/dhs/images/2017_Innovation_Waiver_Progress_Report.pdf*

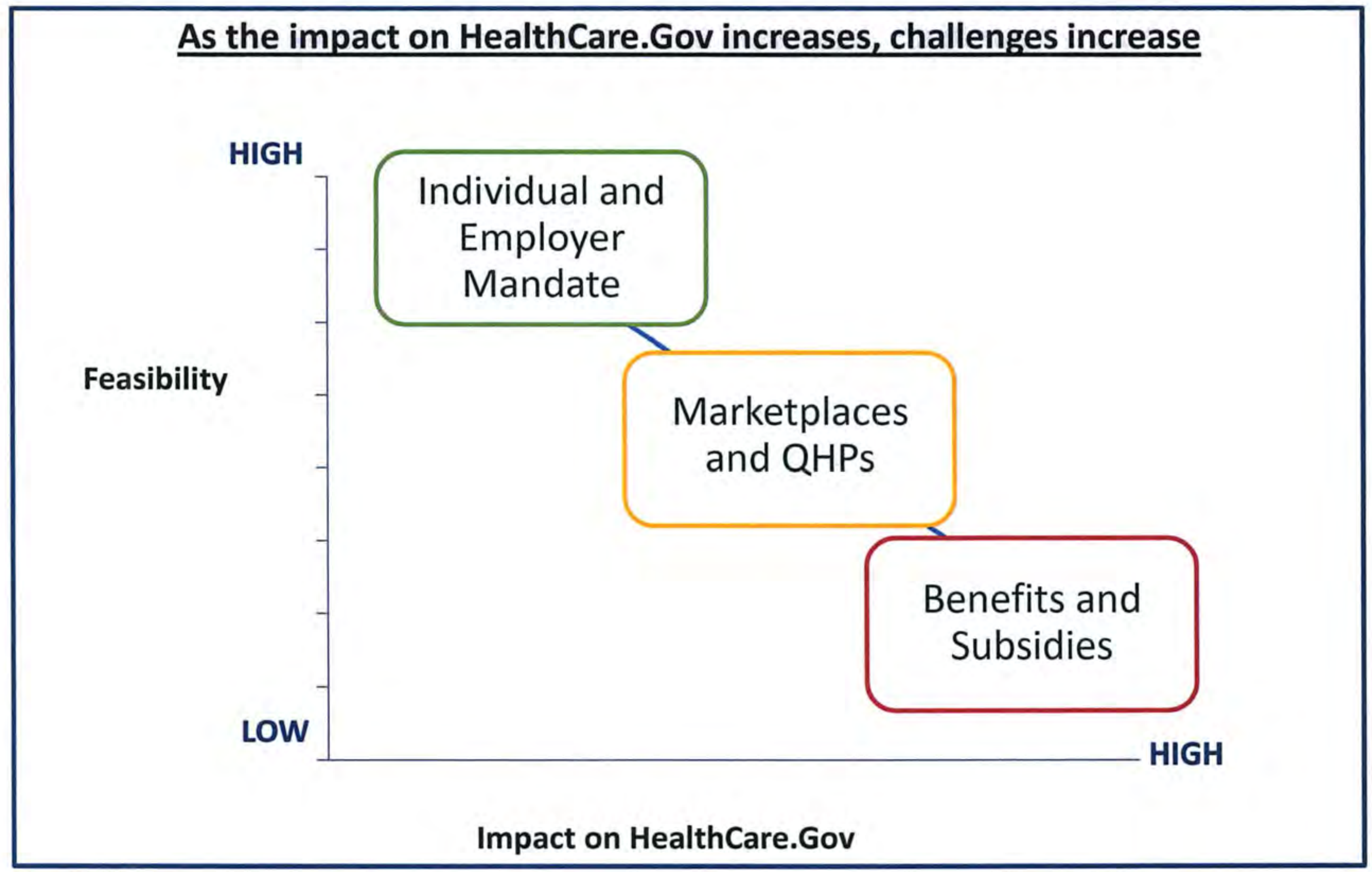
# 1332 Waivers in HealthCare.Gov States

# States Relying on HealthCare.Gov




States considering transitioning to HealthCare.Gov should factor in the potential loss of flexibility in developing 1332 waivers for state specific innovation

# HealthCare.Gov State Confines




**These confines represent the current state of HealthCare.Gov, future improvements may allow for more state flexibility in 2017 and beyond**

# Replacements for the Individual or Employer Mandate

**Easier to do under HealthCare.Gov**

- Individual late enrollment penalty if imposed by QHP issuer
- Eliminate or change scope of employer mandate

**Harder to do under HealthCare.Gov**

- Individual late enrollment penalty if imposed by Marketplace
- More limited enrollment opportunities for individuals
- More generous subsidies for individuals
- Auto-enrollment for individuals

# Marketplaces and QHPs

**Easier to do under HealthCare.Gov**

- ❑ Change the actuarial value of existing metal levels (e.g., wider de minimus variation)

**Harder to do under HealthCare.Gov**

- ❑ Create new metal level (e.g. copper)
- ❑ Change eligibility criteria for catastrophic enrollment

1332 waivers can be used to replace the Marketplace with an alternative model, such as using direct enrollment to obtain subsidies without a central Marketplace

# Benefits, Subsidies and Medicaid-Marketplace Convergence

**Easier to do under HealthCare.Gov**

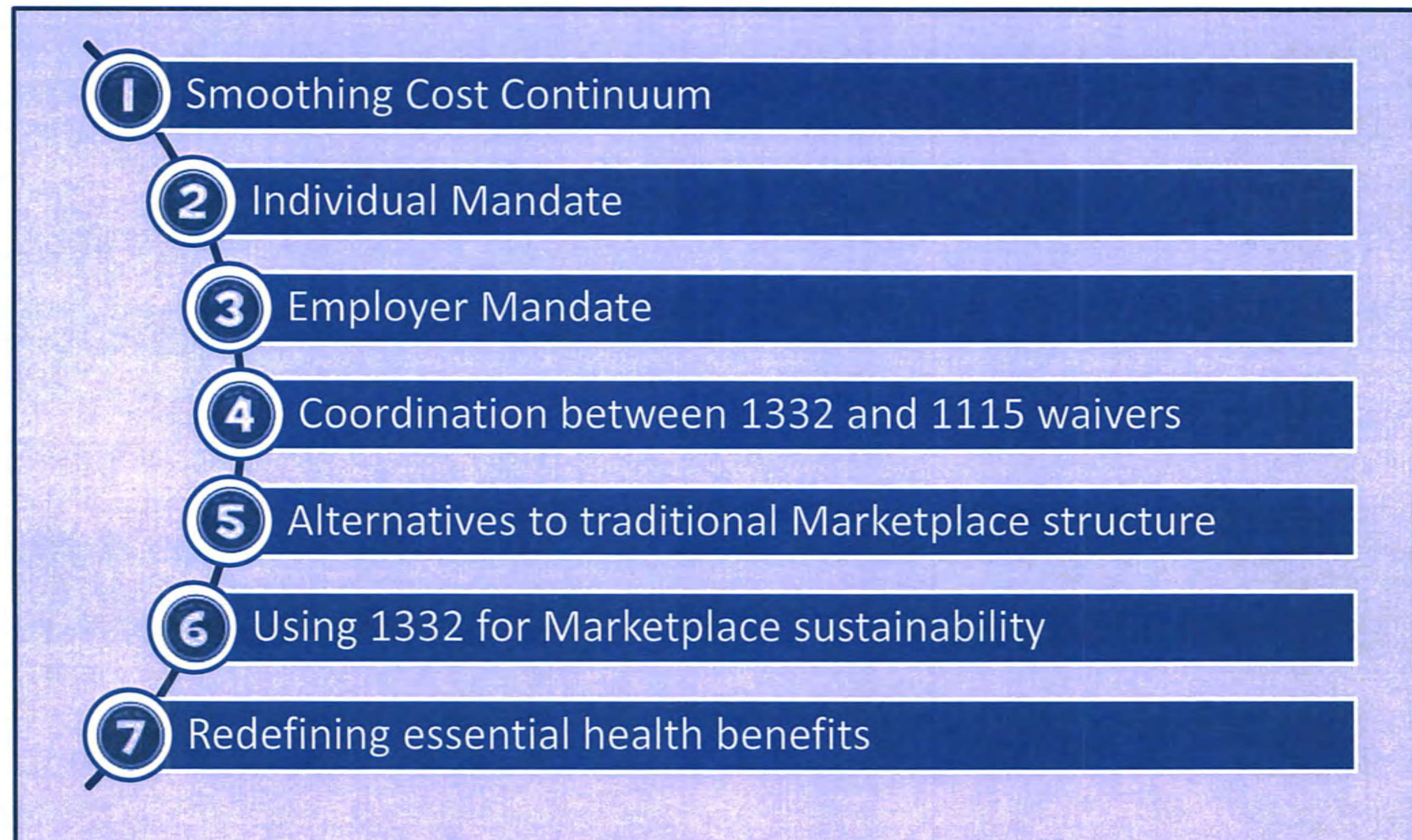
- ❑ Add a new benefit category
- ❑ Permit non-insurers (Medicaid MCOs, ACOs) to be QHP issuers

