SENATE CONCURRENT RESOLUTION 70 STUDY GROUP

FINAL REPORT

JANUARY 15, 2019

State of Delaware

CONTENTS

1
INTRODUCTION

This Study Group was created by Senate Concurrent Resolution 70 (SCR 70) that was introduced on June 20, 2018, by Senator Margaret Rose Henry and subsequently passed on June 28, 2018. SCR 70 noted several descriptive characteristics of Delaware's health insurance landscape including:

- Access to quality, affordable health care is a cornerstone not only of a healthy life, but of a healthy economy and middle-class
- More than 24,000 Delawareans are enrolled in Marketplace plans via ChooseHealthDE.com or Healthcare.gov
- Only one commercial insurer currently sells health plans on Delaware's Marketplace
- Health insurance premiums on an average "Silver" level Marketplace plan in Delaware increased by 25% last year [2018 plan year][1]
- Consumers would benefit from greater competition in the individual insurance marketplace

SCR 70 also resolved that the Governor and Secretary of Health and Social Services may apply for a federal waiver for state innovation under Section 1332 of the Patient Protection and Affordable Care Act (ACA), and if approved, may implement a state plan of innovation that meets the waiver requirements established under federal law and as approved by the United States Secretary of Health and Human Services.

The co-chairs of the Study Group (i.e., Senator Bryan Townsend and Representative Paul Baumbach) are required to compile a report containing a summary of the Study Group's work regarding the issues assigned to it, including any findings and recommendations, and submit the report to all members of the General Assembly and the Governor no later than January 31, 2019.

The SCR 70 Study Group met on the following dates:

- September 5, 2018

[1] Per Commissioner Navarro, for the 2019 plan year, the Department of Insurance approved a rate filing increase of 3 percent.

- September 27, 2018
- October 10, 2018
- November 7, 2018
- November 28, 2018
- December 12, 2018

Through these meetings, there has yet to be a single solution presented within the Study Group that would solve all of our challenges and achieve all of the goals voiced to date that is clearly viable and affordable for the State moving forward. This is not wholly unexpected as the health care sector is a large, important and complex component of Delaware's overall economy. Even as this Study Group concluded its work, continued research and monitoring of the actions of other states across the country is important for us to do, as well as evaluating changes at the federal level that may present new opportunities or begin to close some options that could impact our local healthcare landscape. Moreover, our State has many highly qualified health care resources and entities with connections to larger organizations with regional and national exposure to new ideas. As co-chairs of this Study Group, we hope that our partners continue to assess opportunities for improving the affordability and sustainability of quality health care and health insurance for all Delawareans moving forward.

This report provides a summary of the Study Group's activities through the sixth meeting held on December 12, 2018. Additionally, to facilitate continued discussion within the Study Group, this report contains preliminary recommendations that Delaware should further explore, including developing a federal Section 1332 Waiver application to implement a State-sponsored reinsurance program for the purposes of stabilizing the individual health insurance Marketplace, reducing individual health insurance premiums and increasing access to more affordable health insurance for Delawareans.

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FRAMEWORK AND CONTEXT

The Study Group began with an introduction of all members and a review of the purpose and intent of SCR 70. It was acknowledged that there can be more than one definition of "Medicaid Buy-In", and members of the Study Group expressed excitement to discuss solutions for Delaware's increasing health care costs, but also concern over potential misunderstanding of what the term "Medicaid Buy-In" means. A Study Group member commented that they were not aware of any state operating a Medicaid Buy-In program for the general public regardless of income.

There was initial discussion that Delaware could explore a range of possible actions to stabilize our health insurance market, reduce the cost of health insurance premiums and make it more affordable for more Delawareans to obtain insurance, while taking into consideration the State's limited resources. It was noted that the Study Group should assess the driving principles, such as affordability and accessibility, and then determine which policy levers can be used to achieve those goals.

In the following three meetings, the Study Group invited and received presentations from different experts in the health care arena on topics ranging from:

- A summary of state activity on expanding affordable health insurance options from the National Conference of State Legislators
- An overview of Section 1332 Waivers, a Medicaid "look-a-like" insurance product and an expansion of the State's Title XIX Medicaid program from Mercer Health & Benefits[2] and Oliver Wyman Actuarial Consulting
- A review of the 1332 Waiver process from Delaware's Department of Insurance
- A summary of Maryland's Section 1332 Waiver program from the Director of Policy & Plan Management for Maryland's Health Benefit Exchange
- Provisional estimates of various options for a state-sponsored reinsurance program for the individual Marketplace from Oliver Wyman Actuarial Consulting based on a few key initial data assumptions that had been reviewed by Highmark at the request of the Department of Health and Social Services

[2] Mercer Health & Benefits LLC is the actuarial, financial and policy consultant to Delaware's Medicaid agency

The information shared helped inform the Study Group of different options available to us and supported discussion of initial advantages and disadvantages of different options. It was discussed during the different presentations that it will be important for Delaware to prioritize what challenges the State is trying to address. Different solutions have different effects on affordability and market stability. For example, a full expansion of Title XIX Medicaid could require the State of Delaware to pay tens of millions of dollars for its share of Medicaid program expenses and potentially further de-stabilize the individual market by pulling individuals out of that market and into Medicaid; however, it could also be a more affordable option for many individuals pending potential Medicaid cost-sharing scenarios. As another example, if insurance products can be sold on the Marketplace Exchange with lower premium rates through the use of a reinsurance program, federal tax credits (i.e., premium subsidies) will continue to flow into the State, which can potentially drive positive enrollment momentum, attract more and healthier individuals to buy insurance and further reduce subsequent premiums; however, insurance may still be unaffordable for some higher income groups.

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OPTIONS PRESENTED TO THE STUDY GROUP

Over the course of our meetings, the Study Group was presented with several different options for fulfilling the intent of SCR 70. A full, detailed financial and operational evaluation of each option was beyond the means of this Study Group; however, summary information either qualitative or quantitative, when available, was received to assist the Study Group in assessing the relative cost and complexity of different options. The options discussed to date are summarized below.

EXPANDING MEDICAID TITLE XIX TO HIGHER INCOMES

States are not prohibited from expanding Medicaid to higher income individuals. In fact, Delaware expanded Medicaid in the mid-1990s to adults with incomes up to 100% of the federal poverty level (FPL) and then expanded Medicaid again to adults up to 138% FPL in 2014 under the optional provision in the ACA. Certain other populations, such as children, pregnant women and individuals needing long-term services and supports have even higher income eligibility pathways.

Since Medicaid is joint federal/state program, Delaware must operate its own program within broad, and sometimes restrictive, federal regulations. In exchange for complying with federal requirements and oversight, Delaware receives federal financial support to off-set a significant share of total Medicaid program expenditures. Presently, Delaware's standard federal support level is approximately 57%, meaning that for each dollar of Medicaid program expenditures, the federal government pays 57 cents and the State pays the remaining 43 cents with general funds.

If Delaware were to pursue expanding Medicaid to individuals and families at higher income levels, the State would have many policy, political and operational decisions to make, which would require a significant amount of time and resources. We could propose to the federal government a customized expansion that would include different benefits, cost sharing and/or eligibility requirements than those in our traditional Medicaid program that would have to be negotiated with the federal government and vetted through a public process. These steps take time, and there is no guarantee that Delaware would be granted any of our requested changes. Expanding Medicaid would likely draw people away from our individual Marketplace, which may further destabilize that segment of our insurance market. Operationalizing a larger Medicaid program would also strain our limited State resources.

As the Study Group heard and discussed, there are various advantages and disadvantages of this option from a policy and market perspective. From a financial perspective, even with the federal government helping to pay for a majority of costs, expanding Medicaid would result in a large new State expenditure. While the State could make certain design decisions, such as requiring higher cost sharing for Medicaid enrollees, rough estimates indicate the State share of a Medicaid expansion could range from approximately $40 million to over $100 million each year depending on many factors and policy decisions that would require much more detailed actuarial analyses.

CREATING A LOWER COST EXCHANGE-BASED INSURANCE PRODUCT

The Study Group acknowledged that health care costs in Delaware are high and that those higher costs raise the level of health insurance premiums for consumers. Within the Exchange, certain consumers have some protection from these higher insurance premiums by virtue of the federal tax credits (i.e., premium subsidies) that are available on a sliding income scale. However, enrollment in Delaware's Exchange-based plans has declined over the last few years for several reasons, including affordability, consequences of the economic recession, and changes in the marketplace. Many of those individuals leaving the market include those who do not qualify for federal tax credits.

If a viable insurer was willing and able to offer a lower cost insurance product, premiums would be reduced and insurance could become more affordable. To create a lower cost product, insurers would have to evaluate their provider networks, provider pricing arrangements and overall risk profile among many other considerations in pricing a given risk pool. For example, our Medicaid plans likely pay some providers less (and some more) than what Commercial plans have historically paid. If these lower cost arrangements can be leveraged into lower cost insurance products, affordability could be improved. However, the practicality of some providers accepting lower reimbursement for Commercial plans is uncertain. Some providers may seek higher Medicaid reimbursements levels in return, which would increase the State's Medicaid costs. Based on how the federal tax credits work, the Study Group was shown that if a lower cost plan became the basis for the tax credits (i.e., the second lowest cost Silver plan), consumers might end up paying the same out of pocket premium costs as before for the second lowest cost Silver plan, but perhaps have a narrower set of providers to choose from. If a consumer wanted to retain a traditional plan, it could be more expensive since their tax credits would be based on the new lower cost plan. However, individuals not eligible for tax credits (i.e., those with higher incomes) would benefit from the choice of a lower cost plan.

The Study Group was also presented an option that would require agreement from the federal government through a Section 1332 Waiver to exclude the lower cost plan from the determination of federal tax credits. If this were to happen, consumers would receive the same level of subsidy as they receive currently, could purchase a traditional plan for the same price as they currently pay, but could purchase a lower cost plan at their option for an even lower price.

However, it is unclear whether the federal government would be willing to make and stand-by this type of agreement and potential changes at the federal level could create instability over the long term.

LOWERING INDIVIDUAL HEALTH INSURANCE PREMIUMS THROUGH A SECTION 1332 WAIVER FOR A REINSURANCE PROGRAM

As the Study Group learned, several other states have pursued Section1332 Waivers from the federal government to make changes to their individual health insurance market. The most common strategy employed has been to implement a state-sponsored reinsurance program. A reinsurance program can reduce the cost of health insurance because insurers have some protection against high-cost claims and/or individuals which allows premiums to be lowered. Using reinsurance to lower an insurer's risk is a common practice in different insurance markets across the country. The federal government has established a process for states to follow to obtain a Section 1332 Waiver and while there are several steps to this process, other states have been able to complete the application process in a matter of a few months.

The primary benefit of using a Section 1332 Waiver for a reinsurance program is that when monthly premiums are lowered, the amount of federal tax credit dollars is also reduced. This produces savings to the federal government. With a Section 1332 Waiver, those federal savings can be passed back to Delaware to off-set a large portion of the cost of the state-sponsored reinsurance program.

Similar to the previous option involving a lower cost insurance product, most consumers (i.e., those consumers who are eligible for federal tax credits) would have very little, if any, change in their monthly premium since their portion is tied to their income. However, for individuals not eligible for federal tax credits, reinsurance would result in a lower premium and more affordable coverage. A key difference between reinsurance and reducing premiums through a provider networks option is that providers are not directly impacted by a state-sponsored reinsurance program.

While more robust actuarial modeling would be required, Oliver Wyman Actuarial Consulting presented to the Study Group three different reinsurance scenarios with provisional estimates of the impact of each scenario on premium costs and enrollment levels. The initial estimates assumed a targeted premium reduction of 10%, 15% and 20%, although other choices are also available to us. For example, in the presentation from Maryland regarding their Section 1332 Waiver/reinsurance program, we learned that Maryland targeted a 30% premium reduction. This is indicative of the various policy and design choices we would have to make if Delaware opted to pursue a state-sponsored reinsurance program (e.g., program structure, program administration, impact on insurers, etc.). Based on the estimates provided, a 20% premium reduction in Delaware equates to an approximately $40 million reinsurance program in 2020. With a Section 1332 Waiver and retention of the federal dollar savings, the estimated cost to the

State would only be approximately $5.2 million in 2020 with a potential range of $3.5 million to $7.0 million depending on key factors and pricing assumptions.

Funding to cover the State's net cost to enable the reinsurance program could come from a variety of different sources including, but not limited to: an assessment on insurers, general fund revenues, a State-based individual mandate penalty, a provider assessment or other sources of revenue from the General Assembly.

ENABLING INDIVIDUALS TO BUY INTO THE STATE EMPLOYEE GROUP HEALTH INSURANCE PLAN (GHIP)

Another option that was raised during a Study Group meeting was opening the State employee GHIP to non-State employees (or groups not otherwise eligible to obtain insurance through the GHIP). The impact on the premiums of an influx of new members would need to be modeled as changes to the premiums would likely be required if the risk profile changes materially. Similar to the Medicaid expansion option, if a disproportionate share of individuals with greater health care needs chooses to enroll in the GHIP, premiums could go up significantly and raise the costs to the State by a large amount. Conversely, if lower risk individuals opt for the GHIP, the remaining risk pool in the individual market would be markedly more instable and put pressure on the Exchange-based plans to raise premiums again. At present, estimates of the State's annual share of cost per each active individual in the GHIP is approximately $15,000. This amount is before assessing the impact on the cost of coverage of an influx of new risk. Based on this annual cost (which could vary if individuals were asked to pay more of the cost themselves), for every 1,000 individuals that would take up coverage through the GHIP, the cost to the State would be approximately $15 million. Unlike previous options discussed, there are no federal matching funds to off-set this new Delaware taxpayer expense.

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PRELIMINARY RECOMMENDATIONS

Taking into consideration the different advantages and disadvantages of the options the Study Group has considered, including the level of complexity, range of costs to the State and time required to actually implement a beneficial change, Secretary Walker from the Department of Health and Social Services is proposing that Delaware further evaluate a Section 1332 Waiver to implement a State-sponsored reinsurance program for our individual health insurance market. The primary goals of this recommendation include:

- Reducing average monthly health insurance premiums by a significant level (e.g., a 20% to 30% reduction)
- Minimizing the level of uncertainty and the actual amount of a new State expenditure
- Maximizing the retention of federal dollars staying in Delaware through the receipt of pass-through savings to off-set State costs
- Working with our insurers on reinsurance pricing assumptions to obtain the best return-on-investment for our State

Should this recommendation be supported by the Study Group, several key program design decisions will be needed so that the corresponding actuarial modeling, Section 1332 Waiver application and stakeholder discussions can be completed in a timely manner. A list of key decision points and, where applicable, a preliminary recommendation is provided below for the Study Group's consideration. It is important to note that these design decisions are not wholly independent of each other. Instead, each decision point affects other decision points and therefore influences the final cost and impact of the reinsurance program on our market.

TYPES OF REINSURANCE PROGRAM STRUCTURES

There are three main structures that a reinsurance program can take. These include 1) condition-based programs that reimburse insurers for the claims of individuals with certain chronic conditions, 2) attachment point-based programs that reimburse insurers for a portion of claims between a specified lower and optional upper threshold and 3) percent of claims-based programs that reimburse insurers for a specified percentage of total annual claims. For each structure, there are several key considerations including:

- Care management/coordination: the level of incentive or disincentive for insurers to continue to focus on member care coordination

- Ease of administration: State versus insurer responsibilities to collect and analyze data and process payments. There is the potential that existing federal resources (e.g., EDGE files) could be used to lessen the State's administrative requirements.
- Impact on insurer pricing process: to what degree can lower insurer risk reduce premium prices, including potentially lower margin levels for insurers?
- Flexibility: in what manner can the State adjust the reinsurance program's parameters to align with intended goals?
- Timing of payments: when do the reinsurance payment calculations occur and is there an interim and final settlement or just a single final settlement?

Recommendation: For relative ease of administration, familiarity level of insurers and State flexibility, we are recommending an **attachment-point reinsurance program**. The specific attachment points would be determined as part of the actuarial modeling in consideration of the program design goals. For illustration purposes, to achieve a 25% average premium reduction, the reinsurance program may need to cover 85% of claims costs that exceed $100,000 in a given year. Through the actuarial modeling process an iterative evaluation of options can be explored, and the option best suited to the State's goals can be selected. Having flexibility to reconsider program design on an annual basis may be important to allow for regular reassessment and improvements.

AVERAGE PREMIUM REDUCTION LEVEL

As noted previously, a decision will need to be made regarding the targeted level of average premium reduction that can be achieved through the reinsurance program. Other states have achieved premium reductions ranging from 7.5% (Oregon) to 30% (Maryland). The higher the premium reduction, the larger the reinsurance program and cost to the State becomes. A greater reduction in premiums increases the affordability level with the goal of increasing enrollment (particularly among relatively healthy individuals), which can then create more positive momentum going forward as premiums benefit from a larger and more diverse risk pool. However, human behavior is difficult to predict even in sophisticated simulation models so thoughtful consideration needs to be given to the level of change required to effectuate positive results.

Recommendation: A general thought is that small changes generate small results. If Delaware pursues a reinsurance strategy, it would behoove the State to pursue a larger change to generate more substantial and beneficial outcomes (i.e., more people having access to affordable health insurance). Therefore, we are recommending the State pursue a reinsurance program that will **reduce average premiums by 20% to 30%**. The specific figure will be dependent on actuarial modeling of different scenarios and sources of available funds, but the

general recommendation is to obtain the largest premium reduction that can be supported in a fiscally appropriate and sustainable manner.

STATE SHARE OF THE COST OF REINSURANCE

A Section 1332 Waiver will enable the State to retain federal dollars that would otherwise revert back to the federal government by virtue of premiums in the individual market being reduced. However, the amount of federal pass-through savings is unlikely to cover the full cost of the new reinsurance program. Per the presentation provided to the Study Group, a preliminary range in State costs to support a 20% reinsurance program is $3.5 million to $7.0 million in 2020. These costs would be higher if the reinsurance program targeted a 30% premium reduction.

Recommendation: We recommend **evaluating the sources of potential State funding relative to the amount of dollars needed to achieve the targeted premium reduction and decisions made based on this objective evaluation**. The overall goal of improving affordability and stability applies not only to our health insurance market and the insurers therein, but also to the State's finances, competitiveness and attractiveness to businesses and individuals to visit or live in our state.

FUNDING OPTIONS FOR STATE SHARE OF REINSURANCE

Commensurate with the amount of the State's share required to support the reinsurance program, a source of State funding will be needed. There are two strategies to consider in identifying a source of State funds: a one-time source of funding or a longer-term source of funding. As we heard from the representative from Maryland's program, Maryland opted to apply a state assessment fee on insurers in lieu of the federal health insurer tax that had been suspended for a year. This will be a one-time state assessment on Maryland's carriers, yet it is intended to provide state funding for their reinsurance program for up to three years (which the Maryland representative indicated would give the state time to develop a longer-term solution to their health care cost challenges).

If the federal government again suspends the federal health insurer tax, Delaware may be able to pursue a similar strategy as Maryland; but as a state, we can consider an assessment on insurers regardless of what the federal government does or does not do. Implementing an annual assessment on certain health care providers can also be source of ongoing funds to pay for the reinsurance program. The General Assembly has the choice to appropriate funds from elsewhere in the State's budget at their discretion or consider taxes/fees on things such as hotels and alcohol. We also learned that approximately $8.1 million in tax penalties attributed to the ACA's individual mandate was collected from Delaware residents by the federal government in 2016. The ACA's penalty for not having Minimum Essential Coverage is now $0, so much like the suspension of the federal health insurer tax, Delaware could explore a state-mandate and corresponding penalty to fund the State's share of the reinsurance program.

Recommendation: With the suspension of the federal individual mandate penalty and in consideration of the preliminary estimates of the cost of a reinsurance program, we recommend that the State **develop a state-based individual mandate with a corresponding penalty structure** intended to raise enough funds to cover some or all of the State's expected share of the cost of the reinsurance program. To the extent the State needs less funds than what the federal government collected in 2016, this should be factored into the design of the state-based individual mandate and corresponding penalty structure. If the General Assembly appropriates funds in support of this initiative, the State-based individual mandate penalty amounts could potentially be further reduced for other healthcare related issues. The study group strongly recommends that additional strategies to improve health outcomes and reduce health disease burden remain a focus beyond the scope of SCR70.

CONCLUSION

Addressing the challenges of high health care costs and the related cost of insurance is not unique to Delaware. The fact that several other states have already obtained approval of a Section 1332 Waiver for a reinsurance program, including one state developing a state-based individual mandate to fund its program (New Jersey), and more states are looking at a Section 1332 Waiver as a way to reduce health insurance premiums, indicates that there is viability in this option. We need to determine what is best for our state. The work of the SCR 70 Study Group is contributing to that discussion. The preliminary recommendations in this report are intended to spur further discussion by the Study Group. This final report reflects the collective input from the entire Study Group. More work remains to make Delawareans happier, healthier and more productive.

SCR 70 Medicaid Buy-In Study Group
Final Report Appendix

1. Minutes from the 09/05/18 meeting
2. Minutes from the 09/27/18 meeting
3. Discussion of Delaware's Marketplace Exchange, Medicaid, 1332 Waivers and Reinsurance PowerPoint (Presented by Fred Gibison and Tammy Tomczyk on 09/27/18)
4. Medicaid Buy-In PowerPoint (Presented by the National Conference of State Legislatures on 09/27/18)
5. Minutes from the 10/10/18 meeting
6. Discussion of Title XIX Medicaid Expansion, Medicaid Look-A-Like and Reinsurance options PowerPoint (Presented by Fred Gibison and Tammy Tomczyk on 10/10/18)
7. 1332 Waivers: An Overview PowerPoint (Presented by the Department of Insurance on 10/10/18)
8. Minutes from the 11/07/18 meeting
9. Maryland State Reinsurance Program PowerPoint (Presented by John-Pierre Cardenas on 11/07/18)
10. Further Discussion of 1332 Waiver for Reinsurance, Medicaid Look-A-Like and Title XIX Medicaid Expansion PowerPoint (Presented by Fred Gibison and Tammy Tomczyk on 11/07/18)
11. Minutes from the 11/28/18 meeting
12. First draft of task force report (Prepared by DHSS, in conjunction with Fred Gibison and Tammy Tomczyk, and reviewed on 11/28/18)
13. Minutes from the 12/12/18 meeting
14. Second draft of task force report (Prepared by DHSS, in conjunction with Fred Gibison and Tammy Tomczyk, and reviewed on 12/12/18)

SCR 70 Medicaid Buy-In Study Group

Wednesday, September 5, 2018
1:30 – 3:30 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Task Force Members:

Present:	Email:
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Representative Paul Baumbach	Paul.Baumbach@state.de.us
Senator Catherine Cloutier	Catherine.Cloutier@state.de.us
Representative Michael Ramone	Michael.Ramone@state.de.us
Steve Groff	Stephen.Groff@state.de.us
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Barry Dahllof	bdahllof@christianacare.org
Wayne Smith	wayne@deha.org
Emily Thomas, on behalf of Mike Jackson	Emily.Thomas@state.de.us

Absent:	
Dr. Jill Pillsbury	jpills1952@msn.com
Dr. Greg Bahtiarian	gebatiarian@comcast.net
Mike Jackson	Michael.Jackson@state.de.us

Staff:	
Caitlin Del Collo	Caitlin.DelCollo@state.de.us
Kyle Schwab	Kyle.Schwab@state.de.us

Attendees:	Organization:
Pam Price	Highmark
Andrew Dahlke	Medical Society of Delaware
Jill Fredel	Dept. of Health & Social Services
Steven Costantino	Dept. of Health & Social Services
Geoff Heathe	Christiana Care Health System
Kiki Evinger	Dept. of Health & Social Services
Elizabeth Lewis-Zubaca	Hamilton Goodman Partners

Attendees:	**Organization:**
Vince Ryan	Dept. of Insurance
Jeanne Chiquoine	American Cancer Society
Dustyn Thompson	Delaware United
Molly Magarik	Dept. of Health & Social Services
Drew Wilson	Morris James/Medical Society of Delaware
Robert DeGrazia	Christiana Care Health System
Byron Hobson	Self

The meeting was brought to order at 1:35 pm.

Representative Baumbach began the meeting by inviting the study group members to introduce themselves. After all the members introduced themselves, the Representative invited attendees to do the same. He then invited Secretary Walker to share her expectations, hopes, and fears for the study group.

Secretary Walker indicated that she was looking forward to the conversation, and that the department is excited to discuss options to increase the affordability of health care. She expressed her hope that all options will be put on the table, as well as her fear that the group will limit itself by only thinking about one definition of "Medicaid Buy-In."

Steve Groff also said he was looking forward to the discussion, and expressed concern that the group may limit itself due to its understanding of what Medicaid Buy-In means. He said there are opportunities to do a better job of making healthcare affordable for people, including leveraging the Medicaid program. He also said that any path the group takes comes with risk, and that the group should pay attention to potential costs to the state and consumers.

Representative Ramone said that he is excited to be part of a conversation that could help small business owners by offering more options. He also stated that he believes the community can do a better job.

Emmilyn Lawson said she is excited for the group and shares some of the same concerns that others stated. She said there is already good work being done in the state, and that she is convinced the group will come up with something that works for Delawareans.

Todd Graham stated that Steve Groff said it best. He expressed concern about increasing costs to the state and consumers.

Representative Baumbach acknowledged Dr. Fan as she joined the meeting.

Dr. Nancy Fan expressed appreciation for being asked to serve on the group. She said that the issue is a balance between costs and access.

Unknown said he agrees with Steve. He said the group needs to look at the issue wide open, explore what the costs will be, access, overuse of services, etc. He encouraged a holistic approach.

Commissioner Navarro said the Department of Insurance is always looking at ways to make healthcare more affordable. He mentioned that Delaware law doesn't allow "associated health plans" unless they've existed for five years. The amount of capital needed to start an associated health plan is also a barrier. He said that certain healthcare trends in the country aren't workable for Delaware unless significant changes are made to the Code.

Representative Baumbach invited the study group members from the Office of Management & Budget and the Office of the Controller General to provide comments, but neither member had comments to share.

Representative Baumbach acknowledged Senator Cloutier and Senator Townsend as they joined the meeting. He then stated that his understanding of Medicaid Buy-In is that it is an opportunity to take existing Medicaid infrastructure and create an on-ramp for people who qualify for ACA subsidized plans. He asked Secretary Walker to discuss the range of definitions of Medicaid Buy-In that she would like to see considered.

Secretary Walker stated that the Department has the authority to decide what a Medicaid benefits package looks like, to pursue a 1332 waiver, and to decide which population(s) to target. She noted that Delaware was an early ACA expansion state. She also said that she has heard about small businesses facing 30% increases in insurance rates.

Representative Baumbach invited Senator Cloutier to give remarks about her hopes and fears for the group.

Senator Cloutier said she is pleased the study group was created and that it is long overdue, but fears nothing will come out of the group. She also noted that she constantly hears from small businesses about health insurance.

Representative Baumbach invited Wayne Smith to speak.

Wayne Smith said that there are 10 or 11 other states looking into Medicaid Buy-In programs, and that a bill concerning the issue was vetoed in Nevada. He is concerned that pursuing a Buy-In program would be disruptive to the small group insurance market if commercial reimbursement rates are replaced with Medicaid reimbursement rates. He said that that could cause access issues for smaller providers.

Representative Baumbach asked Senator Townsend to provide comments.

Senator Townsend thanked the Medical Society of Delaware for hosting the meeting, and everyone else for attending. He also thanked Senator Henry for sponsoring the resolution that created the study group. Senator Townsend spoke about the importance of the study group. He mentioned that there are other conversations taking place about health care, including

benchmarking. He invited everyone to stay for the SB 227 Primary Care Reform Task Force meeting. Senator Townsend thanked Rep. Baumbach for co-chairing the study group. He noted that the study group is the same as a task force in terms of FOIA requirements.

Representative Baumbach read the study group's charge as found on lines 54 to 57 of SCR 70. He said the group needs to figure out how it plans to approach the study charge during future meetings.

Senator Townsend noted that the two study group members from the Medical Society of Delaware were unable to make the meeting. He said they would be attending future meetings. He also noted that there will be three members of the public appointed by the Governor to serve on the study group. Senator Townsend referenced the future meeting schedule, which was provided as a handout at the beginning of the meeting. He invited feedback about the schedule, but none of the study group members had any comments. Senator Townsend mentioned the possibility of adding an extra meeting to the schedule if needed. He said that he does not mind hearing comments from other agency employees who are not on the study group who attend the meetings. Senator Townsend also said there will be an opportunity for public comment at each meeting.

Andrew Dahlke said he would be interested in knowing how many other states have done Medicaid Buy-In programs. He suggested picking the best parts of each states' program.

Emmilyn Lawson said it would be helpful to get a high level overview of Medicaid and how it works.

Senator Townsend said that it could take a long time to study the programs in each state. He also said that in doing preliminary research for the study group, he found that there is a lot of variation in terms of how Medicaid Buy-In is defined.

Wayne Smith said that a lot of states have Medicaid Buy-In programs for adults with disabilities.

Steve Groff explained that Medicaid Buy-In for persons with disabilities has been around for a long time. Under the Ticket to Work program, persons with disabilities can pay a small premium to obtain Medicaid coverage, even if their income level is higher than the typical cut-off for Medicaid. Mr. Groff said he is not aware of any state operating a Medicaid Buy-In program for the general public regardless of income.

Secretary Walker said there are resources such as white papers that could be added to future meeting agendas. She suggested having a presentation on what the state and federal match options are under a 1332 waiver. She also said that the group should first think about its driving principles, such as affordability and accessibility, and then figure out which policy levers can be used to achieve that.

Dr. Nancy Fan asked Wayne Smith and Steve Groff what happened with the plan Nevada put forth that was vetoed. Specifically, she wanted to know if the plan was vetoed due to cost, the

definition of Medicaid Buy-In that was used, or because of a general rejection of the concept of Medicaid Buy-In.

Wayne Smith responded that the legislature passed a bill but the Governor vetoed it.

Dr. Nancy Fan asked if the legislature came up with a plan and had a cost attached to it.

Wayne Smith responded that he did not know those details.

Dr. Nancy Fan said the group should identify its end goal as a first step.

Representative Baumbach said the group can approach the study charge two different ways: one way is to get information first, and then set priorities; the other way is to set priorities first, and then get information. He then asked if the group feels as though it has enough information to set priorities.

Secretary Walker said it would be helpful to have everything on the same page first.

Representative Baumbach asked if that means we should figure out a definition for Medicaid Buy-In first.

Secretary Walker replied yes.

Steven Costantino stated that when the term "Medicaid Buy-In" is used, there is presumption that a person is buying Medicaid, but that that presumption is wrong. Instead, what the term means is that a person is using the same Managed Care Organizations (MCOs) in the Medicaid program to design an insurance product that has certain guardrails built into it. One of the guardrails is that the plan has to be somewhat similar to a product that is already offered on the Exchange. The plan also has to have essential benefits and be affordable. He said to think of Medicaid Buy-In as another plan on the Exchange that leverages the power of federal tax credits and reimbursement to pay for plan for people who fall under an expanded poverty guideline. He further explained the Centers for Medicare & Medicaid Services (CMS) doesn't get involved in such plans unless a state applies for a 1332 waiver.

Representative Baumbach asked about a meeting the Department of Insurance had with two consulting organizations regarding 1332 waivers.

