State Strategy for Comprehensive Health System Reform

With Republicans now controlling the White House and both chambers of Congress, repeal of the Affordable Care Act (a.k.a. the ACA or Obamacare) is a virtual surety. What remains in question is what the replacement will look like and when it will be enacted.

In order to avoid the mistakes associated with passage of the ACA, congressional Republicans will need to:

- get bi-partisan support for any replacement measure (or measures, in the event they determine that a piecemeal replacement strategy is best)
- ensure that the 20 million individuals currently covered under the program are able to maintain their coverage
- strategically time the rollout of the replacement in order to avoid risking seats in the House or Senate in the 2018 mid-terms or loss of the White House in 2020.

Given the federal path toward a replacement will be long and arduous, states should consider a parallel "repeal and replace" path that can be approved swiftly and administratively even before federal legislation is enacted.

Background

At the end of 2015 the U.S. Congress passed HR 3762. The measure was passed under the reconciliation process in order to avoid filibuster in the Senate and is, therefore, very narrowly tailored, only including measures dealing with spending and/or revenues. As expected, President Obama vetoed the bill on January 8, 2016.

Briefly, the bill would have repealed key features of Obamacare that are necessary to make the whole system work, including:

- Phase out Medicaid expansion over a two-year period
- Phase out funding for federal premium subsidies over a two-year period
- Repeal penalty taxes associated with the individual and employee taxes

What HR 3762 did <u>not</u> do was repeal insurance market reforms, repeal Section 1332 of the ACA, or restrict state governments from operating health insurance exchanges.

Anticipated Repeal and Replace Timeline

Because HR 3762 is already in bill format, has already been fully vetted by the Senate Parliamentarian, and has previously passed both chambers, it is reasonable to expect this repeal measure to pass (again) in early 2017 and be signed into law by (then) President Trump. Doing this in January or February of 2017 allows both Trump and congressional Republicans to claim an early victory on a hot-button, high-profile issue and make good on a campaign promise. However, once passed, the clock begins ticking on the critical phase-out provisions. If passed in 2017 with a two-year phase-out, both the Medicaid expansion and the federal premium subsidies would completely sunset in 2019.

A congressionally-led replacement plan will be a long, slow process. Republicans aiming for political expediency are unlikely to want a two-year phase-out to be headlining the news in the middle of the 2018 mid-term elections, particularly with 25 Democrat-held Senate seats up for re-election that year. It's possible HR 3762 could be changed to reflect a three-year phase-out, but that timeline would still be extremely aggressive and a phase-out scheduled for 2020 may not be any more politically appealing given it's a presidential election year.

State-Led Efforts

As mentioned previously, HR 3762 does not repeal Section 1332 of the Affordable Care Act. (Indeed, it cannot since including a repeal of Section 1332 would violate the reconciliation requirements, thus making the entire bill subject to a 60-vote minimum as well as a filibuster.) **Given these circumstances, conditions are favorable for states that wish to move forward with their own replacement strategies under a 1332 Waiver.**

Section 1332 of the ACA provides that, starting in 2017, states may take federal dollars now invested in the health system overhaul and use them to redesign their own healthcare systems. In December 2015, the Obama administration released guidance that would considerably limit states' budgetary and operational flexibility under a 1332 Waiver; however, it is entirely reasonable to anticipate that the Trump administration would reverse course and offer significant flexibility. Such flexibility would be granted via administrative rules through CMS with no congressional action necessary.

With this in mind, Arkansas should immediately begin crafting state-level measures aimed at comprehensive health system reform, which would serve as the component parts of any federal waiver.

