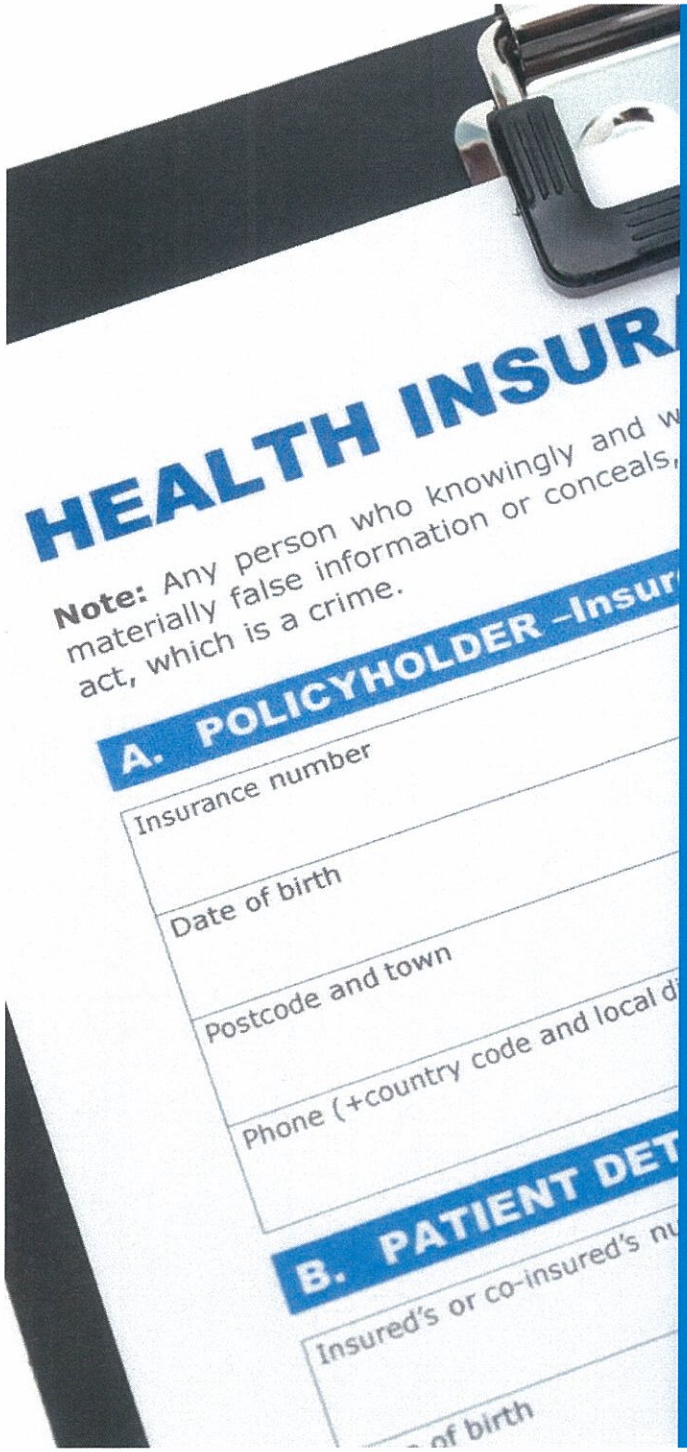

State Based Marketplace Research

Arkansas Health Insurance Marketplace Legislative Oversight Committee

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Objective

- The AHIM Policy Innovations Committee asked PCG to conduct research around four focus areas pertaining to launching and maintaining a successful Marketplace.

- The four focus areas are as follows:
  1) SBM Staffing Levels
  2) Attracting Issuers to the Exchange
  3) Attracting Brokers to the Exchange
  4) SHOP Potential Beneficiaries

State Based Marketplace Staffing Levels

State	Details
California	The Covered California exchange includes staff for roughly 35 positions.
Colorado	The Connect for Health Colorado exchange includes staffing positions for 44 individuals.
Connecticut	There are currently 46 individuals dedicated to the Access Health CT insurance marketplace.
Kentucky	In a November 2012 level two grant request Kentucky posted an organization chart showing staff positions for 31 individuals.
New York	The New York health benefit exchange used federal grants to potentially hire upwards of 78 staff members. Of these staff it is estimated that roughly 51 are dedicated to the exchange full time whereas the remainder are shared between the Exchange/Medicaid as well as the Department of Financial Services.
Rhode Island	The number of staff according to the Rhode Island February 2014 establishment grant was expected to be 25 individuals. Additionally, an Advisory Board and Expert Advisory Committee participate in the exchange.
Washington	According to the Washington Health Benefits Exchange website, there are 9 individuals dedicated to the exchange. All staff are Executive or Director level and support staff if applicable is not mentioned.