Commissioner Navarro stated that staff did meet with two organizations, but that they weren't necessarily consulting. He referenced a statement that a 1332 waiver costs $2 million by saying that it would probably cost a lot more than that. He said that New Jersey just passed a 1332 waiver program. Pennsylvania has not done a 1332 waiver because there are multiple carriers, options, and hospitals in the state, and the exchange is working well. He said Oregon and several Midwestern states have tried to do1332 waiver programs but found the process too cumbersome and price too high. The Commissioner then provided a summary of the situation in Delaware. He said that last year 27,000 people purchased plans through the Exchange, while this year only 20,000 people purchased plans. He attributed the decrease to various factors, including high plan

costs, funding for Health Navigators a shortened enrollment period, and the fact that the federal government conducted maintenance on the Exchange website on Sundays. He noted that the state doesn't have multiple hospitals or carriers, and that Delaware's risk pool is both small and sick. Approximately 95 percent of the state's population has insurance coverage. The Department of Insurance approved a rate filing increase of 3 percent, which is less than the national average. He said that funding will be cut for Navigators this year. He also reiterated his fear that Medicaid Buy-In could destabilize the already unstable market.

Secretary Walker responded to the Commissioner's comments by saying that is why she thinks it is so important to define the group's principles at the outset, and then get information to share with the group. She thinks the group should decide what problem it is trying to solve, and then look for solutions without prescribing what those solutions necessarily need to look like. She stated that the Department also cares about stability and does not want to destabilize the MCOs they work with.

Dr. Nancy Fan said that the group should figure out which population it is trying to help. She reminded the group that Senator Cloutier had mentioned helping small businesses. She also referenced the small percentage of residents who are uninsured, people who make just enough money to disqualify them from Medicaid or ACA cost sharing, and people age 26 to 35 who might not have coverage through their employers. She said if the group wants to help a broader population, then it should adopt a broader definition of what Medicaid Buy-In is.

Secretary Walker said that in her view, insurance is unaffordable for nearly everyone, not just people in certain income brackets. She said she has heard from small and large businesses about premium increases.

Representative Baumbach invited a member of the public to speak.

Byron Hobson introduced himself and said that he is a small business owner. He said he would love to be able to give his employees insurance. He said the study group should set its principles first and then look at existing frameworks and how the principles could fit into them. He noted that many businesses are incorporated in Delaware but operate outside of the state. He questioned how the state can encourage businesses to operate in the state and create jobs. He said health insurance is central to that effort. Mr. Hobson also spoke about defining health care. He said that currently the health care system is centered around illness, and questioned how the system could be changed so that people don't fall ill in the first place. Mr. Hobson mentioned incorporating food and wellness programs into healthcare.

Senator Townsend acknowledged the importance of having shared principles, and stated his hope that the study group could agree on some by the end of the meeting, thereby freeing up future meetings for discussions that leverage the expertise of the people in the room.

Barry Dahllof discussed tracking trends using the S&P, as well as the tension between taking on a high risk pool and keeping costs contained. He said it will take a collective effort to move the needle on this issue.

Representative Baumbach referenced the fact that there are several conversations about health care currently taking place in the state, and that the issue of wholeness in health care could be better addressed by those conversations than the study group. He also said that even though premium rate increases are getting smaller, the increases can still be more than people can afford. Further, he said that the proportion of a person's income that is spent on health care is higher now than it was ten years ago. Representative Baumbach shared the priorities he wrote down, which are to increase affordability while maintaining market stability. He shared his hope that the group could continue discussing priorities at the current meeting, discuss definitions and hear from experts at the next meeting, and then circle back to priorities at a higher, more informed level at the third meeting.

Dustyn Thompson asked if the group can only provide one alternative plan on the marketplace to meet the needs of one demographic, or if multiple plans could be offered that help both small businesses and the 26-35 year old population. He argued that insurance is not affordable for most people, and said that if competition is the answer, it should come from the study group.

Commissioner Navarro said that everyone agrees that competition is key. He said that Highmark made a profit last year, and plans to rebate approximately $5 million to the small group market. He said that once there is an ability for a company to make a profit, they will keep coming back. He said he agrees with Representative Baumbach that insurance is too expensive for too many people. He said that approximately 80 percent of the people who use the exchange qualify for some kind of cost sharing. He also stated that a lot of people are grateful for the ACA because it prevents insurers from denying coverage on the basis of having a pre-existing condition. He said his neighbor, who is a travelling nurse, pays more for health insurance each month than for her mortgage. He said that when Alaska pursued a 1332 waiver at a cost of $50 million, premiums by fifteen to twenty percent.

Secretary Walker said the options are greater than was previously thought, and that the study group should look at those options.

Wayne Smith asked Secretary Walker if the options she referenced are all within the context of a Medicaid Buy-In program, or if the Buy-In program is just one option among several others that could be pursued.

Secretary Walker responded that it depends on what one considers Medicaid Buy-In to be. She referenced a white paper on the subject that discusses different Buy-In programs in the states. She expressed her hope that the group would not get tripped up on the name that is used.

Wayne Smith said that he thinks that is broader than the study charge to examine Medicaid Buy-In.

Secretary Walker replied that the resolution called for other levers, including the 1332 waiver.

Representative Baumbach referenced the resolution and said that there are sections that address both the study of Medicaid Buy-In programs, and the 1332 waiver. He said he interprets that to mean that the discussion can be a bit broader. He then suggested that the group finish discussing

priorities. He reminded the group of the priorities he came up with (increasing affordability while maintaining market stability).

Representative Ramone asked if it is accurate to say that the priority is increasing affordability through the creation of new options.

Representative Baumbach responded that he believes creating options is an implementation detail.

Representative Ramone said that his business lost health insurance coverage because the risk pool was too small. He said businesses need more options, and that by focusing on providing those options, the group will be able to achieve increased affordability.

Representative Baumbach said that increasing options is not inconsistent with increasing affordability.

Representative Ramone said he was hoping that the conversation would include increasing options.

Commissioner Navarro stated the affordable healthcare is a national issue. He discussed the danger of "skinny plans" that cover some services but not others. The Commissioner said he would look into New Jersey's 1332 waiver and report back to the group.

Representative Ramone discussed incentivizing individuals to change their health behaviors. He referenced a quote about America having "sick care" instead of health care.

Representative Baumbach responded by saying that setting affordability and market stability as the group's priorities does not preclude the group from considering incentives.

Senator Townsend agreed that the group could discuss incentives. He stressed the importance of finding a common understanding by the end of the first meeting.

Commissioner Navarro mentioned several things the state is doing to improve healthcare, including participating in the Health Care Commission and the State Employee Benefits Committee, and looking into benchmarking and value based payments.

Dr. Fan said that it is important to keep the study charge in mind, which is to look at the viability of a Medicaid Buy-In program. She said that the reason there are so many conversations happening around healthcare is because it is a complicated issue, and many aspects of healthcare overlap with one another.

Senator Townsend spoke about balancing the conversation so that the group can dig into the issue of Medicaid Buy-In, while still bearing in mind the other ongoing healthcare conversations. Senator Townsend then called on members of the public.

Dustyn Thompson said that young people do want insurance, but don't want to pay for a plan that has a $500 monthly premium and a $9,000 deductible. He then asked Representative Baumbach if creating options for uninsured and underinsured people is covered by the group's priorities.

Representative Baumbach replied that he does think that is covered. He said that in his view, increasing affordability means offering options to people that currently don't purchase health insurance due to cost.

Steve Groff said that he agrees with the priorities, but feels like something is missing. He posed a number of questions to get the group thinking. Specifically, he asked how the group knows that insurance is unaffordable now, and how will the group know when affordability has been achieved. He asked if the concern is that people aren't purchasing plans at all, or that people do have plans, but have so many out of pocket costs that having insurance is not valuable to them. He also asked if there is already a sense of market vulnerability because the state only has one carrier. Finally, he asked the group to think about what it wants to achieve or avoid.

Senator Townsend referred to lines 8 through 10 of the resolution, which mention competition in the marketplace as well as research that shows that per-enrollee spending is less under Medicaid than private insurance.

Steve Groff said it is important to think about what is unique to Delaware that may drive health care trends.

Representative Baumbach spoke about a Robert Wood Johnson Foundation report that found that the states most likely to adopt and benefit from a Medicaid Buy-In program are states where there are few insurance carriers, the premiums are high, and the state has expanded Medicaid. Representative Baumbach said that all of those characteristics are true of Delaware.

Senator Townsend called on Molly Magarik.

Molly Magarik mentioned the importance of considering how many people have switched to a lower level of coverage from one enrollment year to the next due to cost. Additionally, she noted that some people have plans with very high deductibles, which essentially leaves them without coverage.

Senator Townsend discussed options for structuring future meetings.

Dr. Fan said it would be helpful to obtain specific information regarding costs of primary care in Delaware. She said that having that data would help the group determine whether a public option is the way to go.

Wayne Smith agreed with Dr. Fan's comments, and said it is also important to look at differences in behaviors between Medicaid enrollees and non-enrollees.

Dr. Walker said that DHSS could provide information and expertise to the group.

Representative Baumbach invited the study group members to propose ideas for presentations at the next meeting.

Senator Townsend discussed having DHSS present at the next meeting.

Representative Baumbach suggested having CSG or NCSL provide a presentation on what has been tried in other states.

Todd Graham said that the fact that Highmark is now in a position to give rebates to consumers will stimulate more competition in the market. He emphasized the importance of settling on a goal as a group. Mr. Graham also expressed concern about the stability of the market.

Senator Townsend said that the group will certainly consider potential impacts to the market. He suggested spending the next meeting or two learning about different frameworks for Medicaid Buy-In, and then spending the last few meetings looking at how that may or may not work in Delaware.

Barry Dahllof suggested that any members planning to do a presentation provide the information to the group several days ahead of time in order to facilitate a thoughtful discussion.

Senator Townsend agreed with Mr. Dahllof's suggestion.

Commissioner Navarro said that if Delaware does pursue a 1332 waiver, it will cost millions. He also noted that there are always unintended consequences.

Senator Townsend asked if there would be benefits as well.

Commissioner Navarro said yes, there would be benefits. He mentioned that in some states, pursuing waivers has led to fifteen to twenty percent decreases in premium rates.

Barry Dahllof said that the most important thing to consider is the cost to the state and the consumers. He said the attempts to institute Medicaid Buy-In in Nevada and Minnesota failed because the legislatures did not do their due diligence in terms of considering cost. He also cautioned against making apples to apples comparisons with other states.

Senator Townsend said that he does not think the group has to come up with an entire Medicaid Buy-In program by the end of the study group meetings. Rather, he envisions providing a detailed analysis to the legislature that could be used as a first step to pursuing such a program.

Wayne Smith asked about a list of study group members.

Senator Townsend said that a list would be sent after consulting with the Governor's office regarding their appointees. He then asked if there were any questions from the study group members.

Commissioner Navarro asked if Byron Hobson could be appointed to the study group as a member of the public. He said he appreciates Mr. Hobson's perspective and the fact that he has taken time to voluntarily attend the meeting.

Senator Townsend replied that Commissioner Navarro could contact the Governor's office, since they have the appointing authority for members of the public. He then invited Mr. Hobson to speak.

Byron Hobson said that he is a native Delawarean and owns a medical massage facility. He employs 18 therapists. He stated that he has an alternative perspective on healthcare. He also mentioned that insurance does not cover his service, but that people are increasingly seeking alternative forms of healthcare. Mr. Hobson said that he used to have great healthcare, but now he pays around $700 a month for his plan, and his deductible is $8,000. He encouraged the study group to consider healthcare from a holistic standpoint.

Senator Townsend acknowledged Mr. Hobson's ideas but said that the group would need to focus more narrowly on Medicaid Buy-In given the study charge in the resolution. He also announced that the Governor finalized two of the public member appointees to the study group. He then invited Dustyn Thompson to give public comment.

Dustyn Thompson asked about data points to be shared at future meetings.

Steve Groff said that he could bring Medicaid cost information to the next meeting.

Senator Townsend stated that it would be appropriate to spend the next two meetings looking at data.

Dustyn Thompson also asked about being able to compare average costs in the private sector and average costs in Medicaid.

Steve Groff noted that average costs depend on the risk pool.

Representative Ramone suggested that data be shared with the study group ahead of meetings so that members can come ready with a basic level of understanding and ask questions as needed.

Commissioner Navarro asked about dial-in capability for the next meeting.

Senator Townsend assured the group that staff would look into dial-in capability for the next meeting. He concluded the meeting at 3:40 pm.

SCR 70 Medicaid Buy-In Study Group

Thursday, September 27, 2018
1:30 – 3:30 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Task Force Members:

Present:	Email:
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Representative Paul Baumbach	Paul.Baumbach@state.de.us
Representative Michael Ramone	Michael.Ramone@state.de.us
Steve Groff	Stephen.Groff@state.de.us
Dr. Kara Walker	Kara.Walker@state.de.us
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Dr. Nancy Fan	nfanssmith@yahoo.com
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Barry Dahllof	bdahllof@christianacare.org
Wayne Smith	wayne@deha.org
Emily Thomas, on behalf of Mike Jackson	Emily.Thomas@state.de.us
Deb Schultz	schultzdmw@gmail.com
Greg Star	star@carvertise.com

Absent:	
Senator Catherine Cloutier	Catherine.Cloutier@state.de.us
Trinidad Navarro	Trinidad.Navarro@state.de.us
Victoria Brennan	Victoria.Brennan@state.de.us
Dr. Jill Pillsbury	jpills1952@msn.com
Mike Jackson	Michael.Jackson@state.de.us

Staff:	
Caitlin Del Collo	Caitlin.DelCollo@state.de.us
Kyle Schwab	Kyle.Schwab@state.de.us

Attendees:	Organization:
Pam Price	Highmark
Andrew Dahlke	Medical Society of Delaware
Steven Costantino	Dept. of Health & Social Services
Kiki Evinger	Dept. of Health & Social Services
Mat Marshall	Delaware State Senate
Fred Gibson	Mercer
Tammy Tomczyk	Oliver Wyman

Dustyn Thompson	Delaware United
Attendees:	**Organization:**
Robert Varipapa	CNMRI
Dahana Stemrich	
Cheryl Heik	Connections CSP
Jonathan Kirch	American Heart Association
Joann Hasse	League of Women Voters
Tyrah Christianson	
Jeanne Chiquoine	American Cancer Society
Debbie Hamilton	Hamilton Goodman Partners
Jayshree Tailor	Progressive Health of Delaware
Yrene Waldron	Delaware Health Care Facilities Association
Katherine Collison	Division of Public Health, DHSS
Kim Gomes	The Byrd Group
Drew Wilson	Morris James/Medical Society of Delaware
Samantha Scotti (participated via telephone)	NCSL

The meeting was brought to order at 1:36 pm.

Introductions & Approval of Meeting Minutes

Senator Townsend greeted the study group members and attendees. He asked if anyone had any suggested changes to the draft meeting minutes. Since no one provided suggested changes, the study group voted to approve the meeting minutes. The Senator then reviewed the meeting agenda, and invited newly appointed study group members to introduce themselves. After introductions were made, Senator Townsend invited Samantha Scotti from NCSL to begin her presentation.

Presentation & Discussion with NCSL

Samantha Scotti gave a presentation on traditional Medicaid Buy-In programs, as well as the Medicaid for all model. She noted that while many states currently have Medicaid Buy-In programs for working adults with disabilities, no state has successfully implemented a Medicaid for all program. At the end of the presentation, she invited questions.

Representative Baumbach asked about a figure referenced on slide 12. Specifically, the Representative asked if persons with incomes up to 5 percent of the federal poverty line were already eligible to receive Medicaid.

Samantha Scotti indicated that she would check on that figure and follow up with a response.

Representative Baumbach asked Steve Groff for his understanding of the figure.

Steve Groff said that while 5 percent seems low, in non-expansion states, the eligibility limits for Medicaid for adults without children can be extremely low, and are not federally mandated.

Representative Baumbach asked Ms. Scotti whether the premiums charged in a Medicaid for all program are designed to fully fund the program, or whether they are intended to cover only part of the cost, with the rest of the funding coming from the general budget.
Samantha Scotti replied that for the proposals she has researched, the premiums are intended to cover some of the costs.

Representative Baumbach asked if the premiums and the ACA subsidies are designed to cover a subset of the cost the program, with the state paying the balance. He also asked what percentage of the total cost of the program the premiums and ACA subsidies cover.

Samantha Scotti responded that because no Medicaid for all program has been implemented yet, no state has applied for a 1332 waiver to work with their marketplace. As such, she is not sure what that would look like. She added that 1115 waivers, which might be required in order to implement a Medicaid for all program, have to be budget neutral or cost effective.

Representative Baumbach asked if Ms. Scotti is aware of any research that examines the potentially adverse effects of having sicker people join Medicaid via Medicaid expansion.

Samantha Scotti responded that there are studies about risk pools, but she is not aware of any that are specific to states that chose to expand Medicaid. She indicated that NCSL could research that.

Dr. Jayshree Tailor asked about the governor's veto of the Medicaid for all bill in Nevada, as well as the failure of legislation in Connecticut.

Samantha Scotti indicated that the bill in Connecticut did not pass the legislature, and that she would need to check whether it passed out of the first chamber. Regarding the veto in Nevada, she said that there was a concern over a lack of specifics in the bill, particularly surrounding how the program would be funded. Ms. Scotti added that because no state has yet implemented a Medicaid for all program, states are apprehensive about pursuing one.

Senator Townsend commented that the legislation in Massachusetts and Connecticut would have targeted broader populations, whereas other states' legislation was more narrowly focused on certain populations.

Samantha Scotti agreed that there is a spectrum of programs, with traditional Medicaid Buy-In programs on one end, Medicaid for all programs in the middle, and single payer programs on the other end.

Senator Townsend asked whether the bill in Nevada was similarly broad.

Samantha Scotti responded that the bill was broad and would have been an option for everyone in the state.

Senator Townsend referenced the part of the Massachusetts bill that allows employers to buy into Medicaid. He asked if any other states included such provisions in their proposed legislation.

Samantha Scotti responded that Massachusetts is the only state she is aware of that included a provision about employers buying in. She offered to share each states' proposals with the study group.

Senator Townsend inquired about the likelihood of any of the proposed bills in other states becoming law.

Samantha Scotti said that it is difficult for NCSL to predict the viability of any of the bills, but that the legislation is stalled at this point.

Caitlin Del Collo stated that the bill in Massachusetts was sent to study, and that according to Senate staff in Massachusetts, when that happens, it means the bill is unlikely to move forward in the legislative process. Ms. Del Collo then clarified that the SCR 70 Medicaid Buy-In Study Group is different, and is not meant to bury but rather shed light on the issue of Medicaid Buy-In.

Deb Schultz asked about the legislation in Massachusetts and how it fits in with employer-based coverage.

Samantha Scotti replied that NCSL has additional information about the exchange in Massachusetts that she can share.

Deb Schultz asked if the state would receive FMAP for that population.

Samantha Scotti said it is difficult to tell how much money Massachusetts would get through FMAP since the federal government has not yet received a waiver to approve the proposed program.

Senator Townsend asked for confirmation that the proposal from Massachusetts would allow individuals to buy in, as well as employers who employ individuals that make 138 percent of the federal poverty line or less.

Samantha Scotti confirmed that the proposal is for individuals, as well as employers with employees who make 138 percent of the federal poverty line or less.

Representative Baumbach asked if any states have considered expanding their state employee and state retiree health systems to include those who can't afford insurance.

Samantha Scotti replied that some states have discussed this approach, but none has actively pursued it.

Steven Costantino commented that the proposed program in Massachusetts is more like a Medicaid carve-out than a Medicaid buy-in program. He then added that the 5 percent figure

referenced on slide 12 of NCSL's presentation is accurate. He explained that the homeless population has almost no income. The State of Massachusetts chose to set an income limit for Medicaid eligibility at 5 percent of the federal poverty line, which captures the homeless population. Mr. Costantino then said that in Delaware, homeless people already qualify for Medicaid as childless adults.

Steve Groff added that homeless, childless adults in Delaware have been covered by Medicaid since 1996.

Senator Townsend asked if anyone else wished to make a public comment. No one did. The Senator then thanked Samantha Scotti for the presentation and moved onto the next agenda item.

Presentation & Discussion with DHSS/Mercer

Secretary Walker explained that the presentation would address the landscape in Delaware, as well as potential opportunities. She then began discussing the slides.

Senator Townsend asked whether the 240,000 Medicaid enrollees on slide 3 includes the 62,000 people added via Medicaid expansion.

Secretary Walker replied that the 240,000 figure does include the 62,000 enrollees added via expansion. She then noted that the graph on slide 5 illustrates the share of federal and state spending on Medicaid. The Secretary also highlighted the current cost of Medicaid per member per month ($744.78) on slide 6. She said this number is not reflective of what the average cost would be if the Medicaid pool were expanded.

Senator Townsend commented that the increase in the per member per month cost over time appears to be smaller than what one might expect given general rises in health care costs.

Secretary Walker said that Delaware has done a good job of containing the growth of health care costs relative to other states. She said the cost increase for Medicaid has been about 2 percent, whereas cost increases for private insurance are closer to six and seven percent.

Steve Groff said that Medicaid breaks down into four groups of enrollees (the elderly, people with disabilities, adults, and children), each of which has a different per member per month cost. Mr. Groff also said that the impact of the Medicaid expansion in Delaware was small, and only resulted in an additional 10,000 enrollees. He attributed the majority of the increases in the per member per month costs from 2014 to 2017 to increased services for behavioral health and substance abuse issues.

Barry Dahloff referenced a comment Commissioner Navarro made at the previous meeting about insurance rates on the exchange only increasing by 3 percent. He said a lot of trends are moving downward because of collaboration between payers and providers.

Secretary Walker discussed the content of slide 7.

Representative Baumbach asked for an explanation of the difference between the commercial individual market category and the commercial self-insured category on slide 7.

Molly Magarik responded that the State of Delaware's health plan for employees is self-insured, and that many large health systems are also self-insured. She said it is the difference between a person buying a plan from the fully insured commercial market, versus a commercial market that is contained to a group of individuals organized by the self-insured entity (the employer).

Steve Costantino said that ERISA claims are paid directly by the employer through a third party administrator, whereas claims for plans bought on the fully insured commercial market are paid by the insurer.

Secretary Walker said that other states' plans have failed due to a lack of due diligence in considering costs and strategies. She said the goal for this study group is to look at both costs and strategies. She then turned the presentation over to Fred Gibson.

Fred Gibson introduced himself and began discussing slide 9. He stated that Delaware already has a traditional Medicaid Buy-In program for working adults with disabilities. The program has about 100 enrollees. After discussing the competing definitions of Medicaid Buy-IN, Mr. Gibson turned the presentation over to Tammy Tomcyzk.

Tammy Tomcyzk discussed slides 10, 13, 14, 15, and 16. She then turned the presentation over to Fred.

Fred Gibson discussed the Medicaid program beginning with slide 18.

Steve Groff commented that Highmark's plans on the exchange represent a separate line of business from the Medicaid plan it administers as an MCO.

Fred Gibson briefly resumed the presentation before allowing Tammy Tomcyzk to take over.

Tammy Tomcyzk discussed 1332 waivers.

Secretary Walker stated that the take home message about 1332 waivers is that they are a way to leverage federal funds. The study group members then discussed the differences between pursuing a 1332 waiver, an 1115 waiver, and a pure expansion of Medicaid.

Representative Baumbach said that his understanding is that 1332 waivers do not result in new funds from the federal government, just a shifting of costs, whereas 1115 waivers do produce net winners.

Secretary Walker said that DHSS could present potential scenarios at the next meeting. Additionally, she said that there are different tradeoffs depending on which population(s) the study group decides it wants to help.

Senator Townsend agreed that it would be useful to look at scenarios at the next meeting. He observed that an 1115 waiver might be the best approach given the study charge in the resolution; however, he said that it would be worth looking at any strategies that achieve increased affordability of health care.

Deb Schultz asked what would prevent Highmark or AmeriHealth Caritas from setting their premium rates to the current Medicaid per member per month cost ($744.78).

Representative Baumbach commented that there are commercial barriers that could prevent that from happening.

Deb Schultz asked what those barriers are. She also asked if all Medicaid plans are the same.

Emmilyn Lawson explained that not all Medicaid recipients receive the same benefits in their plan. On the exchange, there are different levels of plans (gold, silver, platinum, etc.) from which consumers can choose. With Medicaid, a person receives a set of benefits based on their eligibility. The Medicaid plans for each type of eligible enrollee are the same from AmeriHealth Caritas to Highmark.

Steve Groff said that the biggest difference in plans is that some Medicaid enrollees are eligible for long term care and supports due to their medical needs. Additionally, children enrollees have benefits that differ from adult enrollees.

Senator Townsend said that the question the study group is trying to answer is whether we can allow a population to buy into a plan based on what the per member per month cost is.

Representative Baumbach said that under a 1332 waiver the responsibility of the risk pool is shifted away from the insurers, so they don't have to factor that into the price of the premiums. That results in a net savings.

Fred Gibson said the main goal of a reinsurance program through a 1332 waiver is to lower premiums in order to attract more consumers to the exchange.

Dr. Nancy Fan asked if any of the states that recently received a 1332 waiver saw increased enrollment or cost savings.

Tammy Tomcyzk said that premiums in Alaska decreased 30 percent from 2017 to 2018, and by 2 or 4 percent from 2018 to 2019. She then discussed the content of slide 34.

Representative Baumbach said that New Jersey is reinstating its requirement to have health coverage, which is designed to get more people into the risk pool.

Tammy Tomcyzk added that the penalties the state will collect from those who choose not to have coverage (which previously were collected by the federal government) will fully fund their program. No additional state dollars will be needed.

Senator Townsend said that it would be helpful to consider more 1332 waiver information at the next meeting. He also discussed the issue of whether health outcomes will be better as a result of any recommendations the study group makes.

Secretary Walker said that it would be difficult to talk about health outcomes in the context of the study group, but that generally coverage matters and influences all aspects of a person's health. She offered to share background information on the subject.

Public Comment

Senator Townsend invited public comment.

Dustyn Thompson asked if the state would be able to use cost sharing measures under an 1115 waiver. He also asked if expanding Medicaid to higher income levels will offset costs.

Fred Gibson and Steve Groff both stated that the state could use cost sharing measures with an 1115 waiver.

Senator Townsend asked if the premiums that healthier people pay into a program could subsidize those already in the risk pool.

Fred Gibson said it would depend on the math.

Joann Hasse asked if anyone is considering what would happen if the protection for people with preexisting conditions was removed from law.

Steve Groff said that such a scenario would not impact Medicaid.

Tammy Tomcyzk responded that studies have looked at the impact of guaranteed issue and observed that rates increased by fifteen percent.

Joann Hasse commented that many people do not know what insurers consider preexisting conditions.

Yrene Waldron asked whether the decrease in premiums in Alaska resulted in more insurers joining the marketplace.

Tammy Tomcyzk replied that Alaska still has just one carrier.

Yrene Waldron asked a follow up question about what might happen to the Delaware market.

Tammy Tomcyzk responded to the question.

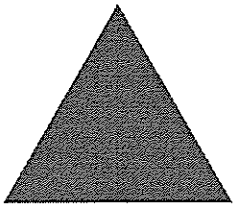
The meeting adjourned at 3:38 pm.

