DEVELOPING NEW STATE LEGISLATIVE HEALTH LEADERS

Health Insurance, Exchanges and Reforms

Richard Cauchi and Ashley Noble, NCSL Health Program
Overview

- State roles in regulating healthcare and health insurance
- Health benefit exchanges or marketplaces
- Emerging issues in health reform
  - Essential Health Benefits and state mandates
  - Network adequacy and surprise bills
- Cost containment and transparency
- ACA and beyond --- what’s next?
  - The Cadillac Tax
  - Court cases and challenges
  - 1332 waivers
State Laws Set the Stage

208 million Americans in “private” or commercial coverage

30+ years of state insurance regulation

1 US Census Bureau, 2014, 2015
Who Regulates Health Insurance? (Pre-ACA, 1950s - 2011)

State Regulated
- Nongroup or Individual Plans
- Limited Benefit Plans

Federally Regulated
- Fully Insured, Small Group Plans
- Medigap Plans
- MEWAs*

Self-Insured (Large) Group Plans

Design adopted from NAIC (National Association of Insurance Commissioners), Oct. 2015 | *Multiple Employer Welfare Arrangements

State Regulated
- Individual/ Nongroup Plans
- Limited Benefit Plans
- State-Run Exchanges & Partnerships
- Brokers; State Exchange Navigators

Federally Regulated
- Fully Insured Group Plans
- Medigap Plans
- MEWAs
- Self-Insured (Large) Group Plans
- Federal Marketplaces in 27+ states
- Fed. Exchange Navigators
Who Decides? Preemption

Provisions of PPACA can potentially preempt state laws

Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

PPACA §1321(d)

- States can go beyond federal rules, but if a state’s laws or regulations prevent a federal law from being implemented, then that law or regulation is preempted.

- Assumption is that each state will enforce federal rules. AL, MO, OK, TX, WY not enforcing.
The Affordable Care Act

Health Insurance Timeline – The State Perspective

2010 – Early Market Reforms

• Eliminates lifetime and annual caps on benefits essential health benefits
• Bans preexisting condition exclusions for children under 19
• Expands dependent coverage to age 26 without limitations
• Requires minimum standard of appeals procedures after an insurer denies a claim
• Implements new medical loss ratio standards
• Requires states to review rate increases
• Establishes temporary federal high risk pools

2014 – “Heavy Lifting”

• Guaranteed issue/renewal
• Modified community rating
• Ban on preexisting condition exclusions
• Coverage of essential health benefits
• Nondiscrimination
• Health insurance marketplaces

• 2015-2017
• States’ changing roles
• New state laws??

Adopted from Kevin Lucia, NCSL webinar Apr. 2015
Health Insurance Exchanges

It’s time! Take action for 2016

First time applying on HealthCare.gov? Have a 2015 Marketplace plan?

TAKE THE FIRST STEP TO APPLY

Log in to keep/change plans

Have a 2015 individual or family plan in Hawaii? Learn about using HealthCare.gov for 2016.

SEE PLANS & PRICES

UNDER 30?

2016 DEADLINES

NEED A 2015 PLAN?

PREVIEW 2016 PLANS

GET CUSTOM GUIDE

SEE DATES

SEE IF YOU CAN ENROLL

State Run Exchanges: 2016 opening pages

Examples only, from participant states, live Nov. 1, 2015
Health Insurance Exchange Structures 2015 to 2016

UPDATE: Oct. 20, 2015
NM is state-run w/ federal site + state SHOP
Interactive version at www.ncsl.org/default.aspx?tabid=21388
Exchange/Marketplace Structures Add Variations

- **13 + DC** entirely *State-based* Exchanges/Marketplaces
- **5** Federally-supported *State-based* Marketplaces
  (Considered State Based [SBE]; negotiated in 2014 for NM, NV, OR, HI)
- **7** State-Partnership Marketplaces
- **27** Federally-facilitated Marketplaces
  (2 of these states run SHOP only: MS, UT)