**Harder to do under HealthCare.Gov**

- ❑ Change value of subsidies or eligibility for subsidies
- ❑ Permit Medicaid beneficiaries to select plans

# Discussion of Future Topics

# Future Topics?



# Discussion

# Thank you!

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Sharon Woda SWoda@Manatt.com

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—WAIVER BACKUP — (2)

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# State Health Reform Assistance Network

## Charting the Road to Coverage

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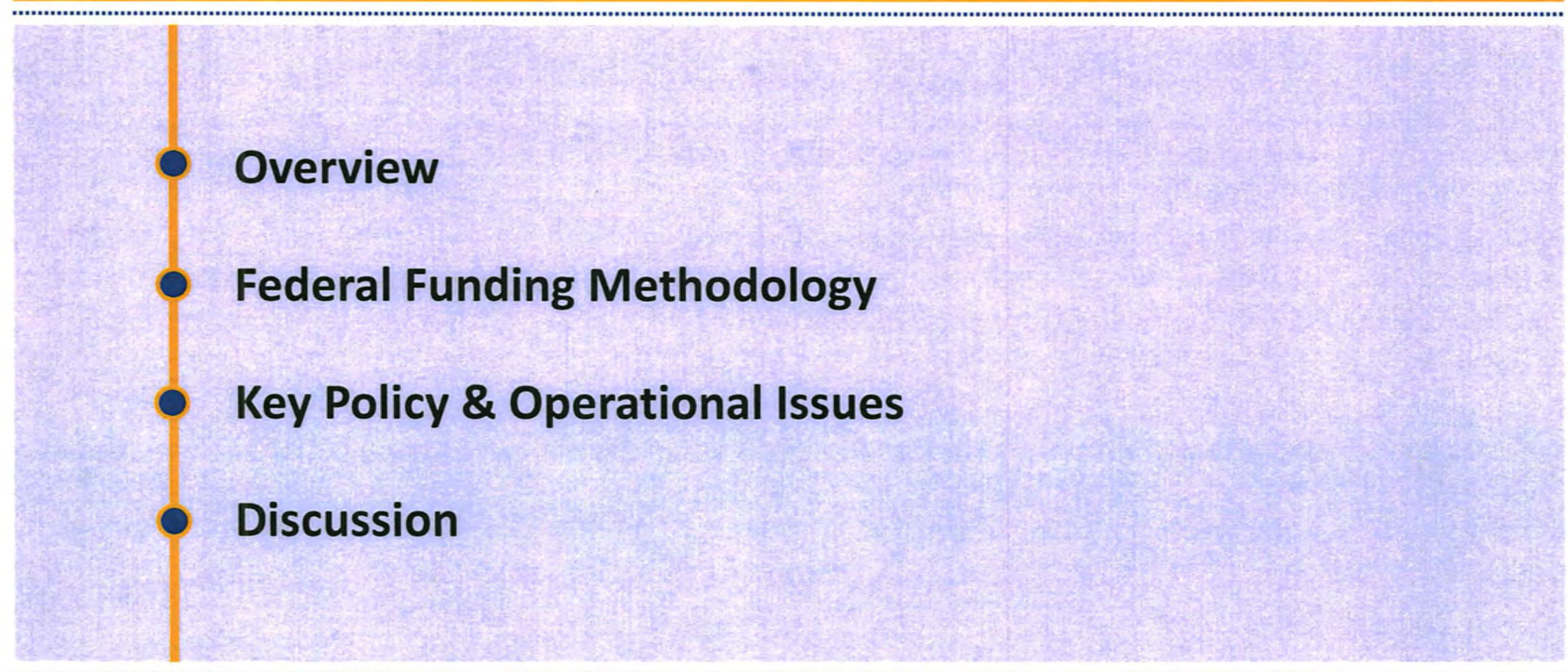
# 1332 State Innovation Waivers: Lessons Learned from the Basic Health Program

Manatt Health Solutions
November 2015

# Agenda



# Overview

# Today's Focus

**Discuss lessons learned from implementing the Basic Health Program (BHP) to inform 1332 planning across two key areas:**

1. **Federal Funding Methodology**
2. **Key Policy and Operational Issues**

# Federal Funding Methodology

# Introduction to BHP & 1332 Federal Funding

**How will CCIIO calculate the amount of federal funds available to the states under a 1332 waiver?**

**Basic Health Program**

*"The amount determined . . .* ***is equal to 95 percent of the premium tax credits under section 36B of title 26, and the cost-sharing reductions under section 1402****, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle."*

PPACA § 1331(d)(3)(A)(i)

**1332 Waiver for Innovation**

*"The Secretary shall provide for an alternative means by which* ***the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges*** *established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver."*

PPACA § 1332(a)(3)

# Approach to Calculating BHP Funding

***"The BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in general alignment with the methodology used by Exchanges."***

42 CFR 600(3)(A)

Determine 95% PTC/CSR funding on a per enrollee basis

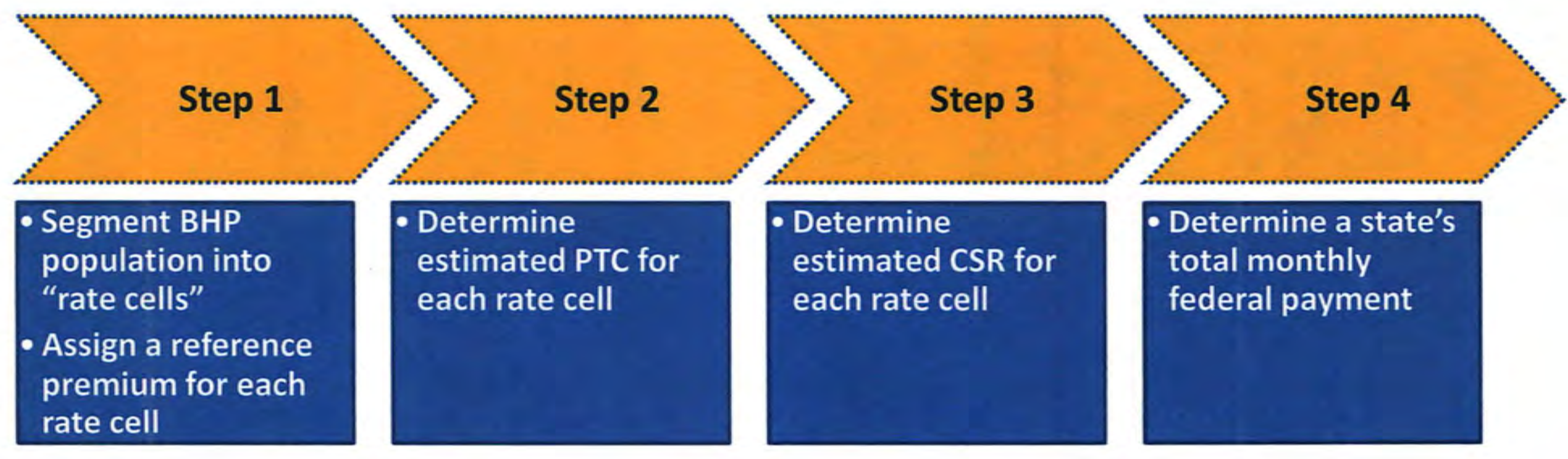
Account for each enrollee's:

- Age
- Income
- Coverage type (self-only or family)
- Geography
- Health status
- Income reconciliation

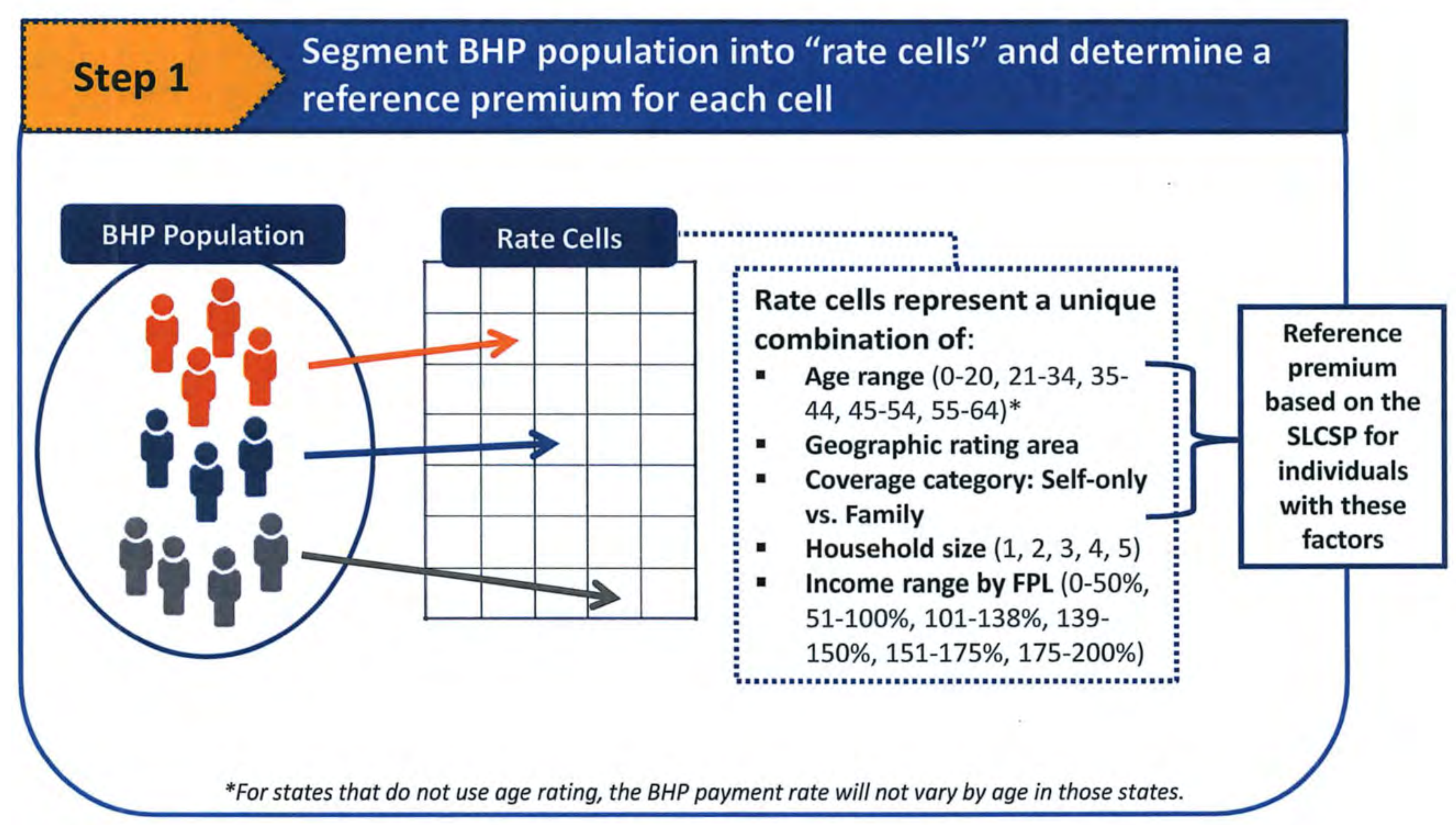
Consider Exchange experience with a special focus on enrollees < 200% FPL.

PPACA § 1331(d)(3)(A)(ii)