Final Report Appendix - Item 3

HEALTH WEALTH CAREER

Government Human Services Consulting

DISCUSSION OF DELAWARE'S MARKETPLACE EXCHANGE, MEDICAID, 1332 WAIVERS AND REINSURANCE



SCR70 TASK FORCE MEETING

SEPTEMBER 27, 2018

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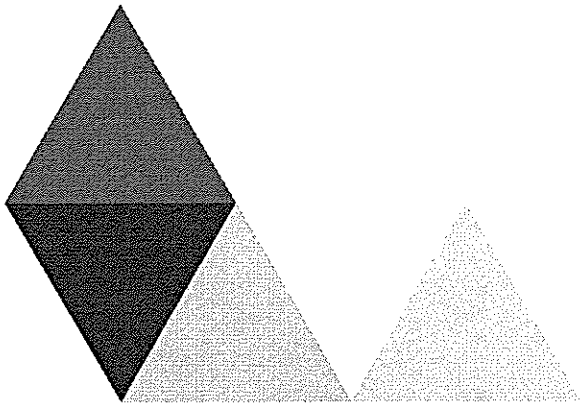

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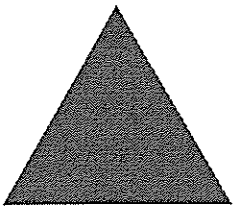
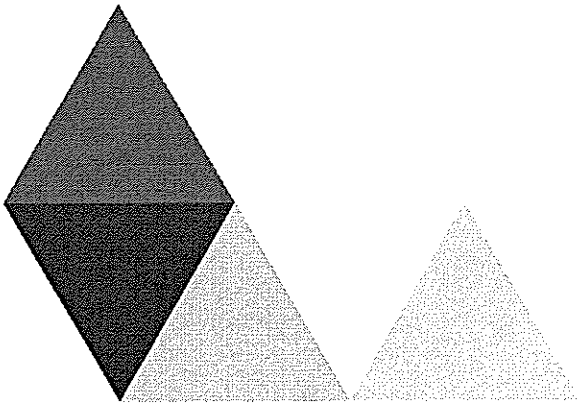
MAKE TOMORROW, TODAY MERCER

HEALTH WEALTH CAREER

BACKGROUND





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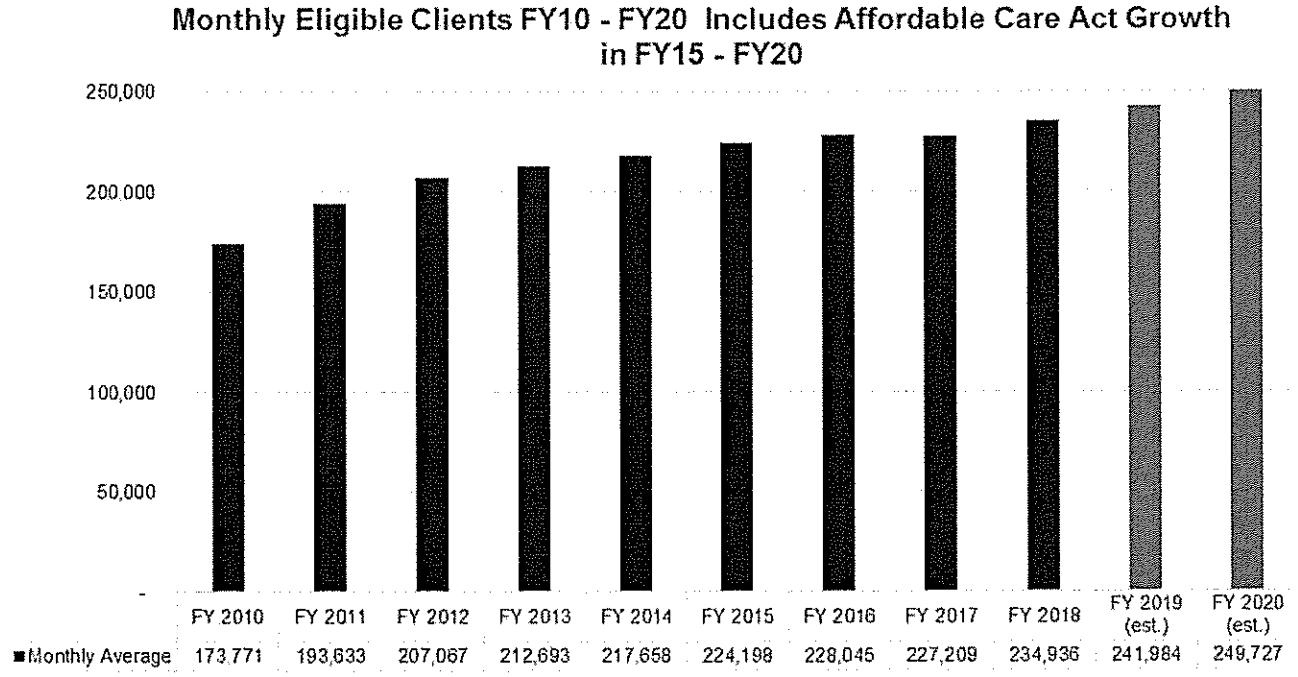
DELAWARE POPULATION STATISTICS

- Estimated total State population: 947,259
- Number of uninsured by county (2017 American Community Survey 1-year estimates)
  - Kent County: 13,163
  - New Castle County: 26,609
  - Sussex County: 11,471
- Exchange enrollment
  - Marketplace Exchange 2018 selections: 24,500 (CMS Public Use File)
  - SHOP: 179 covered lives
- Medicaid enrollment (fee-for-service and managed care): over 240,000 (estimated)
  - FFS enrollment mostly composed of partial Medicare/Medicaid dual eligibles and emergency/labor and delivery non-citizen eligibility groups
- Medicaid Adult expansion: approximately 62,000
  - Approximately 10,000 in the 109% – 138% FPL group (2014 expansion)

GROWTH IN MEDICAID



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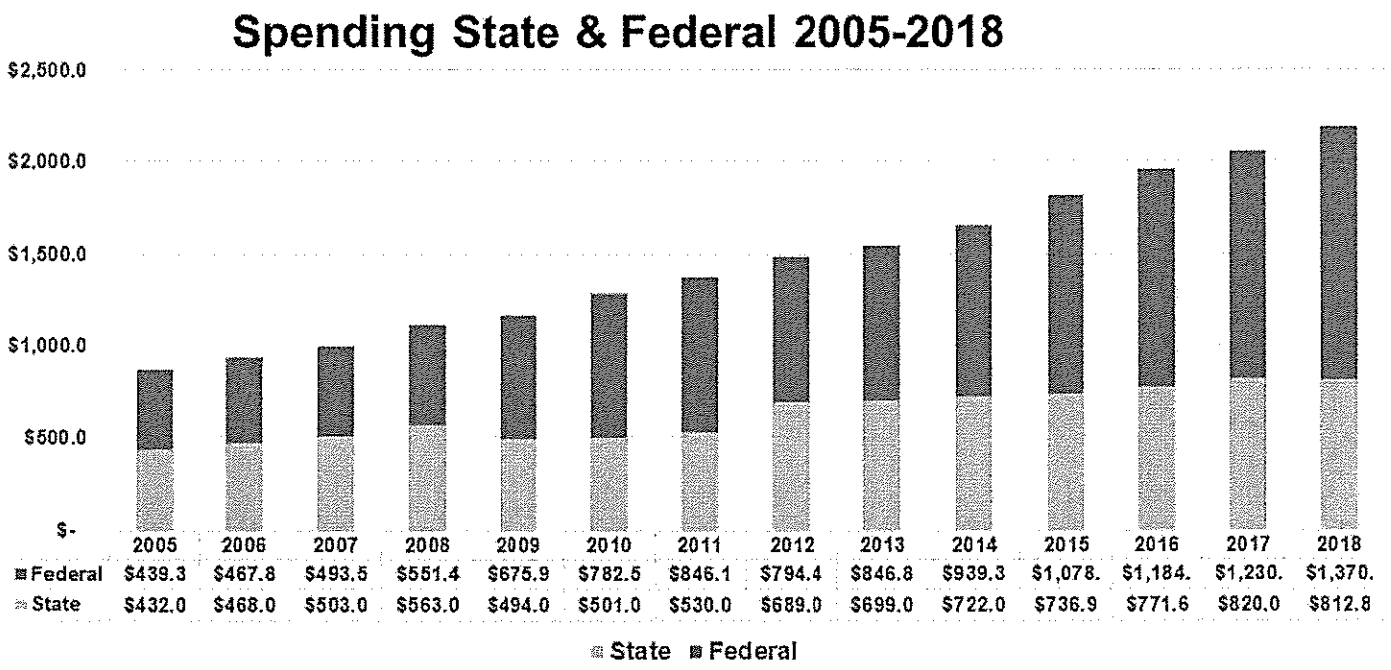
MEDICAID SPENDING



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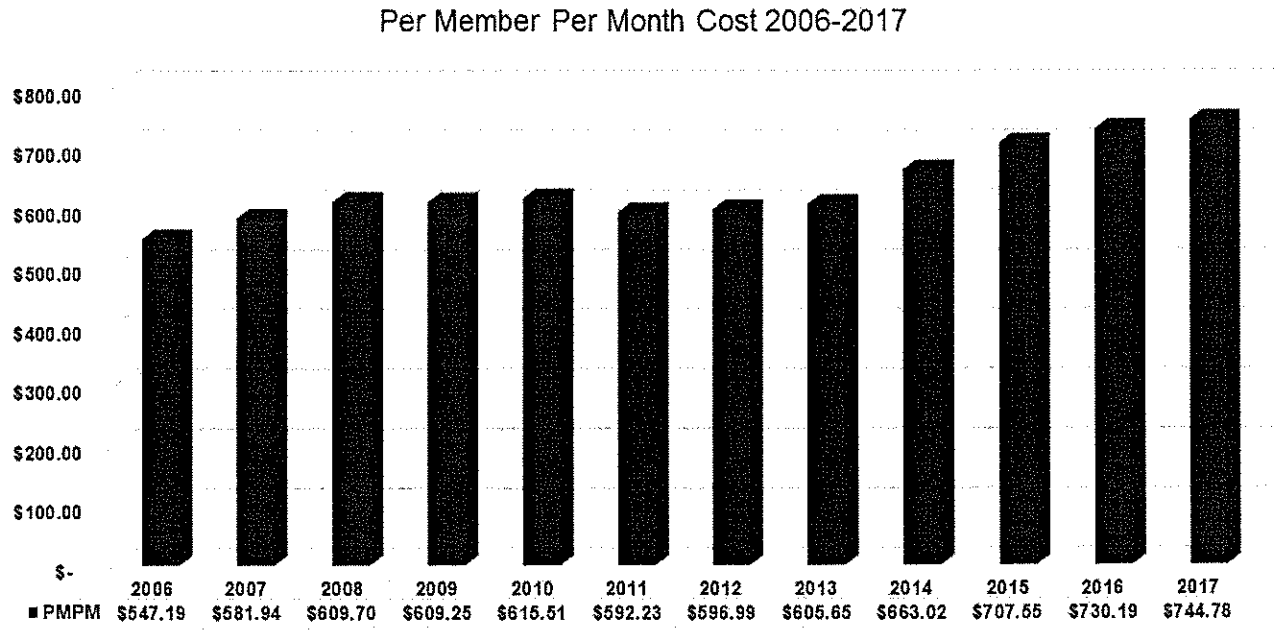
MEDICAID COST PER MEMBER PER MONTH (PMPM)



- Note in 2014, due to the ACA and new managed care contracting, the PMPM calculation is based on CY cost, not SFY cost.

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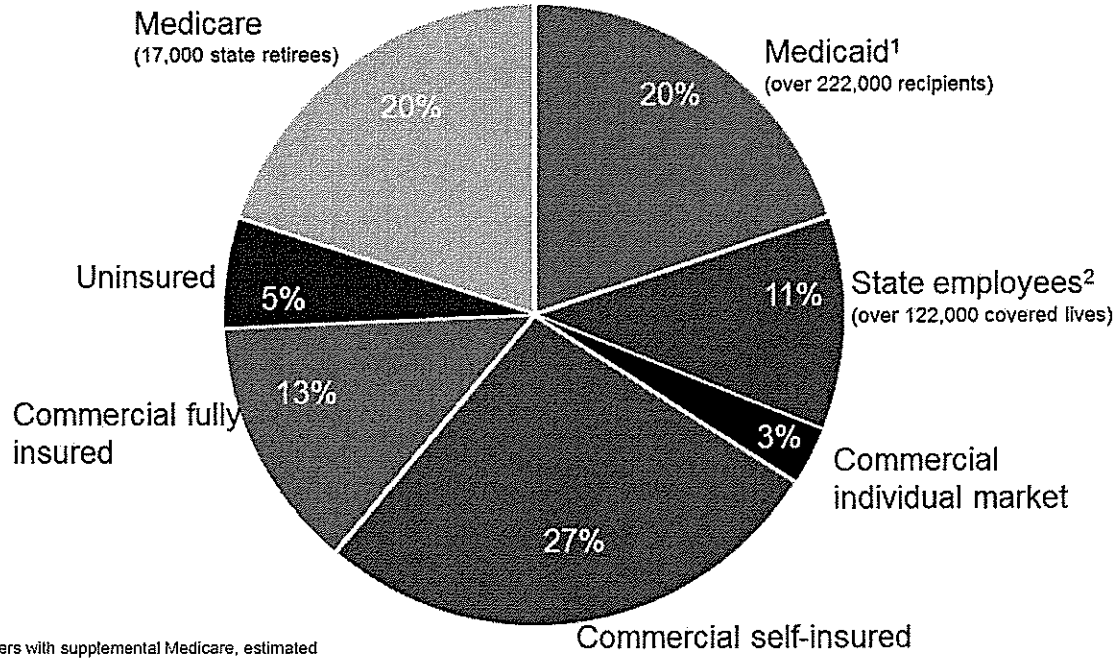
DELAWARE – HEALTH INSURANCE COVERAGE

More than 50% under federal/state authority (Medicaid, State employees, retirees and exchange)



[1] Excluding duals
[2] Excluding members with supplemental Medicare, estimated

Source: CMS Medicare Enrollment Dashboard; Census Population Without Health Insurance Coverage by State: 2013 to 2015; CMS-64 VII Group Break Out Report March 2016; Delaware Health Care Commission Presentation March 3, 2016, "Delaware's Health Insurance Marketplace: Update on Activity"; State of Delaware Final Report on the State Employees Health Plan Task Force submitted December 15, 2015; MACPAC; AHIP Center for Policy and Research 2014 report "Trends in Medigap Enrollment and Coverage Options"; Employee Benefit Research Institute November 2012 Vol. 33 No. 11; United States Census Bureau QuickFacts

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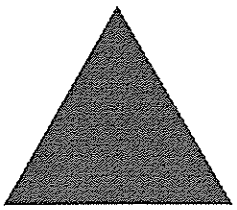
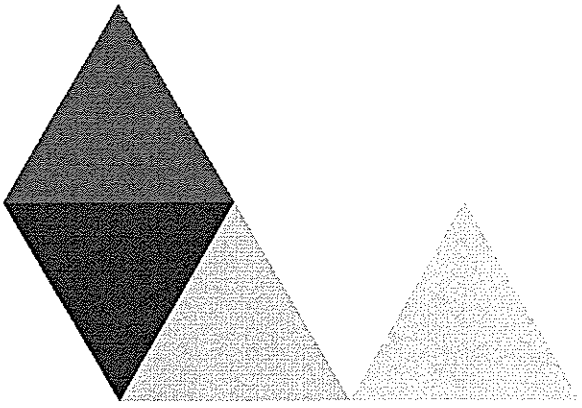
HEALTH WEALTH CAREER

OVERVIEW AND OPTIONS





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WHAT DOES "MEDICAID BUY-IN" MEAN?

- Can mean different things to different people
  - Expansion of the State/Federal Medicaid program to higher income people
  - Leverage Medicaid MCOs to offer an Exchange-based insurance product that complies with all the applicable ACA rules
  - Medicaid look-a-like insurance product not offered on the Exchange, but compliant with ACA requirements
- "Buying into Medicaid" can be a confusing statement
  - Medicaid for Workers with Disabilities (MWD) is a Medicaid option that Delaware offers, for which people have to pay a small monthly premium
    - Often referred to as a "buy-in" program, but this is an optional Medicaid coverage group (like Women with Breast or Cervical Cancer)
    - Less than 100 people enrolled
- Whatever the term means, the overall goal is to create affordable, high-quality health insurance options: For whom?

THE ACA INTRODUCED SIGNIFICANT CHANGES TO THE INDIVIDUAL HEALTH MARKET

- Guarantee Issue
  - Carriers must offer coverage to all US citizens and legal residents not eligible for Medicare or Medicaid, regardless of health status
- Essential Health Benefits Package
  - Requires a comprehensive set of services be covered on all ACA compliant plans, with limitations on annual member cost sharing and no lifetime policy maximums
- Premium and Cost Sharing Subsidies
  - Individuals below 400% FPL pay premiums that are no more than a specified percentage of their income
  - Individuals below 250% FPL receive assistance to pay their cost sharing
- Adjusted Community Rating
  - Rates may only vary by age (3:1 ratio), geography and tobacco use
- The items above put upward pressure on rates

WHAT IS THE HEALTH INSURANCE EXCHANGE?

- Delaware's Marketplace Exchange
  - Federally-operated Exchange where insurers sell and individuals can buy health insurance plans that are compliant with federal regulations
    - A specified package of ten Essential Health Benefits (EHBs) are required to be covered under all plans offered in the Individual ACA market
  - Nearly 25,000 Delawareans obtained coverage
  - Low-income consumers receive federal subsidies, known as Advanced Premium Tax Credits or APTCs, to help cover part of the premium
  - One insurer currently on Delaware's Exchange is Highmark
  - Exchange premiums have increased 25%–30% each of the last few years, but may be stabilizing for the 2019 plan year
  - Affordability concerns, sustainability, take-up rate/declining Exchange enrollment
  - $0 tax penalty for not having minimum essential coverage effective in 2019

FINANCIAL RESULTS IN THE DELAWARE INDIVIDUAL MARKET HAVE BEEN POOR

- Poor financial results have led to large rate increases and carrier exits
- Highmark is the sole remaining carrier in 2018

	2014	2015	2016	2017
Average Membership	28,361	35,433	34,168	28,904
Premium PMPM	$339.54	$377.93	$473.32	$516.29
UW Gain/Loss PMPM	-$28.47	-$91.79	-$45.39	N/A
UW Gain/Loss %	-8.4%	-24.3%	-9.6%	N/A
Total Unique ACA Carriers	4	4	3	3
Unique Exchange Carriers	2	2	2	2

2017 membership is slightly understated relative to prior years; the 2017 results reflect billable ACA Individual market membership for 2017 while the 2016 and prior results reflect members for Delaware's entire Individual market (ACA and grandfathered) based on statutory financial statements. Total grandfathered enrollment in Delaware is estimated to have been between 300 to 600 members in calendar year 2016. UW gain/loss results for 2017 were not provided here, as the accuracy of the 2017 statutory financial data appears as though it may be questionable.

EXCHANGE-BASED HEALTH INSURANCE POLICIES

- Metals (e.g., Platinum, Gold, Silver, Bronze) refer to the different types of insurance plans sold on Exchanges
  - Platinum plans have the highest premiums, but the lowest out-of-pocket cost sharing when a person uses health care services
  - Bronze plans have the lowest premiums, but have the highest out-of-pocket cost sharing when a person uses health care services
  - Silver plans are "in the middle" and the federal government uses for determining APTCs
- Silver plans on the Exchange
  - Second lowest cost Silver plan is the basis for determining federal APTCs
  - Silver plans typically have the highest enrollment due to the requirement that individuals with incomes below 250% FPL must enroll in a Silver plan in order to receive cost sharing subsidies, and middle-of-the-road premium versus coverage levels

DELAWARE EXCHANGE SELECTIONS BY METAL LEVEL

- CMS Public Use File (PUF) with Exchange plan selections for last four years
  - In 2018, 93% of Exchange enrollees chose Silver (62%) or Bronze (31%)
  - In 2015, 79% of Exchange enrollees chose Silver (61%) or Bronze (18%)

METAL LEVEL	2015	2016	2017	2018
Platinum	1,043	810	0	0
Gold	4,078	3,803	2,506	1,513
Silver	15,169	17,353	17,229	15,267
Bronze	4,604	6,149	7,648	7,535
Catastrophic	141	141	201	185
Total	**25,035**	**28,256**	**27,584**	**24,500**

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html

PREMIUM SUBSIDIES ARE PROVIDED TO PURCHASE INDIVIDUAL COVERAGE THROUGH THE EXCHANGE

- APTCs are tied to second lowest cost Silver plan on the Exchange and set on sliding scale such that the premium rate paid by an individual is no more than the applicable percentages of household income
  - Higher incomes pay a larger portion of premium; over 400% FPL pay the full premium amount
  - Presently, APTCs are only available to on-Exchange purchased policies

HOUSEHOLD INCOME	APPLICABLE % OF INCOME
Up to 138% FPL	2.00%
138% - 150% FPL	3.00% - 4.00%
150% - 200% FPL	4.00% - 6.30%
200% - 250% FPL	6.30% - 8.05%
250% - 300% FPL	8.05% - 9.50%
300% - 400% FPL	9.50%

The applicable percent of income figures represent those which were outlined in law for the 2014 plan year, and are revised each year by the ratio of cumulative premium growth since 2013, divided by cumulative income growth since 2013.

HOW PREMIUM SUBSIDIES IMPACT CONSUMERS

- Consumers pay the difference between the policy premium and the amount of their APTC
  - Individuals can use their respective APTC to "buy up" or "buy down" to a different Exchange policy, go with a Silver plan or forego coverage

METAL LEVEL	MONTHLY GROSS PREMIUM (EXAMPLE ONLY)	APTC AMOUNT (SUBSIDY)	NET PREMIUM TO CONSUMER
Platinum	$707	$450	$257
Gold	$629	$450	$179
Silver (most expensive)	$556	$450	$106
Silver (2nd lowest cost)	$550	$450	$100
Silver (lowest cost)	$545	$450	$95
Bronze	$471	$450	$21

Individuals with household income below 250% FPL must enroll in a Silver plan in order to receive cost sharing subsidies.

WHAT IS MEDICAID (TITLE XIX OF THE SOCIAL SECURITY ACT)?

- A health insurance program for low-income adults, children, pregnant women, elderly adults and people with disabilities
- Federal government oversees and monitors state Medicaid programs
  - State plan amendments and waivers
- Program is jointly financed with State general funds and federal matching funds
  - Federal Financial Participation (FFP) refers to the availability of federal funds
  - Federal Medical Assistance Percentage (FMAP) refers to the percentage of total program expenditures that the federal government reimburses Delaware
    - Administrative costs receive 50% FMAP (fixed)
    - Benefits/services costs have a higher FMAP % (can change annually)
- Medicaid (Title XIX) and CHIP (Title XXI) are separate, but similar programs

DELAWARE'S MEDICAID PROGRAM

- Delaware (DMMA) performs the day-to-day operations of the Medicaid program and must comply with numerous federal regulations and policies
- Over 200,000 Medicaid/CHIP members are mandatorily enrolled in capitated, risk-based MCOs
  - Highmark Health Options and AmeriHealth Caritas
  - Payment rates determined by Mercer/DMMA and negotiated with each MCO
- MCOs coordinate care for their members and pay providers for all covered benefits
  - The State still pays for a small number of services for MCO members via traditional fee-for-service
  - Cost sharing (e.g., copays) are only minimally used
- MCOs develop provider networks and negotiate payment arrangements with different providers
  - DMMA added stringent value-based purchasing requirements to the 2018 MCO contracts

DELAWARE'S MEDICAID PROGRAM

- Eligibility process is complex involving income level/FPL, disability/medical needs and/or assets/resources
  - Delaware expanded Medicaid to adults up to 100% FPL in the mid-1990s
  - In 2014 Delaware opted to expand coverage to adults up to 138% FPL
  - These two adult "expansion populations" qualify for a higher FMAP, which is intended to level off at 90% in 2020
- 1115 Waiver is an agreement between Delaware and the federal government
  - Public review and comment
  - Deviations from Medicaid rules
  - Budget neutrality test – federal spending
  - Special terms and conditions
  - Conceptually similar to a 1332 Waiver (not Medicaid), but more comprehensive

INTERACTION BETWEEN DELAWARE'S EXCHANGE AND MEDICAID PROGRAM

- If a person applies for either program, eligibility process determines which program/delivery system
  - Medicaid eligibility takes precedent over Exchange-based enrollment
  - Cannot be enrolled in both delivery systems simultaneously
- Lower income individuals can potentially move back and forth between Medicaid and Exchange eligibility depending on how their income changes
  - Exchange offers insurance options for higher income individuals
- Highmark is the only carrier on the Exchange and one of the two Medicaid MCOs
- Medicaid has a more robust benefit package and lower cost sharing
- DMMA pays the Medicaid MCOs directly based on actuarially sound rates developed by Mercer. Exchange-based plans submit premiums to the Delaware Department of Insurance for review and approval, which are then paid partly by the consumer and partly through APTCs (if applicable)

OPTIONS TO PROMOTE MORE AFFORDABLE HEALTH INSURANCE COVERAGE

- Reinsurance protection for Exchange-based plans (1332 Waiver)
  - Mitigates cost of high-dollar claimants, reduces insurers' risk, lowers premiums
  - New cost for the State
  - Does not change underlying cost dynamics
- Explore alternative APTC subsidy structures on the Exchange to increase risk pool size and draw in healthier individuals
  - Expand APTCs to higher incomes (will require some State funds)
  - Re-distribute APTCs so that average net premium paid by consumers is the same percentage of total premium, but would increase costs to elderly and reduce costs for younger groups compared to current APTC structure (could potentially be designed to require no new State funds)
- Merge Individual/Small Group markets into single risk pool
  - Larger risk base, but may result in carriers reconsidering participation
  - Likely result in higher Small Group premiums and lower Individual premiums

OPTIONS TO PROMOTE MORE AFFORDABLE HEALTH INSURANCE COVERAGE

- Medicaid (or State employees) MCOs required or encouraged to offer an insurance product on or off the Exchange as condition of receiving a State contract
  - Potential to leverage Medicaid provider networks and pricing levels
    - May increase costs to Medicaid depending on provider response
  - Only one other Medicaid MCO not already on the Exchange
  - May not be viewed as good business risk
- Further expand Title XIX Medicaid to higher incomes
  - Numerous political and policy issues to address
  - New cost for the State (regular FMAP level applies), but could require premiums and higher cost sharing than "regular Medicaid"
    - 1332/1115 "Superwaiver" may or may not be feasible for extra federal funds
  - Would likely draw individuals away from the Exchange

1332 WAIVERS

- Beginning January 2017, a 1332 Waiver allows states to modify or opt out of certain ACA coverage provisions, but still receive full ACA funding (e.g., APTCs)
  - Must demonstrate key requirements of the ACA are still met
  - Application must be submitted to the federal government for approval
  - Trump Administration has reminded states of this option and signaled a desire to provide states more "flexibility"
- Approved for an initial five-year period and can be renewed
- Does not directly apply to Medicaid, CHIP or Medicare (i.e., not a Medicaid waiver)
  - Can potentially coordinate with separate waivers for those programs
- Federal government has not (yet) allowed 1332/1115 Waiver combination
- Most states have used 1332 Waivers to request pass-through savings resulting from a new state-based reinsurance program to offset some portion of the new state costs
  - Lower premiums lead to lower APTCs, which are considered "savings" to the federal government, and these savings may be passed-through to the state

1332 WAIVERS

- The provisions that may be waived are specified in law

BENEFITS AND SUBSIDIES	HEALTH INSURANCE MARKETPLACES	FINANCIAL ASSISTANCE	COVERAGE MANDATES
• Essential health benefit requirements • Limitations on cost sharing • Metal tier requirements • Definitions related to markets and employer size	• Manner in which individuals and/or groups enroll in coverage and receive financial assistance • Risk pool definitions • Enrollment periods	• Provisions related to calculation of tax credits and cost sharing reduction subsidies • Benchmark used to calculate subsidies • Definition of minimum essential coverage	• Individual coverage mandate • Large employer coverage mandate
Part I of Subtitle D of Title I of the ACA	Part II of Subtitle D of Title I of the ACA	Sections 36B of the IRC and 1402 of the ACA	Sections 5000A and 4980H of the IRC

1332 WAIVERS

- *1332 Waivers must satisfy four "Guardrails":*

Comprehensive Coverage	Coverage provided under the waiver must be "at least as comprehensive" as coverage absent the waiver
Affordable Coverage	State 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	Coverage must be provided 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

Provisions Waived Must be Balanced with the Guardrails

REINSURANCE PROGRAMS

- The cost related to reinsurance is the expected value of the claims covered by the reinsurance program, plus any administrative duties on the reinsurer
  - Actuarial modeling is required to estimate reinsurance cost
- To date, seven 1332 Waivers have been used to establish state-based reinsurance programs
  - Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin
    - In these states, premium reductions have varied from -7.5% (Oregon) to -30.0% (Maryland)
  - Hawaii used a 1332 Waiver for an alternate means through which small groups could enroll in the Small Business Health Options Program and receive small business tax credits
  - Other states have developed a 1332 Waiver and withdrew for varying reasons
- Under a 1332 Waiver, savings from less APTCs, due to reduced premiums, can be a pass-through to the state to fund a program in the ACA market

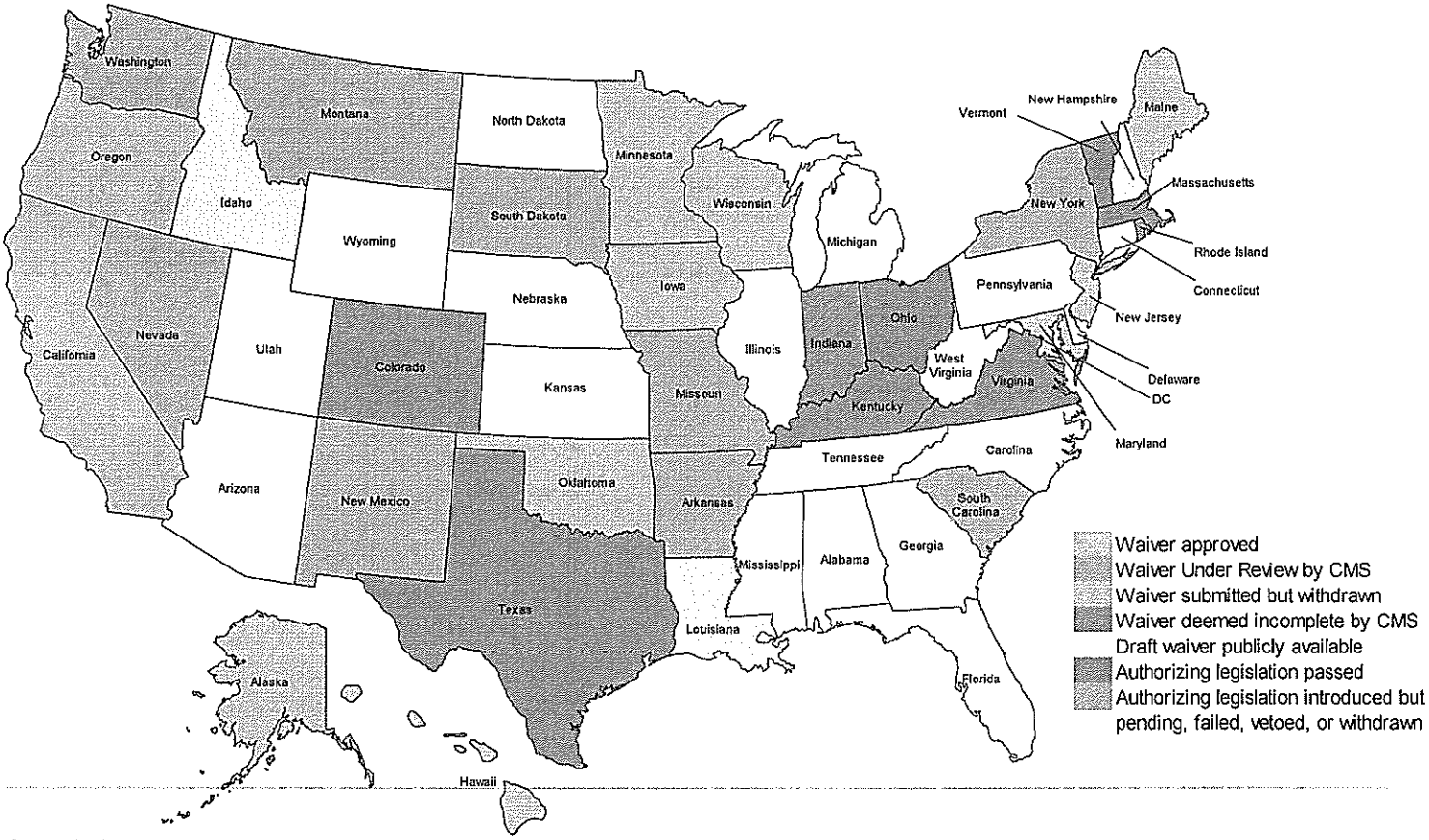
REINSURANCE PROGRAMS

- Reinsurance programs are designed to reduce or mitigate the carriers' risk so that premiums are lower with a variety of designs that can be considered
  - Condition-based
    - Members with certain higher cost disease/chronic condition or diagnosis (e.g., premature infants, transplants, hemophilia)
    - Similar to Maine and Alaska
  - Attachment point-based
    - Based on claims cost for a member in a given year
    - Example: 50% percentage of applicable expenses between $45k and $250k
    - Similar to transitional reinsurance program that was in place under the ACA from 2014–2016
  - Percent of claims dollars-based
    - A specified percentage of the carrier's total claims cost in a given year is reimbursed

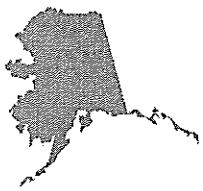
REINSURANCE PROGRAMS

- Several features of reinsurance programs and how they vary by type of program should be considered
  - Incentive for carriers to continue to manage care
  - Ease of administration
  - Impact to carrier pricing process
  - Protection against catastrophic claim volatility
  - Flexibility of program parameters
  - Feasible timing of payments to carriers

SIGNIFICANT ACTIVITY AROUND SECTION 1332 WAIVERS IS OCCURRING ACROSS THE COUNTRY



1332 WAIVERS WERE APPROVED IN FOUR STATES IN 2016/2017

	**Hawaii:** Waived several provisions related to the SHOP that were in conflict with the Hawaii Prepaid Healthcare Act (state employer mandate). Waiver allows for direct enrollment of groups with carriers, and an alternate program for distributing small business tax credits.
	**Alaska:** Established a condition-based reinsurance program in the individual market that functions as an invisible high risk pool. Individuals are ceded to the Alaska Reinsurance Program but maintain current coverage with carrier. Alaska will receive significant pass-through funding toward the $60M program in 2018. Premium rates were projected to decrease 20% under the waiver application.
	**Minnesota:** Established a parameter-based reinsurance program (80% of claims between $50K and $250K) in the individual market with funding of $271M for 2018. Requested that pass-through funding also include savings associated with BHP program, which was denied. Premium was projected to decrease 20% under the waiver application.
	**Oregon:** Established a parameter-based reinsurance program in the individual market with funding of $90M for 2018 (50% of claims between some attachment point and $1M). State portion funded by 0.3% premium assessment on major medical policies and excess funds in two state programs. Premium projected to decrease 7% under the waiver application.

FOUR OTHER STATES HAD 1332 WAIVERS APPROVED IN 2018

Wisconsin: Proposes to establish a parameter-based reinsurance program (50% of claims between $50K and $250K) in the individual market with a funding cap of $200M for 2019. State portion would be funded by general revenues.