Informing your residents

Exchange Subsidies: How They Work

- **Available when income is up to 400% FPL**
  - $47,080 for an individual; $97,000 for family of 4 (2015-16 plans)
  - 84% received a health premium subsidy (tax credit) in 2015
  - 60% paid $0 or less than $125 a month in premiums
  - 43% had per-person deductibles of $1,000 or more
- People earning up to 250% of federal poverty ($29,175 for a single person), eligible for added “lower cost sharing” but only with a “silver level” plan
- Estimated 2.2 million could get lower co-pays/deductibles IF choose a “silver” plan

How Well Is ACA Coverage Working for Enrollees?

A new Commonwealth Fund survey shows that those who used their marketplace or Medicaid plans to find or see a doctor, go to the hospital, or buy prescription drugs had positive experiences.

**Physician Choices**

91% of U.S. adults who used their insurance to get healthcare are satisfied with their choice of doctors.

**Primary Care Access**

77% of adults who tried to find a new primary care physician found it was easy to do so.

60% of those who found a new primary care doctor were able to get an appointment within two weeks.

**Table 1: June 30, 2015 Total Effected Enrollment and Financial Assistance by State**

<table>
<thead>
<tr>
<th>State</th>
<th>Total Enrollment</th>
<th>APTC Enrollment</th>
<th>Percentage of Enrollment with APTC</th>
<th>CSR Enrollment</th>
<th>Percentage of Enrollment with CSR</th>
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</thead>
<tbody>
<tr>
<td>National Total</td>
<td>9,940,079</td>
<td>8,319,966</td>
<td>83.7%</td>
<td>5,572,853</td>
<td>56.0%</td>
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<tr>
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<td>19,380</td>
<td>17,107</td>
<td>88.8%</td>
<td>10,331</td>
<td>53.3%</td>
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<td>AL</td>
<td>541,363</td>
<td>328,432</td>
<td>60.0%</td>
<td>183,006</td>
<td>27.6%</td>
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<td>AR</td>
<td>55,436</td>
<td>46,799</td>
<td>90.0%</td>
<td>29,395</td>
<td>52.1%</td>
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<td>AZ</td>
<td>154,121</td>
<td>137,514</td>
<td>88.2%</td>
<td>83,165</td>
<td>54.0%</td>
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<tr>
<td>CA</td>
<td>1,593,567</td>
<td>1,227,770</td>
<td>81.1%</td>
<td>715,158</td>
<td>51.3%</td>
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<td>CO</td>
<td>122,976</td>
<td>108,017</td>
<td>88.3%</td>
<td>33,052</td>
<td>26.9%</td>
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<td>CT</td>
<td>92,213</td>
<td>72,037</td>
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<td>37,841</td>
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<td>DE</td>
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<td>19,173</td>
<td>83.6%</td>
<td>10,267</td>
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<td>99.0%</td>
<td>290,163</td>
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<td>94,131</td>
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</table>

**2016 Premium Changes in the Affordable Care Act’s Health Insurance Marketplaces: Analysis**

**Updated Oct. 7, 2013 to include final rates for CA, CO, KY, and NY, and an update to FFL cross rates.**

The table below presents an update to our previous analysis of 2016 change in premiums for the second lowest cost (“Silver”) plan marketplace plans in major cities in the 40 states and the District of Columbia, where we were able to find complete data on rates.