Attracting Issuers to the Exchange

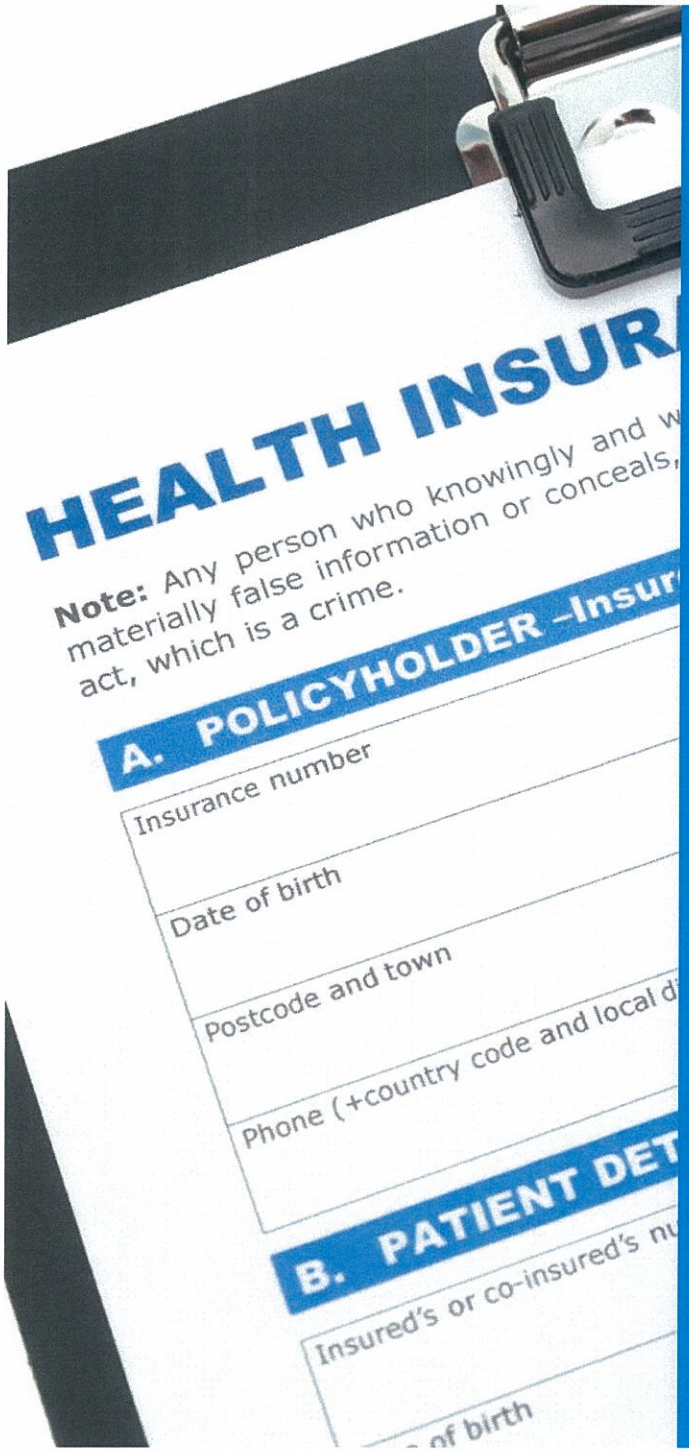
State Marketplaces included on the previous slide made the following policy decisions in an effort to drive competition:

1) **Set Rules Around Health Plans to be Offered:**
    a) Some states selectively contracted with health plans;
    b) Other states prohibited selective contracting;
    c) Flexibility on geographic regions where plans offered; and
    d) Not adding to federal rules.
2) **Action to Enhance Consumer Engagement:**
    a) Transparency of Cost and Quality Information
    b) Meaningful Plan Differences
3) **SHOP exchanges as a tool for increased choice:**
    a) Employee choice model adopted by SBMs

Attracting Brokers to the Exchange & SHOP

- States have not been found to have any specific incentives to attract brokers to the Exchange.
- The primary means for attracting Brokers appears to be outreach towards the broker community.
- SHOP: The State Health Access Data Assistance Center (SHADAC) releases estimates relating to employer-sponsored insurance every year from the Medical Expenditure Panel Survey – Insurance Component (MEPS IC). The below table identifies the estimated number of small businesses within the state of Arkansas in year 2012 and their respective number of employees.