Premium rates are projected to decrease 10.6% under the waiver.

Maine: Proposes to establish a condition-based reinsurance program (8 conditions) in the Individual market that functions as an invisible high risk pool. Total funding for the program is estimated at $93 million for 2019. Pass-through funding of roughly $33M is expected, with the remainder funded by ceded premiums associated with covered individuals and a $4 PMPM assessment on health plans.

Premium rates are projected to decrease 9% under the waiver.

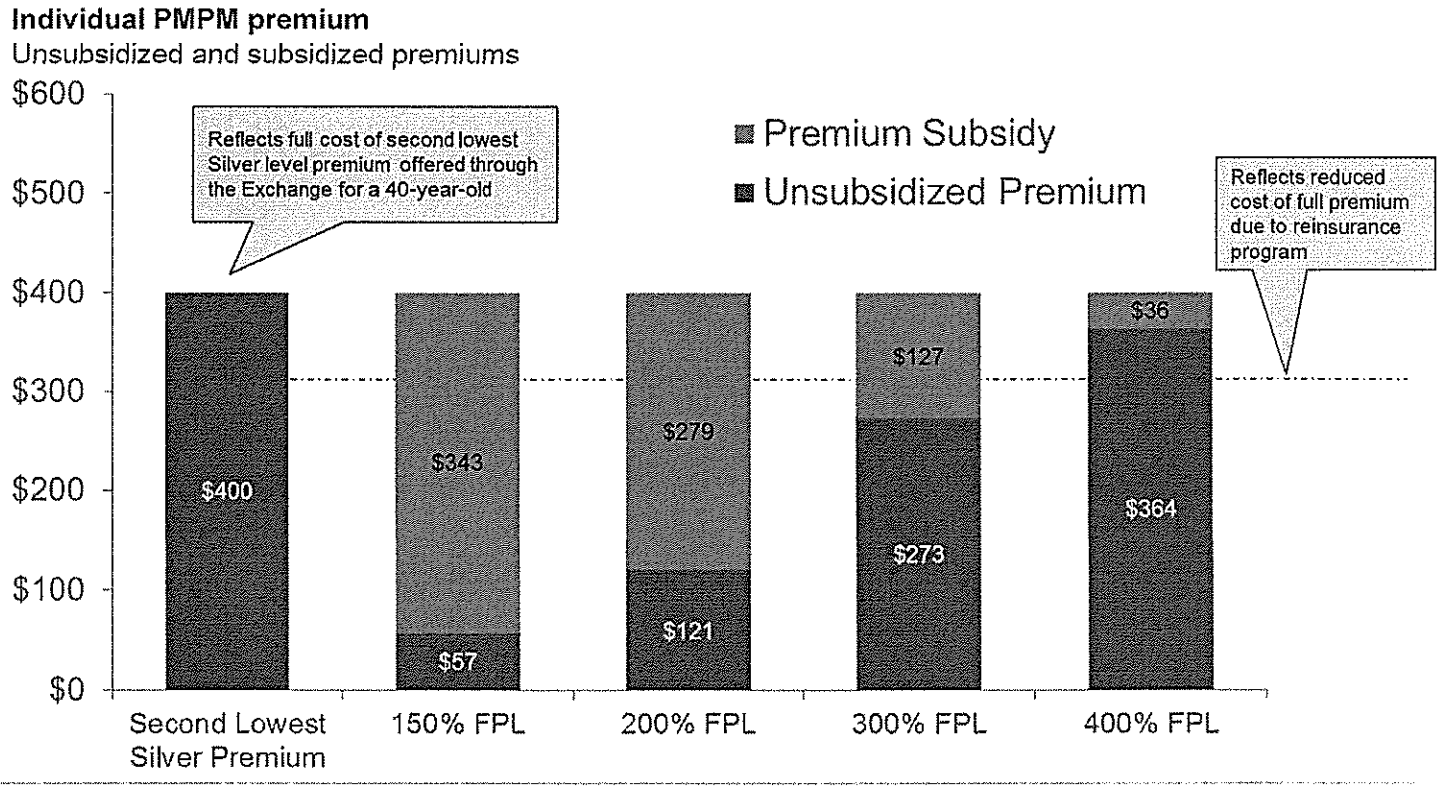
Maryland: Proposes to establish a parameter-based reinsurance program (80% of claims between an attachment point to be determined and $250K) in the individual market with funding of $462M for 2019. State portion funded by a 2.75% assessment on certain health plans and Medicaid MCOs.

Premium rates are projected to decrease 30.0% under the waiver.

New Jersey: Proposes to establish a parameter-based reinsurance program (60% of claims between $40K and $215K) in the individual market with funding of $324M for 2019. State portion funded by money collected under state individual shared responsibility tax, with any remainder from general revenues.

Premium rates are projected to decrease 15.3% under the waiver.

EXAMPLE OF PREMIUM SUBSIDIES FOR A 40-YEAR-OLD IN THE EXCHANGE



PASS-THROUGH SAVINGS UNDER A 1332 WAIVER FOR REINSURANCE – HYPOTHETICAL EXAMPLE

	BASELINE			WITH 10% PREMIUM REDUCTION DUE TO REINSURANCE			MEMBER SAVINGS	APTC SAVINGS
Household Income	(1) Full Premium	(2) APTC	(3) Net Consumer Premium	(4) New Full Premium	(5) APTC	(6) Net Consumer Premium	Member Savings (3) – (6)	APTC Savings (2) – (5)
A Low	$400	$250	$150	$360	$210	$150	$0	$40
B Medium	$400	$25	$375	$360	$0	$360	$15	$25
C High	$400	$0	$400	$360	$0	$360	$40	$0

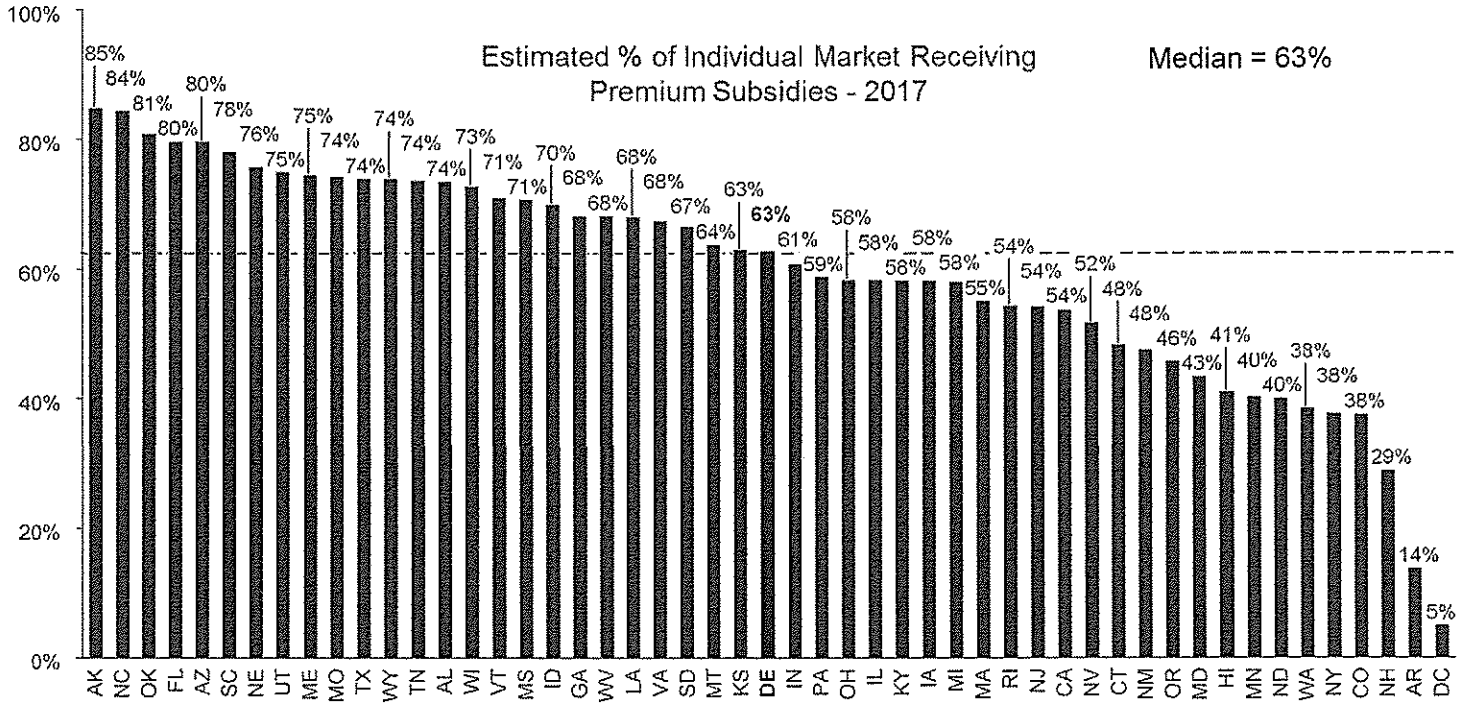
Household A: Low income family; Premium with reinsurance is still above the subsidized premium level, so entire $40 premium savings accrues to the federal government as lower APTC payments

Household B: Moderate income family; Premium with reinsurance falls below subsidized premium level; $40 savings is split between the member and the federal government

Household C: High income family: Not eligible for premium subsidies so the entire premium savings accrues to the member

APTC savings that are generated, once offset by other reductions in federal revenue, can/may be passed through to the state under a 1332 Waiver to use in funding a program in the ACA market

PASS-THROUGH SAVINGS ARE DIRECTLY RELATED TO VOLUME OF INDIVIDUALS RECEIVING APTCS



Sources: 2017 Risk Adjustment Report and 2017 Effectuated Enrollment Report

SOURCES OF SUPPLEMENTAL STATE FUNDING FOR REINSURANCE

- Carrier assessments: a direct tax on carriers, most commonly applied on a PMPM or percent of premium basis, which ultimately gets passed to groups or individuals in the form of additional rate increases
- Provider tax: such as a fixed charge per hospital admission (e.g., $2.00 per hospital day) or a percentage of all physician revenue; tax increases the cost of healthcare services that will get passed along to payers
- Other taxes: Examples of the most popular of these types include taxes on gasoline, alcohol and hotels (focus on out-of-state visitors?)
- Re-appropriation of existing State funds: evaluate State budget and determine if funds can be shifted/re-allocated
- Federal funds: some federal proposals have included funds for the intent of making that money available to states in order to stabilize the Individual market

SEVERAL ADDITIONAL RISKS SHOULD BE CONSIDERED IN FILING FOR A 1332 WAIVER

Changes in Market Dynamics	• Examples of changes that could have a significant impact on the modeled results include:
	  • CSR funding being reinstated in the future
	  • Reintroduction of the individual mandate penalty
	  • Significant carrier entrance/exits and/or future rate corrections

Treasury Department Projections May Differ	• There is the potential that Treasury Department projections may differ from actuarial modeling, resulting in a different level of pass-through savings being approved by CMS
Membership Volumes May Be Different Than Anticipated	• If a 1332 Waiver is approved, a specific amount of pass-through savings will be estimated by CMS based on projected membership levels. To the extent actual membership levels differ from those projected, the cost to the State of funding a reinsurance pool with static parameters could be different than anticipated
Administration	• Administrative feasibility and cost associated with implementing the waiver scenario must be considered

ELEMENTS OF A 1332 WAIVER APPLICATION

- The list of provisions the state seeks to waive
- Data, assumptions, targets, actuarial analysis and other information sufficient to determine that the proposed waiver meets the guardrails
- A detailed 10-year budget plan that is deficit neutral to the Federal government
- A detailed analysis of the impact of the waiver on health insurance coverage in the state
- A description and copy of the enacted state legislation granting authority to agency for the waiver
- A detailed plan as to how the state will implement the waiver, including a timeline
- A summary of feedback from 30-day public comment period, public hearings and tribal engagement
- HHS may request, or a state may propose, additional information to aid in the review of the application

1332 WAIVER APPLICATION REVIEW PROCESS

- The Departments (HHS and Department of Treasury) conduct a preliminary review within 45 days of submission completeness. Written notice will be provided to the state that the preliminary determination has been made. The written notice will either indicate that the application is complete or will identify elements missing from the application.
- The preliminary determination that the application was complete does not preclude a finding during the review process that a necessary element of the application is missing or insufficient.
- Following the preliminary determination that a state's application is complete, the Departments will provide for a public notice and comment period.
- The final decision of the Secretaries of HHS and the Treasury will be issued no later than 180 days after the determination that an application is complete.
- Upon approval, HHS will issue Specific Terms and Conditions (STC) to which a state must agree.

KEY REQUIREMENTS UNDER SPECIFIC TERMS AND CONDITIONS

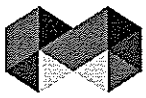
- Communication – the state must keep the Departments (e.g., HSS, Treasury) apprised of any changes
  - Changes to state law or appropriation amount
  - Changes to the waiver program such as changes to eligibility for the program
  - The state may terminate waiver or submit for extension
- Annual Reporting
  - Progress of the waiver
  - Data to show compliance with 1332(b)(1)(A) – (D)
  - Summary of the annual post-award public forum, including all public comments and action taken in response to such concerns or comments
    - Within six months of effective date and annually, the state will provide public with opportunity to comment on the progress of the waiver
    - Public notice required
  - Other information consistent with the state's approved terms and conditions

INTRODUCTION TO MERCER AND OLIVER WYMAN

- Mercer Health & Benefits, LLC (Mercer)
  - Large health benefits consulting company
  - Government health care consulting group is over 250 professionals dedicated to public health and welfare programs – mostly state agencies/Medicaid programs
  - We are Delaware's Medicaid actuarial, financial, policy, EQRO and strategic consulting partner and the Department's SIM payment reform consultant
  - Fred Gibison leads Mercer's engagement with Delaware
- Oliver Wyman Actuarial Consulting, Inc (OW)
  - Management consulting firm specializing in banking, insurance, health and life sciences and other industry operations
  - Actuarial services to insurance carriers and program sponsors, providers, and state and federal regulators
  - Completed the actuarial evaluations for four state 1332 waiver submissions
  - Tammy Tomczyk lead actuary with OW

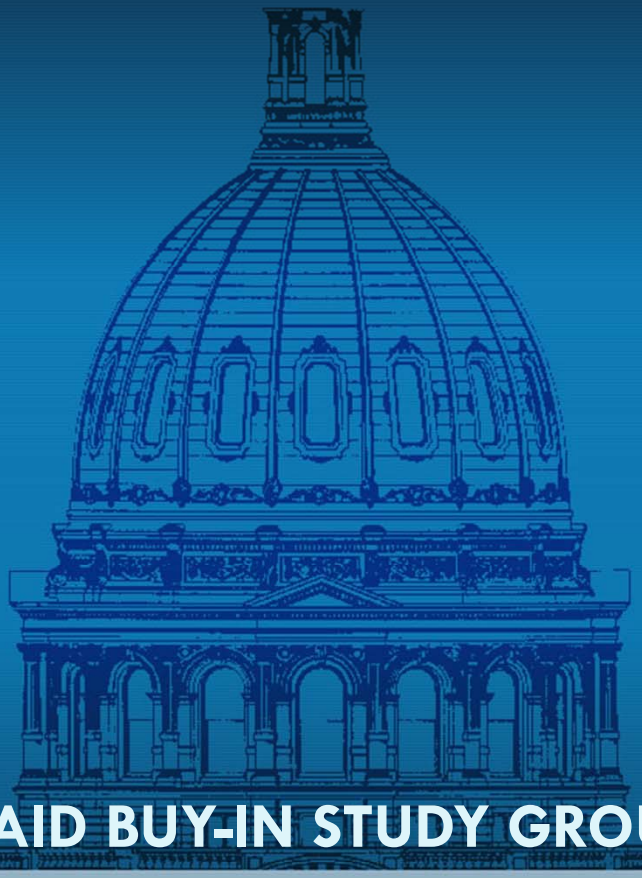
MERCER

MAKE TOMORROW, TODAY



OLIVER WYMAN

Services provided by Mercer Health & Benefits LLC.



Strong States, Strong Nation

NCSL

MEDICAID BUY-IN STUDY GROUP MEETING

NATIONAL CONFERENCE of STATE LEGISLATURES

Newark, Del.

Sept. 27, 2018

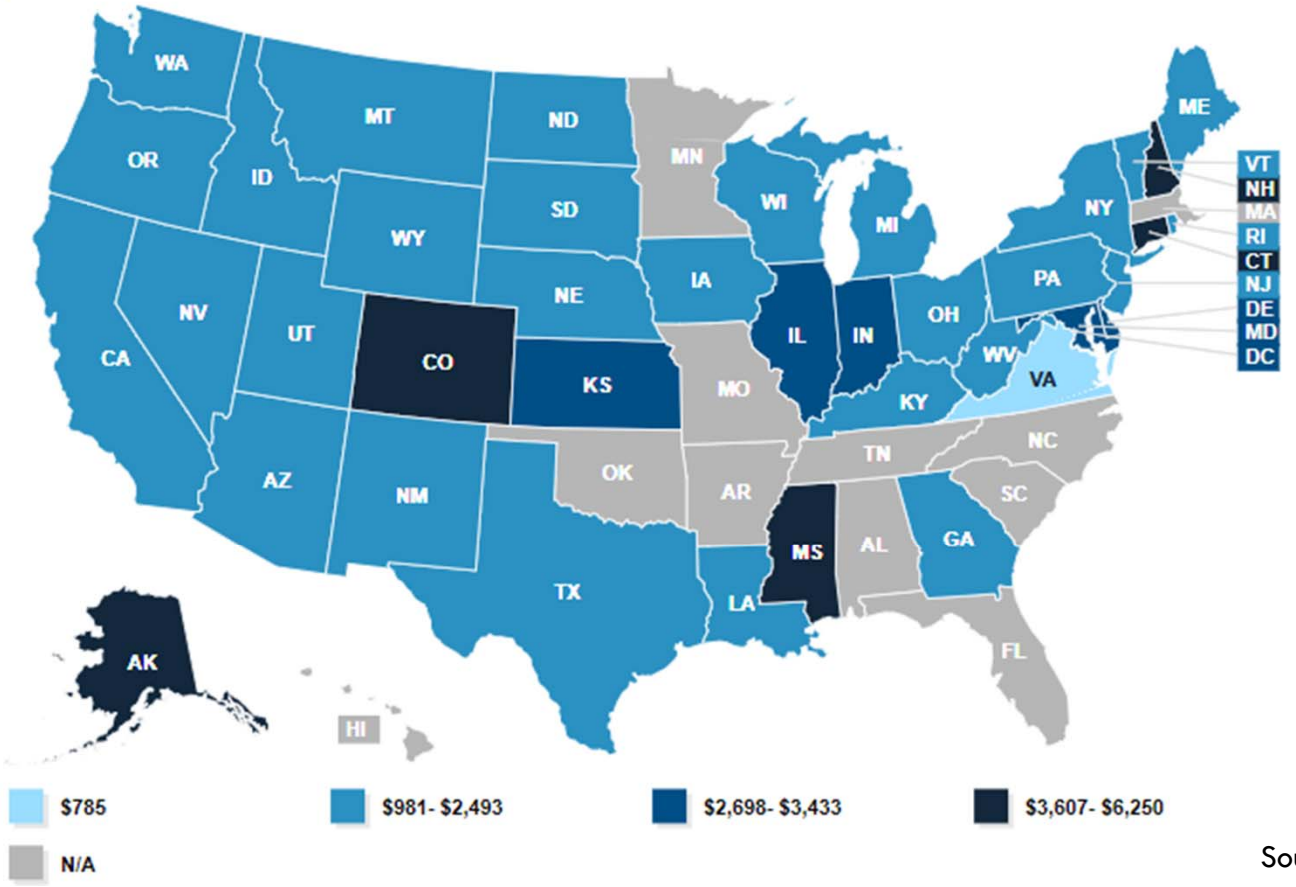
Welcome

- Medicaid Buy-in Program Overviews
  - Traditional Medicaid Buy-in
  - Medicaid-for-all
- State Examples
- Q & A

Traditional Medicaid Buy-in

- Extends eligibility to working adults with disabilities
- Intent: Allows workers with disabilities to work without jeopardizing health care
- Eligibility: Based on employment, disability, income and assets
- Costs: Premiums/cost sharing charged in some states and typically based off sliding fee scale based on income
- Coverage: Provides “traditional” Medicaid (regular Medicaid state plan benefits)

Monthly Income Limits: Buy-In Programs for Working People with Disabilities



Source: Kaiser Family Foundation

Traditional Medicaid Buy-in: Example

COLORADO
Department of Health Care Policy & Financing

Who qualifies?

- You must be between 16 and 64 years old,
- You must be employed,
- You must have a qualifying disability. The Social Security Administration (SSA) listings describes what disabilities qualify, and
- Your income must be below 450% of the Federal Poverty Level (FPL). For example, you can make about $4,523 a month and qualify.

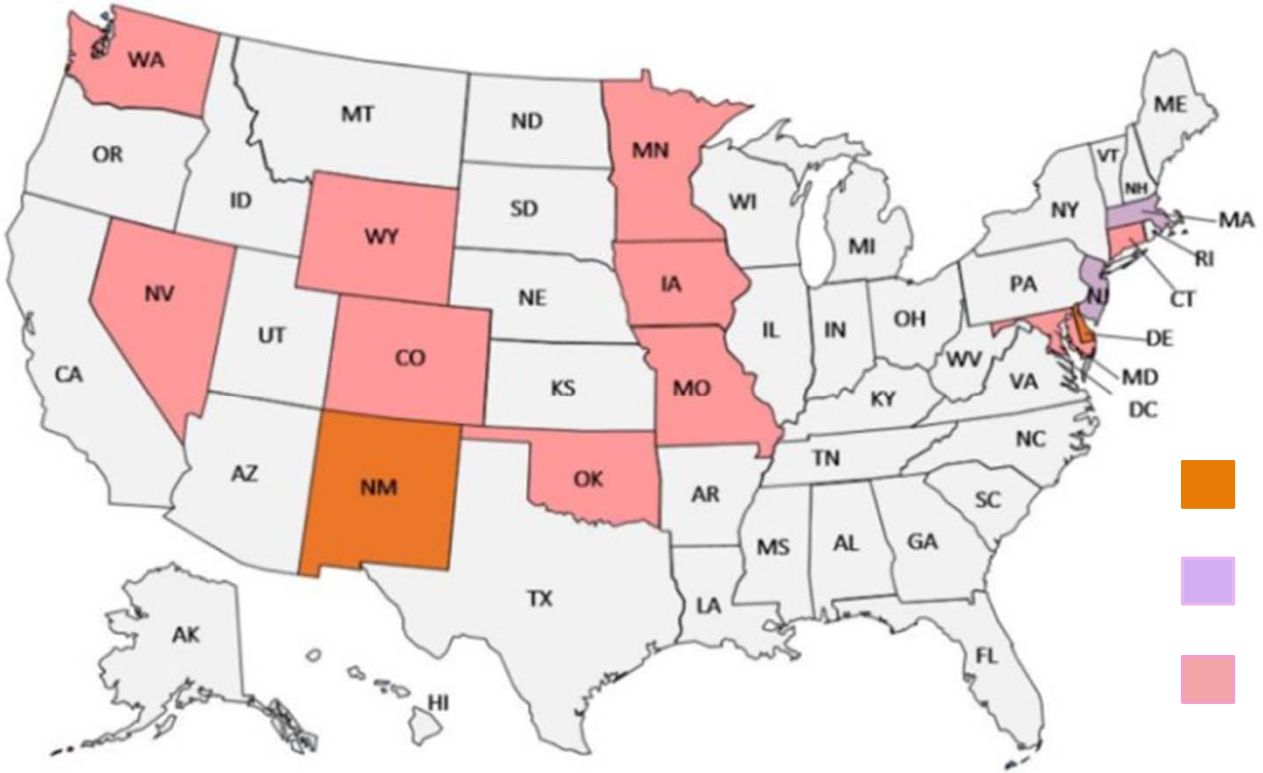
What Does it Cost?

Federal Poverty Level (FPL)	Monthly Income for an Individual	You Pay Each Month
0-40%	$0 - $405*	$0
41-133%	$406 - $1,346*	$25
134-200%	$1,347 - $2,024*	$90
201-300%	$2,025 - $3,035*	$130
301-450%	$3,036 - $4,553*	$200

Medicaid-Buy-In/ Medicaid-for-All

- Allows states' residents to purchase a Medicaid-like plan
- Intent:
  - Allow counties with limited commercial health plans to offer other options or expand competition
  - Offer affordable coverage to workers who cannot afford private insurance
- Eligibility: Could target broad or narrow group
- Costs: Proposals are structured like private insurance plans, may require premiums, copayments, deductibles, etc.
- Coverage: State determined benefit package (e.g., dental, long-term care, etc.)

Medicaid-Buy-In Proposals (As of June 29, 2018)



Source: State Health and Value Strategies, Heather Howard

Medicaid-Buy-In: Nevada Assembly Bill 374 (Vetoed)

- Offered a public "Nevada Care Plan" option in the state's ACA marketplace
- Directed the state's Medicaid director to seek the necessary Medicaid waivers to allow otherwise ineligible Nevadans to enroll in the program and to allow individuals to use any applicable ACA subsidies to pay their premiums
- Required the Nevada Care Plan to provide the same benefits offered by the state's existing Medicaid program
- Did not specify rates for premiums or copays
  - "The Director (of the Nevada Department of Health and Human Services) shall, in consultation with the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange, adopt such regulations as necessary to carry out the provisions of this section."

Medicaid-Buy-In: New Jersey Senate Bill 987 (pending)

- Revises the eligibility criteria for the current NJ FamilyCare "buy-in" program to allow coverage to be purchased for any child who is a resident of New Jersey and who is not otherwise eligible for NJ FamilyCare or Medicaid, rather than limit eligibility to children whose family income exceeds 350% of the federal poverty level
  - Medicaid buy-in targeted to a specific population
- Would give the state's Medicaid commissioner the authorization to set premiums and cost-sharing mechanisms for the program

Medicaid-Buy-In:
Connecticut Assembly Bill 5463 (failed)

- This proposal would have created a Medicaid buy-in program open to all incomes, known as the HUSKY E program
- The program must:
  - Include, but not be limited to, the ten essential health benefits required pursuant to 42 USC 18022,
  - Be funded by premiums assessed by the commissioner and federal premium tax credits and cost-sharing subsidies (subject to federal approval)

Medicaid Buy-in: Massachusetts Senate Bill 2202 (Pending)

- Would give the state an option to offer a tailored Medicaid plan for purchase by an individual or by an employer as an employer-sponsored insurance plan for employers of Medicaid eligible individuals
  - Any plan offered to an employer shall require the employer to pay no less than 50 percent of the projected cost of coverage for participating employees
- Allows the plan to set alternate eligibility and cost-sharing standards beyond those established currently in law

Utah's 1115 Expansion Waiver

- The Centers for Medicare & Medicaid Services (CMS) approved an 1115 waiver allowing Utah to expand Medicaid services to up to 6,000 low-income adults without children
- Adults with incomes up to 5 percent of the federal poverty line who are chronically homeless or suffer from substance use issues would gain coverage
- Targeted Medicaid expansion, not "buy-in"

Thank you!

Samantha Scotti

samatha.scotti@ncsl.org

SCR 70 Medicaid Buy-In Study Group

Wednesday, October 10, 2018
1:30 – 3:30 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Task Force Members:

Present:	Email:
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Representative Michael Ramone	Michael.Ramone@state.de.us
Steve Groff	Stephen.Groff@state.de.us
Dr. Kara Walker	Kara.Walker@state.de.us
Emmilyn Lawson	elawson@amerihealthcaritasde.com
Dr. Nancy Fan	nfanssmith@yahoo.com
Todd Graham	todd.graham@highmark.com
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Emily Thomas	Emily.Thomas@state.de.us
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Greg Star	star@carvertise.com
Victoria Brennan	Victoria.Brennan@state.de.us
Dr. Julia Pillsbury	jpills1952@msn.com
Dr. Jayshree Tailor	jayshreeptailor@gmail.com
Dr. Robert Varipapa	drbob@cnmri.com

Absent:	
Representative Paul Baumbach	Paul.Baumbach@state.de.us
Senator Catherine Cloutier	Catherine.Cloutier@state.de.us
Trinidad Navarro	Trinidad.Navarro@state.de.us

Staff:	
Caitlin Del Collo	Caitlin.DelCollo@state.de.us

Attendees:	Organization:
Pam Price	Highmark
Andrew Dahlke	Medical Society of Delaware
Steven Costantino	Dept. of Health & Social Services
Kiki Evinger	Dept. of Health & Social Services
Fred Gibison	Mercer
Tammy Tomczyk	Oliver Wyman
Kim Gomes	Byrd Group

Christine Schiltz	Parkowski, Guerke & Swayze
Joe Bryan	OGOU
Ben Kellman	AmeriHealth Caritas
Stephanie Myers	AmeriHealth Caritas
Jonathan Kirch	American Heart Association
Andrew Wilson	Medical Society of Delaware/Morris James
Elisabeth Scheneman	DHSS
Tanisha Merced	DOI
Vince Ryan	DOI
Jeanne Chiquoine	American Cancer Society
Molly Magarik	DHSS
Dustyn Thompson	Delaware United

The meeting was brought to order at 1:39 pm.

Senator Townsend began the meeting by asking if anyone had changes to make to the meeting minutes.

Caitlin Del Collo stated that Dr. Walker identified an unknown speaker from the draft minutes, and that the minutes had already been updated to reflect the correct speaker. As no one else had changes to make, the study group voted unanimously to approve the meeting minutes.

Senator Townsend invited the first presenter to begin.

Presentation by DHSS Consultants

Fred Gibison explained that the presentation would cover three different scenarios: a true expansion of Medicaid; a Medicaid look-alike plan; and a 1332 waiver reinsurance program.

Mr. Gibison began by stating that there is no federal prohibition on increasing the income limits for Medicaid eligibility. A state can set its income eligibility limit at any percentage of the federal poverty line; however, he noted that there are political considerations to increasing it at both the state and federal levels. There are two ways to do an expansion: a state plan amendment (which could be done in several months), or an 1115 waiver (which would take 18-24 months or longer).

Tammy Tomcyzk noted on slide 6 that the population of people earning 400 percent of the federal poverty level who enroll on the exchange has decreased over the last few years. She explained that when a market is bifurcated, particularly in the example of increasing the Medicaid eligibility limit to 400 percent of the federal poverty level, that results in a sicker, more morbid exchange population.

Molly Magarik asked about the impacts to the small group insurance market.

Tammy Tomcyzk responded that there could be a detrimental impact to that market, but that it hasn't been studied as much as the impacts to the individual market.

Fred Gibison asked if anyone else had questions.

Wayne Smith asked if Nevada used the same per member per month cost assumptions in its proposed legislation.

Fred Gibison replied that the proposal in Nevada was more similar to the second "Medicaid Lookalike" option. He then began discussing that option. He noted that if a Medicaid lookalike plan became the second lowest cost silver plan on the exchange, then tax credits would be calculated based on that plan. This would lower the federal government's share of the cost, but not the consumer's. However, that benchmarking provision could potentially be waived through a 1332 waiver.

Dr. Nancy Fan asked about waivable provisions in 1332 waivers.

Fred Gibison responded that there are a variety of waivable provisions that could all be waived at the same time.