**Table 1: Most by Silver Premiums for a 40 Year Old Non-Smoker Making $30,000 / Year**

<table>
<thead>
<tr>
<th>State</th>
<th>Major City</th>
<th>2nd Lowest Cost Silver Before Tax Credit</th>
<th>2nd Lowest Cost Silver After Tax Credit</th>
<th>% Change from 2013</th>
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<tr>
<td>AL</td>
<td>Birmingham</td>
<td>$86</td>
<td>$86</td>
<td>0.0%</td>
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<tr>
<td>AK</td>
<td>Anchorage</td>
<td>$67</td>
<td>$67</td>
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<tr>
<td>AZ</td>
<td>Phoenix</td>
<td>$79</td>
<td>$79</td>
<td>0.0%</td>
</tr>
<tr>
<td>AR</td>
<td>Little Rock</td>
<td>$61</td>
<td>$61</td>
<td>0.0%</td>
</tr>
<tr>
<td>CA</td>
<td>Los Angeles</td>
<td>$94</td>
<td>$94</td>
<td>0.0%</td>
</tr>
<tr>
<td>CO</td>
<td>Denver</td>
<td>$79</td>
<td>$79</td>
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<td>CT</td>
<td>Hartford</td>
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<td>Washington</td>
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<td>FL</td>
<td>Orlando</td>
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<td>$62</td>
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<tr>
<td>GA</td>
<td>Atlanta</td>
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<td>HI</td>
<td>Honolulu</td>
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<td>Chicago</td>
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<tr>
<td>IN</td>
<td>Indianapolis</td>
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<tr>
<td>LA</td>
<td>New Orleans</td>
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<tr>
<td>MA</td>
<td>Boston</td>
<td>$68</td>
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<tr>
<td>ME</td>
<td>Portland</td>
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<tr>
<td>MI</td>
<td>Detroit</td>
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<tr>
<td>MN</td>
<td>Minneapolis</td>
<td>$77</td>
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<tr>
<td>MS</td>
<td>Jackson</td>
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<td>MS</td>
<td>Jackson</td>
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<td>NH</td>
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<tr>
<td>NY</td>
<td>New York</td>
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<td>0.0%</td>
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<tr>
<td>ND</td>
<td>Fargo</td>
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<td>$79</td>
<td>0.0%</td>
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<tr>
<td>OH</td>
<td>Columbus</td>
<td>$85</td>
<td>$85</td>
<td>0.0%</td>
</tr>
<tr>
<td>OK</td>
<td>Oklahoma City</td>
<td>$79</td>
<td>$79</td>
<td>0.0%</td>
</tr>
<tr>
<td>OR</td>
<td>Portland</td>
<td>$113</td>
<td>$113</td>
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<td>Philadelphia</td>
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<td>$90</td>
<td>0.0%</td>
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<td>SC</td>
<td>Charleston</td>
<td>$78</td>
<td>$78</td>
<td>0.0%</td>
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<tr>
<td>SD</td>
<td>Sioux Falls</td>
<td>$78</td>
<td>$78</td>
<td>0.0%</td>
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<tr>
<td>TN</td>
<td>Memphis</td>
<td>$79</td>
<td>$79</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Adapted by NCSC - 10/30/2015

The Future of Insurance Reform:
Emerging Issues and State Flexibility

- Essential Health Benefits (EHB) benchmark framework
  - States and HHS set benchmark plans for 2014-16; now set 2017
  - Adequacy of provider networks
  - Fewer levers to affect premiums – network design remains
  - State pushback against “narrow” networks?

- Transparency
  - Insurer data is critical to assessing consumer experience
    - E.g., EHB, network adequacy
  - Will states move ahead with implementation of transparency requirements?

- Nondiscrimination
  - Will states take further steps to limit discriminatory benefit designs?