Type	< 50 Employees	>50 Employees
Number of Businesses	45,359	2,080
Number of Employees	256,323	56,624



Section 1332 Waivers and the Future of Arkansas Healthcare Innovation

Arkansas Health Insurance Marketplace Legislative Oversight Committee

May 20, 2015

PCG | Health

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Agenda

Executive Summary

Federal Regulations Governing 1332 Waivers

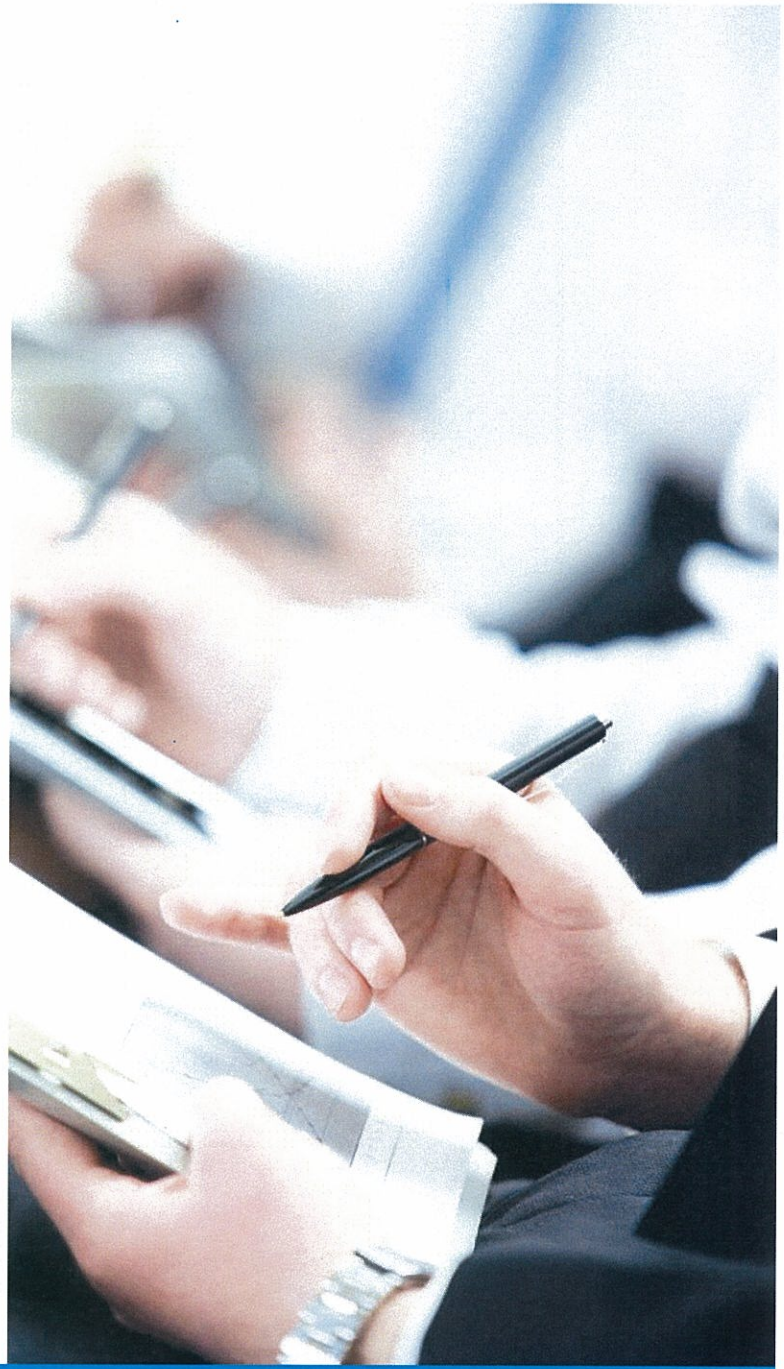
- Waivable Provisions
- Waiver Principles
- Application Criteria and Supporting Documentation
- Draft Timeline

Opportunities to Leverage 1332 Waivers to Advance Market Innovation

- Option #1 – Support Existing Private Option Model
- Option #2 – Consumer-Driven Reform
- Comparison of Options

Implementation

Contacts



Executive Summary

- The four sections of PCG's report were intended to:
  - Identify the provisions of the ACA that may be waived;
  - Provide options and examples of waiver concepts that appear permissible under the law;
  - Assess how 1332 waiver provisions might be used to work towards program integration; and
  - Identify key activities and timelines to be considered.
- Our report reached three important conclusions:
  - Section 1332 waivers give states broad latitude in the design of a Marketplace;
  - Section 1332 waivers have the potential to redraw the boundaries among major health benefit coverage sources; and
  - Planning would need to begin soon to implement in time for 2017.