Ten Guiding Principles

In the last several years, Arkansas has been on the leading edge of health system reform. State policy makers have been well-served in all areas by adherence to a set of guiding principles. Going forward, the state should develop a blueprint for broad health system reform and all policies crafted under that blueprint should strictly adhere to the following guiding principles:

1. Incentivize Work for Able-Bodied Adults
2. Improve Efficiency
3. Promote Competition
4. Increase Transparency and Value
5. Promote Consumerism and Personal Responsibility
6. Modernize Governance
7. Ensure Free and Fair Markets
8. Ease the Burden on Arkansas Taxpayers
9. Offer Meaningful Assistance to Arkansans in Need
10. Support Arkansas Businesses

Proposed Policy Changes

In addition to 1332 Waivers, Arkansas should leverage other mechanisms of change at both the state and federal levels. With established guiding principles in mind, the state's initial blueprint should include the policy changes that are organized into three mechanisms: the federal 1332 Waiver, the federal 1115 Waiver, and Arkansas legislation at the state level.

Mechanism of Change: Federal 1332 Waiver

Policy Area	Current State	Future State	Guiding Principle
Fix the Special Enrollment Period (SEP)	ACA allows for multiple SEPs	Limit the number of SEPs in order to prevent gaming of the system	Ensure Free and Fair Markets Promote Consumerism and Personal Responsibility
Adjust the grace period	ACA allows a 90-day grace period	Limit grace period to 30 days	Ensure Free and Fair Markets Promote Consumerism and Personal Responsibility
Adjust the age band rating	ACA compressed the ratio to 3:1	Expand the ratio to 5:1	Ensure Free and Fair Markets Promote Consumerism and Personal Responsibility Offer Meaningful Assistance to Arkansans in Need
Expand use of federal premium subsidies	ACA limits use of the federal premium subsidies to the individual market	Allow subsidies to be used in the group market, including use toward the purchase of ESI plans	Incentivize Work Improve Efficiency Support Arkansas Businesses Offer Meaningful Assistance to Arkansans in Need

Policy Area	Current State	Future State	Guiding Principle
Modify Essential Health Benefits (EHB) requirements	ACA requires comprehensive coverage within ten specified categories	Allow insurers to offer plans with slimmed-down benefits within each category	Ensure Free and Fair Markets Promote Competition Increases Value Promote Consumerism and Personal Responsibility Support Arkansas Businesses
Waive Federal Technology Fee for a limited time	Federal guidance requires SBE-FP states to pay a fee for use of the federal exchange technology	Until such time as a federal replacement plan is implemented, CMS should waive the Federal Technology Fee for SBE-FP states.	Ease the Burden on Arkansas Taxpayers Modernize Governance

Mechanism of Change: Federal 1115 Waiver

Policy Area	Current State	Future State	Guiding Principle
Include additional provisions for Arkansas Works beneficiaries	Current administration will not allow	Include work requirements as part of Arkansas Works	Incentivize Work Offer Meaningful Assistance to Arkansans in Need Support Arkansas Businesses
Realign Arkansas Works benefits	Current coverage source is Medicaid which involves a complex set of federal rules and regulations. Current system has no incentives for upward mobility due to existing coverage cliffs.	Change coverage source to health insurance marketplace plans for all able-bodied working adults. State policy will guide terms of coverage including establishment of smooth transitions points and incentives for upward mobility.	Ensure Free and Fair Markets Ease the Burden on Arkansas Taxpayers

Mechanism of Change: State Legislation

Policy Area	Current State	Future State	Guiding Principle
Create a defined contribution market	Group plans currently sold in the state are defined benefit plans	Allow employers to predict and control costs year-over-year by offering defined contribution plans	Promote Competition Increase Transparency and Value Promote Consumerism and Personal Responsibility Ensure Free and Fair Markets
Expand access to SHOP	SHOP currently limited to small employers (<50)	Allow employers of any size to purchase defined contribution coverage through SHOP	Promote Competition Increase Transparency and Value Promote Consumerism and Personal Responsibility Ensure Free and Fair Markets
Expand use of the state's Premium Aggregator	Anticipated utility currently limited without defined contribution system in place	Allow combinations of defined contributions from both public and private sources; should include employee, employer(s), Medicaid, CHIP, federal premium subsidies, and charitable contributions	Incentivize Work Improve Efficiency Promote Consumerism and Personal Responsibility
Modernize the Employee Benefits Division	Currently a defined benefit system	Transition all public employees to a defined contribution system; designate employer default plan as an HSA-compatible high-deductible health plan (HDHP)	Promote Competition Increase Transparency and Value Promote Consumerism and Personal Responsibility Ensure Free and Fair Markets Ese the Burden on Arkansas Taxpayers Modernize Governance

Conclusion

Arkansans know Arkansas, and as such, the state should be charting its own path forward. This path should begin with immediate preparation of a blueprint, development of federal waivers, and crafting of state legislation to ensure progress is defined and measured by Arkansas—not Washington, DC.