- External events will matter

Source: Kevin Lucia, NCSL Webinar, Apr. 24, 2015
Health Insurance Plans and Essential Health Benefits (EHBs)

All Marketplace Plans and Individual/Small Group MUST Provide Coverage for:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic disease management
- Pediatric services, including oral and vision care
Group Discussion Questions

- Are EHBs addressing the primary drivers of healthcare needs or costs?
  - If not, what kinds of diseases, treatments, or drugs would you like to see covered in your states?
- What kinds of benefits are already covered in your state?
- Do you think that there should be no such thing as “mandated” or required benefits, and instead let healthcare plans choose what benefits to offer consumers?
  - If so, how might you design legislation to encourage this change while still remaining in compliance with federal law?
Health Plan Networks: Network Adequacy

- **ACA/NAIC* Standard**
  
  Maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay

- **Existing Components**
  
  - Access to Providers
  - Access to Non-Participating Providers
  - Access Plan (Filing or Certification)
  - Emergency Services Access 24/7
  - Geographic Standards
  - ACA Compliance

*National Association of Insurance Commissioners*
State Approaches to Network Adequacy

Health Insurance and Network Adequacy

LEGEND
- Quantitative measures for all marketplace plans
- Quantitative measures for some marketplace plans (e.g., HMOs)
- Qualitative measures
- Both quantitative and qualitative measures
- No data

Physicians who work in hospitals are often employed as contractors. These physicians are not required to contract with health insurance carriers as in-network providers.

When a patient begins treatment in a hospital, the patient will probably not have the opportunity to ensure that every provider who treats him/her is a member of his/her insurance plan’s network.

This can lead to costly surprises when a patient receives the treatment bill.
Group Discussion Questions

- Have network adequacy issues been causing any problems in your state?
- Are there any models that you think might work?
- Is your state more interested in a hands-off, market-oriented approach, in which consumers will demand more or better coverage networks and transparency from carriers?
- What are the pros and cons of these approaches?
Healthcare Costs—Fast Facts from CMS

- Private Health Insurance: $961.7 billion
- Hospital Expenditures: $936.9 billion
- Physician and Clinic Services Expenditures: $586.7 billion
- Medicare: $585.7 billion
- Medicaid: $449.4 billion
- Out of Pocket Spending: $339.4 billion
- Prescription Drugs: $271.1 billion

2013 data
Healthcare Costs—Fast Facts from CMS

Who Pays?

- **Households:** 28%
  (Personal pay, share of premiums, deductibles, co-pays, out-of-pocket, out-of-network, over-the-counter drugs, high-cost dental/vision, etc.)

- **Federal Government:** 26%

- **Private Businesses:** 21%

- **State and Local Governments:** 17%

- **Other Private Revenues:** 7%

2013 data
Health Insurance Premiums

**Average Premiums for Employer-Sponsored Health Plans**
(combined employer and employee contributions)

- **Family Coverage**
  - $1,462.08/month

- **Individual Coverage**
  - $520.92/month

**Average 2015 Marketplace Premiums**
Nationwide

- **Bronze plans**
  - $256/month

- **Silver plans**
  - $314/month

- **Gold plans**
  - $369/month

- **Platinum plans**
  - $441/month
Price Transparency and Cost Containment

State Transparency Initiatives

- Itemized billing laws
- All-payer Claims Databases (APCDs)
- Charge reporting requirements
- Provision of cost estimates prior to treatment

Private Sector Initiatives

- Spectrum Health in MI posts average costs for several common procedures on its website
- Maricopa Integrated Health System in AZ published Direct Pay Pricing Lists for 2013 on their website
- Aetna has a Member Payment Estimator on its website
44 states, the District of Columbia, and 3 US territories have Federally-Approved Rate Review programs.
Group Discussion Questions

- Do you think rate review as it exists now is working to control premium increases effectively?
  - If not, what do you think should change?
  - Do you think the 10% rate increase trigger in the ACA goes too far?
  - Do you think it doesn’t go far enough?

- What cost containment and transparency strategies might work in your states?
In 2018, potential extra costs to state employees, local public employees (and private-sector) employers in many states

40% surcharges for high premium health policies (more than $10,200 individual; $27,500 for family)

Overall, 10% of single and 6% of family insurance premiums could exceed the Cadillac tax threshold in 2018 (CRS, 8/2015)

Threat to existing plan coverage or $87 billion in revenue over 10 years?

Law could be changed …..?