Tanisha Merced commented that the Medicaid lookalike plan seems more similar to a silver plan than a bronze plan. She then asked what the point would be of introducing the lookalike onto the exchange.

Fred Gibison responded that the silver plan has better coverage than the bronze plan.

Tanisha Merced said she assumes that the Medicaid lookalike plan would be designed to match the silver plan as closely as possible.

Fred Gibison confirmed that assumption.

Dr. Julia Pillsbury asked if both the silver plan and the Medicaid lookalike plan would have deductibles and coinsurance.

Fred Gibison replied that both plans would have deductibles and coinsurance.

Dr. Julia Pillsbury asked what the typical deductible is for a silver plan.

Tammy Tomcyzk replied that a silver plan has a 70 percent actuarial value, meaning the carrier pays for 70 percent, and the customer pays 30 percent (through the deductible and copayments). Deductibles typically are $1,500 to $2,500. She then noted that people under 250 percent of the federal poverty level receive cost sharing subsidies; further, people under 150 percent of the federal poverty level receive an actuarial value of 94 percent. Their deductibles can be as low as $300-500. Individuals between 150 and 200 percent of the federal poverty level receive an actuarial value of 87 percent, and typically have deductibles in the range of $500-1,000. Ms.

Tomcyzk also explained that every insurer who participates on the exchange must offer at least one silver and one gold plan. The cost sharing subsidies only apply to silver plans.

Dr. Julia Pillsbury commented that deductibles increased after Obamacare passed, and that patients haven't been paying them. As a result, her practice has a lot of outstanding debt. She expressed concern about what would happen under a Medicaid lookalike plan.

Fred Gibison acknowledged Dr. Pillsbury's concern. He then continued with the presentation. He said that if an insurance carrier can't somehow leverage the lower cost lookalike plan, then that carrier would be at a disadvantage. Further, he raised the question of whether the Medicaid MCOs would willingly participate in the exchange. He said that some states have considered mandating that the MCOs participate in the exchange as a condition of receiving a contract.

Steven Costantino asked a question about carriers and qualified health plans (QHPs).

Tammy Tomcyzk said that in order to have a waiver, there must be a waivable provision. In this scenario, the waivable provision is using the second lowest cost silver plan as a benchmark. If only one MCO joined the exchange, it would have to offer two silver plans. Ms. Tomcyzk then stressed that the enabling legislation must somehow demonstrate that the Medicaid MCOs would not participate on the exchange unless the waiver were approved.

Barry Dahllof asked what would reduce the uninsured rate without destabilizing the exchange.

Fred Gibison responded that making the exchange more affordable would help because it would attract people who want insurance but have always thought they couldn't afford it. He also said expanding government funded healthcare, having a more robust economy, and people getting jobs that offer employer sponsored coverage would help.

Stephen Groff asked about the implications of mandating products on the exchange given that Delaware does not have its own state based exchange.

Tammy Tomcyzk said the Centers for Medicare and Medicaid Services (CMS) has indicated that it will not do anything differently on the federal exchange to accommodate states' waivers. Ms. Tomcyzk then gave an overview of the third scenario: a reinsurance program. She explained that reinsurance programs are often put in place in order to mitigate the risk of high dollar claimants. Ms. Tomcyzk is often asked why a state doesn't pay a portion of the premiums of nonsubsidized individuals if the goal is to lower premiums. She explained that if the state were to implement a reinsurance program without a waiver, all of the savings generated would go to the federal government. However, if the state does a reinsurance program through a 1332 waiver, the savings go to the state. Specifically, Ms. Tomcyzk said that as premiums come down because of the reinsurance program, healthier individuals who previously left the market will reenter and improve the overall risk pool. That, in turn, lowers premiums even further. She then noted that there will never be a point at which federal dollars totally cover the cost of a reinsurance program.

Ms. Tomcyzk presented three reinsurance scenarios: a ten percent reduction in ACA premiums; a fifteen percent reduction in ACA premiums; and a twenty percent reduction in ACA premiums. The data used in the scenarios was taken from publicly available data, as well as experience from other states and actuarial judgement.

Representative Ramone, referencing figures on slides 15 and 16 showing the total number of members enrolled through the ACA, commented that he does not believe that only 3,000 people would leave the exchange from 2018 to 2019.

Tammy Tomcyzk responded by discussing several factors that impacted the numbers, including that healthier people left the market, which made the risk pool sicker, and in turn required rate increases. She also mentioned that there were issues with the rollout of the federal health exchange, and that carriers lost money in 2014, 2015, and 2016, but then made money in 2017. Further, Ms. Tomcyzk noted that the numbers would be more precise if more data were available.

Representative Ramone said that people make decisions about health insurance based on yesterday's data, rather than projected futures.

Tammy Tomcyzk shared further caveats about the data used.

Emmilyn Lawson asked how we can tell that the people who have left the exchange are actually uninsured. For example, she asked whether a certain portion of those who left are now covered by employer-sponsored coverage.

Tammy Tomcyzk said we don't know for sure whether those who have left the exchange have obtained coverage through other means, such as through employer based coverage or Medicaid. She then continued discussing the content of the slides.

Stephen Groff, referencing slide 16, asked why the state doesn't just give non-APTC eligible individuals $150 to offset the cost of their premiums. He said it appears that that would be cheaper.

Tammy Tomcyzk responded that the state can do that; however, without a waiver, the state can't leverage the 69 percent up to 82 percent. Ms. Tomcyzk then concluded the presentation.

Presentation by Vince Ryan, Department of Insurance

Vince Ryan explained that the purpose of the department's presentation is to address what steps would need to be taken in order to pursue a 1332 waiver. He said that the most important step would be to pass enabling legislation permitting the state to file a 1332 waiver. The next step would be to hire actuarial consultants to help prepare the application. The department estimates that it would cost $100,000 to hire consultants to conduct a study. Additionally, the state would need to reconcile the legislative calendar with the statutory timeframes attached to 1332 waivers.

Public Comment

Senator Townsend invited public comment. No one indicated that they wished to comment.

Discussion

Senator Townsend invited the study group members to make comments or ask questions.

Secretary Walker expressed appreciation for the presentation by DOI. She offered to work through further scenarios or answer questions from study group members pertaining to the options presented.

Greg Star asked if the next meeting could include more information about Maryland's reinsurance program.

Senator Townsend asked DOI and DHSS staff to respond.

Vince Ryan offered to contact staff in the Maryland Insurance Administration to invite them to come to the next meeting.

Representative Ramone asked about the large decrease in premiums in Maryland.

Tammy Tomcyzk responded by saying that the reduction was due to multiple factors, not just the reinsurance program.

Tanisha Merced commented that Maryland's surcharge will be used to pay for more than just the first year.

Next Steps

Senator Townsend stated that the next meeting would consist of a presentation by DHSS/Mercer, further information from DOI regarding the Maryland model, and discussion.

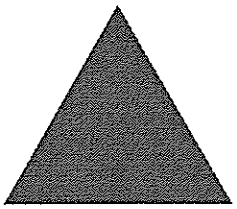
The meeting adjourned at 3:32 pm.

Final Report Appendix - Item 6

HEALTH WEALTH CAREER

Government Human Services Consulting

DISCUSSION OF TITLE XIX MEDICAID EXPANSION, MEDICAID LOOK-A-LIKE AND REINSURANCE OPTIONS



SCR70 TASK FORCE MEETING

OCTOBER 10, 2018

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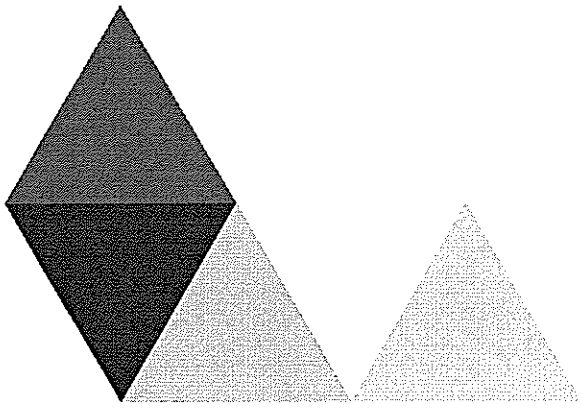

OLIVER WYMAN

MAKE TOMORROW, TODAY MERCER

OPTIONS INCLUDED IN THIS PRESENTATION

- Expansion of Medicaid Title XIX to higher incomes:
  - Potential design considerations
  - Pros/cons
  - Ballpark figures
- Creating a "Medicaid Look-A-Like" insurance offering on the Exchange:
  - Potential design considerations
  - Pros/cons
- Estimates of funding for a 1332 Waiver for reinsurance for Exchange-based plans:
  - Three different reinsurance scenarios presented
  - Pros/cons
- There are many facets of each strategy that can be customized/proposed

Information contained in this presentation should be considered provisional. More time would be needed to fully explore these options and develop better estimates.

TITLE XIX MEDICAID EXPANSION

- Federal law does not prohibit states from expanding Title XIX Medicaid to higher incomes:
  - Could propose to go up to 200% FPL, 300% FPL, 400% FPL or higher
- There would be many political, policy and operational issues to resolve:
  - The current federal administration may not support expanding Medicaid to higher incomes (not consistent with Medicaid's focus/intent)
  - Provider/stakeholder input
- Delaware can expand Medicaid either through a state plan amendment or an amendment to the 1115 Waiver:
  - A state plan amendment could theoretically be done in a few months
  - An 1115 Waiver would require 18 to 24 months or longer
- Under current federal law, an expansion of Medicaid to higher incomes would receive federal matching funds at the State's current FMAP (about 57%):
  - The State would have to pay for about 43% of the cost

TITLE XIX MEDICAID EXPANSION

- Expanding Title XIX would increase the role of DHSS in providing health care to Delawareans:
  - More State responsibility and influence on health care market
- The State could choose to deliver benefits to the higher income expansion group through:
  - Traditional FFS
  - Risk-based managed care
  - New payment/delivery arrangements
- In an 1115 Waiver, the State could propose/negotiate program design aspects:
  - Work requirements
  - Member cost-sharing/premiums
  - Different benefit package(s)
  - Other research or demonstration ideas

TITLE XIX MEDICAID EXPANSION

- Depending on member cost-sharing requirements, the consumers' cost of Medicaid coverage could be designed to be less than the out-of-pocket cost of Exchange-based coverage, making it more affordable for eligible Delawareans
- A Medicaid expansion would likely draw consumers away from the Exchange:
  - Per federal rules, individuals eligible for Medicaid can still choose to obtain health insurance through the Exchange, but are not eligible for federal APTCs
  - Would further destabilize the Exchange or render the Exchange nonexistent
- A 1332/1115 "Superwaiver" has been talked about:
  - A 1332 Waiver might be used to re-direct federal APTCs to cost of the Medicaid expansion
  - An 1115 Waiver to expand Medicaid/modify program requirements:
  - In some scenarios, the federal APTCs might cover much more than 57% of the cost
  - But Medicaid has a requirement for state spending/state share

TITLE XIX MEDICAID EXPANSION – BALLPARK EXAMPLES (NOT ACTUARIALLY SOUND)

- Up to 200% FPL:
  - Approximately 7,800 Exchange enrollees
  - Approximately 7,200 uninsured enrollees
  - Estimate $525 average per member per month (PMPM):
    - $94.5 million annual total of which about $41 million would be new State cost
- Up to 400% FPL:
  - Approximately 18,000 Exchange enrollees
  - Approximately 22,000 uninsured enrollees
  - Estimate $495 average PMPM:
    - $237.6 million annual total of which about $102 million would be new State cost
- Actual enrollment will be more/less as some people will choose to remain uninsured, not be aware of options or changes in economy
- Actual costs will be impacted by program design and risk of enrolled population

MEDICAID LOOK-A-LIKE PRODUCT PROS/CONS

- Primary goal is to significantly lower premiums by leveraging the Medicaid MCOs' provider networks and provider pricing:
  - May be narrower provider networks/fewer choices for consumers
  - Consumers will evaluate the cost benefit of lower cost health insurance versus the availability of providers
  - It is unclear how much premiums can be reduced
- Providers may not be willing to accept lower payment terms:
  - May require a compromise of paying providers higher than regular Medicaid, but less than fees that underlie current Individual market premiums
  - Providers may demand that fees increase in the State's Medicaid program, leading to additional State cost
- Continues to promote the Individual market as source of affordable health insurance
- Only one other insurer in Medicaid program that is not already participating on the Exchange

MEDICAID LOOK-A-LIKE PRODUCT IMPACT ON FEDERAL APTCS (ON EXCHANGE)

- If the Look-A-Like product is the second lowest cost Silver Plan (SLCSP) on the Exchange, federal APTCs would be expected to be reduced
- Most consumers under 400% FPL would have the option to continue to pay a similar amount to that which they are paying currently; however, in order to do so, they may need to enroll in the Look-A-Like product rather than the product they are currently enrolled in:
  - In fact, consumers may be required to pay more than they do currently to get access to the networks/providers associated with the plan they are currently enrolled in
- Consumers over 400% FPL would have the option to purchase the Look-A-Like product, likely at a lower cost than the product they are currently enrolled in
- See example on next slide

MEDICAID LOOK-A-LIKE PRODUCT IMPACT ON FEDERAL APTCS (ON EXCHANGE)

- Example of impact on APTCs and amount consumers pay if the lower cost Medicaid Look-A-Like product is <u>included</u> in the determination of the SLCSP:

		CURRENT ACA MARKET			ACA WITH MEDICAID LOOK-A-LIKE AS THE SLCSP		
CONSUMER	PLAN TYPE	GROSS PREMIUM	APTC	CONSUMER PAYS	GROSS PREMIUM	APTC	CONSUMER PAYS
A (APTC Eligible)	Current ACA Product	$600	$500	$100	$600	$300	$300
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$300	$100
B (not APTC Eligible)	Current ACA Product	$600	$0	$600	$600	$0	$600
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$0	$400

USE A 1332 WAIVER TO WAIVE USING THE MEDICAID LOOK-A-LIKE PLAN AS BASIS FOR APTC

- Waiver to exclude the lower cost Look-A-Like plan from being considered when determining the SLCSP on the Exchange:
  - APTCs would continue to be based on the current ACA products
  - Both subsidized and non-subsidized consumers could then choose to buy the lower cost Look-A-Like plan for less out-of-pocket cost

		CURRENT ACA MARKET			ACA WITH MEDICAID LOOK-A-LIKE NOT THE SLCSP		
CONSUMER	PLAN TYPE	GROSS PREMIUM	APTC	CONSUMER PAYS	GROSS PREMIUM	APTC	CONSUMER PAYS
A (APTC Eligible)	Current ACA Product	$600	$500	$100	$600	$500	$100
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$500	$0
B (not APTC Eligible)	Current ACA Product	$600	$0	$600	$600	$0	$600
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$0	$400

  - Potential for pass-through savings for Consumer A who buys lower cost product

MEDICAID LOOK-A-LIKE PLAN

- No state has pursued a strategy to combine a Medicaid Look-A-Like plan with a 1332 Waiver yet
- Federal government may or may not approve:
  - Depends on interpretation of ability to waive Sections 36B of the IRC and 1402 of the ACA
- Any potential carrier not able to leverage Medicaid/lower cost arrangement may be at a competitive disadvantage
- Will MCOs do this willingly or will the State have to mandate as a condition of a Medicaid contract?
  - Could destabilize the Medicaid program

REINSURANCE PROS/CONS

- Mitigates cost of high-dollar claimants:
  - "High-dollar claimants" can be defined based on conditions/diseases, attachment point or percent of claim dollars
- Reduces insurers' risk:
  - If the health insurer is protected from high-dollar claimants, the insurer has less financial risk exposure in developing their premiums
- Lowers premiums:
  - With reinsurance program payments being available and the reduced financial risk associated with high-dollar claimants, insurers will be able to lower premiums, likely attract more enrollment and create positive momentum for the Exchange
- Cost for the State:
  - Depending on the design of the reinsurance program and how many federal dollars can be re-directed using a 1332 Waiver, the cost to the State will vary
- Does not change underlying cost dynamics:
  - Provider prices, utilization and quality of care are not directly impacted

COST TO THE STATE FOR REINSURANCE

- A 1332 Waiver would allow Delaware to keep existing federal dollars in the State to offset the cost of reinsurance, as well as receive new dollars from additional savings to the federal government due to improved morbidity of the risk pool
- Without an approved 1332 Waiver, federal savings from a reinsurance program that lowers premiums and, therefore, lowers APTC subsidies will not benefit Delaware:
  - Non-subsidized individuals will benefit from lower premiums
  - Delaware would have to fund the entire cost of a reinsurance program without the 1332 Waiver
  - Many more people can benefit if Delaware can hold on to and repurpose the dollars that represent federal savings, and use those dollars to further stabilize the ACA market through additional reinsurance
- Federal savings will not be sufficient to cover the full cost of a reinsurance program, even with a 1332 Waiver:
  - The amount of potential federal savings is directly related to how much premiums are reduced and how many people receive federal APTCs

REINSURANCE SCENARIOS

- Estimates were developed for three provisional reinsurance scenarios to illustrate their potential impact and cost, and to facilitate further discussion:
  - 10% reduction in ACA premiums
  - 15% reduction in ACA premiums
  - 20% reduction in ACA premiums
- Modeling was performed based on publicly available information, experience from other states and actuarial judgement:
  - Results are provisional in nature and would require more time and data to further refine

ESTIMATED INDIVIDUAL ACA ENROLLMENT AND AVERAGE MONTHLY PREMIUM RATES (2016 TO 2018)

INDIVIDUAL ACA ENROLLMENT	2016	2017	2018
Total Members	34,417	28,683	23,318
APTC Members	19,250	18,028	16,163
Non-APTC Members	15,167	10,655	7,155
% of Members with APTC	**56%**	**63%**	**69%**

INDIVIDUAL ACA PREMIUM PMPM	2016	2017	2018
Average Premium (members eligible for APTC)	$481	$582	$763
Average Consumer Pay (after APTC)	$151	$162	$122
Average APTC Amount	$331	$420	$642
Average Premium (members not eligible for APTC)	$456	$552	$717

- APTC Members are individuals who are eligible to receive federal APTC subsidies
- Not everyone who obtains insurance on the Exchange is eligible for APTCs
- The first three rows of the second table apply to members who are eligible for APTCs

Estimates were developed utilizing publicly available information, including 2016 MLR data, 2017 Supplemental Health Care Exhibits, 2Q18 Exhibit of Premium Utilization and Enrollment, CMS open enrollment public use files, CMS effectuated enrollment snapshots, 2016 and 2017 risk-adjustment reported information, and publicly available rate filing information (e.g., URRT data)

PROJECTED 2020 INDIVIDUAL ENROLLMENT, PREMIUM RATES AND FEDERAL APTC SPENDING

	CALENDAR YEAR 2020			
INDIVIDUAL ACA ENROLLMENT	**BASE LINE**	**10% REIN**	**15% REIN**	**20% REIN**
Total Members	20,257	20,382	20,630	20,940
APTC Members	14,049	14,049	14,049	14,049
Non-APTC Members	**6,209**	**6,333**	**6,581**	**6,892**
% of Members with APTC	69%	69%	68%	67%
INDIVIDUAL ACA PREMIUM PMPM	**BASE LINE**	**10% REIN**	**15% REIN**	**20% REIN**
Average Premium (members eligible for APTC)	$906	$814	$766	$717
Average Consumer Pay (after APTC)	$117	$117	$117	$117
Average APTC Amount	$789	$697	$649	$600
Average Premium (members not eligible for APTC)	$746	$670	$630	$590
Federal APTC Spend ($ millions)	**$133.0**	**$117.5**	**$109.4**	**$101.2**

- To estimate 2020 results, we relied on prior microsimulation modeling we have performed, as well as actuarial judgement
- 2020 projected results reflect the impact of the effective repeal of the individual mandate penalty, 2019 filed rate changes, an assumption that premium rates will increase by approximately 8% between 2019 and 2020 due to trend, and expected morbidity improvements (due to enrollment growth) under the reinsurance scenarios

ESTIMATED STATE COST OF REINSURANCE PROGRAM WITH A 1332 WAIVER

($ MILLIONS)	CALENDAR YEAR 2020			
	10% REIN	15% REIN	20% REIN	CALCULATION
Reinsurance Pool Cost[1]	$18.4	$27.8	$37.4	A
Pass-Through APTC Savings	($15.5)	($23.7)	($31.9)	B
Change in Exchange User Fees	$0.6	$0.9	$1.2	C
State Share of Reinsurance Pool Cost	**$3.5**	**$5.1**	**$6.7**	**D = A + B + C**
State Share of Total Reinsurance Pool Cost	19%	18%	18%	D / A

[1] Cost of Reinsurance Pool assumes carrier claim costs plus fixed administrative expenses are equal to 88.2% of premium

- Under a 1332 Waiver, the net cost to implement a reinsurance program is equal to the gross cost of the reinsurance program, less any federal pass-through funding due to projected savings in federal APTC spending, plus any projected reductions in federal exchange fees being collected

SENSITIVITY TESTING OF KEY ASSUMPTIONS

NET COST TO THE STATE (IN $MILLIONS)	CALENDAR YEAR 2020		
CHANGE IN ASSUMPTION[1]	10% REIN	15% REIN	20% REIN
Baseline Estimate	***$3.5***	***$5.1***	***$6.7***
Total Membership +10% (Baseline and Reinsurance)[2]	$3.9	$5.6	$7.4
Total Membership -10% (Baseline and Reinsurance)[2]	$3.2	$4.6	$6.0
Average Premium PMPM +10% (Baseline and Reinsurance)[2]	$3.8	$5.5	$7.3
Average Premium PMPM -10% (Baseline and Reinsurance)[2]	$3.1	$4.5	$6.0
Non-APTC Enrollment Grows 2x More Than Assumed	$3.6	$5.5	$7.7
Non-APTC Enrollment Does Not Grow	$3.4	$4.7	$5.7
Carrier Assumes 100% of Admin is Fixed[3]	$4.2	$6.1	$8.2
Carrier Assumes 0% of Admin is Fixed[3]	$2.8	$4.0	$5.3
Carrier Assumes 50% of Expected Morbidity Improvement[3]	$3.6	$5.5	$7.5
Carrier Assumes No Morbidity Improvement[3]	$3.8	$6.0	$8.4

[1]In sensitivity testing our baseline assumptions, we only made the change listed for each scenario, even though changes in other assumptions would be expected
[2]10% higher/lower in both the baseline and reinsurance scenarios
[3]For rate development purposes

KEY LIMITATIONS AND CONDITIONS RELATED TO REINSURANCE COST ANALYSIS

- The estimates are not based on robust microsimulation modeling and, therefore, may not fully recognize all interactions between changes in premium, enrollment and morbidity specific to the Delaware market that might occur
- Values are based on estimates of future events; therefore, actual results will vary
- Estimates assume no shift in membership to or from the Individual market from the Group market, or between metal plans, as a result of any premium reductions
- Cost estimates do not incorporate any estimated expenses associated with administration of the corresponding program
- Estimates do not reflect any impact to enrollment of the recently finalized rules related to short-term, limited duration insurance plans or association health plans
- Estimates are on a projected 2020 cost basis

REINSURANCE CONSIDERATIONS

- Several features of reinsurance programs and how they vary should be considered when selecting a type of program:
  - Incentive for carriers to continue to manage care
  - Ease of administration
  - Impact to carrier pricing process
  - Flexibility of program parameters
  - Feasible timing of payments to carriers
- State staff may be required to administer the reinsurance program, which could be additional burden/responsibility:
  - Responsibilities of the entity administering the program would include data collection, validation and payment of amounts owed
- Annual modeling and reporting to CMS/Treasury for pass-through calculations is required

SOURCES OF SUPPLEMENTAL STATE FUNDING FOR REINSURANCE

- Carrier assessments: a direct tax on carriers, most commonly applied on a PMPM or percent of premium basis, which ultimately gets passed on to groups or individuals in the form of additional rate increases
- Provider tax: such as a fixed charge per hospital admission (e.g., $2.00 per hospital day) or a percentage of all physician revenue; tax increases the cost of health care services that will get passed along to payers
- Other taxes: examples of the most popular of these include taxes on gasoline, alcohol and hotels (focus on out-of-state visitors?)
- Re-appropriation of existing State funds: evaluate State budget and determine whether funds can be shifted/re-allocated
- Federal funds: some federal proposals have included funds with the intent of making that money available to states in order to stabilize the Individual market

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1332 Waivers: An Overview

TRINIDAD NAVARRO, INSURANCE COMMISSIONER

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§ 1332 of Affordable Care Act

- Permits states to apply for State Innovation Waivers
- Waivers enable states to develop innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver

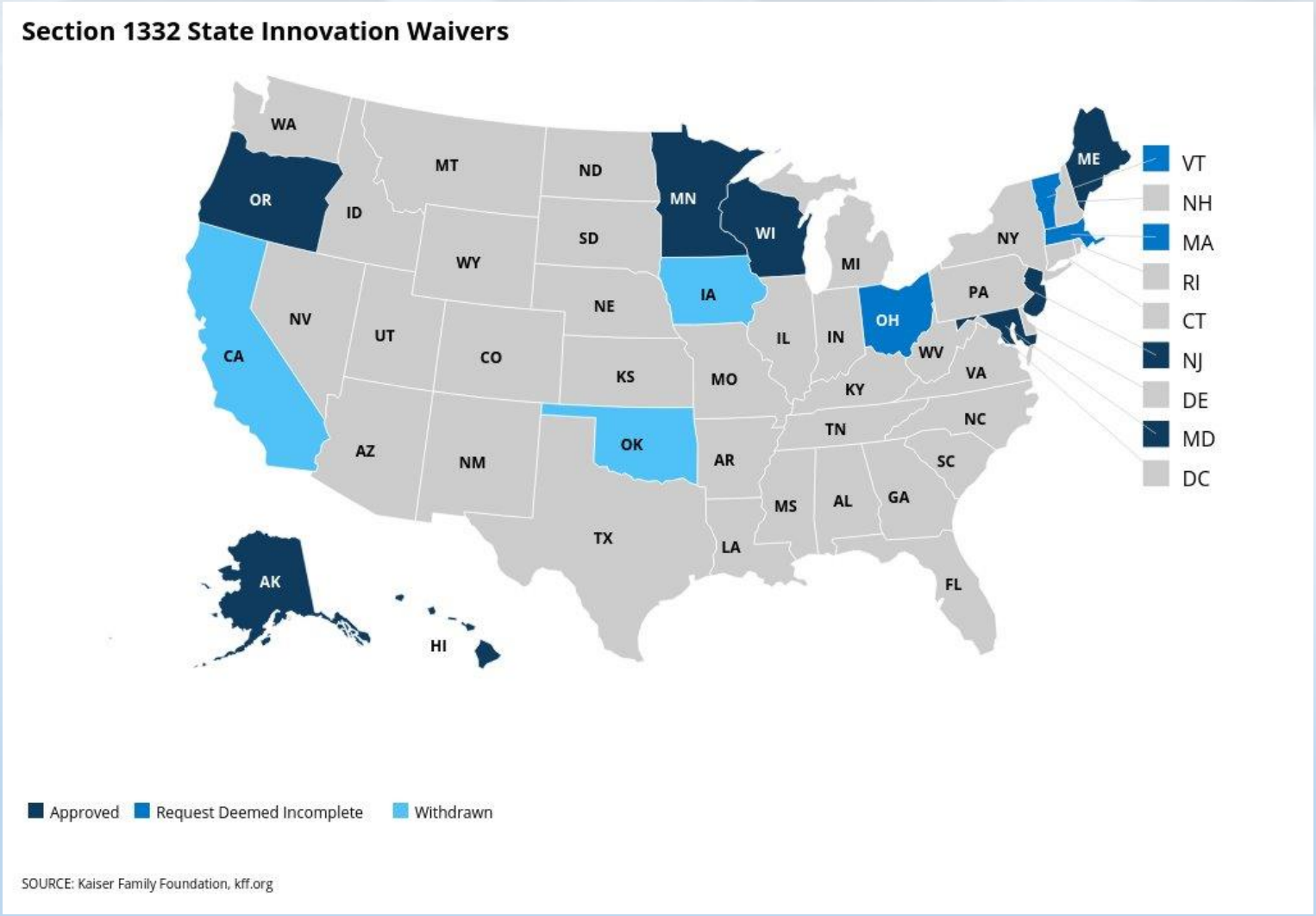
1332 Waiver Application Process

1. Enabling legislation permitting the state to pursue a 1332 Waiver
2. Retain actuarial consultants to begin application
3. Provide public notice and comment period
4. Public hearings
5. Submit application to US DHHS and US Dept. of Treasury
6. DHHS and Treasury conduct initial review within 45 days of state's submission to determine if application is complete
7. Once it is determined that an application is complete, Treasury and DHHS will provide for public notice and comment period
8. Final decision of DHHS and Treasury will be issued no later than 180 days after the application is deemed complete and has satisfied the requirements

1332 Waiver Application Requirements

1. List of provisions state seeks to waive and reasons why
2. Data, assumptions, targets and goals to determine that the proposed waiver will provide coverage that is at least, comprehensive, affordable and accessible in scope absent waiver
3. Actuarial analyses to support state's estimates that the waiver will comply with the comprehensive coverage, affordability and scope of coverage requirements
4. Detailed 10 year budget plan to ensure program will be deficit neutral to Federal government
5. Analysis detailing how the waiver will impact health insurance coverage in the state
6. Detailed plan and timeline as to how the state will implement a waiver

What Other States Have Done



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What Other States Have Done

- Alaska
  - Purpose of Waiver: Reinsurance
  - Premiums expected to be reduced by 20% in first year than they would be without the Total cost:
  - Cost to State: $55Million (appropriated by General Assembly)
- New Jersey
  - Purpose of Waiver: Reinsurance
  - Premiums to drop approx. 15%
  - Total cost: $323.7 million
  - Cost to State: $105.8 million (appropriated by General Assembly)

What Other States Have Done (continued)

- Maryland
  - Purpose of Waiver: Reinsurance
    - Allow federal pass-through funding to partially finance the Maryland Reinsurance Program claims
  - Premiums expected drop approx. 30%
  - Total cost: $462 million
  - State cost: $303 million
    - 2.75% surcharge on annual premiums from individual market to fund state portion → ~ $365 million

What could Delaware do?

- Depends on costs of 1332 waiver program and the costs of application process
- House Joint Resolution 13
  - Requires health insurance companies on Marketplace to file reports by 1/2/2019 detailing how they passed along savings realized from the moratorium on the federal health insurance industry fee to consumers
  - Permits General Assembly to consider imposing fee on health insurers not to exceed the federal health insurance industry fee for purposes of establishing a state-run reinsurance fund

SCR 70 Medicaid Buy-In Study Group

Wednesday, November 7, 2018
1:30 – 3:30 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Task Force Members:

Present:	Email:
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Representative Paul Baumbach	Paul.Baumbach@state.de.us
Representative Michael Ramone	Michael.Ramone@state.de.us
Steve Groff	Stephen.Groff@state.de.us
Dr. Kara Walker	Kara.Walker@state.de.us
Emmilyn Lawson	elawson@amerihealthcaritasde.com
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Dr. Robert Varipapa	drbob@cnmri.com
Trinidad Navarro	Trinidad.Navarro@state.de.us

Absent:	
Senator Catherine Cloutier	Catherine.Cloutier@state.de.us
Victoria Brennan	Victoria.Brennan@state.de.us
Deb Schultz	schultzdmw@gmail.com
Greg Star	star@carvertise.com

Staff:	
Caitlin Del Collo	Caitlin.DelCollo@state.de.us

Attendees:	Organization:
Jean-Pierre Cardenas	Maryland Health Benefit Exchange
Pam Price	Highmark
Steven Costantino	Dept. of Health & Social Services
Kiki Evinger	Dept. of Health & Social Services
Fred Gibison	Mercer
Tammy Tomczyk	Oliver Wyman
Jonathan Kirch	American Heart Association

Christine Schiltz	Parkowski, Guerke & Swayze
Jose Tieso	DXC
Steven Costantino	Dept. of Health & Social Services
Drew Wilson	Medical Society of Delaware/Morris James
Jack Guerin	Unitarian Universalist DE Advocacy Network
Kathy Collison	Division of Public Health, DHSS
Joe Bryant	Governor's Office
Jeanne Chiquoine	American Cancer Society
Dustyn Thompson	Delaware United
Cheryl Heik	Connections

The meeting was brought to order at 1:35 pm.