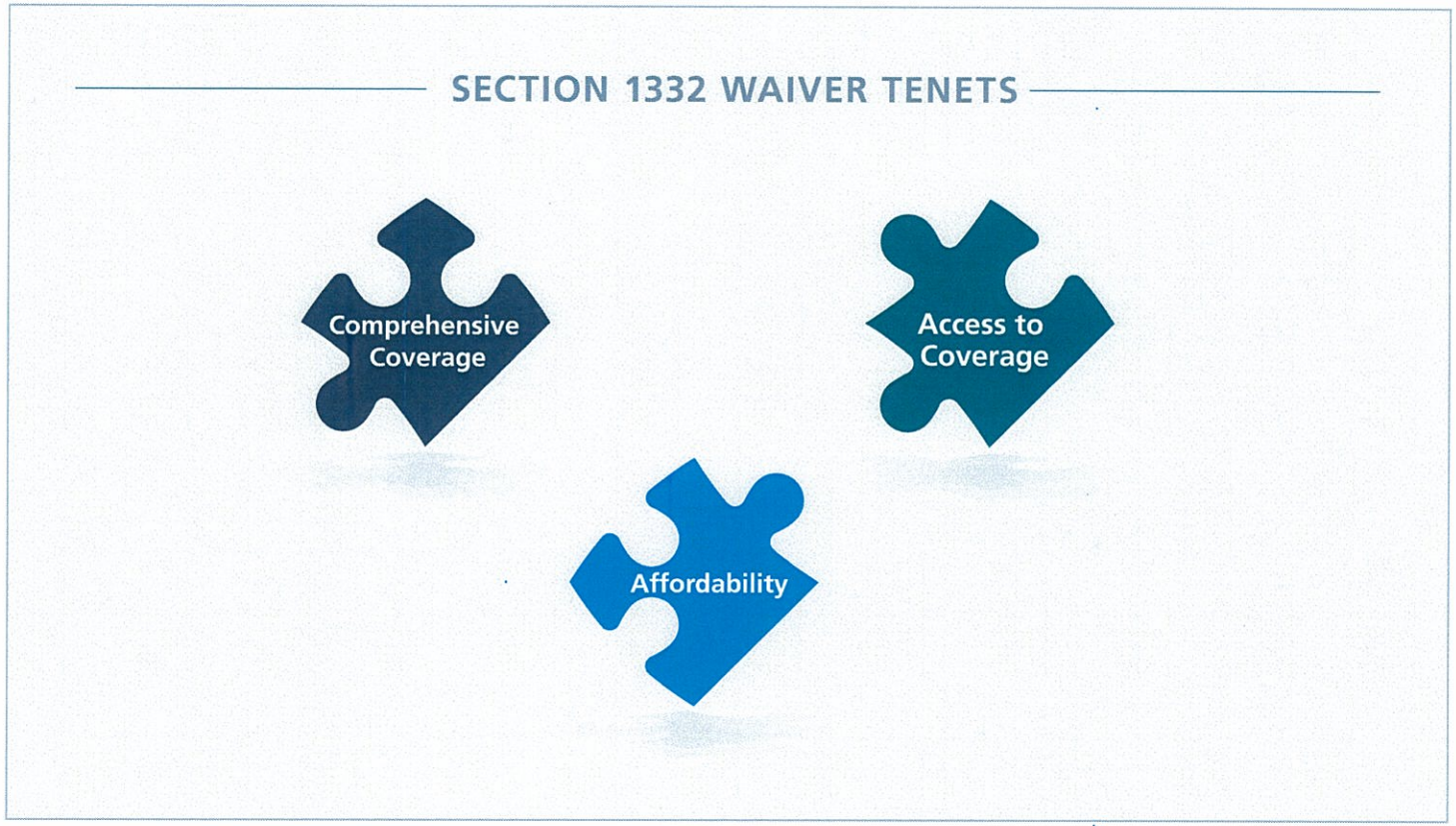
Federal Regulations Governing 1332 Waivers

Waivable Provisions

Key provisions of the ACA may be waived under the authority of Section 1332, including:

Subtitle D, Part I	Sections 1301-1304: QHP and EHB requirements
Subtitle D, Part II	Sections 1311-1311: Marketplace requirements
Subtitle E, Part I	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H, and 5000A: APTCs, individual and employer mandates

Waiver Principles



Application Criteria

Complete Application

1) Compliance with the public notice requirements set forth in 31 CFR Part 33.
2) Copy of the enacted state legislation.
3) List of the provisions the state seeks to waive.
4) Analyses, actuarial certifications, data, and assumptions.

