HEALTH SEMINAR FOR NEWER LEGISLATORS

Health Insurance and Health Reforms | April 14, 2018

Colleen Becker, NCSL Policy Specialist
Overview

- **State Roles in regulating health care and health insurance**
  - Legislative = NCSL
  - Executive agencies/Insurance Departments = NAIC, NGA

- **History and Recent Issues in Health Reform**
  - Health Benefit Exchanges or Marketplaces (impact on your districts)
  - State Mandates and Essential Health Benefits

- **2018-2019 pending issues for states and insurers**

- **Federal Health reforms v. State Innovation**—current law, congressional actions, regulations
Health Care Costs—2016
Fast Facts from CMS*, published Feb 2017

Strong States, Strong Nation

Where Does the Money Go?

- Private Health Insurance: $1.123 trillion
- Medicaid: $565 billion
  - State Share: $212 billion
- Medicare: $672 billion
- Out of Pocket Spending: $352 billion

Where the money goes - examples
- Hospital Expenditures: $1.082 trillion
- Physician and Clinic Services Expenditures: $664 billion
- Prescription Drugs: $450 billion

* Centers for Medicare & Medicaid Services
http://content.healthaffairs.org/content/36/3/553.full
State Laws Set the Stage

216+ million Americans in “private” or commercial coverage
40+ years of state insurance regulation

Benefits and Standards
- Rate review & premium approval
- Consumer protections; appeals
- Financial reliability standards
- Enforcement fines/shut-downs

US Census Bureau, 2016
The Affordable Care Act - The State Perspective

Early Market Reforms
- Eliminates lifetime and annual caps on benefits
- Bans preexisting condition exclusions (2010: children; 2014: ages 0 through 64)
- Expands dependent coverage to age 26 without limitations
- Requires minimum standard of appeals procedures after an insurer denies a claim
- Requires states to review rate increases
- Implements new medical loss ratio standards
- Establishes temporary federal high risk pools

Moving Forward
- Guaranteed issue/renewal
- Modified community rating (price by age)
- Coverage of essential health benefits
- Nondiscrimination
- Health insurance marketplaces
- Subsidized insurance for 8-9 million

Adopted from Kevin Lucia, NCSL webinar
Health Insurance Exchange Structures 2017-2018

UPDATE: March 2018
Interactive version at www.ncsl.org/default.aspx?tabid=21388

State-run exchange
State-run authority;
Federally-assisted website
State-federal partnership
Federally run individual
Marketplace; State-run SHOP
Federally facilitated
marketplace (exchange)
Exchange Subsidies: How They’ve Worked

- 2014-2018: Available when income is up to 400% FPL *
  - 84% received a health premium subsidy (tax credit)
  - 60% paid $0 or less than $125 a month in premiums
  - 43% had per-person deductibles of $1,000 or more

Federal Poverty Guidelines 2018 for Individuals: $12,140 per year
Up to 400% = $48,560 per year

All Exchanges and almost all individual & small group plans MUST provide coverage for 10 essential health benefits:

- 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
- Children: must include oral and vision care.

SUBJECT TO CHANGE BY FEDERAL LAW OR REGULATION
Options for Legislatures

- 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”
- Compare your state to your neighbors
- What changes will affect access, affordability and/or quality
- Consider a Section 1332 type-waiver specific to your state
- Will you need a special session or study workgroup to respond to federal changes in time?
HEALTH SEMINAR FOR NEWER LEGISLATORS

La Jolla, California | April 13-15, 2018
National Conference of State Legislatures
Invitational Health Seminar for Newer Legislators

Health Insurance Issues and Health Reforms

April 14, 2018

Justin Giovannelli, J.D., M.P.P.
Overview

• Health Insurance Markets in 2018 and 2019
  • Premiums, insurer participation, enrollment, uninsurance

• Upcoming federal regulatory changes
  • Short-term plans, association health plans (AHPs)

• State-level market stability initiatives
  • Including use of Section 1332 “innovation waivers”

• Other options for state action
  • Benefit requirements, provider networks, surprise bills
2018 Premiums

- Unsubsidized individual market premiums rose substantially
  - Average premium increases for a 40 year-old:
    - Lowest cost silver: 32%
    - Lowest cost gold: 19.1%
  - Wide variation across states
    - Alaska → -22.5% (silver), -27.9% (gold)
    - Arizona → -2.0% (silver), -4.9% (gold)
    - Iowa → 117.5% (silver), 40.9% (gold)
- Consumers eligible for subsidies are largely insulated from these increases
  - Average premium for a 40 year-old at 249% of poverty ($30K):
    - Lowest cost bronze: -50%
    - Lowest cost silver: -8%
    - Lowest cost gold: -16%
Factors Affecting Premiums

• Decision to halt reimbursements for cost-sharing reduction (CSR) payments

• Legislative and regulatory uncertainty
  • Especially regarding the individual mandate

• Medical inflation

• Presence of risk-sharing programs (e.g., reinsurance)

