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Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Flexibility

Prepared by

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Introduction

Chairman Alexander, Ranking Member Murray, and distinguished members of the Committee, it is an honor to have the opportunity to provide this testimony to you regarding state flexibility to help stabilize the individual insurance market.

My name is Tammy Tomczyk. I am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and I meet that body's qualification standards for providing this testimony. I have nearly twenty-five years of experience as a health care actuary and have been actively involved for more than seven years in helping health plans, regulators, and other stakeholders understand and react to changes brought about by the Affordable Care Act (ACA). Most recently, I have been working with states to help them assess the impact that potential policy changes could have on premiums and enrollment in their local insurance markets, and supporting states in their efforts to apply for Section 1332 waivers.

I am also a Senior Principal and Consulting Actuary with the firm of Oliver Wyman Actuarial Consulting, a business unit of Marsh & McLennan Companies (MMC). MMC is a leading professional services firm with a global network of more than 60,000 experts in risk, strategy, and people. The businesses of MMC, including Oliver Wyman, Mercer and Marsh & McLennan Agency, collaborate with our clients to navigate the increasingly complex healthcare marketplace to help individuals, families and employees stay healthy and productive, enable innovation, and lower costs.

While this hearing is focused on issues that most directly affect Americans who receive health insurance coverage via the individual market, it is important to remember the significant role US businesses – which cover nearly 61% of Americans – play in our healthcare system. Congress should take careful consideration of how potential reforms in the individual marketplace may impact employer-sponsored healthcare coverage. MMC shares your goal of expanding health coverage to more people while preserving the employer-based system that Americans value so highly.

My testimony will focus on the following topics:

- Flexibility currently available to states under Section 1332 of the ACA
- Ways in which states have used Section 1332 waivers to date
- Current limitations of Section 1332, its implementing regulation, and additional guidance issued by the previous administration
- Potential areas for additional state flexibility

Background

Starting in 2017, Section 1332 affords states the flexibility to waive certain provisions of the ACA in an effort to develop innovative ways to provide access to quality health care and foster strong insurance markets. The ACA limits the scope of Section 1332 waivers, preserving certain aspects of the law such as prohibitions against imposing pre-existing condition requirements, underwriting based on health status, and lifetime maximum coverage limits. Key provisions that may be waived under Section 1332 fall within the following four basic categories:

Qualified Health Plans: States may revise the list of benefits that must be covered by plans sold through the Marketplace, including essential health benefits, cost sharing limitations, metal-tier requirements, and definitions related to markets and employer size.

Health Insurance Marketplaces: States can put in place alternate ways for individuals and/or groups to enroll in coverage and receive financial assistance, make revisions to enrollment periods, modify risk pool definitions, and make changes regarding limitations for coverage to citizens and lawful residents.

Financial Assistance: States can alter both the ACA rules and Internal Revenue Code provisions related to tax credits and cost sharing reduction subsidies. These alterations include family contribution requirements, the benchmark used to calculate the amount of the subsidies, and the definition of minimum essential coverage.

Individual and Employer Mandates: States can modify one or both of the requirements that most individuals have minimum essential coverage or pay a financial penalty, and the requirement that employers with 50 or more employees offer coverage to employees working 30 or more hours per week.

In waiving one or more of the provisions listed above, states must demonstrate in their waiver application that the proposed changes satisfy each of the following four criteria, often referred to as "guardrails:"

1. ***Comprehensiveness of Coverage*** – States must demonstrate that, under the waiver, coverage would be at least as comprehensive as it is absent the waiver
2. ***Affordability of Coverage*** – States must demonstrate that, under the waiver, coverage would be at least as affordable as it is absent the waiver
3. ***Scope of Coverage*** – States must demonstrate that, under the waiver, coverage would be provided to at least as many residents as it is absent the waiver
4. ***Deficit Neutrality*** – States must demonstrate that the waiver will not increase the federal deficit

Federal regulations outline several additional requirements that a successful waiver application must meet.[1] Prior to submitting a Section 1332 waiver application, a state must enact a law providing for its implementation. The state must provide public notice of the waiver application and allow for a comment period, including public hearings. Through actuarial analyses and actuarial certifications, the state must demonstrate that the proposed waiver satisfies the comprehensiveness, affordability, and scope of coverage requirements outlined above. To demonstrate the waiver will be deficit neutral to the federal government, the state's application must also reflect economic analyses, including a 10-year budget plan. Finally, the application must both describe the data and assumptions used to demonstrate the guardrails are met, and provide an implementation timeline.