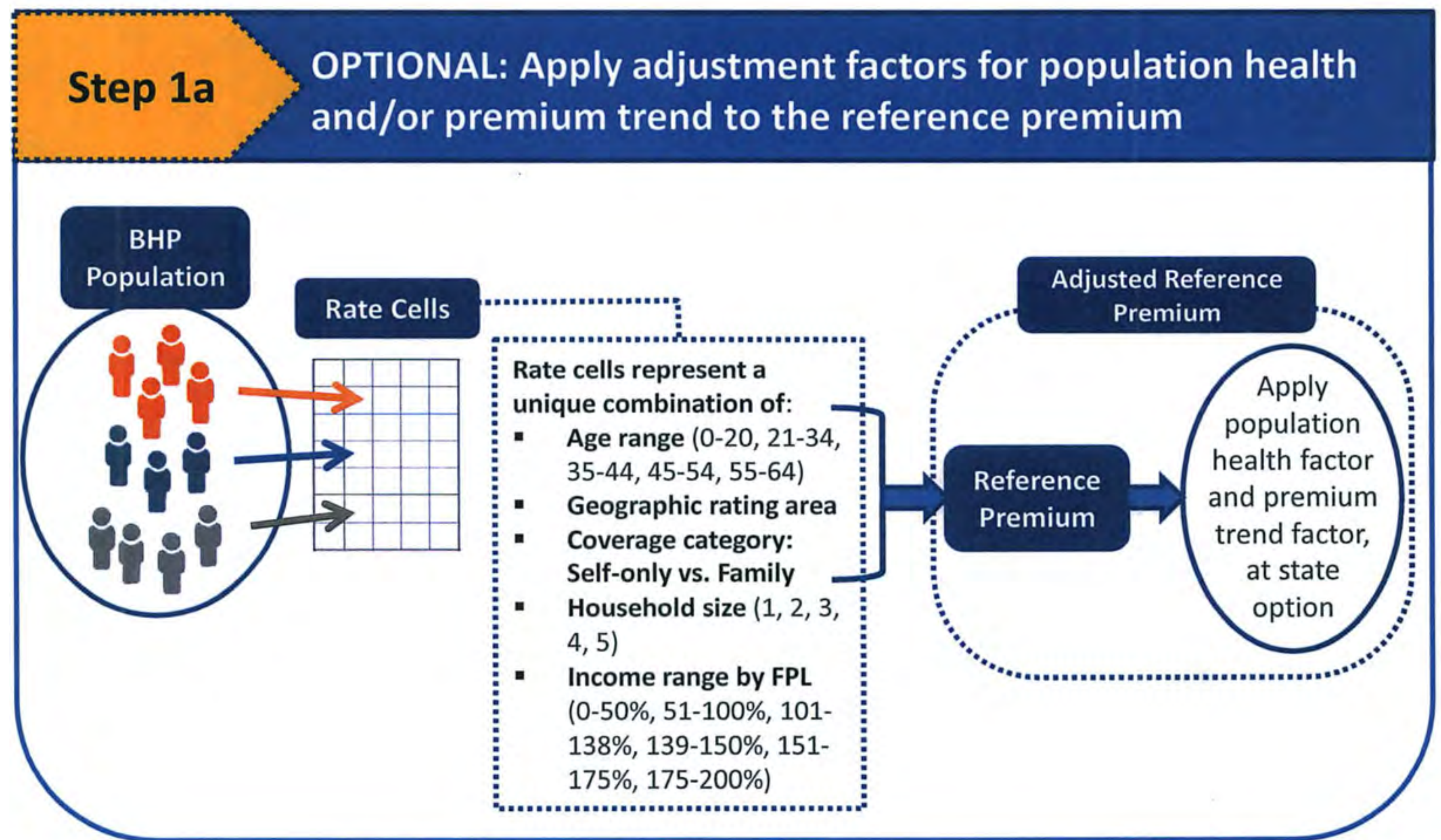
# Overview of BHP Funding Methodology



# BHP Federal Funding Methodology

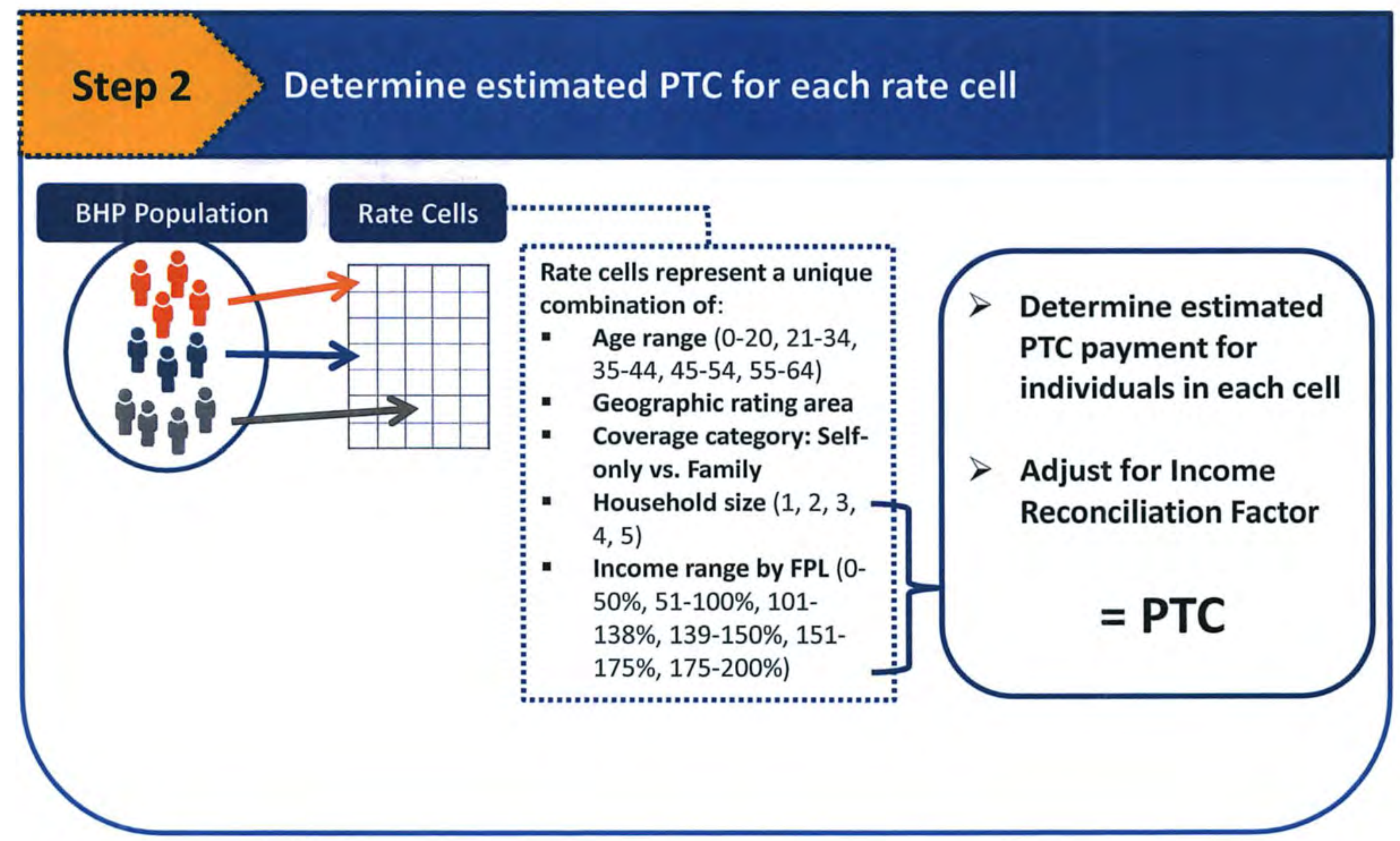


# BHP Federal Funding Methodology, cont.



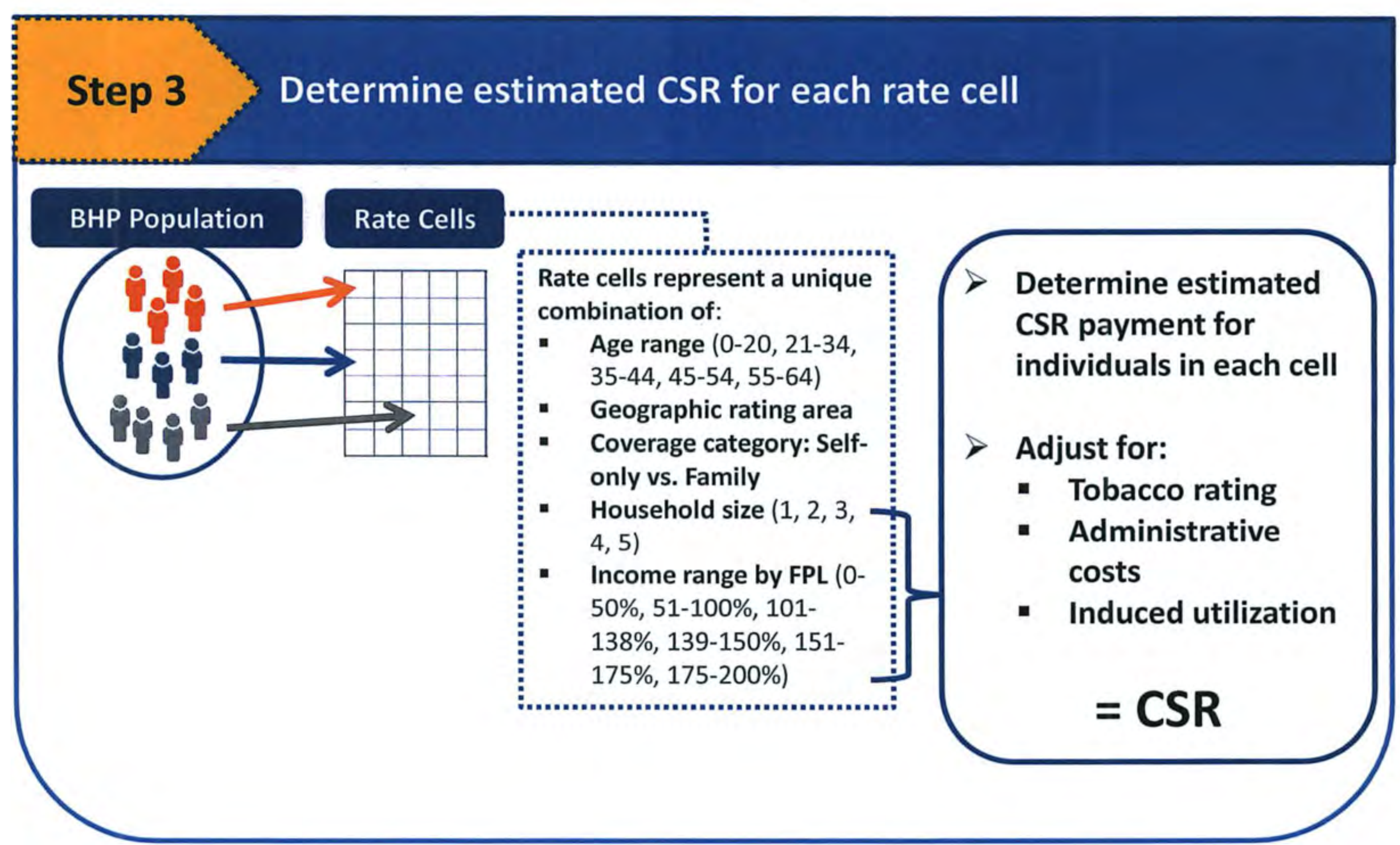

***Note:*** *Population Health Factor (PHF): PHF= 1 through 2018 (until subsequent methodology alters), unless state proposes state-specific adjustment.*
*Premium Trend Factor (PTF): State option to use the prior year's premiums as the basis for the federal payments, in which case, the reference premium is adjusted for the PTF.*