Required Supporting Documentation

1) Actuarial analysis/certification
2) Economic analysis
3) 10-year budget plan
4) Compliance confirmation
5) Impact on healthcare population
6) Impact on state market
7) Key assumptions

Federal Public Notice and Approval Process

Arkansas Actions

1) Pass authorizing legislation
2) State public notice and comment period (90 days)
3) Public hearing period (30 days)
4) Submit waiver application

Federal Requirements

1) Continue communication with AR throughout
2) Preliminary review of application (45 days)
3) Decision-making period (180 days)
   - Public notice and comment period (90 days)

Opportunities to Leverage 1332 Waivers to Advance Market Innovation

A number of provisions can be waived in order to develop an Arkansas-specific healthcare delivery system.

Examples of Waiver Authority

The following is an outline of specific ACA provisions that are waivable under Section 1332.

1) Increase competition and product offerings

Section	Applicability
Subtitle D, Part I, Section 1301	Allow carriers to participate on the Marketplace even if they do not offer Silver and Gold plans.

Examples of Waiver Authority

The following is an outline of specific ACA provisions that are waivable under Section 1332.

2) Modify the small employer insurance market and promote consumer choice

Section	Applicability
Subtitle D, Part II, Section 1312	Expand the SHOP to large businesses, allow employers to offer tax-free vouchers for the purchase of Marketplace QHPs.

Examples of Waiver Authority

The following is an outline of specific ACA provisions that are waivable under Section 1332.

3) Increase access to private insurance and reduce dependence on entitlement programs

Section	Applicability
Internal Revenue Code of 1986, Section 36B	Expand APTC/CSR eligibility and make more people eligible for private coverage.

Option #1 – Waive Marketplace Provisions to Support Existing Private Option Model

One approach would be to combine 1332 and 1115 waivers to allow Medicaid to leverage the commercial market for coverage of the healthy members of the newly-eligible population.

Outline:

- Medicaid negotiates two or more Medicaid-specific QHPs.
- These would be more consistent with Title XIX.
- No state wraparound services.
- State could pay in full as premiums and without administering CSRs. State receives full Medicaid match.
- State would need to demonstrate comparability to the Private Option model.

Option #1 – Waive Marketplace Provisions to Support Existing Private Option Model

Execution:

Amend the Private Option waiver to:

- Provide coverage for Medicaid eligibles through Medicaid-specific QHPs.
- Simplify 1115 waiver provisions around reduced cost sharing administration.
- Eliminate wrap around benefit plan.

Waive sections of 1332 to:

- Design plans that do not fit into the prescribed parameters for current QHPs.
- Make plans specific to the Medicaid population.

Option #2 – Consumer-Driven Reform

A second option could be using a 1332 waiver to cover the non-disabled, non-elderly population into private insurance outside of Medicaid. Remaining Medicaid program focuses on special health care needs populations not easily served by private market.

Outline:

- Stratify population by health needs and employment capacity instead of just income.
- Outside of Medicaid, many federal rules may no longer apply, such as limitations on work requirements.
- Potential for block-grant like approach that is administered on a fixed budget.
- Medicaid focuses on remaining special health care needs populations. May negotiate with federal government to apply cost reductions to some portion of state share.

Option #2 – Consumer-Driven Reform

Execution:

Waive sections of 1332 to:

- Design Plan Types.
- Design Benefit Mandates.
- Add provision that you cannot be eligible for Medicaid to be Marketplace eligible.
- Add eligibility criteria, such as requirement to participate in employment search or training.
- Modify IRS rules about eligibility for tax credits and cost sharing reductions.