Introductions & Approval of Draft Meeting Minutes

Representative Baumbach took attendance and determined that there was a quorum. He asked if any changes needed to be made to the draft meeting minutes.

Caitlin Del Collo stated that Tammy Tomcyzk clarified that her comment at the bottom of page 2 pertained to the exchange population, rather than the Medicaid population.

Representative Baumbach asked if anyone else had a suggested change or correction. No one did. He then asked for a motion to approve the draft minutes.

Wayne Smith made a motion to approve the minutes. Trinidad Navarro seconded the motion. The minutes were then approved by a unanimous vote of the task force members.

Presentation on Maryland's State Reinsurance Program

Representative Baumbach invited Jean-Pierre Cardenas, Maryland Health Benefit Exchange, to begin his presentation.

Jean-Pierre Cardenas delivered a powerpoint presentation concerning the creation of Maryland's state reinsurance program.

Secretary Walker asked if there was a lot of momentum behind the reinsurance program, given the quick timeline in which the program was developed.

Mr. Cardenas responded that Maryland had a legislative task force called the Health Insurance Coverage Protection Commission that was charged with coming up with recommendations. In December 2017, the Commission recommended that the state institute a reinsurance program. The administration saw this legislative energy and decided to align its efforts with it. Mr.

Cardenas then said that if Delaware wanted to begin a reinsurance program, it would take approximately 3 months to do the necessary data analysis.

Representative Baumbach asked if Maryland enacted an individual mandate after the federal government removed the individual mandate from law. He also asked how a mandate would impact a reinsurance program.

Mr. Cardenas said the state did not enact an individual mandate, but that such a mandate is a current priority for Maryland's General Assembly. Mr. Cardenas then explained that when applying for a waiver to do a reinsurance program, the state does not have to mention efforts/actions that would have happened absent the waiver. For example, if Delaware were to enact an individual mandate regardless of its pursuit of a waiver, it would not have to specifically address the mandate in the waiver application. However, Mr. Cardenas said that it is important to consider how the revenue from an individual mandate is allocated. For example, New Jersey uses the money it collects from its individual mandate to fund some of its reinsurance program. Since the individual mandate is a source of funding for New Jersey's reinsurance program, the mandate had to be accounted for in the state's application for its waiver.

Secretary Walker asked Mr. Cardenas to talk about how the reinsurance program will operate going forward.

Mr. Cardenas responded that there are a number of items up for consideration by the Health Insurance Coverage Protection Commission, including a merger of the individual and small group insurance markets. The Commission is also considering a standalone individual mandate, as well as an individual mandate with an auto-enrollment feature. The last option would entail the state creating an individual mandate, and then instead of collecting penalties from those who choose not to get coverage, using those funds to help people purchase a plan.

Steve Costantino asked about expected impacts to enrollment.

Mr. Cardenas responded that the reduction in premiums was expected to result in a 5.8% increase in enrollment.

Representative Baumbach asked about the federal health insurance tax (HIT) and the fact that it was waived (on a one-time basis) in 2018.

Mr. Cardenas said that the HIT rate varies based on whether a company is for profit or not for profit. Some companies have a negative rate, while others have a positive rate of up to 3%; however, the aggregate rate across all company types is 2.75%. When the federal government waived the HIT in 2018, the State of Maryland decided to assess a 2.75% fee on insurance carriers as a funding source for the State Reinsurance Program.

Representative Baumbach noted that Delaware will not be able to take advantage of the tax holiday on the HIT, as it was a one-time waiver. He then asked Mr. Cardenas what the state of Maryland would have done if it had not been able to leverage the tax holiday.

Mr. Cardenas said that there were a number of bills that were proposed, including one called the "Kitchen Sink" bill. The bill would have increased certain assessments. For example, the bill would have increased assessments on hospitals. The rationale for the increase was that taxing hospitals in order to reduce the number of uninsured would reduce rates of uncompensated care. Another, smaller assessment would have taxed carriers that do not participate in the individual market. Currently there are four carriers in Maryland's small group market, and the market is very profitable. Meanwhile the individual market has only two carriers. This tax would have generated an estimated $35 million for the State Reinsurance Program.

Representative Baumbach responded that $35 million is about 9% of the amount of money projected to be collected by Maryland's state-based health insurance premium assessment, which includes an assessment on Medicaid Managed Care Organizations (MCOs).

Mr. Cardenas confirmed Representative Baumbach's statement. He also stated that a bill was introduced into the House of Representatives in Congress that would waive the HIT for 2020 and 2021. One recommendation is to create triggering legislation to recoup any money that would be lost if a federal tax holiday occurred in the future. He also said that the HIT has often been waived in the past, regardless of the administration in charge.

Representative Ramone asked where the recouped funding comes from.

Mr. Cardenas responded that it comes from carriers bearing the risk. He then noted that the cost of the HIT was already factored into members' premiums.

Wayne Smith said that Alaska structured its reinsurance program differently. Specifically, the state removed the highest cost members and put them in their own risk pool. He said that this approach lowered premiums. He asked Mr. Cardenas if the state of Maryland considered that approach versus the one that was pursued.

Mr. Cardenas said that Mr. Smith's question involves the difference between a claims-based reinsurance program (also referred to as an invisible high risk pool) and a condition-based reinsurance program. Maryland's program is claims-based. Mr. Cardenas then said that Alaska is unique in that it has a small population, so one person with a very high risk can really impact the risk pool. Further, he said it depends on the size of the risk pool. In a small population, removing people from the risk pool may be advantageous. Since Maryland's population is mid-sized, it made more sense to do a claims-based reinsurance program. Mr. Cardenas added that an analysis was done that suggested that a claims-based reinsurance program is more effective than a condition-based one. Nonetheless, Mr. Cardenas said that an independent analysis would need to be done in Delaware to identify where the risk is.

Representative Baumbach asked which stakeholders were least enthusiastic about the legislation that created the reinsurance program.

Mr. Cardenas said that the enacting bill had unanimous support, but the second bill pertaining to funding source received some pushback. Even so, the funding bill had bipartisan support.

Representative Baumbach asked which special interest groups were least enthusiastic.

Mr. Cardenas said that the idea to leverage the holiday on the HIT came from CareFirst, but that the other carrier in the market, Kaiser Permanente, didn't like the bill because they only pay a 1% assessment under federal rules, rather than 2.75%. Ultimately, however, there was consensus that something needed to be done.

Wayne Smith asked if there is any indication that the reinsurance program is going to increase enrollment in health coverage.

Mr. Cardenas said that it is too early to say, but noted that reduced premiums only help enrollment to the extent that the public knows about them. Maryland set aside $1 million to advertise the reduction in premiums.

Representative Baumbach thanked Mr. Cardenas for his presentation.

Presentation on Potential Programs for Delaware

Secretary Walker stated that the department, in conjunction with Mercer and Oliver Wyman, came up with more detailed scenarios for Delaware. She added that Highmark provided information to Mercer and Oliver Wyman so they could perform a more accurate analysis of Delaware's market.

Tammy Tomcyzk began the presentation on slide 4. She stated that she changed two assumptions in the scenarios based on feedback provided by Highmark. Specifically, she changed the percentage of the population that gets subsidies in 2018 from 69% to 73%. Further, she changed the expected baseline rate increases for APTC eligible members from $906 to $945 PMPM, and the expected baseline rate increases for non-APTC eligible members from $746 to $779 PMPM. Additionally, the expected federal APTC spend increased from $133 million to $148.6 million. She cautioned that more detailed analysis would be needed for Delaware to pursue a waiver; at the same time, however, she said that her preliminary analysis and more detailed analysis for New Jersey's waiver were reasonably close in numbers.

Secretary Walker asked Ms. Tomcyzk to pause on slide 9. She said that the tables on slides 8 and 9 are interconnected and represent different choices about how far to go with the reinsurance program in terms of the state's share of the cost and the percentage reinsured.

Ms. Tomcyzk referred back to slide 7 and said that the impact on membership is not linear from baseline to 10%, 10% to 15%, etc. She also noted that people do not come back to the market for small increases.

Representative Baumbach said that another factor in membership is the expected rate increase absent the reinsurance program. For example, membership would probably be impacted more if rates were set to go up 10%, but with the reinsurance program decreased by 10%, than if rates were set to go up 40%, and with the reinsurance program, only increased by 20%. He asked if the underlying rate increase is accounted for in the sensitivity analysis.

Ms. Tomcyzk said that it is accounted for in the model. She said that the expected rate increase from 2019 to 2020 would be 12.7% without a reinsurance program. In order to get that number to zero, the state would need to implement the 10% reinsurance program. The halo effect would apply in this situation. She stressed that it is harder to get people to come back to the exchange than it is to get them to leave it. Further, she said that it is better to keep premiums flat than to allow them to rise by a certain percentage one year, and fall by the same percentage the following year. Ms. Tomcyzk then proceeded to address potential funding sources for a reinsurance program.

Secretary Walker said that the department is happy to prepare a proposed recommendation, and that pursuing a 1332 waiver provides options that would improve affordability and maximize federal dollars.

Senator Townsend asked how/whether pursuing a waiver fits in with what the Department of Insurance is working on, as well as the Governor's Recommended Budget process.

Representative Baumbach commented that he likes the idea of doing triggering legislation to take advantage of possible future tax holidays.

Secretary Walker said DHSS is willing to work with the Department of Insurance on a waiver application. Additionally, she said the waiver would be added to the priority list for the governor's recommended budget. Further, the Secretary stated that there has been talk of another federal tax holiday, but it isn't confirmed yet.

Senator Townsend said that it is a matter of prioritization.

Secretary Walker noted that Governor Carney attended the press event about open enrollment on the marketplace. She said that collectively, DHSS, Commissioner Navarro, and representatives from Westside Family Healthcare expressed concern about significant barriers in the marketplace due to changes at the federal level. The Secretary then said that pursuing a 1332 waiver would allow stakeholders to pursue a program that helps Delaware, and in a way that takes into account its unique features and parameters. She added that stakeholders don't want to

have to provide uncompensated care for uninsured people. However, if the state implements a reinsurance program, it will enable people to seek primary care for their needs.

Commissioner Navarro, referencing slide 8, asked if the state's share of the cost of a 20% reinsurance program would really be $5.2 million.

Secretary Walker replied that $5.2 million is what it is projected to cost the state, but that the funding still needs to be discussed. She also said that the cost is very small in comparison to the estimated $40 or $60 million needed for the Medicaid Lookalike option explored in a previous meeting.

Emmilyn Lawson said that it seems like there is a clearer path to pursuing a reinsurance program than a Medicaid Lookalike plan.

Commissioner Navarro said that the state would need to pay for consultants to conduct an analysis. He said that while he appreciates reports that the Centers for Medicare & Medicaid Services (CMS) is easy to work with, he is concerned that the federal government won't continue to fund it at the same level. Finally, he said that the figure $5.2 million seems too good to be true.

Secretary Walker replied that that is why the DHSS wanted to work through the numbers on multiple scenarios. She said it seems like a reasonable goal to pursue a program that would cost the state around $5.2 million. The next steps include figuring out funding sources and conducting an in-depth actuarial analysis. The Secretary also said that legislation would need to explicitly say that a 1332 waiver will be prepared.

Representative Baumbach asked if there is consensus among the study group that they should pursue a 1332 waiver, and disregard other options that were previously discussed.

Secretary Walker said that that is DHSS's perspective.

Wayne Smith agreed that the group should pursue a waiver, and added that it seems to be more achievable than the other options. He noted the early successes from Alaska's and Maryland's reinsurance programs.

Representative Baumbach asked if anyone had objections to focusing on a 1332 waiver. No one objected. He then asked if Secretary Walker had a sense of what DHSS would like to prepare for the next meeting.

Secretary Walker deferred to Mr. Gibison and Ms. Tomcyzk.

Ms. Tomcyzk said that she could look into specific funding options.

Representative Baumbach asked if it would be helpful for the study group to decide between a 10%, 15%, or 20% reinsurance program.

Senator Townsend asked if it is difficult to run the numbers for all three reinsurance program scenarios.

Secretary Walker said that the department already has most of the numbers, but that if the group chose to pursue one reinsurance level over the others, they could provide additional context for that scenario.

Representative Baumbach said that he tends toward the 20% reinsurance program. He also said that he would prefer that the decision making surrounding the details of the program be done by the experts in the study group rather than the General Assembly. He said it would be helpful to know which type of program – claims-based or condition-based – would be better for Delaware, and why.

Senator Townsend said that he agrees, but isn't sure that the study group needs to know that level of detail in order to get started.

Secretary Walker said that enabling legislation could be passed first, followed by legislation establishing a funding structure.

Representative Baumbach said that there may be stakeholders within the study group who would want to know whether the program will be implemented via two bills or one, and who would want to make sure that the details are not decided behind closed doors.

Secretary Walker proposed that the study group discuss a narrower set of funding options at the next meeting.

Senator Townsend asked if the study group members would like to discuss any other options that were presented at previous meetings, such as opening up the state employee health insurance system to non-employees.

Secretary Walker responded that the group could weigh in on whether to implement an individual mandate.

Senator Townsend suggested saving the discussion on funding options for the next meeting, and opening the floor for discussion on options not related to the 1332 waiver/reinsurance program.

Greg Star asked what the study group members should do once the group makes its final recommendation. He asked if members should contact their legislators.

Senator Townsend responded that typically the legislators on a task force continue to have involvement with the subject. He then asked for clarification that the study group isn't going to draft a 1332 waiver application in its report.

Secretary Walker and Representative Baumbach confirmed that the study group report would not include a draft 1332 waiver application.

Senator Townsend discussed structuring the report in a way that is useful to the public, including explaining what was discussed, why the options were or weren't pursued, and attaching information in the appendices.

Representative Baumbach said that if there is unanimous support by the study group for the recommendation, then enabling legislation should be easy to pass. However, if there is a lot of disagreement between study group members, then resulting legislation will need help to get through.

Commissioner Navarro provided comments about allowing non-state employees to buy into the state employee health plans. Specifically, he said that as a retiree from New Castle County with dependents, he would have to pay over $2,000 a month in premiums to buy into a retiree health plan. The Commissioner noted that retirees get a discounted rate, and that he can't imagine how much it would cost a non-retiree/non-employee to buy in. Regarding the individual mandate, Commissioner Navarro asked whether it would require coverage of essential health benefits, or be more like a skinny/catastrophic coverage plan. He said he supports pursuing a 20% reinsurance program, and would like to hear what Highmark thinks about it.

Senator Townsend asked that Highmark provide a reaction to pursuing a 1332 waiver/reinsurance program at the next meeting.

Representative Baumbach said it would be better to get Highmark's reaction at the Nov. 28th meeting than the December 12th model so that their feedback could be taken into consideration.

Senator Townsend said it would be helpful for Highmark, DHSS, and DOI to coordinate ahead of the next meeting. He also said that if the study group chooses not to pursue certain options, it should explain why in the final report.

Secretary Walker said that DHSS did consider a state employee health insurance buy-in program internally, but found that premiums would be more costly than those in platinum plans.

Representative Baumbach asked if we could have a 15 minute presentation to that effect so that the study group can report that it formally considered the option and decided not to pursue it. He then asked if the group should move on to public comment.

Senator Townsend agreed.

Public Comment

Dustyn Thompson thanked the study group for its work, but expressed disappointment that other options didn't get as much attention as the 1332 waiver/reinsurance program, including cost sharing reductions. He said that the study group missed the opportunity to ask important questions such as who can be included in or excluded from the market in order to stabilize it. He

asked for confirmation that the federal tax holiday could not be leveraged as a funding source if Delaware pursued a reinsurance program.

Representative Baumbach replied that it could not unless the federal government reauthorizes the tax holiday.

Dustyn Thompson continued that he is disappointed to hear discussion about instituting an individual mandate. He said that he has been unable to buy insurance for several years, and that each year he has had to pay the penalty. He said that the $1800 he spent on the penalty could have been used to pay for his homebirth, defraying school costs, or buying a home. He said the concept of an individual mandate is regressive.

Jonathan Kirch said that he appreciated how Commissioner Navarro framed his comments. He said the American Heart Association supports efforts to rewrite principles on health care, and that that will likely come in the form of universal healthcare. He said the issue of affordability has really gotten away from us, and that the options up for discussion only work at the margins to make healthcare affordable. Mr. Kirch also suggested that perhaps one group of experts and stakeholders explore a 1332 waiver, while another focus on looming healthcare cost challenges.

Senator Townsend said that any person working on a 1332 waiver will inevitably be involved in the larger health care issues at hand. He said that the study group and its final report are not the end of the conversation. He then explained that the report will reflect what was discussed and why certain options were chosen or not.

Representative Baumbach said that Delaware rarely likes to be first to implement a program/law, and that if Maryland were further along in its program, and knew which next steps to take, then it might be easier to adopt a certain solution. The Representative asked if there was any other public comment. There was none.

The meeting was adjourned at 3:45 pm.

Final Report Appendix - Item 9

Maryland State Reinsurance Program

John-Pierre Cardenas, Director of Policy and Plan Management

November 7, 2018

A service of Maryland Health Benefit Exchange

Agenda

- Individual Market Performance in Maryland
- Legislative History
- Decision Point: Funding Source
- Decision Point: Reinsurance Impact
- Maryland State Reinsurance Program Waiver
- State Innovation Waiver Timeline
- State Reinsurance Program Impact
- New 1332 Guidance: Impact on Future Applications

Individual Market Performance in Maryland - Marketplace Metrics

MARYLAND HEALTHBENEFIT EXCHANGE

Table 1. Maryland Health Connection Marketplace Metrics 2014 – Present.

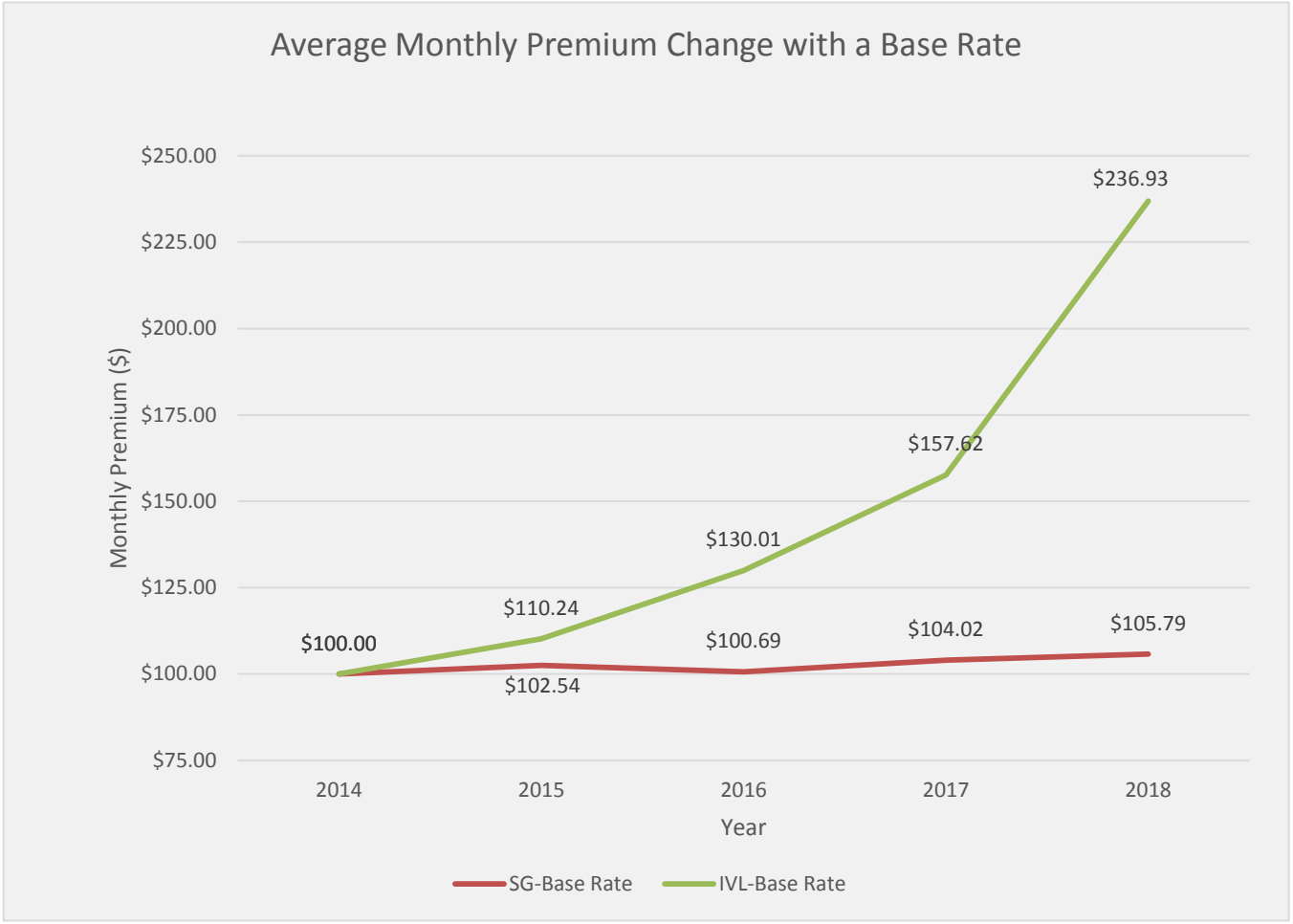
Benefit Year	Participating Issuers (#)	QHPs Offered (#)	Enrollment	Subsidized/ Unsubsidized (%)	Premium Change (%)	Rate Justification
2014	4	45	81,553	80/20	-	-
2015	5	53	131,974	70/30	10.24%	Sicker/Older Pool | MHIP Migration | Increased unit cost of care | Increased utilization | Health Insurer Fee
2016	5	53	162,652	70/30	17.93%	Actual claims experience higher than 2015 rates | Pent-up demand in formerly uninsured entrants | Risk Adjustment payments | Increased cost and utilization trends | Reduction in reinsurance payments
2017	3	23	157,637	78/22	21.24%	Increased unit cost of care, claims, morbidity of pool | Cessation of the reinsurance program
2018	2	21	153,571	79/21	50.32%	New members entering risk pool | Current members terminating coverage | Increased churn and trend | Loss of CSR | Individual mandate enforcement not included in rate

Sources: MHBE Annual Reports, MHBE Plan Management, MIA Rate Decisions, Issuer Rate Justifications.

Individual Market Performance in Maryland -

MARYLAND HEALTHBENEFIT EXCHANGE

Average (%) Premium Increases Individual & Small Group Using a Base Rate



Legislative History

2018 Legislative Session: HB – 1795 & SB 387

- Two bills from the 2018 Maryland Legislative Session impact the State Reinsurance Program House Bill 1795 – Establishment of a Reinsurance Program & Senate Bill 387 Maryland Health Care Access Act of 2018.

- Signed by Governor Larry Hogan on April 5 and April 10. These bills are a bipartisan short-term solution to address premium affordability and market stabilization in Maryland's individual health insurance marketplace.

- HB 1795, establishes a claims-based State Reinsurance Program to offset the impact of high cost enrollees in the individual marketplace. MHBE is required to apply for a State Innovation Waiver under section 1332 of the Affordable Care Act

- SB 387 places a 2.75% assessment on carriers to recoup the aggregate amount of the health insurance provider fee that was previously assessed under Section 9010 of the ACA. The Tax Cuts and Jobs Act of 2017 waived this fee for 2018. This funding source provides an estimated $365 million (MIA/OCA) for the State Reinsurance Program.

Decision Point: Funding Source

MARYLAND HEALTHBENEFIT EXCHANGE

State-based Health Insurance Premium Assessment

- The 2.75% premium assessment is broad-based and is applicable to all premiums that would have been subject to the federal assessment under Section 9010 of the ACA and where the state has the statutory authority to do so.

- Premiums for health benefits subject to ERISA and Federal programs (ex. Medicare, FEHBs, etc.) are exempt from the state assessment.

- 2.75% is the rate that results in the aggregate amount that would have been assessed under the federal HIT. Each issuer is assessed a different rate at the federal level based on the issuer's situation.

- The assessment will impact issuers differentially depending on their treatment under the federal assessment.

Decision Point: Funding Source

MARYLAND HEALTHBENEFIT EXCHANGE

State-based Health Insurance Premium Assessment

- The broad-based nature of the assessment allows the state to assess Medicaid Managed Care Organizations under taxation rules, and increase federal contribution to the SRP.

- The state assessment is federally tax-deductible (important for determining aggregate percentage).

- Of the $365 million (FY 2019) projected for collection under the assessment:

    - $196.5 million from Commercial Carriers
    - $168.4 million from Medicaid MCOs (62% of that amount is federal share)

Decision Point: Reinsurance Impact

MARYLAND HEALTHBENEFIT EXCHANGE

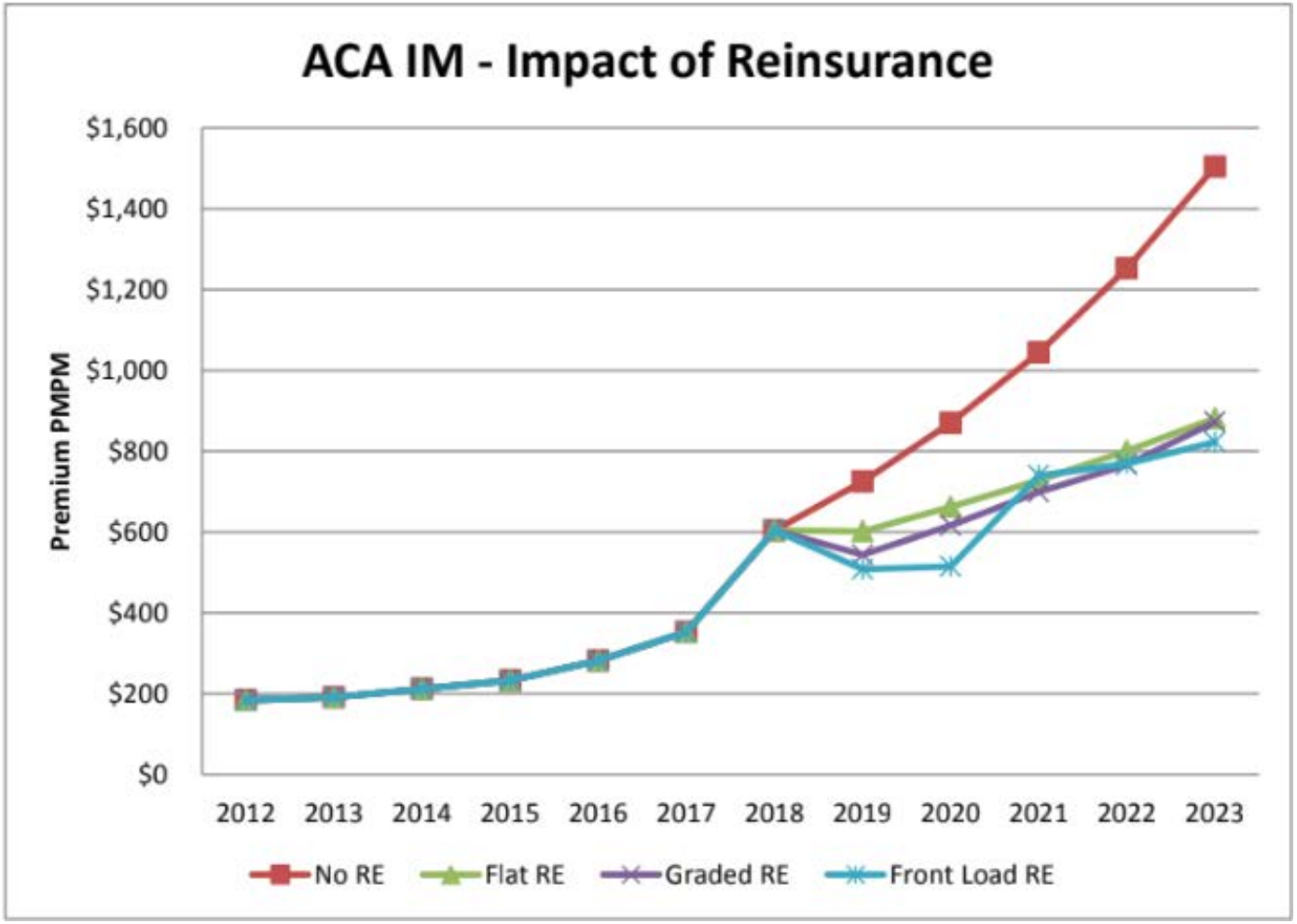
"Front loading" Federal Pass-through funds

- The State Reinsurance Program was envisioned as a bridge program to:
  - Support market stability in the short-term
  - Provide the legislature with time to develop a long-term solution
- State-based HI Assessment for the SRP would only be collected once (FY 2019).
- Funding allocation (and thereby federal pass-through dollars) over the five-year waiver resulted in different market impacts.
  - Federal pass-through may be "additive" and not "supplementary."
  - Pass-through funding may *increase* the size of the reinsurance program, state funding allocation is not a *cap* on program impact.

Decision Point: State Reinsurance Program Impact

MARYLAND HEALTHBENEFIT EXCHANGE

Reinsurance Impact Models



Maryland State Reinsurance Program Waiver

MARYLAND HEALTHBENEFIT EXCHANGE

Application to Establish the State Reinsurance Program

- **Waived Provision:** Maryland waived Section 1312(c)(1) of the Affordable Care Act – determination of the market index rate. This allows Maryland carriers to include expected State Reinsurance Program payments when determining their market index rate.

- **Affordability:** Federal pass-through funding, through net premium tax credits savings, will fund a reinsurance program that targets a 30% premium reduction offset for 2019 and 2020. Total program costs for 2019 are approximately $462 million.

- **Coverage:** Maryland estimates that the premium impact will result in a 5.8% increase in individual market enrollment in 2019.

- **Federal Deficit:** The decreased premiums will decrease federal spending on tax credits. Actuarial analysis estimates that federal savings will be $280 million, $293 million, and $32 million in 2019, 2020, and 2021, respectively.