States that are granted a waiver may receive pass-through funding from the federal government equal to any reductions in federal spending for premium tax credits, cost sharing reduction payments, and small business tax credits.[2] The state can then use these funds to pay for a portion of its reforms. The waiver application must include information needed to estimate the pass-through funding amount including data on enrollment, premiums, and federal subsidies. All waivers are approved for a period of five years,[3] and states must comply with quarterly and annual reporting requirements.[4]

Recent 1332 Waiver activity

While Section 1332 waivers may be viewed as an opportunity for states to take action to promote stability in their individual markets, only fourteen states have enacted legislation authorizing the submission of a Section 1332 waiver as of August 25, 2017.[5] Only two states, Hawai'i and Alaska, hold waivers that have been approved by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Treasury.

Hawai'i's waiver was unique in that it sought to waive the requirement under the ACA that it operate a web-based Small Business Health Options Program (SHOP). The SHOP has requirements that conflict with a long-standing state law requiring employers to provide robust health insurance coverage to employees at minimal cost. Through its waiver, small employers will enroll directly with health plans offering coverage that meets the requirements of the Hawai'i Prepaid Healthcare Act. The State will receive pass-through funding equal to small employer tax credits that otherwise would have been paid to employers, and these funds will be used to supplement the State's long standing Prepaid Premium Supplementation Fund.

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[1] Application, Review and Reporting Process for Waivers for State Innovation, Federal Register Vol. 77, No. 38, page 11700, February 27, 2012

[2] ACA, §1332(a)(3)

[3] ACA, §1332(e)

[4] 31 CFR 33.124 and 45 CFR 155.1324

[5] http://www.statenetwork.org/more-states-looking-to-section-1332-waivers/

Alaska's waiver is focused on a State-managed program, the Alaska Reinsurance Program (ARP), aimed at relieving health plans of costs associated with individuals with certain high-cost conditions by ceding those costs to a separate risk pool. Although costs for these individuals are ceded to the ARP, existence of the ARP is essentially unknown to them. Ceded members pay the same premium as similarly situated members whose costs are not ceded to the ARP, and members' coverage continues with the carrier through which they enrolled, meaning they continue to have access to the same network providers, receive the same covered services, and have the same cost sharing provisions as individuals who are not ceded to the ARP.

Initial 2017 rate filings for Alaska's individual market indicated premiums that were projected to increase by 42 percent. However, State action and the introduction of the ARP, which was initially funded using $55 million in State funds, reduced those increases to roughly 7 percent. In addition, Premera, the State's only health plan currently offering coverage in the individual market, recently filed for a rate decrease of more than 20 percent for 2018.[6]

Oliver Wyman assisted the State of Alaska by providing the required actuarial analyses to support its Section 1332 waiver application. Our modeling showed that investing $60 million into the high-risk pool in 2018, and lowering premiums by that amount, would result in a net decline in federal outlays for premium subsidies and other items of $49 million. The waiver proposed that the federal government provide pass-through funding of $49 million to Alaska, leaving $11 million to be borne by the State.

In March of 2017, while Alaska's Section 1332 waiver was under review by the federal government, it received much attention from the administration and was highlighted by HHS Secretary Price as a model that other states should consider.[7] Minnesota,[8] Oklahoma,[9] Oregon,[10] and New Hampshire[11] have all passed Sectoin 1332 authorizing legislation and are in the process of preparing or have submitted waiver applications. Each of these states is proposing to implement a reinsurance program and is using an approach similar to Alaska's. However these states' proposed reinsurance programs are not based on individuals' specified health conditions like Alaska's and are instead structured similarly to the transitional reinsurance program that was in place under the ACA from 2014 through 2016.

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[6] Erica Martinson, "Premera expects big cut in health insurance premiums on Alaska's individual market," Alaska Dispatch News, August 2, 2017, https://www.adn.com/alaska-news/health/2017/08/01/premera-expects-a-21-6-percent-decrease-in-individual-market-premiums-for-2018/

[7] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf

[8] https://www.revisor.mn.gov/bills/bill.php?b=house&f=HF5&ssn=0&y=2017

[9] https://legiscan.com/OK/text/HB2406/id/1624145

[10] https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2391/Enrolled

[11] http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2017&id=714&txtFormat=html

Minnesota and Oklahoma have already submitted their waiver applications, while Oregon and New Hampshire have released draft applications. The expected impact of these reinsurance programs varies widely by state, from a reduction in average premiums of roughly 7 percent in Oregon[12] and New Hampshire,[13] to a reduction in average premiums of as much as a 20 percent in Minnesota[14] and 34 percent in Oklahoma.[15] All four states are projecting that the waiver will lead to an increase in the number of insured individuals.