The passage of the Affordable Care Act ushered in a seismic and unwelcomed shift in the boundaries between state and federal authority but America's system of limited government remains largely dependent on the key principle of federalism. With this in mind, the role of states should be vastly expanded. States should not sit idly by waiting for federal direction regarding the future of health system reform; rather, states should operate as laboratories of innovation as they were intended.

Additional Detail

Fix the Special Enrollment Period

Healthcare.gov explains that a Special Enrollment Period (SEP) is a time outside the yearly Open Enrollment Period when individuals can sign up for health insurance. Certain life events like losing health coverage, moving, getting married, having a baby, or adopting a child will qualify for an SEP. Once qualified for an SEP, a consumer usually has up to 60 days following the event to enroll in a plan. The regulation that provides for these SEPs is 45 CFR 155.420. The problem with the criteria for SEPs is that it can be open-ended, like "other exceptional circumstances." SEPs can be abused if a person waits until they are sick to sign up for coverage through an SEP and then drops coverage shortly afterward. Individuals who enroll through SEPs are thus more likely to enroll for shorter periods of time. The biggest challenge is identifying people who game the system because applicants are not required to prove or document the purpose of the SEP, instead they simply check a box.

Adjust the Grace Period

Under a rule at 45 CFR 156.270, issued by the Centers for Medicare and Medicaid Services (CMS), consumers get a 90-day grace period to pay their outstanding premiums before insurers are permitted to drop their coverage. The rule applies to all consumers, in all states, who purchase coverage through the health insurance marketplaces, are eligible to receive a federal premium subsidy, and have paid at least one monthly premium since enrolling in the QHP.

During the first 30 days of the grace period, carriers are required to continue to pay providers. If a consumer fails to make payment during the 90-day grace period, coverage is terminated 60 days retroactively. For example, a consumer who fails to pay their QHP premium due May 1 has a grace period ending July 31 to make their payment. If they fail to make this payment during the grace period, their coverage terminates retroactive to May 31 and they may not reapply for coverage until the next open enrollment period. However, if they receive health care during the 90-day grace period, either the carriers or the providers are on the hook for the associated costs in the event the beneficiary fails to pay.

Under a Section 1332 waiver, Arkansas would shorten the grace period to 30 days and terminate coverage retroactive to the first of the month for which a premium payment was not received in order to reduce uncompensated care and to prevent gaming of the system.

Adjust the Age Band Rating

Currently, issuers are prohibited from rating premiums for adults based on anything but age, location, and tobacco use. The limit for rating based on age is 3:1, meaning that a 64-year-old won't pay more than three times what a 21-year-old pays for the same plan. The result is higher premiums for younger, healthier enrollees and less incentive for healthy individuals to seek coverage. Previously, the age ratio was determined by the states. In Arkansas, the rating ratio has formerly been 5:1. A wider age-rating ratio would distribute the cost of premiums to more fairly reflect the market.

Expand Use of Federal Premium Subsidies

Federal premium subsidies were included as a provision of the ACA. They are intended to help offset the cost of premiums for individuals with incomes within 100%-400% of the Federal Poverty Line. Currently, federal premium subsidies may only be used for the purchase of individual (non-group) insurance coverage for individuals who do not qualify for other government health plans or whose employer-sponsored insurance is deemed unaffordable (in excess of 9.5% of the employee's income.)

Expanding use of the federal premium subsidies for group coverage (defined benefit or defined contribution) would have the effect of allowing families to stay on a single plan rather than being enrolled in disparate programs and policies. Such an arrangement would also strengthen employer-sponsored insurance and save taxpayer dollars since the employer's contribution could be leveraged against the total cost of coverage.