• Reinstatement of health insurer tax for 2018
  • Was suspended in 2017; will be suspended in 2019
2018 Carrier Participation

- Fewer insurers are participating in 2018 than in 2017
  - 2018: About 3.5 carriers per state, on average
    - 2017 → 4.3; 2016 → 5.6

- Wide variation across (and sometimes within) states
  - Eight states have only 1 insurer
  - Three have more than 10
    - CA: 85% of enrollees have 3+; but 3% (6 counties) have 1
  - Rural counties have fewer options

- Nationwide:
  - 48% of enrollees (18% of counties) have 3+
  - 26% of enrollees (52% of counties) have 1
  - No bare counties.
2018 Carrier Participation by County
Factors Affecting Participation

• Insurers’ financial performance in the individual market
  • Performance generally poor in 2014 and 2015
    • Generally sicker-than-expected enrollees
    • Data through Q3 2017 shows insurers regaining profitability

• Legislative and regulatory uncertainty
  • Regarding the individual mandate, cost-sharing reductions (CSRs).
2018 Enrollment

• 11.8 million plan selections through the Affordable Care Act (ACA) marketplaces
  • Down about 4% compared to 2017 (12.2 million)
  • Compared to last year, states that run their own marketplaces did a bit better than those that don’t (flat vs. down 5%)
  • About 800,000 additional enrollments in the Basic Health Plan (MN and NY only)

• Off-marketplace
  • About 5 million enrolled in ACA-compliant individual coverage (2017)
  • About 1-2m in non-compliant coverage (transitional and grandfathered)
Uninsured Rate

Percentage of adults under age 65 who were uninsured

Expectations for 2019

• What’s happened?
  • Individual mandate repealed
  • Federal regulatory changes (proposed)
  • No significant federal legislation to stabilize markets

• What are we likely to see?
  • Premiums
    • Risk of further substantial increases
  • Participation
    • Unlikely to see increases
  • Enrollment
    • Likely to decrease

• Results will vary by state
Short-term Plans: Background

• Designed to fill temporary gaps in coverage

• Not considered individual health insurance under federal law. Separate risk pool from ACA-compliant market.

• Exempt from ACA standards. Unless state provides otherwise:
  • Can deny coverage, impose pre-existing exclusions, charge higher rates based on health status
  • No required benefits
  • No caps on consumer out-of-pocket spending

• Old rule (applied through 2016): coverage duration is less than 12 months
Short-term Plans: Background

• Rule change in 2016. Concerns:
  • Consumers were using short-term, limited duration insurance (STLDI) as primary coverage (not as a gap-filler)
  • STLDI causing adverse selection against compliant market

• Current rule: Coverage duration must be less than 3 months, including renewals.
  • Enrollment in STLDI does NOT satisfy individual mandate

• Proposed rule change in 2018.
  • Extend duration allowance to less than 12 months
  • Allow renewals (with issuer’s consent) beyond this term
  • No mandate penalty in 2019
Short-term Plans: The Intent of the Rule Change

• Responding to executive order directing agencies to consider regulations expanding access to STLDI

• (1) Increasing duration allowance gives consumers more options at lower premiums
  • For those who can’t access or afford:
    • ACA-compliant coverage
    • E.g., not eligible for tax credits; miss enrollment window
    • Consolidated Omnibus Budget Reconciliation Act (COBRA)
  • Medical underwriting, limited benefits, mean lower premiums for those who qualify

• (2) Gives states more flexibility to regulate
Short-term Plans: The Risks

• For individuals:
  • Plans generally only available to those who pass medical underwriting
  • Reduced access to some services and providers
    • Routinely exclude coverage for preventive, maternity, mental health and substance use services, and for prescription drugs
  • Increased out-of-pocket costs for some consumers
    • Limited benefits and cost-sharing protections

• For markets:
  • Plans playing by different rules → segmentation and adverse selection
    • Plans mainly attractive to young and healthy
    • Siphons off healthy risks, leaving compliant market smaller, sicker, and more expensive
      • Effect is exacerbated by repeal of mandate penalty
State Options to Address Short-Term Plans

• Level the playing field
  • Require compliance with (some/all) individual market rules

• Limit coverage to short periods
  • Set shorter duration; limit renewals

• Reduce risk of market segmentation
  • Assess STLDI issuers; invest funds in reinsurance
  • Set minimum medical loss ratio (MLR)

• Improve transparency and oversight
  • Track enrollment; conduct regulatory review
  • Require additional consumer disclosures
Association Health Plans (AHPs):
Background and Current Framework

- AHP → health plan sponsored by an employer-based association, such as a professional or trade group

- AHPs exist under the ACA but are not a distinct category of health insurance coverage.
  - AHP coverage sold to:
    - Individuals is regulated as individual market coverage;
    - Small groups is regulated as small group market coverage

- **Exception:** when a group of employers can be considered bound together as a bona fide single employer group → may be treated as a large-employer health plan
Association Health Plans: Proposed Rule