Comparison of Options

Option	Required law changes/waivers (state/federal)	State cost-effectiveness implications (as FMAP decreases)	Impact on insurance market/Medicaid	Impact on coverage/Impact of churn	Operational considerations	Other possible future ramifications
Waiving Marketplace Provisions to Support the HCIP Model	Federal law Certain waivers of Title XIX: - Section 1902(a)(17): re delivery system - Section 1902(a)(23): re mandatory premium assistance As well as others based on design of program: - Section 1902(a)(23): re provider networks - Section 1902(a)(34): re retro coverage - Section 1902(a)(10)(B): re comparability of coverage - Section 1902(a)(43): re EPSDT coverage - 42 CFR 431.53 re: non-emergency medical transport Additionally, under Section 1332:	Pros: - Will get FMAP - Administering all benefits through carriers may leverage efficiencies and lower state admin costs. Cons: - Reimbursement for all benefits would be at the commercial rates and rates would likely be un-negotiated.[24] - For the current HCIP population, coverage costs may be higher given the different in provider	Impact on Insurance Market – Increase overall risk pool but not enrollment in standard QHP plans. Carriers may need to adapt plans. Impact on Medicaid – Decreased enrollment in Medicaid Fee for Service (with primarily the highest risk beneficiaries remaining) is likely to impact Medicaid Fee for Service cost.	Impact on Coverage - Likely to be largely the same as standard Medicaid coverage with all benefits administered through QHPs. Impact of Churn – Would be minimized as beneficiaries remain within a unified coverage system (with a sliding scale of costs and additional benefits, all administered through QHPs) as income changes. Beneficiaries would become acclimated to being insurance enrollees and not move back	- No wrap would be required. - Insurance Department would have to update QHP form reviews to ensure plans are compliant with new standards. - Cost-sharing reduction payment approaches could be simplified. - Broker commissions may not be "baked into" the rates, so state could decide how to administer consumer assistance.	Making Medicaid a large and proactive participant on the marketplace could make it a driver of private insurance going forward, particularly if coverage and cost pressures grow in the future when the state share increases under the FMAP; and, in the circumstance of a financial downturn, the size of the Medicaid population and attempted influence of the state as a negotiator could dwarf the broader population and typical market forces.

[24] The market-wide rate uniformity requirements (42 U.S. Code § 18012; 45 CFR 156.80) do not appear to be waivable under a Section 1332 Waiver, which would preclude Medicaid negotiating rates specific to that population, although it is possible waiver could be negotiated. Section 1332 does allow for waiver of the prohibition in Section 1311 of the marketplace excluding plans through the imposition of premium price controls.

Option	Required law changes/waivers (state/federal)	State cost-effectiveness implications (as FMAP decreases)	Impact on insurance market/Medicaid	Impact on coverage/Impact of churn	Operational considerations	Other possible future ramifications
Consumer-Driven Model	Federal Law Under Section 1332: - ACA sections 1301-1304: possible waivers re EHB standards, AV/ coverage levels and cost-sharing restrictions; also possible creation of a population-specific coverage level - ACA sections 1311-1313: re marketplace eligibility - ACA sections 1401 and 1402: re APTCs and CSRs eligibility and, possibly, amount of financial assistance Changes to Medicaid eligibility via a Section 1115 Waiver and/or a Medicaid state plan amendment. State Law - Authorizing legislation	There should be no cost for the state, since coverage would theoretically be financed solely through federally-funded APTCs and CSRs. However, given the unique twist of this proposal, whether CMS would approve a waiver that fully eliminates any financial obligation of the state for covering this population (even if it is cost-neutral for the federal government) would be subject to negotiation. Whether the state could succeed in having this population included in the existing federal APTC/CSR population – or whether the state would receive Medicaid funds to	Impact on Insurance Market – Expansion of the insurance market risk pool. Impact on Medicaid - Decreased enrollment in Medicaid Fee for Service (with primarily the highest-risk beneficiaries remaining) is likely to impact Medicaid Fee for Service cost.	Impact on Coverage - Could mirror current QHP (vs. Medicaid) coverage. Subject to negotiations with CMS, Medicaid-specific benefits could no longer be provided (NEMT, EPSDT) for the enrolled population (though the medically frail would not be included). Cost-sharing would remain comparable through cost-sharing reductions. In the alternative, the state could waive federal QHP essential health benefit standards to add Medicaid-specific benefits, such as NEMT and EPSDT, for the	- This program will be able to be administered through Arkansas's State-Based marketplace. - There are questions about whether the state would have to administer APTCs and CSRs.	Limiting the Medicaid program for newly-eligible adults to the medically frail could create challenges to operating that program through Medicaid Fee for Service plans.

- PCG developed a comparison tool to summarize how each model impacts the following areas:
  - Required law changes
  - State cost-effectiveness implications
  - Impact on insurance market and Medicaid
  - Impact on coverage and churn
  - Operational considerations
  - Future ramifications

Timeline for 2017 Implementation

Questions?

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