See NCSL fact sheet
Supreme Court June 2015 decision resolved: Both state-run and federally-facilitated exchanges can continue to provide premium subsidies “established by the state”

- 22 states have statutes to block some state involvement
- Several provisions occur without a state role (individual & employer mandate, essential benefits, marketplaces; no collection of fines or fees)

See NCSL handout for details
Direct Primary Care

Allows individuals to contract with provider groups for needed care, bypassing the need for an insurer.

The direct medical care act, provides that direct primary care agreements do not constitute insurance, specifies that direct primary care agreements include provisions for payment of a direct fee, prohibits direct primary care providers from billing insurers for direct primary care, provides that direct primary care agreements shall not be regulated as insurance. A primary care provider or agent of a primary care provider is not required to obtain a certificate of authority or license under the act to market, sell, or offer to sell a direct primary care agreement.

- Passed and signed into law in
  - Idaho S 1062 - Enacted 04/09/2015
  - Mississippi S 2687 – Enacted 03/18/2015

Purchasing Insurance Across State Lines

Allows insurers to sell their products across state lines, generally using the regulatory standards from other state(s). Section 1333 of ACA permits states to form health care choice inter-state compacts and allow insurers to sell policies in any state participating in the compact. Two or more states may enter into compacts under which one or more insurance plans may be offered in the such states, subject to the laws and regulations of the state in which it was written.

Five signed laws, but none have been implemented across two or more states.

- Rhode Island was the first state to pass an out-of-state purchasing law, signed in 2008 similar to the design later authorized by the PPACA in 2010.
- Wyoming was the first state, in March 2010, to enact a signed law based on the free-market model but also including a multi-state compact related to federal health reform.
- Georgia, HB 47 - Signed into law May 2011, the first state with a law passed since the federal Affordable Care Act.
- Kentucky (HB 265 - Signed into law, 2012).
- Maine (HB 979 - Signed into law, 2011; effective date Jan. 1, 2014).
In 2017, section 1332 of the ACA invites states to find alternative ways to meet the coverage goals of the law while staying within its fiscal constraints.

**What May Be Waived?**
States may propose alternatives to “four pillars” of the ACA:

- **Benefits and Subsidies.** States may modify the rules governing covered benefits, as well as the subsidies that are available through the marketplaces.
- **Marketplaces and Qualified Health Plans.** States may replace their marketplaces or supplant the plan certification process with alternative ways to provide health plan choice, determine eligibility for subsidies, and enroll consumers in coverage.
- **The Individual Mandate.** States may modify or eliminate the requirement.
- **The Employer Mandate.** States may modify or eliminate the requirement.

Adopted from The Commonwealth Fund, April 15, 2015
Future Limits or “Waiver Guardrails”
State 1332 Innovation Waivers Must Satisfy Four Criteria:

- **Comprehensive Coverage.** States must provide coverage that is “at least as comprehensive” as coverage absent the waiver.

- **Affordable Coverage.** States must provide “coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable” as coverage absent the waiver.

- **Scope of Coverage.** States must provide coverage to “at least a comparable number of residents” as would have been covered without the waiver.

- **Federal Deficit.** The waiver must not increase the federal deficit.

- **An act of the legislature** is required to begin a 1332 waiver.
Legislator Group Discussion:

- What ACA/Obamacare provision(s) would you recommend be waived for your state?
Some Take-home Options for Legislatures
(Health Insurance and Marketplaces)

- Hold an oversight briefing or hearing on Marketplace results
- Consider legislation to define or refine the insurance department’s power to regulate (networks, premiums, brokers)
- Examine cost containment “innovations”
- Examine the small employer / small business health care market
- Compare your state to your neighbors
- What changes will affect 1) access 2) affordability 3) quality of healthcare?
- Consider impact of a Section 1332 waiver specific to your state
DEVELOPING NEW STATE LEGISLATIVE HEALTH LEADERS

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