- Would make it easier for employers to join together to form associations that would be treated as large-group coverage
  - AHP could form solely for purpose of offering insurance
  - Commonality of interest could be demonstrated where members are:
    - In the same trade/industry, etc., or
    - Have their principal place of business in the same geographic region (including multistate metro areas)

- Would allow membership by the self-employed
Association Health Plans: Proposed Rule

• Would prevent AHPs from conditioning membership on health status, or using health status in determining benefit eligibility and premiums

• As a large-group plan, an AHP would NOT be subject to ACA rules regarding premium rating and benefits

• Raises possibility of pre-emption of state regulatory authority
Association Health Plans: The Intent of Rule Change

• Responding to executive order directing agencies to consider regulations expanding access to AHPs

• Make it easier for small employers and the self-employed to achieve advantages of scale sometimes enjoyed by large employers
  • Reducing administrative costs
  • Facilitating self-insurance
  • Greater market power

• Gives consumers more options at lower premiums
Association Health Plans: The Risks

- AHPs have a long history of financial instability, insolvencies, and fraud
  - States generally have a better track record than the feds in limiting these problems

- Tradeoffs that come with increased plan flexibility
  - Proposal allows AHPs to vary rates by age (without limitation), gender, occupation, and group size
  - Benefit packages can be designed to discourage enrollment by those likely to use care

- Plans playing by different rules → segmentation and adverse selection
  - Siphons off healthy risks, leaving compliant market smaller, sicker, and more expensive
  - This was pre-ACA experience (e.g., Kentucky)
State Options to Address AHPs

- Level the playing field
  - Require compliance with (some/all) individual/small group market rules

- Limit membership to small businesses
  - Employers with at least 1 employee

- Reduce risk of market segmentation
  - Assess AHPs; invest funds in reinsurance

- Assert jurisdiction over out-of-state AHPs
Other State Responses to Market Trends: Increasing Availability of Low Premium, Limited Benefit Plans

• Idaho: state-based health plans
  • Would allow sale of plans that do not comply with many ACA standards
  • HHS signaled it would step in to enforce federal law. Discussions ongoing.

• Iowa: Farm Bureau coverage
  • New statute excludes coverage offered by a nonprofit ag organization from the definition of insurance
  • Coverage is not subject to ACA standards
  • State regulation limited to oversight of the third-party administrator (TPA)

• Section 1332 waivers to broaden eligibility for catastrophic coverage
  • Under consideration in CO and VA
Other State Responses to Market Trends: Reinsurance

- Proven mechanism for mitigating premium increases by spreading costs of high-cost enrollees
  - Federal temporary reinsurance program reduced premiums in 2014-16.
  - No new federal dollars are likely this year

- State-operated reinsurance programs can access federal “pass-through” funding with a Section 1332 waiver
  - Three states (AK, MN, OR) have waiver programs in place
  - Several others (e.g., WI, ME, MD) headed down that path for 2019
Other State Responses to Market Trends: Coverage Mandate

- States have authority to create their own incentives for individuals to maintain coverage
  - MA already does this
  - MA, or federal requirement, as a starting point?

- Details can be customized
  - What types of coverage satisfy the requirement?
  - Penalty amount
  - Exemptions
  - What to do with penalty funds?
    - General fund? Reinsurance? Hold for consumer?

- Mandates under consideration in a number of states
  - Action unlikely for 2019
Other Areas of State Flexibility: Benefit Requirements

- ACA requires issuers in the individual and small group markets to cover 10 categories of “essential” health benefits
  - Benefits are defined by reference to a state-selected benchmark plan (chosen among 10 options)
- Proposed rule would give states more options to define their benchmark plan
- Some states may select benchmark through regulatory process. Others may prefer (or be required by state law) to do so via legislation.
Other Areas of State Flexibility: Provider Networks

• States are the traditional regulators of health plan provider networks

• ACA contains federal standard for marketplace health plans
  • Does not displace state regulation
  • Feds have ceded oversight of this standard to the states

• The National Association of Insurance Commissioners (NAIC) has adopted a network adequacy model act
  • Requires stronger disclosures by plans concerning network development and operation
  • Bolsters authority of state regulators to decide whether a network is adequate
  • Sets rules designed to improve accuracy of provider directories
Other Areas of State Flexibility: Surprise Bills

- Consumer faces unexpected charges from an out-of-network provider (a version of balance billing)
  - E.g., consumer obtains care at in-network emergency department or hospital, but is treated by an out-of-network anesthesiologist

- No federal rules limiting consumer exposure to surprise bills

- Fewer than half of states have laws that shield consumers
  - About a half dozen have a comprehensive approach
    - Prohibit balance billing
    - Incorporate payment standards to ensure fair compensation for providers
Justin Giovannelli, J.D., M.P.P.

Associate Research Professor
Georgetown University
Center on Health Insurance Reforms
Justin.Giovannelli@georgetown.edu