Modify Essential Health Benefits

The Affordable Care Act requires non-grand fathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

While states may use a 1332 Waiver to make changes to the EHB requirements or change which plan is used as a benchmark for determining the federal subsidy amount, a state must demonstrate that coverage under its waiver would be "at least as comprehensive" as marketplace coverage. Questions remain about how much flexibility a state might have in providing comparable coverage and, specifically, what "at least as comprehensive" means. HHS will need to further clarify how this test will work in practice, as well as provide additional guidance on the types of data that states must include in their application to demonstrate that they meet this requirement. For instance, though the Obama administration would likely have narrowly interpreted the meaning of "at least as comprehensive", the Trump administration may provide a broader interpretation, thus allowing states to select a new benchmark that maintains the ten statutorily-required categories but allows benefit flexibility within each category.

Waive Federal Technology Fee for a Limited Time

Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs) sold through the Individual Exchange and the Small Group Health Options Program (SHOP) are subject to a user fee. 45 CFR 155.160 requires issuers to remit user fee payments if assessed by a State-based Exchange. The U.S. Department of Health and Human Services (HHS) also requires a fee from issuers in the Federally-facilitated Exchange (FFE) in 45 CFR 156.50. Effective Plan Year 2017, the Arkansas Individual Exchange is a State-based Exchange on the Federal Platform (SBM-FP), meaning that technical functions related to individual QHPs will operate through Healthcare.gov, which is the federal technology platform. AHIM established a 3% user fee under Arkansas Code § 23-61-805 and that assessment will replace the 3.5% fee currently assessed by the FFE.

Over the past three years, Healthcare.gov technology was provided at no charge to the states that transitioned to an SBE-FP model but, in 2017, the fee will be 1.5%. HHS should allow AHIM to conduct its operations without incurring this fee because the state successfully functioned as an SBM for SHOP and will use minimal functions provided by federal technology for the Individual Marketplace. While the technology fee is for a bundle of services, those needed by the state are only part of the bundle. Finally, HHS allowed other states with failed models to use the federal technology without incurring a fee and therefore build a reserve through state-level assessments. Arkansas should also have three years to fund its operations without remitting a fee for the technology through Healthcare.gov.

Include Additional Provisions for Arkansas Works Beneficiaries

In approving the Arkansas Works waiver, CMS limited the financial support offered to employers under Employer Sponsored Insurance (ESI) provisions. Arkansas seeks to rebuild a robust ESI market, assuring that state residents who are employed full time receive their health coverage through plans offered by their employers. Under the new Administration, Arkansas should seek to increase financial incentives, especially to small employers, to support affordable coverage for lower income workers.

Further, some states have sought to limit the length of Medicaid eligibility for able-bodied adults to incentivize them to work. Michigan sought a 4-year limit that was largely not approved by CMS (coverage changed to a different plan after 4 years but was not terminated). Time limited coverage would not apply to those verified to be working some limited number of hours per week (for example, 32 hours per week).

Re-align Arkansas Works Benefits

Remove the Medicaid eligibility category of below 138% FPL, returning the Medicaid program to serve the truly vulnerable. All able-bodied working adults will obtain coverage from the private marketplace, regardless of income, with no Medicaid wrap or governance. There should be bright line of distinction between the two.

Once in the private marketplace, the state can offer premium assistance based on income, but only to those with a minimum income level equal to at least part-time work (i.e. 30 hours x minimum wage). The amount of the assistance can still be based on household size using the standard Federal Poverty Line FPL factor. But this will act as a "floor" that ensures all receiving assistance are active in the workforce. Certain exemption can be granted (e.g. full-time students, stay-at-home parent, temporarily unemployed, etc.).

Assistance would scale down as income increased, with assistance ending at 200% FPL. The more an individual earns the more they will pay, but with smooth transition points that do not discourage upward mobility. All levels of assistance will have some degree of cost-sharing for the individual built into the plan design.