- **Implementation:** Maryland requested that the Departments assist the state in implementation of the waiver through modification through the EDGE server infrastructure

Maryland State Reinsurance Program Waiver

MARYLAND HEALTHBENEFIT EXCHANGE

Estimated Maryland/Federal Funding

Waiver Year	SRP Amount	Estimated Federal Funding	% Federal	Estimated State Funding	% State
2019	$462,000,000	$303,534,000	65.70%	$158,466,000	34.30%
2020	$451,000,000	$315,700,000	70.80%	$135,300,000	29.20%
2021	$287,000,000	$212,380,000	74.00%	$74,620,000	26.00%
Total	$1,200,000,000	$831,614,000	69.30%	$368,386,000	30.70%
		Medicaid MCO Revenues: $168,400,000 *Federal Share (62%):* $104,408,000			
Adjusted Total	$1,200,000,000	$936,022,000	78.00%	$263,978,000	22.00%

State Innovation Waiver Timeline

State Application Drafting & Public Comment Period

- **Early March,** MHBE begins work with Wakely Consulting Group to begin data gathering & analysis for the draft waiver application for public comment.
- **April 10,** Governor Larry Hogan signs bills authorizing the Maryland Health Benefit Exchange to submit a 1332 waiver for a State Reinsurance Program
- **April 20**, the Maryland Health Benefit Exchange (MHBE) released a draft application for a State Innovation Waiver, starting the 30-day state public comment period.
- **April 26 – May 10**, MHBE held four public hearings across Maryland to present the application to the public.

State Innovation Waiver Timeline

Summary of Public Comment

- **Coordination with the Federal Risk Adjustment Program**
  - Many stakeholders have expressed concern over potential issuer payments under the SRP and the federal Risk Adjustment program that would be duplicative of the same risk.
  - Both carriers request that Wakely conduct a study to determine the degree of overlap between the two programs, if any.
- **Establishing a State Reinsurance Program That Will Attract New Entrants**
  - Many stakeholders expressed that the SRP could be leveraged to create a market environment that is favorable for new entrants. They caution, however, that the program should not be constructed in a manner that would support certain care delivery models over others.
- **Incentives for Utilization/Care Management and Quality Improvement**
  - Stakeholders expressed that the SRP should be explored as a tool to increase quality and reward effective utilization/care management.
  - Respondents suggest that the SRP could be used to further the goals of other state initiatives, such as the All-Payer Model and the Medicare Waiver.

State Innovation Waiver Timeline

Final Application Submission, Amendment, and Federal Public Comment Period

- **May 31**, the Maryland Health Benefit Exchange (MHBE) submitted a final application to the U.S. Departments of Health and Human Services and the Treasury.
- **July 5**, MHBE receives notice from waiver application reviewers that the waiver was deemed complete, starting the 30-day federal public comment period.
- **August 15**, MHBE submits an amendment to the State Innovation Waiver Application to include state response to stakeholder concern on the interaction between Federal Risk Adjustment and the SRP.
- **August 22**, MHBE receives notice that the State Innovation Waiver to Establish a State Reinsurance Program has been approved.
- **August 24**, MHBE Board of Trustees resolves to account for program interaction between Federal Risk Adjustment and the SRP through equalizing profitability between sick and health members.

State Reinsurance Program Impact

Rate Impact of the SRP by Issuer.[1]

Carrier (Network)	Enrollment[2] (on/off MHC)	2019 Rates (w/o Reinsurance)	2019 Rates (w/ Reinsurance)
CareFirst (HMO)	109,368	18.5%	-17%
CareFirst (PPO)	13,074	91.4%	-11.1%
Kaiser Permanente (HMO)	69,837	37.4%	-7.4%
Total	192,279	30.2%	-13.2%

[1]As of October 1, 2018, 18,009 enrollees do not receive APTC on Maryland Health Connection.
[2]Enrollment as of June 30, 2018.

State Reinsurance Program Impact

Premiums after Reinsurance and Silver-loading

- Consumers will receive less APTC but still more than otherwise due to "silver-loading." Example:
  - The SRP reduced premiums for silver plans from -7.2% to -14.5%.
  - Silver plan premiums on Maryland Health Connection are 11% to 28% higher than off-Exchange premiums.
- Consumers will pay less if their base premium decrease was greater than their APTC decrease and vice versa. Example:
  - The SRP reduced premiums differently depending on metal level and carrier
    - Bronze plans -4.4% to -19.1%
    - Silver plans -7.2% to -14.5%
    - Gold plans -9.3% to -15.3%
- Reinsurance programs and "silver-loading" narrow the gap between gold and silver plans, i.e. lowers the barriers to "buying-up."

[3]As of October 1, 2018, 112,587 enrollees receive APTC.

Flexibilities under the ICA

- Under the new guidance states may leverage FFM capability to implement their state plans. This includes, but is not limited to, data sharing, plan management, financial assistance, and consumer assistance.
    - States are responsible for funding customization and operational support
- Under the Intergovernmental Cooperation Act (ICA) federal agencies may provide certain technical and specialized services to state governments to help implement their state plans.
    - CMS services covered under the ICA are not considered as an increase in federal spending due to the state plan when determining deficit neutrality
    - The new guidance may allow states to implement reinsurance programs under the ICA. State would be able to pay CMS to utilize the EDGE server infrastructure, to determine reinsurance payments, with pass-through dollars.

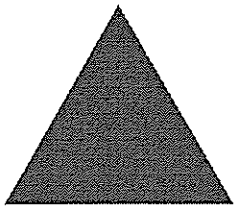
Questions?

For more information contact John-Pierre Cardenas, jcardenas@maryland.gov

Final Report Appendix - Item 10
HEALTH WEALTH CAREER

Government Human Services Consulting

FURTHER DISCUSSION OF 1332 WAIVER FOR REINSURANCE, MEDICAID LOOK-A-LIKE AND TITLE XIX MEDICAID EXPANSION



SCR70 TASK FORCE MEETING

NOVEMBER 7, 2018

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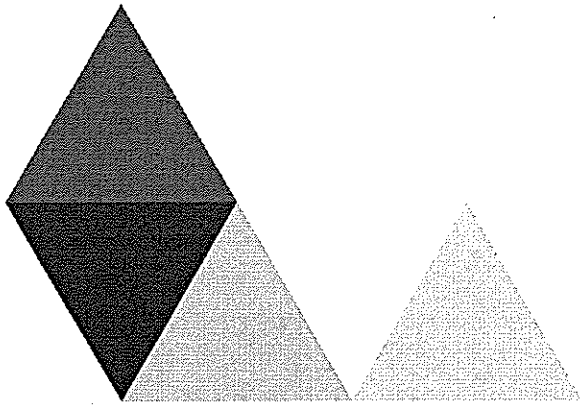

OLIVER WYMAN

MAKE TOMORROW, TODAY MERCER

INCLUDED IN THIS PRESENTATION

- Estimates of funding for a 1332 Waiver for reinsurance for Exchange-based plans:
  - Focus of our presentation today
  - Three different reinsurance scenarios – 10%/15%/20%
  - Further refinement relative to our October 10 presentation (still estimates)
  - Considerations
  - Funding sources
- Creating a "Medicaid Look-A-Like" insurance offering on the Exchange:
  - Same information as provided at the October 10 meeting
- Expansion of Medicaid Title XIX to higher incomes:
  - Same information as provided at the October 10 meeting
- There are many facets of each strategy that can be customized/proposed

Information contained in this presentation should be considered provisional. More time would be needed to fully explore these options and develop better estimates.

REINSURANCE PROS/CONS

- Mitigates cost of high-dollar claimants:
  - "High-dollar claimants" can be defined based on conditions/diseases, attachment point or percent of claim dollars
- Reduces insurers' risk:
  - If the health insurer is protected from high-dollar claimants, the insurer has less financial risk exposure in developing their premiums
- Lowers premiums:
  - With reinsurance program payments being available and the reduced financial risk associated with high-dollar claimants, insurers will be able to lower premiums, likely attract more enrollment and create positive momentum for the Exchange
- Cost for the State:
  - Depending on the design of the reinsurance program and how many federal dollars can be redirected using a 1332 Waiver, the cost to the State will vary
- Does not change underlying cost dynamics:
  - Provider prices, utilization and quality of care are not directly impacted

COST TO THE STATE FOR REINSURANCE

- A 1332 Waiver would allow Delaware to keep existing federal dollars in the State to offset the cost of reinsurance, as well as receive new dollars resulting from additional savings to the federal government due to improved morbidity of the risk pool
- Without an approved 1332 Waiver, federal savings from a reinsurance program that lowers premiums and, therefore, lowers the advance premium tax credit (APTC) subsidies will not benefit Delaware:
  - Non-subsidized individuals will benefit from lower premiums
  - Without the 1332 Waiver, Delaware would have to fund the entire cost of a reinsurance program
  - Many more people can benefit if Delaware can hold on to and repurpose the dollars that represent federal savings, and use those dollars to further stabilize the ACA market through additional reinsurance
- Federal savings will not be sufficient to cover the full cost of a reinsurance program, even with a 1332 Waiver:
  - The amount of potential federal savings is directly related to how much premiums are reduced and how many people receive federal APTCs

REINSURANCE SCENARIOS

- Estimates were developed for three provisional reinsurance scenarios to illustrate their potential impact and cost, and to facilitate further discussion:
  - 10% reduction in ACA premiums
  - 15% reduction in ACA premiums
  - 20% reduction in ACA premiums
- Modeling was performed based on publicly available information, carrier input, experience from other states and actuarial judgement:
  - Results are provisional in nature and would require more time and data to further refine

ESTIMATED INDIVIDUAL ACA ENROLLMENT AND AVERAGE MONTHLY PREMIUM RATES (2016 TO 2018)

INDIVIDUAL ACA ENROLLMENT	2016	2017	2018
Total Members	34,417	28,683	23,542
APTC Members	19,250	18,028	17,200
Non-APTC Members	15,167	10,655	6,342
% of Members with APTC	**56%**	**63%**	**73%**

INDIVIDUAL ACA PREMIUM PMPM	2016	2017	2018
Average Premium (members eligible for APTC)	$481	$582	$763
Average Consumer Pay (after APTC)	$151	$162	$122
Average APTC Amount	$331	$420	$642
Average Premium (members not eligible for APTC)	$456	$552	$717

- APTC members are individuals who are eligible to receive federal APTC subsidies
- Not everyone who obtains insurance on the Exchange is eligible for APTCs
- The first three rows of the second table apply to members who are eligible for APTCs

Estimates were developed utilizing publicly available information and carrier feedback, including 2016 MLR data, 2017 Supplemental Health Care Exhibits, 2Q18 Exhibit of Premium Utilization and Enrollment, CMS open enrollment public use files, CMS effectuated enrollment snapshots, 2016 and 2017 risk-adjustment reported information and publicly available rate filing information (e.g., URRT data)

PROJECTED 2020 INDIVIDUAL ENROLLMENT, PREMIUM RATES AND FEDERAL APTC SPENDING

	CALENDAR YEAR 2020			
INDIVIDUAL ACA ENROLLMENT	**BASE LINE**	**10% REIN**	**15% REIN**	**20% REIN**
Total Members	20,452	20,562	20,782	21,057
APTC Members	14,949	14,949	14,949	14,949
Non-APTC Members	**5,504**	**5,614**	**5,834**	**6,109**
% of Members with APTC	73%	73%	72%	71%
INDIVIDUAL ACA PREMIUM PMPM	**BASE LINE**	**10% REIN**	**15% REIN**	**20% REIN**
Average Premium (members eligible for APTC)	$945	$849	$799	$749
Average Consumer Pay (after APTC)	$117	$117	$117	$117
Average APTC Amount	$828	$732	$683	$632
Average Premium (members not eligible for APTC)	$779	$700	$659	$617
Federal APTC Spend ($ millions)	**$148.6**	**$131.4**	**$122.5**	**$113.3**

- To estimate 2020 results, we relied on prior microsimulation modeling we have performed, as well as actuarial judgement
- 2020 projected results reflect the impact of the effective repeal of the individual mandate penalty, 2019 filed rate changes, an assumption that premium rates will increase by approximately 12.7% between 2019 and 2020 due to trend and the return of the ACA Insurer Fee, and expected morbidity improvements (due to enrollment growth) under the reinsurance scenarios

ESTIMATED STATE COST OF REINSURANCE PROGRAM WITH A 1332 WAIVER

($ MILLIONS)	CALENDAR YEAR 2020			
	10% REIN	15% REIN	20% REIN	CALCULATION
Reinsurance Pool Cost[1]	$19.3	$29.2	$39.2	A
Pass-Through APTC Savings	($17.2)	($26.1)	($35.2)	B
Change in Exchange User Fees	$0.7	$1.0	$1.3	C
State Share of Reinsurance Pool Cost	**$2.8**	**$4.1**	**$5.2**	**D = A + B + C**
State Share of Total Reinsurance Pool Cost	14%	14%	13%	D / A

[1] Cost of Reinsurance Pool assumes that carrier claim costs, plus fixed administrative expenses are equal to 88.2% of premium

- Under a 1332 Waiver, the net cost to implement a reinsurance program is equal to the gross cost of the reinsurance program, less any federal pass-through funding due to projected savings in federal APTC spending, plus any projected reductions in federal Exchange fees being collected

SENSITIVITY TESTING OF KEY ASSUMPTIONS

NET COST TO THE STATE (IN $MILLIONS)	CALENDAR YEAR 2020		
CHANGE IN ASSUMPTION[1]	10% REIN	15% REIN	20% REIN
Baseline Estimate	***$2.8***	***$4.1***	***$5.2***
Total Membership +10% (Baseline and Reinsurance)[2]	$3.1	$4.5	$5.8
Total Membership -10% (Baseline and Reinsurance)[2]	$2.5	$3.7	$4.7
Average Premium PMPM +10% (Baseline and Reinsurance)[2]	$3.0	$4.4	$5.7
Average Premium PMPM -10% (Baseline and Reinsurance)[2]	$2.4	$3.6	$4.6
Non-APTC Enrollment Grows 2x More Than Assumed	$2.9	$4.4	$6.2
Non-APTC Enrollment Does Not Grow	$2.7	$3.7	$4.3
Carrier Assumes 100% of Admin is Fixed[3]	$3.7	$5.4	$7.0
Carrier Assumes 0% of Admin is Fixed[3]	$1.9	$2.7	$3.5
Carrier Assumes 50% of Expected Morbidity Improvement[3]	$2.9	$4.4	$6.0
Carrier Assumes No Morbidity Improvement[3]	$3.1	$4.9	$6.9

[1]In sensitivity testing our baseline assumptions, we only made the change listed for each scenario, even though changes in other assumptions would be expected
[2]10% higher/lower in both the baseline and reinsurance scenarios
[3]For rate development purposes

POTENTIAL SOURCES OF SUPPLEMENTAL STATE FUNDING FOR REINSURANCE

- **Carrier assessments:** a direct tax on carriers, most commonly applied on a PMPM or percent of premium basis, which ultimately gets passed on to groups or individuals in the form of additional rate increases:
  - We estimate that the total commercial, fully insured employer market (i.e., non-ASO) in Delaware has roughly 120,000 covered lives
  - Based on this, to fund a $4.0 million program, an assessment on the commercial fully insured market (including the Individual market) equal to approximately $2.35 PMPM would be required; If ASO groups were included, we estimate that the required assessment would decrease by $0.75 – $1.00 PMPM
- **State-based individual mandate penalty:** revenue from the state-based penalty is redirected to be used for the reinsurance program:
  - Approximately $8.1 million in individual mandate penalty revenue was collected from Delaware residents in 2016
  - Based primarily on expected changes in enrollment, we estimate that penalty revenue under a state-based mandate (with a similar penalty structure as existed previously at the federal level) could be as high as $14.8 – $20.8 million in 2020

POTENTIAL SOURCES OF SUPPLEMENTAL STATE FUNDING FOR REINSURANCE (CONTINUED)

- **Provider tax:** such as a fixed charge per hospital admission (e.g., $2.00 per hospital day) or a percentage of all physician revenue; tax will increase the cost of health care services and will get passed along to payers:
  - Per CMS cost reports, there were 240,000 hospital admissions[1] and 1,200,000 inpatient days at Delaware facilities in Fiscal Year 2016
  - Based on this, to fund a $4.0 million program, we estimate that the tax per hospital admission would need to be approximately $17.00; alternatively, the tax per hospital inpatient day would need to be approximately $3.00
- **Re-appropriation of existing State funds:** evaluate State budget and determine whether funds can be shifted/reallocated
- **Federal funds:** some federal proposals have included funds with the intent of making that money available to states in order to stabilize the Individual market
- **Other sales taxes:** examples of the most popular of these include taxes on gasoline, alcohol and hotels

[1]Excludes approximately 26,000 hospital admissions and 268,000 inpatient days from rehabilitation, psychiatric and behavioral health-specific treatment centers (e.g., Delaware Psychiatric Center, Dover Behavioral Health System)

KEY LIMITATIONS AND CONDITIONS RELATED TO REINSURANCE COST ANALYSIS

- The estimates are not based on robust microsimulation modeling and, therefore, may not fully recognize all interactions between changes in premium, enrollment and morbidity specific to the Delaware market that might occur
- Values are based on estimates of future events; therefore, actual results will vary
- Estimates assume no shift in membership to or from the Individual market from the Group market, or between metal plans, as a result of any premium reductions
- Cost estimates do not incorporate any estimated expenses associated with administration of the corresponding program
- Estimates do not reflect any impact to enrollment of the recently finalized rules related to short-term, limited duration insurance plans or association health plans
- Estimates are on a projected 2020 cost basis

KEY REINSURANCE CONSIDERATIONS

- **Program structure:**
  - Attachment point-based vs. condition-based
  - Incentive for carriers to continue managing care
- **State risk** associated with under/overestimating program cost and/or federal pass-through savings:
  - Flexibility of funding source
  - Flexibility of program parameters (e.g., attachment points)
- **Program administration:**
  - Process for collecting data, validating data and determining payments
  - Annual reporting
- **Carrier impact:**
  - Timing of payments (i.e., cash flow)
  - Results vary carrier-to-carrier, resulting in non-uniform impact to premium rates
  - Interaction of reinsurance with risk-adjustment program (i.e., double counting)

MEDICAID LOOK-A-LIKE PRODUCT PROS/CONS

- Primary goal is to significantly lower premiums by leveraging the Medicaid MCOs' provider networks and provider pricing:
  - May be narrower provider networks/fewer choices for consumers
  - Consumers will evaluate the cost benefit of lower-cost health insurance versus the availability of providers
  - It is unclear how much premiums can be reduced
- Providers may not be willing to accept lower payment terms:
  - May require a compromise of paying providers higher than regular Medicaid, but less than fees that underlie current Individual market premiums
  - Providers may demand that fees increase in the State's Medicaid program, leading to additional State cost
- Continues to promote the Individual market as source of affordable health insurance
- Only one other insurer in Medicaid program that is not already participating on the Exchange

MEDICAID LOOK-A-LIKE PRODUCT IMPACT ON FEDERAL APTCS (ON EXCHANGE)

- If the Look-A-Like product is the second lowest-cost Silver Plan (SLCSP) on the Exchange, federal APTCs would be expected to be reduced
- Most consumers under 400% FPL would have the option to continue to pay a similar amount to that which they are paying currently; however, in order to do so, they may need to enroll in the Look-A-Like product rather than the product they are currently enrolled in:
  - In fact, consumers may be required to pay more than they do currently to get access to the networks/providers associated with the plan they are currently enrolled in
- Consumers over 400% FPL would have the option to purchase the Look-A-Like product, likely at a lower cost than the product they are currently enrolled in
- See example on next slide

MEDICAID LOOK-A-LIKE PRODUCT IMPACT ON FEDERAL APTCS (ON EXCHANGE)

- Example of impact on APTCs and amount consumers pay if the lower-cost Medicaid Look-A-Like product is included in the determination of the SLCSP:

		CURRENT ACA MARKET			ACA WITH MEDICAID LOOK-A-LIKE AS THE SLCSP		
CONSUMER	PLAN TYPE	GROSS PREMIUM	APTC	CONSUMER PAYS	GROSS PREMIUM	APTC	CONSUMER PAYS
A (APTC Eligible)	Current ACA Product	$600	$500	$100	$600	$300	$300
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$300	$100
B (not APTC Eligible)	Current ACA Product	$600	$0	$600	$600	$0	$600
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$0	$400

USE A 1332 WAIVER TO WAIVE USING THE MEDICAID LOOK-A-LIKE PLAN AS BASIS FOR APTC

- Waiver to exclude the lower-cost Look-A-Like plan from being considered when determining the SLCSP on the Exchange:
  - APTCs would continue to be based on the current ACA products
  - Both subsidized and non-subsidized consumers could then choose to buy the lower-cost Look-A-Like plan for less out-of-pocket cost

		CURRENT ACA MARKET			ACA WITH MEDICAID LOOK-A-LIKE NOT THE SLCSP		
CONSUMER	PLAN TYPE	GROSS PREMIUM	APTC	CONSUMER PAYS	GROSS PREMIUM	APTC	CONSUMER PAYS
A (APTC Eligible)	Current ACA Product	$600	$500	$100	$600	$500	$100
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$500	$0
B (not APTC Eligible)	Current ACA Product	$600	$0	$600	$600	$0	$600
	Medicaid Look-A-Like	N/A	N/A	N/A	$400	$0	$400

  - Potential for pass-through savings for Consumer A who buys lower-cost product

MEDICAID LOOK-A-LIKE PLAN

- No state has pursued a strategy to combine a Medicaid Look-A-Like plan with a 1332 Waiver yet
- Federal government may or may not approve:
  - Depends on interpretation of ability to waive Sections 36B of the IRC and 1402 of the ACA
- Any potential carrier not able to leverage Medicaid/lower-cost arrangement may be at a competitive disadvantage
- Will MCOs do this willingly or will the State have to mandate as a condition of a Medicaid contract?
  - Could destabilize the Medicaid program

TITLE XIX MEDICAID EXPANSION

- Federal law does not prohibit states from expanding Title XIX Medicaid to higher incomes:
  - Could propose to go up to 200% FPL, 300% FPL, 400% FPL or higher
- There would be many political, policy and operational issues to resolve:
  - The current federal administration may not support expanding Medicaid to higher incomes (not consistent with Medicaid's focus/intent)
  - Provider/stakeholder input
- Delaware can expand Medicaid either through a state plan amendment or an amendment to the 1115 Waiver:
  - A state plan amendment could theoretically be done in a few months
  - An 1115 Waiver would require 18 to 24 months or longer
- Under current federal law, an expansion of Medicaid to higher incomes would receive federal matching funds at the State's current FMAP (about 57%):
  - The State would have to pay for about 43% of the cost

TITLE XIX MEDICAID EXPANSION

- Expanding Title XIX would increase the role of DHSS in providing health care to Delawareans:
  - More State responsibility and influence on health care market
- The State could choose to deliver benefits to the higher income expansion group through:
  - Traditional FFS
  - Risk-based managed care
  - New payment/delivery arrangements
- In an 1115 Waiver, the State could propose/negotiate program design aspects:
  - Work requirements
  - Member cost-sharing/premiums
  - Different benefit package(s)
  - Other research or demonstration ideas

TITLE XIX MEDICAID EXPANSION

- Depending on member cost-sharing requirements, the consumers' cost of Medicaid coverage could be designed to be less than the out-of-pocket cost of Exchange-based coverage, making it more affordable for eligible Delawareans
- A Medicaid expansion would likely draw consumers away from the Exchange:
  - Per federal rules, individuals eligible for Medicaid can still choose to obtain health insurance through the Exchange, but are not eligible for federal APTCs
  - Would further destabilize the Exchange or render the Exchange nonexistent
- A 1332/1115 "Superwaiver" has been talked about:
  - A 1332 Waiver might be used to redirect federal APTCs to cost of the Medicaid expansion
  - An 1115 Waiver to expand Medicaid/modify program requirements
  - In some scenarios, the federal APTCs might cover much more than 57% of the cost
  - But Medicaid has a requirement for state spending/state share

TITLE XIX MEDICAID EXPANSION – BALLPARK EXAMPLES (NOT ACTUARIALLY SOUND)

- Up to 200% FPL:
  - Approximately 7,800 Exchange enrollees
  - Approximately 7,200 uninsured enrollees
  - Estimate $525 average per member per month (PMPM):
    - $94.5 million annual total of which about $41 million would be new State cost
- Up to 400% FPL:
  - Approximately 18,000 Exchange enrollees
  - Approximately 22,000 uninsured enrollees
  - Estimate $495 average PMPM:
    - $237.6 million annual total of which about $102 million would be new State cost
- Actual enrollment will be more/less as some people will choose to remain uninsured, not be aware of options or changes in economy
- Actual costs will be impacted by program design and risk of enrolled population

MERCER

MAKE TOMORROW, TODAY

OLIVER WYMAN

Services provided by Mercer Health & Benefits LLC.

SCR 70 Medicaid Buy-In Study Group

Wednesday, November 28, 2018
1:30 – 3:30 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Task Force Members:

Present:	Email:
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Representative Paul Baumbach	Paul.Baumbach@state.de.us
Representative Michael Ramone	Michael.Ramone@state.de.us
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Absent:	
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Deb Schultz	schultzdmw@gmail.com

Staff:	
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Read Scott	Read.Scott@state.de.us

Attendees:	Organization:
Pam Price	Highmark
Steven Costantino	Dept. of Health & Social Services
Kiki Evinger	Dept. of Health & Social Services
Molly Magarik	Dept. of Health & Social Services
Fred Gibison	Mercer
Tammy Tomczyk	Oliver Wyman

Jonathan Kirch	American Heart Association
Christine Schiltz	Parkowski, Guerke & Swayze
Drew Wilson	Medical Society of Delaware/Morris James
Jack Guerin	Unitarian Universalist DE Advocacy Network
Kathy Collison	Division of Public Health, DHSS
Joe Bryant	Governor's Office
Jennifer Harris	N/A
Rebecca Byrd	The Byrd Group
Cheryl Heiks	Webster Consulting/Connections

The meeting was brought to order at 1:35 p.m.

Approval of Draft Meeting Minutes:

Dr. Fan motioned to approve the draft meeting minutes without changes. Commissioner Navarro seconded the motion. The study group voted unanimously to approve the draft minutes as-is.

Discussion of Draft Recommendations:

The study group discussed the draft recommendations report put together by DHSS in conjunction with Fred Gibison and Tammy Tomcyzk of Mercer and Oliver Wyman, respectively. In general, the study group members discussed the following matters:

- **Whether the study group should pursue a 20% or 30% reinsurance program.**
  - ✓ Emmilyn Lawson asked if there is data on reinsurance programs above 30%. Tommy Tomcyzk indicated that none of the other state models have gone above 30%.
  - ✓ Commissioner Navarro and Todd Graham said they think the program should be at 20%.
  - ✓ Dr. Fan suggested that we start the reinsurance program at 20% but revisit that number annually and adjust as needed.

- **Whether to keep the recommendation to pursue a state level individual mandate/penalty.**
  - ✓ It was noted that when the federal mandate/penalty was in place, Delawareans paid $8.7 million in penalties.
  - ✓ The study group decided unanimously to keep the individual mandate/penalty as a recommendation.

- **Incentives for individuals to change their health behaviors.**
  - ✓ Rep. Ramone proposed offering monetary incentives to insured individuals to encourage healthier behavior/actions, such as offering discounts on premiums for using a Fitbit to document regular exercise, etc.

- ✓ Todd Graham said that there isn't any data to support the idea that using a Fitbit changes health behavior or reduces health care costs.
- ✓ Dr. Varipapa cited individuals' concern about having their health information tracked by "Big Brother."

Public Comment:

Jonathan Kirch & Jack Guerrin spoke during the public comment portion of the hearing. Mr. Kirch said that a substantial number of people will benefit from the study groups' efforts. Mr. Guerrin asked whether the study group continues after its report is issued.

The meeting was adjourned at 3:15 p.m.

SENATE CONCURRENT RESOLUTION 70 STUDY GROUP

PRELIMINARY RECOMMENDATIONS FOR DISCUSSION

NOVEMBER 28, 2018

State of Delaware

CONTENTS

1
INTRODUCTION

This Study Group was created by Senate Concurrent Resolution 70 (SCR 70) that was introduced on June 20, 2018, by Senator Margaret Rose Henry and subsequently passed on June 28, 2018. SCR 70 noted several descriptive characteristics of Delaware's health insurance landscape including:

- Access to quality, affordable health care is a cornerstone not only of a healthy life, but of a healthy economy and middle-class
- More than 24,000 Delawareans are enrolled in Marketplace plans via ChooseHealthDE.com or Healthcare.gov
- Only one commercial insurer currently sells health plans on Delaware's Marketplace
- Health insurance premiums on an average "Silver" level Marketplace plan in Delaware increased by 25% last year [2018 plan year][1]
- Consumers would benefit from greater competition in the individual insurance marketplace

SCR 70 also resolved that the Governor and Secretary of Health and Social Services may apply for a federal waiver for state innovation under Section 1332 of the Patient Protection and Affordable Care Act (ACA), and if approved, may implement a state plan of innovation that meets the waiver requirements established under federal law and as approved by the United States Secretary of Health and Human Services.

The Co-chairs of the Study Group (i.e., Senator Bryan Townsend and Representative Paul Baumbach) are required to compile a report containing a summary of the Study Group's work regarding the issues assigned to it, including any findings and recommendations, and submit the report to all members of the General Assembly and the Governor no later than January 31, 2019.

The SCR 70 Study Group has met four times so far as follows:

- September 5, 2018

[1] Per Commissioner Navarro, for the 2019 plan year, the Department of Insurance approved a rate filing increase of 3 percent.

- September 27, 2018
- October 10, 2018
- November 7, 2018

The remaining two Study Group meetings are scheduled to be held on:

- November 28, 2018
- December 12, 2018

Through these meetings, there has yet to be a single solution presented within the Study Group that would solve all of our challenges and achieve all of the goals voiced to date that is clearly viable and affordable for the State moving forward. This is not wholly unexpected as the health care sector is a large, important and complex component of Delaware's overall economy. Even after this Study Group concludes its work, continued research and monitoring of the actions of other states across the country is important for us to do, as well as evaluating changes at the federal level that may present new opportunities or begin to close some options that could impact our local healthcare landscape. Moreover, our State has many highly qualified health care resources and entities with connections to larger organizations with regional and national exposure to new ideas. As Co-Chairs of this Study Group, we hope that our partners continue to assess opportunities for improving the affordability and sustainability of quality health care and health insurance for all Delawareans moving forward.

This report provides a summary of the Study Group's activities through the fourth meeting held on November 7, 2018. Additionally, to facilitate continued discussion within the Study Group, this report contains preliminary recommendations that Delaware should further explore, including developing a federal Section 1332 Waiver application to implement a State-sponsored reinsurance program for the purposes of stabilizing the individual health insurance Marketplace, reducing individual health insurance premiums and increasing access to more affordable health insurance for Delawareans.

2
FRAMEWORK AND CONTEXT

The Study Group began with an introduction of all members and a review of the purpose and intent of SCR 70. It was acknowledged that there can be more than one definition of "Medicaid Buy-in", and members of the Study Group expressed excitement to discuss solutions for Delaware's increasing health care costs, but also concern over potential misunderstanding of what the term Medicaid buy-in means. A Study Group member commented that they were not aware of any state operating a Medicaid Buy-in program for the general public regardless of income.

There was initial discussion that Delaware could explore a range of possible actions to stabilize our health insurance market, reduce the cost of health insurance premiums and make it more affordable for more Delawareans to obtain insurance, while taking into consideration the State's limited resources. It was noted that the Study Group should assess the driving principles, such as affordability and accessibility, and then determine which policy levers can be used to achieve those goals.