# BHP Federal Funding Methodology, cont.




*Note: The PTC portion of each rate represents the average that all persons in the rate cell would receive.*

# BHP Federal Funding Methodology, cont.




*Note: The PTC portion of each rate represents the average that all persons in the rate cell would receive.*

# BHP Federal Funding Methodology, cont.

**Step 4** Determine a state's total monthly federal payment

**Payment for Rate Cell X** = (95% PTC + 95% CSR) x Projected # of Enrollees

**Payment for Rate Cell Y** = (95% PTC + 95% CSR) x Projected # of Enrollees

**Payment for Rate Cell Z** = (95% PTC + 95% CSR) x Projected # of Enrollees

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**Total Monthly Payment to State**

# Key Policy & Operational Issues

# Population Health Factor

## BHP Approach

- CMS assumes no health status differences between BHP and QHP enrollees (i.e., Population Health Factor =1)
- States have the option to propose and implement a retrospective risk adjustment if they believe their BHP population to be less healthy than their Marketplace population.
- MN opted to develop and implement risk adjustment protocol as part of payment methodology; NY opted not to pursue risk adjustment.

## Key Insights

- Payment methodology flexibility is helpful to states operating in an uncertain environment but also complicates the payment process.
- In the absence of Marketplace data, actuarial analysis was crucial to states in predicting their expected BHP populations.
- Analysis of potential variables and models for 1332 waivers will be able to build off of 2014-2016 Marketplace data.

# Prospective Payments to States

## BHP Approach

- CMS determines BHP payments to states on a prospective, state-specific, quarterly basis, multiplying payment rates by projected BHP enrollment.
- Payments are adjusted retrospectively based on actual enrollment but are not corrected for any other factors (except in states pursuing optional risk adjustment).
- Additional payments are deposited into the BHP Trust Fund, while reductions are applied to the state's prospective payment in the upcoming quarter.

## Key Insights

- Prospective methodology provides states with predictability.
- Quarterly payments allow for incremental adjustment rather than one annual adjustment of the entire amount.
- 1332 does not require states to set up a Trust Fund.

# Risk Pool

## BHP Approach

- The BHP population is excluded from the individual Marketplace.
- States conducted analyses to determine the impact this would have on the relative health of their Marketplace population.

## Key Insights

- If a state uses its 1332 waiver to implement an alternative coverage vehicle for a subset of its Marketplace population, there will be risk pool implications.

# Funding for Program Administration

## BHP Approach

- 1331(d)(2) requires that BHP federal funding "only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for" BHP enrollees.
- States must identify other (non-federal) funding sources to cover BHP program administration costs.

## Key Insights

- Nothing in the 1332 requirements appears to impose the same prohibition on states.

# Non-Filer Households

## BHP Approach

- CMS permits BHP enrollees to be non-filers.
- For non-filer households, use Medicaid rules to determining household size and income.
- For filer households, use Marketplace rules to determining household size and income.

## Key Insights

- Flexibility critical but complicated to administer.
- NY used Medicaid non-filer rules with retrospective sampling and CMS is evaluating potential payment adjustments.

# Medicaid/Marketplace Alignment

## BHP Approach

- To the extent possible, CMS aligned BHP rules with Medicaid and/or Marketplace rules.
- Where Marketplace and Medicaid rules conflicted, CMS sought to align BHP with one program or the other, or where possible, provide States with flexibility to choose how to align.

## Key Insights

- 1332 waivers provide an opportunity to align Marketplace rules with Medicaid rules.

### State Flexibility

Most E&E features, including:

- Authorized Representatives
- CACs
- Eligibility Verification
- Eligibility Effective Date
- Enrollment Period
- Eligibility Appeals
- Eligibility Redeterminations

Some enrollee premiums & cost sharing features, including:

- Premium Grace Periods
- Reenrollment Standards

**Marketplace:**

- First day of the following month if QHP selected between 1st-15th or first day of second following month if QHP selected between 16th and last day. 45 CFR 155.420(b)(1)

**Medicaid**:

- First day of the month if individual was eligible any time during that month. 42 CFR 435.915(b)

# Launch & Coverage Transitions

## BHP Approach

- Permitted to phase-in enrollment in 2015 only.
- MN employed block renewal process for January 1, 2015.
- NY opted for phased-in approach:
  - Transition Period (April 1-Dec 31, 2015) for lawfully present non-citizens with household incomes 0-133% FPL
  - Full Launch (January 1, 2016)

## Key Insights

- High potential for disruption (among consumers, IT systems, etc.)
- Phased-in approach allows time for coverage conversion, near-term use of federal funding, and additional time for system build, staff training, and enrollee verification.
- Assistors and consistent messaging critical to all coverage transitions.

# Discussion/Questions?

# Next Steps

# Next Steps

| Webinar Topic | Date |
|---|---|
| 1332 State Innovation Waivers: What's Next for States | 4/20/15 ✓ |
| 1332 State Innovation Waivers: What Can be Waived? | 5/29/15 ✓ |
| 1332 State Innovation Waivers: Getting off the Ground | 7/13/15 ✓ |
| 1332 State Innovation Waivers: Coordinating 1332 and 1115 Waivers | 8/24/15 ✓ |
| 1332 State Innovation Waivers: Issues Related to Coordinated Waivers | 10/6/15 ✓ |
| 1332 State Innovation Waivers: Learning from the Basic Health Program | TODAY ✓ |
| Topic TBD | TBD-- December |

# Thank you!

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WAIVER BACKUP (3)

A Robert Wood Johnson Foundation program

# State Health Reform Assistance Network

## Charting the Road to Coverage

Support provided by

Robert Wood Johnson Foundation

State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

# 1332 State Innovation Waivers: What's Next for States

Manatt Health Solutions

April 2015

# Agenda

- 1332 Waivers: Basics
- Obtaining a Waiver
- Waiver Possibilities
- Future Topics for Workgroup
- Discussion

# 1332 Waivers: Basics

# What can be waived?

**States may request waivers from HHS and the Treasury Department of certain requirements of the Affordable Care Act (ACA), effective 01/01/2017**

1 ***Individual Mandate***

States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health coverage.

2 ***Employer Mandate***

States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable coverage to their full-time employees.

3 ***Benefits and Subsidies***

States may modify the rules governing covered benefits and subsidies. States that reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies for alternative approaches.

4 ***Exchanges and QHPs***

States can modify or eliminate QHP certification and the Exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.

ACA § 1332(a)(2)

Section 1332 waivers can be coordinated with 1115 waivers, which may create opportunities for states to address differences among these federal programs that may impede efforts to pursue multi-payer delivery system reform.

# What can't be waived?

## States may not waive fair play rules

***Guaranteed Issue***

States may not waive non-discrimination provisions prohibiting carriers from denying coverage or increasing premiums based on medical history. States are precluded from waiving rules that guarantee equal access at fair prices for all enrollees.

# What are the Statutory Guardrails?

**A state waiver application must satisfy four criteria to be granted**

**1 *Scope of Coverage***

The waiver must provide coverage to at least as many people as the ACA would provide without the waiver.

**2 *Comprehensive Coverage***

The waiver must provide coverage that is at least as "comprehensive" as coverage offered through the Exchange.

**3 *Affordability***

The waiver must provide "coverage and cost sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as Exchange coverage.