Create a Defined Contribution Market
Currently, the most common option for offering employee healthcare benefits, known as defined benefit, references a traditional model of employers offering a pre-selected, specific range of healthcare plans. In this model, the employer tends to be more proactive than the employee in selecting and managing healthcare benefits. Defined contribution plans allow employers the option to choose a set dollar amount to contribute towards an employee's healthcare. The employee is then responsible for researching and purchasing the insurance policy that best suits his need.

According to the National Federation of Independent Businesses (NFIB), "With [defined contribution], an employer can determine up-front how much to contribute to employees' health insurance. This gives financial predictability, making it easier to plan and grow the business. Done correctly, [defined contribution] can improve employer-employee relations by offering employees more choices and better choices than they currently have. Employees would no longer be limited to their employer's one-size-fits-all insurance choice. The portability of [defined contribution] plans removes a source of tension between employers and employees."[1]

The transition from defined benefit health plans to defined contribution health plans is almost identical to the transition in employee retirement plans away from pension plans (a defined benefit) to 401k plans (a defined contribution arrangement).

Expand Access to SHOP
As a general rule, SHOP is currently limited to groups of 50 full-time employees. This is because the state regulations restrict small group plans to the same number. Allowing larger groups to access the SHOP would provide access to stable coverage. Allowing various associations and other groups to pool together also increases the buying power of consumers through SHOP. Not only does SHOP provide easy access to choices and efficient plan selection, which reduces the administrative efforts on the part of employers, it is also an existing, robust solution to purchase coverage online.

Expand Use of the State's Premium Aggregator
The Arkansas Health Insurance Marketplace (AHIM) is in the process of enhancing the payment management system associated with the state small group health insurance exchange. The new "premium aggregation" feature will operationally enable employers to make a defined contribution for employees to use toward the purchase of a health plan of their choice. The system will also have the capability to allow combinations of contributions from multiple employers (e.g. contributions from multiple part-time employers for a single employee or contributions from a husband's employer and a wife's employer to be applied toward the purchase of a single family plan.)

However, the premium aggregator's utility is limited in the absence of a state defined contribution market that would allow employers and employees to take full advantage of efficiencies in the system. According to the Heritage Foundation, "The premium aggregator is

[1] NFIB, Healthcare Solutions: Defined Contribution http://www.nfib.com/cribsheets/defined-contributions/

especially effective in purchasing a defined-contribution plan. With traditional defined-benefit plans, the couple is normally faced with a difficult decision to choose one spouse's employer benefits plan or the other. Such a wasted opportunity can be avoided in a defined-contribution market with a premium aggregator. Premium aggregator functions increase plan affordability and coverage for nontraditional employment situations, benefiting consumers beyond the strengths of defined-contribution markets."[2]

In addition to contributions from private sources, the premium aggregator could also allow contributions from public sources such as the federal or state government (i.e. federal subsidies, Medicare contributions, and Medicaid/CHIP contributions) as well as contributions from non-profit or charitable organizations (e.g. churches, civic clubs, etc.)

Modernize the Employee Benefits Division

The Employee Benefits Division (EBD) of the Arkansas Department of Finance and Administration (DFA) administers health insurance benefits ("ARBenefits") for state and public school employees and retirees. The ARBenefits schedule is established under Arkansas State Law, is self-insured and, therefore, not subject to the Employee Retirement Income Security Act (ERISA) of 1974. EBD has the administrative oversight of the day-to-day operations of the Plan with such functions as determining and maintaining eligibility, managing appeals, coordination of member communication and more. EBD contracts with Health Advantage and QualChoice to coordinate these benefits.

This benefit model does not leverage state purchasing dollars to strengthen the competitiveness of the commercial health insurance market in Arkansas. Arkansas could enact several reforms to direct benefit dollars to employees, who would then select their own coverage in a commercial marketplace. State law would designate the default plan as a High Deductible Health Plan (HDHP) that is compatible with a Health Savings Account (HSA).

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[2] Heritage Foundation, Consumer Power: 5 Lessons from Utah's Heath Care Reform by Gregg Girvan http://www.heritage.org/research/reports/2010/08/consumer-power-5-lessons-from-utah-s-heath-care-reform