Current limitations to Section 1332 waivers

While Section 1332 provides states with flexibility to revise and shape their insurance markets to meet local needs, there are some limitations that impede states' ability to pursue certain strategies to stabilize and strengthen their markets. Some of these limitations include the following:

- Section 1332 places restrictions on which provisions of the ACA can be waived. The current statute does not allow states to make certain changes that might help stabilize their individual markets and increase the number of young or healthy individuals enrolled in the risk pool. These changes could include widening the 3:1 age curve to produce premiums that align more closely with underlying risk by age, introducing benefits and other provisions that encourage individuals to maintain continuous coverage, and implementing rules that work to eliminate inappropriate steerage of Medicare and Medicaid individuals into the individual market.
- Federal guidance issued in December 2015 includes prescriptive rules that limit a state's ability to produce actuarial analyses that support meaningful changes expected to drive down premiums and increase enrollment. For example, Section 1332 by itself does appear to allow states to modify premium structures to vary by both age and income, and lowering subsidized premiums for younger individuals could improve the average morbidity of the risk pool. However, guidance issued by the prior administration in December 2015 looks beyond statute and regulation and requires that the impact a waiver will have on specific groups, such as low income individuals, the elderly, and those with significant health needs, will also be considered when assessing whether a waiver meets statutory guidelines.
- The December 2015 guidance also specifies that compliance with coverage, affordability and deficit neutrality requirements will be measured each year, rather than in aggregate over the lifetime of the waiver. This could prohibit innovative waivers that may require a ramp-up or phase-in period to become fully effective and may not initially meet all of the guardrails even though they will over the lifetime of the waiver.

[12] http://healthcare.oregon.gov/Documents/draft-OR1332-waiver-app.pdf

[13] https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf

[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf

[15] https://www.ok.gov/health2/documents/1332%20State%20Innovation%20Waiver%20Final.pdf

- While states may submit coordinated applications for a 1332 waiver and a Medicaid-related 1115 waiver, the December 2015 guidance indicates that each waiver will be evaluated separately under the applicable federal guidelines, and that savings from an 1115 waiver cannot be used to offset spending under a 1332 waiver when demonstrating deficit neutrality requirements have been met. This restriction limits states' ability to develop waivers that reduce costs and/or increase the number of individuals covered when looking at the broader population.

In addition, while Section 1332 does allow states, within the confines of the law, to modify how federal funding is employed at the state level, it does not make available new federal funding. This means that certain waivers, such as Alaska's reinsurance waiver and the reinsurance waivers currently being considered by several states, require additional funding at the state level. Therefore, states with budgetary constraints may be limited in the waivers they can pursue.

Finally, states that utilize Healthcare.gov may face barriers to the implementation of certain waivers, such as those that would alter premium and/or cost sharing subsides, if the federal exchange is unable to implement state-specific requirements. These same barriers may not exist for state-based exchanges.

Areas for consideration

Each state is unique in terms of its demographic and socioeconomic make-up, insurance markets, Medicaid programs, and existing federal waivers. Therefore, solutions that work best for one state may not be the most efficient or affordable solution for another. Allowing states to study and implement state-based solutions that are most effective for their local market may help in efforts to stabilize the individual markets.

Congress or the administration could provide greater flexibility around 1332 waivers and allow states to address their unique challenges and circumstances by taking the following actions:

- Allow states to waive or alter additional provisions of the ACA not currently outlined in Section 1332 while still maintaining basic consumer protections
- Rescind the December 2015 guidance on Section 1332 and allow states to:
    - Demonstrate each of the guardrails are met in aggregate for the market
    - Meet deficit neutrality and other guardrail requirements over the lifetime of the waiver, rather than each year
    - Permit states to submit coordinated waiver applications that allow recognition of savings from current or proposed 1115 waivers when assessing whether a 1332 waiver application meets the deficit neutrality guardrail

- Afford states more flexibility in defining the essential health benefits (EHBs) that must be covered by all plans
- Allow for more flexibility around plan design, permitting states to explore value-based benefits with lower out of pocket maximums for high-value services in exchange for slightly higher out of pocket maximums for lower-value services to ensure individuals in lower-cost bronze plans do not forgo needed services for managing chronic conditions

In addition, Congress or the administration could consider the following items in support of Section 1332 waivers:

- Provide for a more streamlined and expedited waiver approval process that allows states to take actions that can impact rates sooner, including fast-tracking approval of applications for waivers that have already been approved and implemented in other states
- Provide grants to states that support efforts to explore and apply for Section 1332 waivers
- Provide additional up-front guidance around reporting requirements for approved waivers, allowing states to better plan for implementation

Thank you again for the opportunity to provide this testimony, and I welcome any questions you may have.