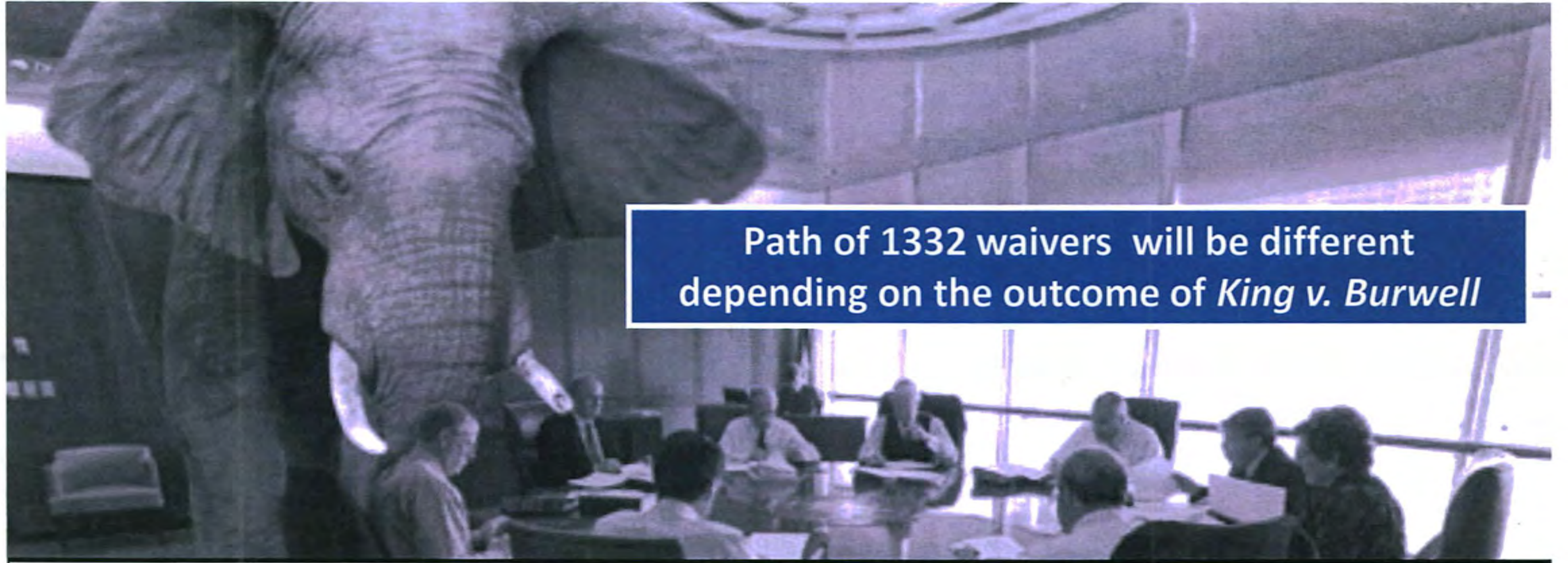
**4 *Federal Deficit***

The waiver must not increase the federal deficit.



ACA § 1332(b)(1)

# Where does *King vs. Burwell* fit?




***Ruling in Favor of Federal Government***

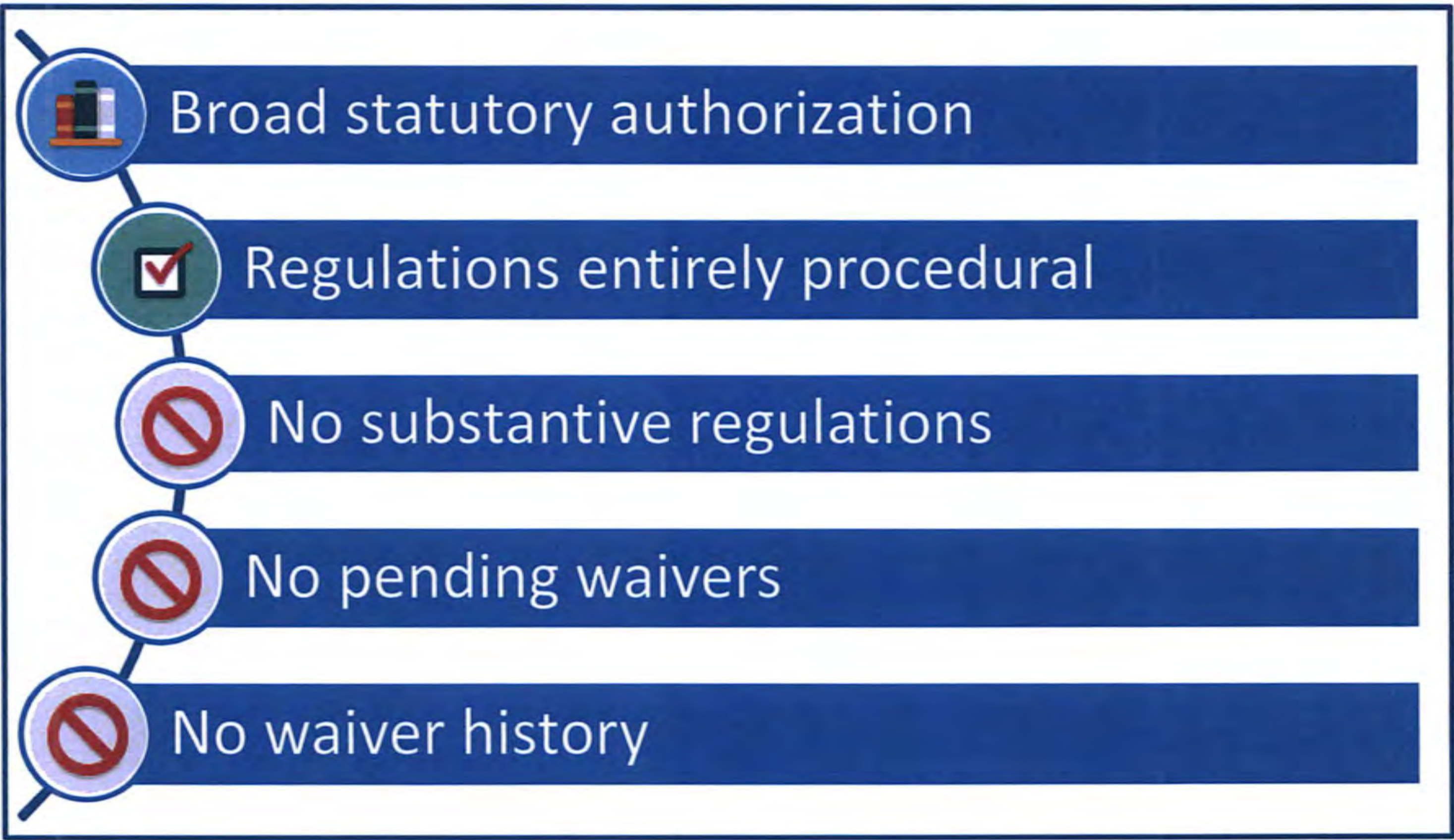
1332 will serve as a pathway for states to introduce innovative programs specific to state priorities.

***Ruling in Favor of Plaintiff***

1332 waiver effective date may be advanced to provide flexibility to continue flow of subsidies in current FFM states.

# 1332 Provides New Opportunities for States

## Working off an (almost) blank slate



# Obtaining a Waiver

# Steps in Waiver Process

**State**

- Consider state goals and determine if 1332 waiver is desirable
- Have sufficient state authority to implement the waiver
- Draft waiver application
- Hold pre-application hearing
- Include in waiver application:
  - Actuarial/economic analyses
  - Implementation timeline
  - Ten-year budget plan

**HHS and Treasury**

- Deem the waiver application complete
- Conduct federal notice and comment period
- Review the application within 180 days of determining it is complete
- Approve or reject the waiver application

**Implementation**

- Waivers implemented in 2017 or later
- Quarterly and annual reports submitted to Treasury and HHS
- Waiver renewals begin no later than 2022 because the term of waiver may not exceed five years

There is no deadline for submitting a waiver application and states may submit prior to 2017

# State Authority

**Section 1332 requires that a state have authority under state law to submit *and* implement a waiver request**

**States may use preexisting law that grants state authority**

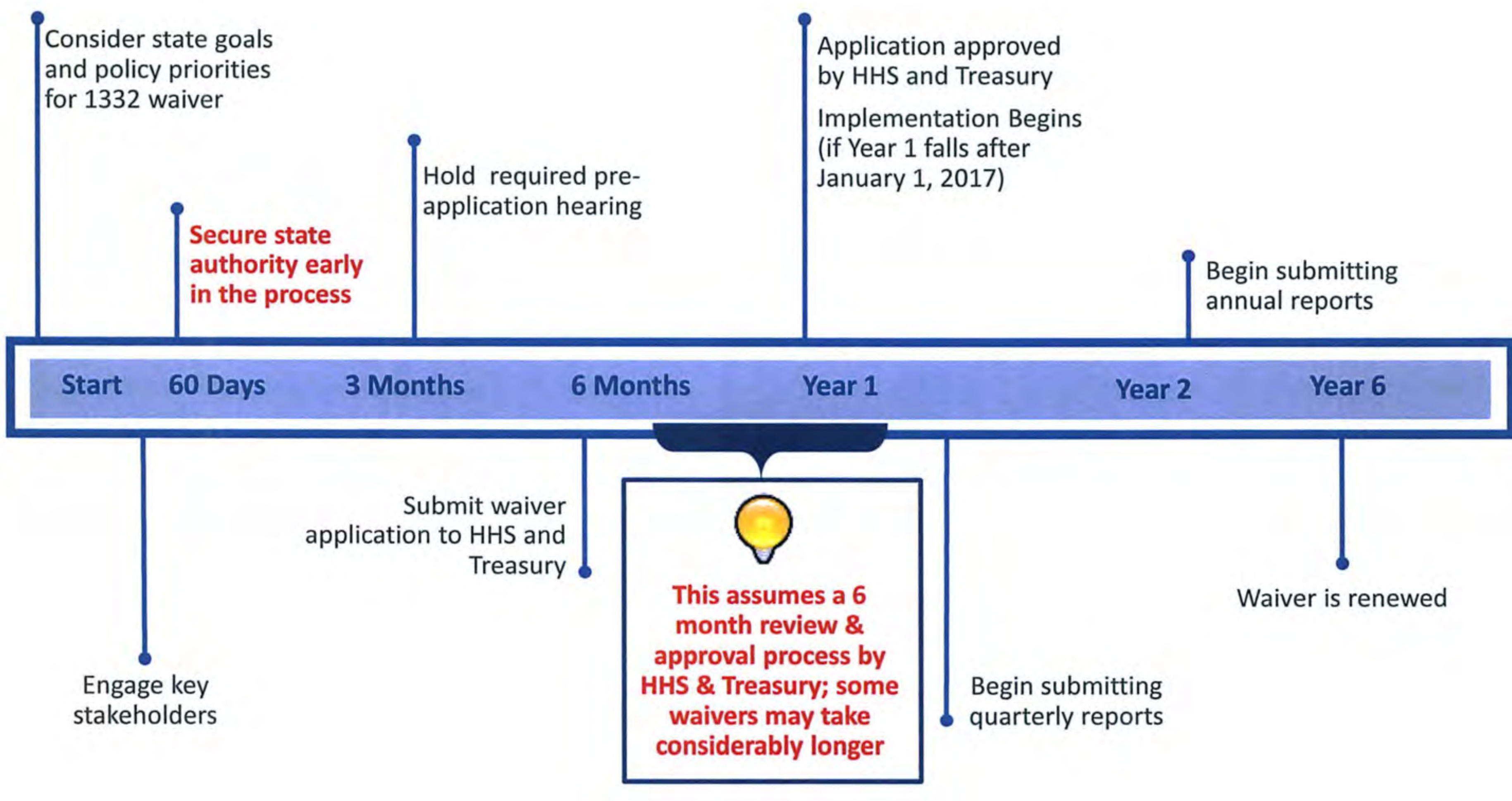
ACA § 1332(a)(1)(C), (b)(2)(A)

# Stakeholder Engagement

The most compelling ideas for innovation may emerge after state officials and key stakeholders come together and forge consensus around the needs of their public programs and commercial insurance markets.

Hawaii's 1332 taskforce may be a model for other states wanting to ensure all options are considered in a public and transparent way through their engagement of stakeholders in a review of available options.

# Sample 1332 Implementation Timeline



# Waiver Possibilities

# Possibilities for 1332 Waivers

**A wide open opportunity for states to innovate, subject to the statutory guardrails**

1 ***Far Reaching Policy Initiatives***

Opportunity to alter the ACA coverage paradigm by: changing subsidy structure, waiving individual or employer mandate, or replacing the Exchange entirely.

2 ***Targeted Fixes***

Opportunity to address specific ACA issues including: aligning income rules for Medicaid and APTC, addressing the "family glitch", or delaying extension of rate regulation to 51 – 100 small employer market.

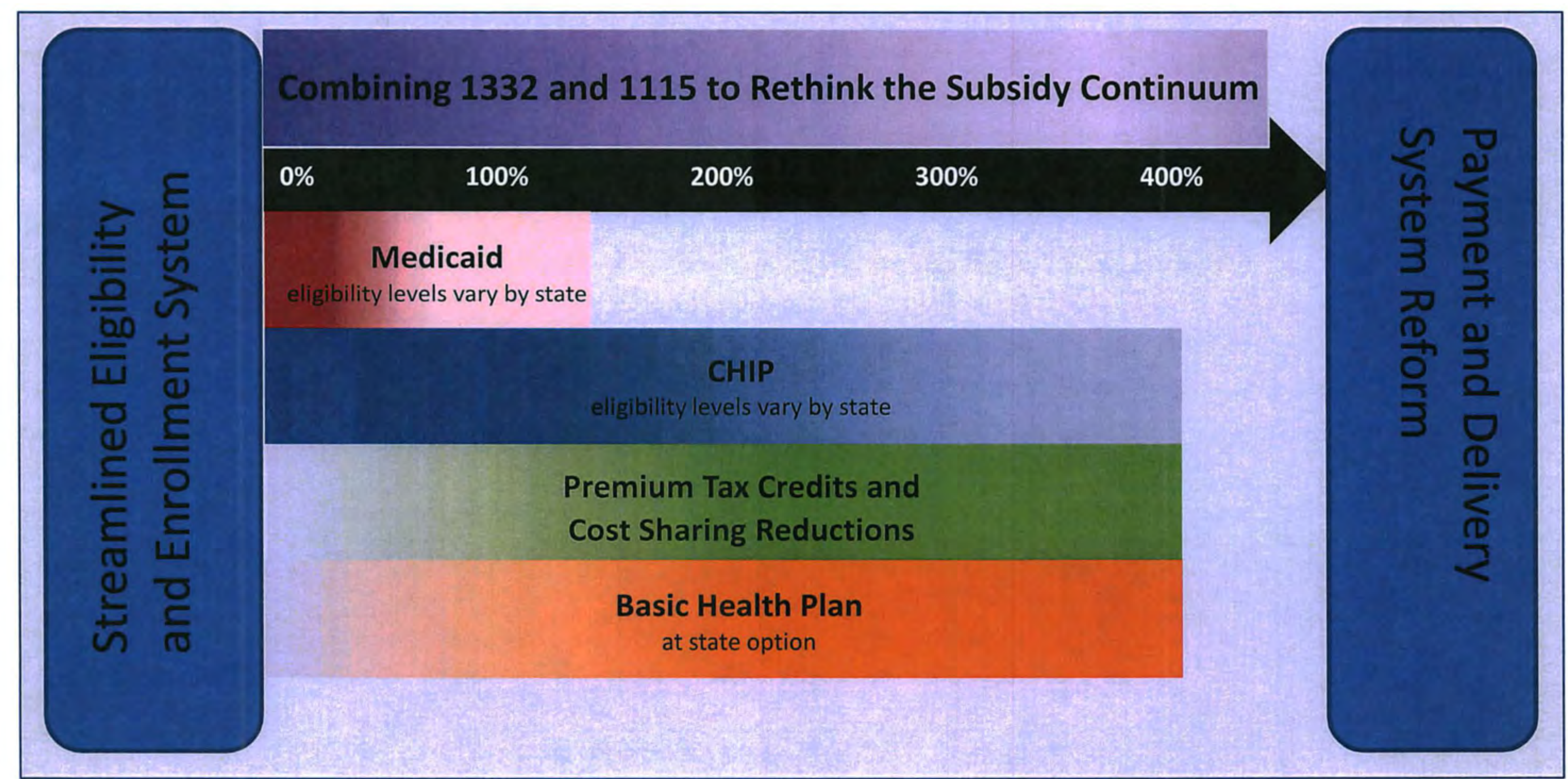
3 ***State Specific Innovation***

Opportunity to address each state's unique healthcare landscape and market. One example would be for a state to weigh subsidies based off different rating area average premium costs.

4 ***Sustainability***

States with limited individual public markets may redefine who is eligible for the Exchange to increase economies of scale.

# Waiver Example: Smoothing the Cost Continuum




**Considerations:**

1. Goals
2. What needs to be waived
3. How to meet the guardrails

# Waiver Example: Increasing Sustainability

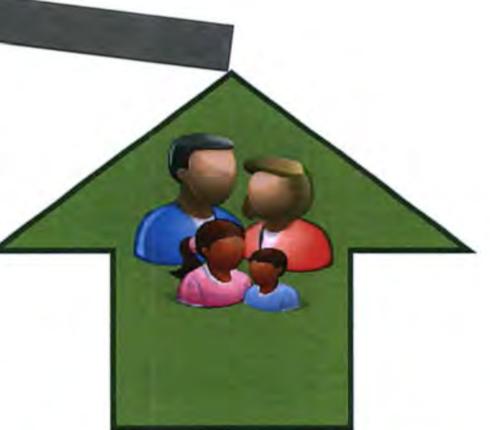
## Go Lean on Operations

- Replace public exchange with direct to issuer model
- Public partnership with web-brokers
- Eliminate SHOP

Exchange Sustainability

## Expand the Population

- Medicaid Premium Assistance for QHPs
- Allow state employees to purchase QHPs



**Considerations:**
1. Goals
2. What needs to be waived
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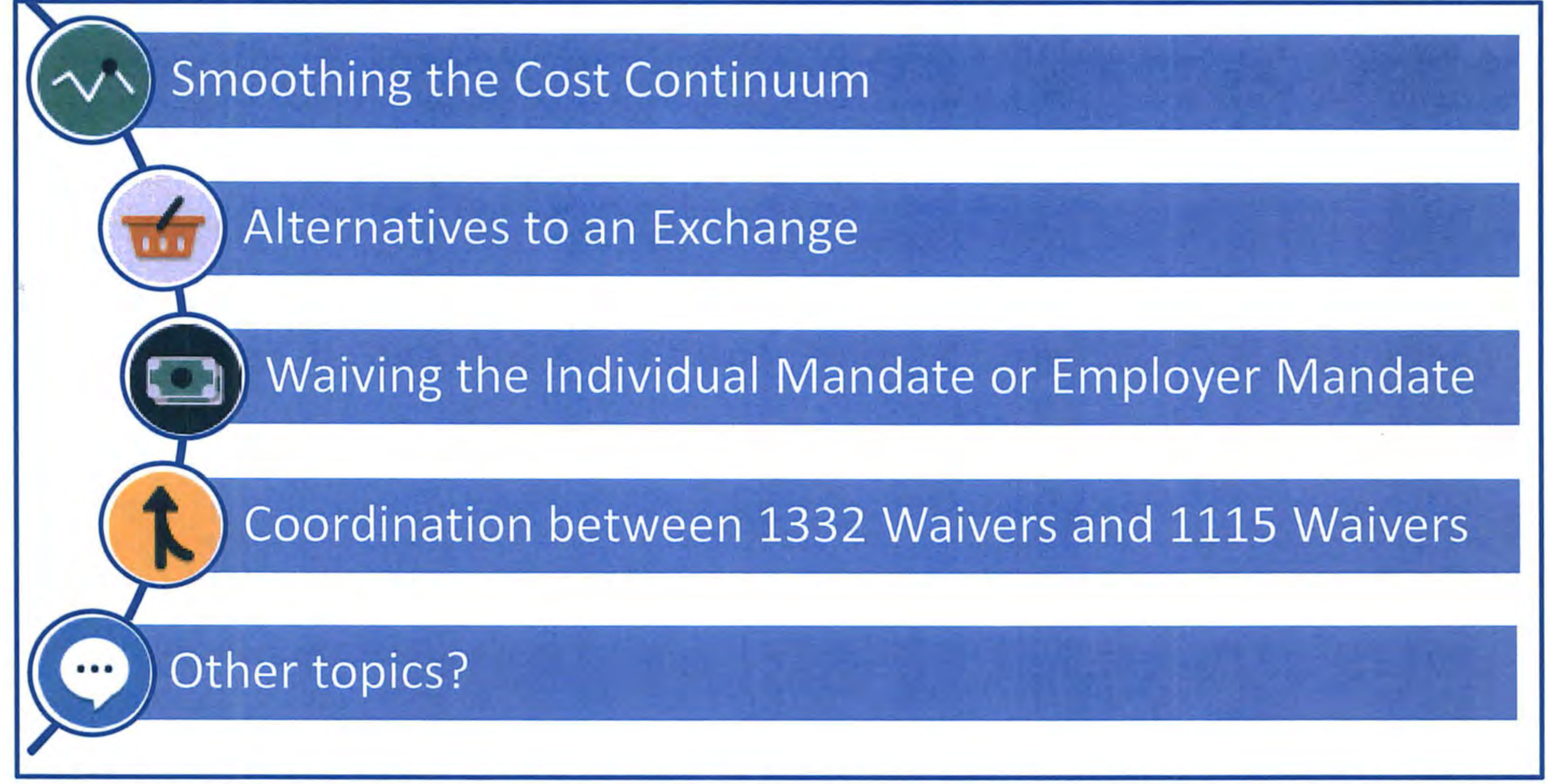
# Future Topics for Workgroup

# Future Topics for Workgroup Discussion



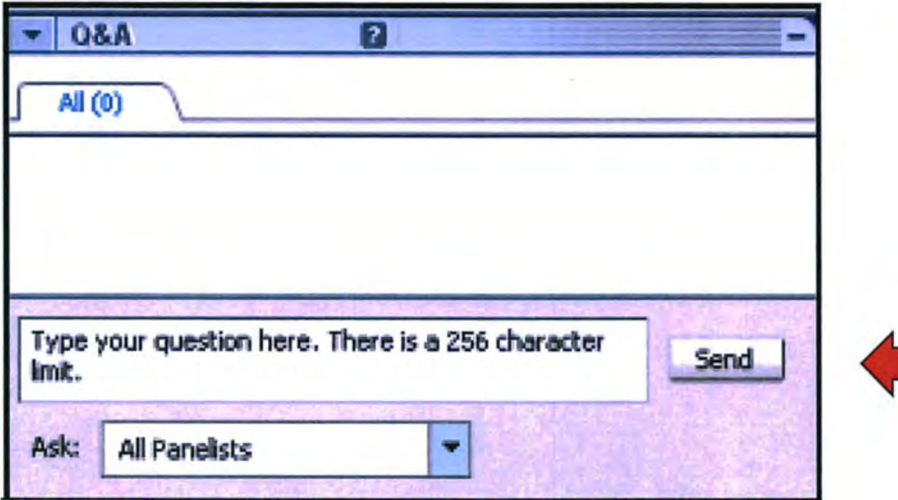

Please contact Galen Benshoof at benshoof@princeton.edu for additional suggestions

# Discussion

# Submitting Questions

**To ask a question:**

1. Ask question verbally
2. Submit question in writing



# Thank you!

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