In the following three meetings, the Study Group invited and received presentations from different experts in the health care arena on topics ranging from:

- A summary of state activity on expanding affordable health insurance options from the National Conference of State Legislators
- An overview of Section 1332 Waivers, a Medicaid "look-a-like" insurance product and an expansion of the State's Title XIX Medicaid program from Mercer Health & Benefits[2] and Oliver Wyman Actuarial Consulting
- A review of the 1332 Waiver process from Delaware's Department of Insurance
- A summary of Maryland's Section 1332 Waiver program from the Director of Policy & Plan Management for Maryland's Health Benefit Exchange

[2] Mercer Health & Benefits LLC is the actuarial, financial and policy consultant to Delaware's Medicaid agency

- Provisional estimates of various options for a state-sponsored reinsurance program for the individual Marketplace from Oliver Wyman Actuarial Consulting based on a few key initial data assumptions that had been reviewed by Highmark at the request of the Department of Health and Social Services

The information shared helped inform the Study Group of different options available to us and supported discussion of initial advantages and disadvantages of different options. It was discussed during the different presentations that it will be important for Delaware to prioritize what challenges the State is trying to address. Different solutions have different effects on affordability and market stability. For example, a full expansion of Title XIX Medicaid could require the State of Delaware to pay tens of millions of dollars for its share of Medicaid program expenses and potentially further de-stabilize the individual market by pulling individuals out of that market and into Medicaid; however, it could also be a more affordable option for many individuals pending potential Medicaid cost-sharing scenarios. As another example, if insurance products can be sold on the Marketplace Exchange with lower premium rates through the use of a reinsurance program, federal tax credits (i.e., premium subsidies) will continue to flow into the State, which can potentially drive positive enrollment momentum, attract more and healthier individuals to buy insurance and further reduce subsequent premiums; however, insurance may still be unaffordable for some higher income groups.

3
OPTIONS PRESENTED TO THE STUDY GROUP

Over the course of our meetings, the Study Group was presented with several different options for fulfilling the intent of SCR 70. A full, detailed financial and operational evaluation of each option was beyond the means of this Study Group; however, summary information either qualitative or quantitative, when available, was received to assist the Study Group in assessing the relative cost and complexity of different options. The options discussed to date are summarized below.

EXPANDING MEDICAID TITLE XIX TO HIGHER INCOMES

States are not prohibited from expanding Medicaid to higher income individuals. In fact, Delaware expanded Medicaid in the mid-1990s to adults with incomes up to 100% of the federal poverty level (FPL) and then expanded Medicaid again to adults up to 138% FPL in 2014 under the optional provision in the ACA. Certain other populations, such as children, pregnant women and individuals needing long-term services and supports have even higher income eligibility pathways.

Since Medicaid is joint federal/state program, Delaware must operate its own program within broad, and sometimes restrictive, federal regulations. In exchange for complying with federal requirements and oversight, Delaware receives federal financial support to off-set a significant share of total Medicaid program expenditures. Presently, Delaware's standard federal support level is approximately 57%, meaning that for each dollar of Medicaid program expenditures, the federal government pays 57 cents and the State pays the remaining 43 cents with general funds.

If Delaware were to pursue expanding Medicaid to individuals and families at higher income levels, the State would have many policy, political and operational decisions to make, which would require a significant amount of time and resources. We could propose to the federal government a customized expansion that would include different benefits, cost sharing and/or eligibility requirements than those in our traditional Medicaid program that would have to be negotiated with the federal government and vetted through a public process. These steps take time, and there is no guarantee that Delaware would be granted any of our requested changes. Expanding Medicaid would likely draw people away from our individual Marketplace, which may

further destabilize that segment of our insurance market. Operationalizing a larger Medicaid program would also strain our limited State resources.

As the Study Group heard and discussed, there are various advantages and disadvantages of this option from a policy and market perspective. From a financial perspective, even with the federal government helping to pay for a majority of costs, expanding Medicaid would result in a large new State expenditure. While the State could make certain design decisions, such as requiring higher cost sharing for Medicaid enrollees, rough estimates indicate the State share of a Medicaid expansion could range from approximately $40 million to over $100 million each year depending on many factors and policy decisions that would require much more detailed actuarial analyses.

CREATING A LOWER COST EXCHANGE-BASED INSURANCE PRODUCT

The Study Group acknowledged that health care costs in Delaware are high and that those higher costs raise the level of health insurance premiums for consumers. Within the Exchange, certain consumers have some protection from these higher insurance premiums by virtue of the federal tax credits (i.e., premium subsidies) that are available on a sliding income scale. However, enrollment in Delaware's Exchange-based plans has declined over the last few years with most of the individuals leaving the market being those who do not qualify for federal tax credits.

If a viable insurer was willing and able to offer a lower cost insurance product, premiums would be reduced and insurance could become more affordable. To create a lower cost product, insurers would have to evaluate their provider networks, provider pricing arrangements and overall risk profile among many other considerations in pricing a given risk pool. For example, our Medicaid plans likely pay some providers less (and some more) than what Commercial plans have historically paid. If these lower cost arrangements can be leveraged into lower cost insurance products, affordability could be improved. However, the practicality of some providers accepting lower reimbursement for Commercial plans is uncertain. Some providers may seek higher Medicaid reimbursements levels in return, which would increase the State's Medicaid costs. Based on how the federal tax credits work, the Study Group was shown that if a lower cost plan became the basis for the tax credits (i.e., the second lowest cost Silver plan), consumers might end up paying the same out of pocket premium costs as before for the second lowest cost Silver plan, but perhaps have a narrower set of providers to choose from. If a consumer wanted to retain a traditional plan, it could be more expensive since their tax credits would be based on the new lower cost plan. However, individuals not eligible for tax credits (i.e., those with higher incomes) would benefit from the choice of a lower cost plan.

The Study Group was also presented an option that would require agreement from the federal government through a Section 1332 Waiver to exclude the lower cost plan from the

determination of federal tax credits. If this were to happen, consumers would receive the same level of subsidy as they receive currently, could purchase a traditional plan for the same price as they currently pay, but could purchase a lower cost plan at their option for an even lower price. However, it is unclear whether the federal government would be willing to make and stand-by this type of agreement and potential changes at the federal level could create instability over the long term.

LOWERING INDIVIDUAL HEALTH INSURANCE PREMIUMS THROUGH A SECTION 1332 WAIVER FOR A REINSURANCE PROGRAM

As the Study Group learned, several other states have pursued Section1332 Waivers from the federal government to make changes to their individual health insurance market. The most common strategy employed has been to implement a state-sponsored reinsurance program. A reinsurance program reduces the cost of health insurance because insurers have some protection against high-cost claims and/or individuals, and this allows premiums to be lowered. Using reinsurance to lower an insurer's risk is a common practice in different insurance markets across the country. The federal government has established a process for states to follow to obtain a Section 1332 Waiver and while there are several steps to this process, other states have been able to complete the application process in a matter of a few months.

The primary benefit of using a Section 1332 Waiver for a reinsurance program is that when monthly premiums are lowered, the amount of federal tax credit dollars is also reduced. This produces savings to the federal government. With a Section 1332 Waiver, those federal savings can be passed back to Delaware to off-set a large portion of the cost of the state-sponsored reinsurance program.

Similar to the previous option involving a lower cost insurance product, most consumers (i.e., those consumers who are eligible for federal tax credits) would have very little, if any, change in their monthly premium since their portion is tied to their income. However, for individuals not eligible for federal tax credits, reinsurance would result in a lower premium and more affordable coverage. A key difference between reinsurance and reducing premiums through a provider networks option is that providers are not directly impacted by a state-sponsored reinsurance program.

While more robust actuarial modeling would be required, Oliver Wyman Actuarial Consulting presented to the Study Group three different reinsurance scenarios with provisional estimates of the impact of each scenario on premium costs and enrollment levels. The initial estimates assumed a targeted premium reduction of 10%, 15% and 20%, although other choices are also available to us. For example, in the presentation from Maryland regarding their Section 1332 Waiver/reinsurance program, we learned that Maryland targeted a 30% premium reduction. This is indicative of the various policy and design choices we would have to make if Delaware opted to pursue a state-sponsored reinsurance program (e.g., program structure, program

administration, impact on insurers, etc.). Based on the estimates provided, a 20% premium reduction in Delaware equates to an approximately $40 million reinsurance program in 2020. With a Section 1332 Waiver and retention of the federal dollar savings, the estimated cost to the State would only be approximately $5.2 million in 2020 with a potential range of $3.5 million to $7.0 million depending on key factors and pricing assumptions.

Funding to cover the State's net cost to enable the reinsurance program could come from a variety of different sources including, but not limited to: an assessment on insurers, general fund revenues, a State-based individual mandate penalty, a provider assessment or other sources of revenue from the General Assembly.

ENABLING INDIVIDUALS TO BUY INTO THE STATE EMPLOYEE GROUP HEALTH INSURANCE PLAN (GHIP)

Another option that was raised during a Study Group meeting was opening the State employee GHIP to non-State employees (or groups not otherwise eligible to obtain insurance through the GHIP). The impact on the premiums of an influx of new members would need to be modeled as changes to the premiums would likely be required if the risk profile changes materially. Similar to the Medicaid expansion option, if a disproportionate share of individuals with greater health care needs chooses to enroll in the GHIP, premiums could go up significantly and raise the costs to the State by a large amount. Conversely, if lower risk individuals opt for the GHIP, the remaining risk pool in the individual market would be markedly more instable and put pressure on the Exchange-based plans to raise premiums again. At present, estimates of the State's annual share of cost per each active individual in the GHIP is approximately $15,000. This amount is before assessing the impact on the cost of coverage of an influx of new risk. Based on this annual cost (which could vary if individuals were asked to pay more of the cost themselves), for every 1,000 individuals that would take up coverage through the GHIP, the cost to the State would be approximately $15 million. Unlike previous options discussed, there are no federal matching funds to off-set this new Delaware taxpayer expense.

4
PRELIMINARY RECOMMENDATIONS

Taking into consideration the different advantages and disadvantages of the options the Study Group has considered, including the level of complexity, range of costs to the State and time required to actually implement a beneficial change, Secretary Walker from the Department of Health and Social Services is proposing that Delaware further evaluate a Section 1332 Waiver to implement a State-sponsored reinsurance program for our individual health insurance market. The primary goals of this recommendation include:

- Reducing average monthly health insurance premiums by a significant level (e.g., a 20% to 30% reduction)
- Minimizing the level of uncertainty and the actual amount of a new State expenditure
- Maximizing the retention of federal dollars staying in Delaware through the receipt of pass-through savings to off-set State costs
- Working with our insurers on reinsurance pricing assumptions to obtain the best return-on-investment for our State

Should this recommendation be supported by the Study Group, several key program design decisions will be needed so that the corresponding actuarial modeling, Section 1332 Waiver application and stakeholder discussions can be completed in a timely manner. A list of key decision points and, where applicable, a preliminary recommendation is provided below for the Study Group's consideration. It is important to note that these design decisions are not wholly independent of each other. Instead, each decision point affects other decision points and therefore influences the final cost and impact of the reinsurance program on our market.

TYPES OF REINSURANCE PROGRAM STRUCTURES

There are three main structures that a reinsurance program can take. These include 1) condition-based programs that reimburse insurers for the claims of individuals with certain chronic conditions, 2) attachment point-based programs that reimburse insurers for a portion of claims between a specified lower and optional upper threshold and 3) percent of claims-based programs that reimburse insurers for a specified percentage of total annual claims. For each structure, there are several key considerations including:

- Care management/coordination: the level of incentive or disincentive for insurers to continue to focus on member care coordination
- Ease of administration: State versus insurer responsibilities to collect and analyze data and process payments. There is the potential that existing federal resources (e.g., EDGE files) could be used to lessen the State's administrative requirements.
- Impact on insurer pricing process: to what degree can lower insurer risk reduce premium prices, including potentially lower margin levels for insurers?
- Flexibility: in what manner can the State adjust the reinsurance program's parameters to align with intended goals?
- Timing of payments: when do the reinsurance payment calculations occur and is there an interim and final settlement or just a single final settlement?

Recommendation: For relative ease of administration, familiarity level of insurers and State flexibility, we are recommending an **attachment-point reinsurance program**. The specific attachment points would be determined as part of the actuarial modeling in consideration of the program design goals. For illustration purposes, to achieve a 25% average premium reduction, the reinsurance program may need to cover 85% of claims costs that exceed $100,000 in a given year. Through the actuarial modeling process an iterative evaluation of options can be explored, and the option best suited to the State's goals can be selected.

AVERAGE PREMIUM REDUCTION LEVEL

As noted previously, a decision will need to be made regarding the targeted level of average premium reduction that can be achieved through the reinsurance program. Other states have achieved premium reductions ranging from 7.5% (Oregon) to 30% (Maryland). The higher the premium reduction, the larger the reinsurance program and cost to the State becomes. A greater reduction in premiums increases the affordability level with the goal of increasing enrollment (particularly among relatively healthy individuals), which can then create more positive momentum going forward as premiums benefit from a larger and more diverse risk pool. However, human behavior is difficult to predict even in sophisticated simulation models so thoughtful consideration needs to be given to the level of change required to effectuate positive results.

Recommendation: A general thought is that small changes generate small results. If Delaware pursues a reinsurance strategy, it would behoove the State to pursue a larger change to generate more substantial and beneficial outcomes (i.e., more people having access to affordable health insurance). Therefore, we are recommending the State pursue a reinsurance program that will **reduce average premiums by 20% to 30%**. The specific figure will be dependent on actuarial modeling of different scenarios and sources of available funds, but the

general recommendation is to obtain the largest premium reduction that can be supported in a fiscally appropriate and sustainable manner.

STATE SHARE OF THE COST OF REINSURANCE

A Section 1332 Waiver will enable the State to retain federal dollars that would otherwise revert back to the federal government by virtue of premiums in the individual market being reduced. However, the amount of federal pass-through savings is unlikely to cover the full cost of the new reinsurance program. Per the presentation provided to the Study Group, a preliminary range in State costs to support a 20% reinsurance program is $3.5 million to $7.0 million in 2020. These costs would be higher if the reinsurance program targeted a 30% premium reduction.

Recommendation: We recommend **evaluating the sources of potential State funding relative to the amount of dollars needed to achieve the targeted premium reduction and decisions made based on this objective evaluation**. The overall goal of improving affordability and stability applies not only to our health insurance market and the insurers therein, but also to the State's finances, competitiveness and attractiveness to businesses and individuals to visit or live in our state.

FUNDING OPTIONS FOR STATE SHARE OF REINSURANCE

Commensurate with the amount of the State's share required to support the reinsurance program, a source of State funding will be needed. There are two strategies to consider in identifying a source of State funds: a one-time source of funding or a longer-term source of funding. As we heard from the representative from Maryland's program, Maryland opted to apply a state assessment fee on insurers in lieu of the federal health insurer tax that had been suspended for a year. This will be a one-time state assessment on Maryland's carriers, yet it is intended to provide state funding for their reinsurance program for up to three years (which the Maryland representative indicated would give the state time to develop a longer-term solution to their health care cost challenges).

If the federal government again suspends the federal health insurer tax, Delaware may be able to pursue a similar strategy as Maryland; but as a state, we can consider an assessment on insurers regardless of what the federal government does or does not do. Implementing an annual assessment on certain health care providers can also be source of ongoing funds to pay for the reinsurance program. The General Assembly has the choice to appropriate funds from elsewhere in the State's budget at their discretion or consider taxes/fees on things such as hotels and alcohol. We also learned that approximately $8.1 million in tax penalties attributed to the ACA's individual mandate was collected from Delaware residents by the federal government in 2016. The ACA's penalty for not having Minimum Essential Coverage is now $0, so much like the suspension of the federal health insurer tax, Delaware could explore a state-mandate and corresponding penalty to fund the State's share of the reinsurance program.

Recommendation: With the suspension of the federal individual mandate penalty and in consideration of the preliminary estimates of the cost of a reinsurance program, we recommend that the State **develop a state-based individual mandate with a corresponding penalty structure** intended to raise enough funds to cover some or all of the State's expected share of the cost of the reinsurance program. To the extent the State needs less funds than what the federal government collected in 2016, this should be factored into the design of the state-based individual mandate and corresponding penalty structure. If the General Assembly appropriates funds in support of this initiative, the State-based individual mandate penalty amounts could potentially be further reduced.

CONCLUSION

Addressing the challenges of high health care costs and the related cost of insurance is not unique to Delaware. The fact that several other states have already obtained approval of a Section 1332 Waiver for a reinsurance program, including one state developing a state-based individual mandate to fund its program (New Jersey), and more states are looking at a Section 1332 Waiver as a way to reduce health insurance premiums, indicates that there is viability in this option. We need to determine what is best for our state. The work of the SCR 70 Study Group is contributing to that discussion. The preliminary recommendations in this report are intended to spur further discussion by the Study Group. The final report that we are required to submit will reflect the collective input from the entire Study Group.

SCR 70 Medicaid Buy-In Study Group

Wednesday, December 12, 2018
1:30 – 3:30 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Task Force Members:

Present:	Email:
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Representative Michael Ramone	Michael.Ramone@state.de.us
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Absent:	
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Attendees:	Organization:
Pam Price	Highmark
Steven Costantino	Dept. of Health & Social Services
Molly Magarik	Dept. of Health & Social Services
Jonathan Kirch	American Heart Association
Christine Schiltz	Parkowski, Guerke & Swayze
Drew Wilson	Medical Society of Delaware/Morris James

Kim Gomes	The Byrd Group
Cheryl Heiks	Webster Consulting/Connections
Kristin Bricker	Network Delaware
Jill Fredel	DHSS
Julie McIndoe	Delaware United
Yrene Waldren	DHCFA
Stephanie Myers	AmeriHealth Caritas
Andrew Dahlke	Medical Society of Delaware
Jeanne Chiquoine	American Cancer Society
Dustyn Thompson	Delaware United
T. McLaughlin	DHSS
Vince Ryan	DOI

The meeting was brought to order at 1:41 p.m.

Approval of Draft Meeting Minutes:

Senator Townsend asked if there were any changes to the draft minutes for the 11/28/18 meeting. After no one offered any changes, he made a motion to approve the minutes, and once the motion was seconded, the minutes were unanimously approved by the task force members.

Discussion of Draft Recommendations:

The study group discussed the updated draft of the recommendations report put together by DHSS in conjunction with Fred Gibison and Tammy Tomcyzk of Mercer and Oliver Wyman, respectively. Secretary Walker discussed each of the changes/revisions made to the report. The task force members did not offer any objections to the revisions.

Following Secretary Walker's comments, Senator Townsend opened the floor to the other task force members for additional comments about the report. In general, the study group members discussed the following matters:

- **The number of part-time state employees who are not eligible for health insurance coverage through the state.**
    - ✓ Dr. Julia Pillsbury ask how many part time state employees were not eligible for health insurance coverage through the state.
    - ✓ Secretary Walker said she would have to look into the exact number.
    - ✓ Senator Townsend and Rep. Ramone both indicated that they don't recall hearing from any constituents who are part time state employees expressing concern that they are unable to receive health insurance through the state.
- **General housekeeping items.**

- ✓ Senator Townsend proposed that an appendix should be included with the final report, which would include all meeting minutes, presentations and handouts given to the task force.

- ✓ Secretary Walker made a motion to approve the report as amended, along with an appendix. Once the motion was seconded, the report was unanimously approved.

- **Timetable for next steps.**

  - ✓ Dr. Nancy Fan asked if the timetable for implementing a potential program would be for the year 2020.

  - ✓ Secretary Walker said yes, because there wouldn't be enough time for it to happen for the 2019 enrollment.

  - ✓ Secretary Walker and Sen. Townsend discussed when enacting legislation should be introduced. Rep. Ramone asked if enacting legislation would in fact have to be passed in order to implement the task force's recommendations, and Secretary Walker said that yes there would have to be enacting legislation.

  - ✓ Rep. Ramone and Sen. Townsend discussed concerns about giving the General Assembly enough time to evaluate and understand the proposal. They talked about introducing a resolution in January 2019 recognizing the work/conclusions of the task force, in order to put the issue on the radar of legislators and to tee up introducing enacting legislation in April.

  - ✓ Sen. Townsend summarized the discussion by saying, for now, the timeline looks like a resolution will be introduced in January to put the issue on the radar of the legislature, hopefully they will have the necessary data from DHSS's analysis in February and March, in order to decide whether a proposed program could be part of this year's state budget.

Public Comment:

Dustyn Thompson asked during the public comment period why the group had decided to endorse an individual mandate as part of the task force recommendations, and why they dropped other ideas like a premium assessment, etc. He expressed concerns over the individual mandate, saying it punishes working people who are "too poor to afford" insurance.

Jill Fredel thanked the task force for their work and expressed that she thought the recommendations had the potential to help a lot of Delawareans who are struggling to afford the current health insurance options available to Delaware consumers.

Jonathan Kirch said that while the recommendations of the task force do not resolve the issue of access to affordable to health care with any permanence, it will help a lot of people, and that a potential program is worth pursuing, even if there is more work to be done.

Yrene Waldren thanked the task force members for their courage to discuss and work on such an important issue.

Senator Townsend thanked all of the members of the task force for their efforts and service.

The meeting was adjourned at 2:39 p.m.

SENATE CONCURRENT RESOLUTION 70 STUDY GROUP

PRELIMINARY RECOMMENDATIONS FOR DISCUSSION

NOVEMBER 28, 2018

State of Delaware

CONTENTS

1
INTRODUCTION

This Study Group was created by Senate Concurrent Resolution 70 (SCR 70) that was introduced on June 20, 2018, by Senator Margaret Rose Henry and subsequently passed on June 28, 2018. SCR 70 noted several descriptive characteristics of Delaware's health insurance landscape including:

- Access to quality, affordable health care is a cornerstone not only of a healthy life, but of a healthy economy and middle-class
- More than 24,000 Delawareans are enrolled in Marketplace plans via ChooseHealthDE.com or Healthcare.gov
- Only one commercial insurer currently sells health plans on Delaware's Marketplace
- Health insurance premiums on an average "Silver" level Marketplace plan in Delaware increased by 25% last year [2018 plan year][1]
- Consumers would benefit from greater competition in the individual insurance marketplace

SCR 70 also resolved that the Governor and Secretary of Health and Social Services may apply for a federal waiver for state innovation under Section 1332 of the Patient Protection and Affordable Care Act (ACA), and if approved, may implement a state plan of innovation that meets the waiver requirements established under federal law and as approved by the United States Secretary of Health and Human Services.

The Co-chairs of the Study Group (i.e., Senator Bryan Townsend and Representative Paul Baumbach) are required to compile a report containing a summary of the Study Group's work regarding the issues assigned to it, including any findings and recommendations, and submit the report to all members of the General Assembly and the Governor no later than January 31, 2019.

The SCR 70 Study Group has met four times so far as follows:

- September 5, 2018

[1] Per Commissioner Navarro, for the 2019 plan year, the Department of Insurance approved a rate filing increase of 3 percent.

- September 27, 2018
- October 10, 2018
- November 7, 2018

The remaining two Study Group meetings are scheduled to be held on:

- November 28, 2018
- December 12, 2018

Through these meetings, there has yet to be a single solution presented within the Study Group that would solve all of our challenges and achieve all of the goals voiced to date that is clearly viable and affordable for the State moving forward. This is not wholly unexpected as the health care sector is a large, important and complex component of Delaware's overall economy. Even after this Study Group concludes its work, continued research and monitoring of the actions of other states across the country is important for us to do, as well as evaluating changes at the federal level that may present new opportunities or begin to close some options that could impact our local healthcare landscape. Moreover, our State has many highly qualified health care resources and entities with connections to larger organizations with regional and national exposure to new ideas. As Co-Chairs of this Study Group, we hope that our partners continue to assess opportunities for improving the affordability and sustainability of quality health care and health insurance for all Delawareans moving forward.

This report provides a summary of the Study Group's activities through the fourth meeting held on November 7, 2018. Additionally, to facilitate continued discussion within the Study Group, this report contains preliminary recommendations that Delaware should further explore, including developing a federal Section 1332 Waiver application to implement a State-sponsored reinsurance program for the purposes of stabilizing the individual health insurance Marketplace, reducing individual health insurance premiums and increasing access to more affordable health insurance for Delawareans.

2
FRAMEWORK AND CONTEXT

The Study Group began with an introduction of all members and a review of the purpose and intent of SCR 70. It was acknowledged that there can be more than one definition of "Medicaid Buy-in", and members of the Study Group expressed excitement to discuss solutions for Delaware's increasing health care costs, but also concern over potential misunderstanding of what the term Medicaid buy-in means. A Study Group member commented that they were not aware of any state operating a Medicaid Buy-in program for the general public regardless of income.

There was initial discussion that Delaware could explore a range of possible actions to stabilize our health insurance market, reduce the cost of health insurance premiums and make it more affordable for more Delawareans to obtain insurance, while taking into consideration the State's limited resources. It was noted that the Study Group should assess the driving principles, such as affordability and accessibility, and then determine which policy levers can be used to achieve those goals.

In the following three meetings, the Study Group invited and received presentations from different experts in the health care arena on topics ranging from:

- A summary of state activity on expanding affordable health insurance options from the National Conference of State Legislators
- An overview of Section 1332 Waivers, a Medicaid "look-a-like" insurance product and an expansion of the State's Title XIX Medicaid program from Mercer Health & Benefits[2] and Oliver Wyman Actuarial Consulting
- A review of the 1332 Waiver process from Delaware's Department of Insurance
- A summary of Maryland's Section 1332 Waiver program from the Director of Policy & Plan Management for Maryland's Health Benefit Exchange
- Provisional estimates of various options for a state-sponsored reinsurance program for the individual Marketplace from Oliver Wyman Actuarial Consulting based on a few key initial data assumptions that had been reviewed by Highmark at the request of the Department of Health and Social Services

[2] Mercer Health & Benefits LLC is the actuarial, financial and policy consultant to Delaware's Medicaid agency

The information shared helped inform the Study Group of different options available to us and supported discussion of initial advantages and disadvantages of different options. It was discussed during the different presentations that it will be important for Delaware to prioritize what challenges the State is trying to address. Different solutions have different effects on affordability and market stability. For example, a full expansion of Title XIX Medicaid could require the State of Delaware to pay tens of millions of dollars for its share of Medicaid program expenses and potentially further de-stabilize the individual market by pulling individuals out of that market and into Medicaid; however, it could also be a more affordable option for many individuals pending potential Medicaid cost-sharing scenarios. As another example, if insurance products can be sold on the Marketplace Exchange with lower premium rates through the use of a reinsurance program, federal tax credits (i.e., premium subsidies) will continue to flow into the State, which can potentially drive positive enrollment momentum, attract more and healthier individuals to buy insurance and further reduce subsequent premiums; however, insurance may still be unaffordable for some higher income groups.

3
OPTIONS PRESENTED TO THE STUDY GROUP

Over the course of our meetings, the Study Group was presented with several different options for fulfilling the intent of SCR 70. A full, detailed financial and operational evaluation of each option was beyond the means of this Study Group; however, summary information either qualitative or quantitative, when available, was received to assist the Study Group in assessing the relative cost and complexity of different options. The options discussed to date are summarized below.

EXPANDING MEDICAID TITLE XIX TO HIGHER INCOMES

States are not prohibited from expanding Medicaid to higher income individuals. In fact, Delaware expanded Medicaid in the mid-1990s to adults with incomes up to 100% of the federal poverty level (FPL) and then expanded Medicaid again to adults up to 138% FPL in 2014 under the optional provision in the ACA. Certain other populations, such as children, pregnant women and individuals needing long-term services and supports have even higher income eligibility pathways.

Since Medicaid is joint federal/state program, Delaware must operate its own program within broad, and sometimes restrictive, federal regulations. In exchange for complying with federal requirements and oversight, Delaware receives federal financial support to off-set a significant share of total Medicaid program expenditures. Presently, Delaware's standard federal support level is approximately 57%, meaning that for each dollar of Medicaid program expenditures, the federal government pays 57 cents and the State pays the remaining 43 cents with general funds.

If Delaware were to pursue expanding Medicaid to individuals and families at higher income levels, the State would have many policy, political and operational decisions to make, which would require a significant amount of time and resources. We could propose to the federal government a customized expansion that would include different benefits, cost sharing and/or eligibility requirements than those in our traditional Medicaid program that would have to be negotiated with the federal government and vetted through a public process. These steps take time, and there is no guarantee that Delaware would be granted any of our requested changes. Expanding Medicaid would likely draw people away from our individual Marketplace, which may further destabilize that segment of our insurance market. Operationalizing a larger Medicaid program would also strain our limited State resources.

As the Study Group heard and discussed, there are various advantages and disadvantages of this option from a policy and market perspective. From a financial perspective, even with the federal government helping to pay for a majority of costs, expanding Medicaid would result in a large new State expenditure. While the State could make certain design decisions, such as requiring higher cost sharing for Medicaid enrollees, rough estimates indicate the State share of a Medicaid expansion could range from approximately $40 million to over $100 million each year depending on many factors and policy decisions that would require much more detailed actuarial analyses.

CREATING A LOWER COST EXCHANGE-BASED INSURANCE PRODUCT

The Study Group acknowledged that health care costs in Delaware are high and that those higher costs raise the level of health insurance premiums for consumers. Within the Exchange, certain consumers have some protection from these higher insurance premiums by virtue of the federal tax credits (i.e., premium subsidies) that are available on a sliding income scale. However, enrollment in Delaware's Exchange-based plans has declined over the last few years for several reasons, including affordability, consequences of the economic recession, and changes in the marketplace. Many of those ~~with most of the~~ individuals leaving the market ~~being~~ include those who do not qualify for federal tax credits.

If a viable insurer was willing and able to offer a lower cost insurance product, premiums would be reduced and insurance could become more affordable. To create a lower cost product, insurers would have to evaluate their provider networks, provider pricing arrangements and overall risk profile among many other considerations in pricing a given risk pool. For example, our Medicaid plans likely pay some providers less (and some more) than what Commercial plans have historically paid. If these lower cost arrangements can be leveraged into lower cost insurance products, affordability could be improved. However, the practicality of some providers accepting lower reimbursement for Commercial plans is uncertain. Some providers may seek higher Medicaid reimbursements levels in return, which would increase the State's Medicaid costs. Based on how the federal tax credits work, the Study Group was shown that if a lower cost plan became the basis for the tax credits (i.e., the second lowest cost Silver plan), consumers might end up paying the same out of pocket premium costs as before for the second lowest cost Silver plan, but perhaps have a narrower set of providers to choose from. If a consumer wanted to retain a traditional plan, it could be more expensive since their tax credits would be based on the new lower cost plan. However, individuals not eligible for tax credits (i.e., those with higher incomes) would benefit from the choice of a lower cost plan.

The Study Group was also presented an option that would require agreement from the federal government through a Section 1332 Waiver to exclude the lower cost plan from the determination of federal tax credits. If this were to happen, consumers would receive the same level of subsidy as they receive currently, could purchase a traditional plan for the same price as

they currently pay, but could purchase a lower cost plan at their option for an even lower price. However, it is unclear whether the federal government would be willing to make and stand-by this type of agreement and potential changes at the federal level could create instability over the long term.

LOWERING INDIVIDUAL HEALTH INSURANCE PREMIUMS THROUGH A SECTION 1332 WAIVER FOR A REINSURANCE PROGRAM

As the Study Group learned, several other states have pursued Section1332 Waivers from the federal government to make changes to their individual health insurance market. The most common strategy employed has been to implement a state-sponsored reinsurance program. A reinsurance program can reduces the cost of health insurance because insurers have some protection against high-cost claims and/or individuals which, and this allows premiums to be lowered. Using reinsurance to lower an insurer's risk is a common practice in different insurance markets across the country. The federal government has established a process for states to follow to obtain a Section 1332 Waiver and while there are several steps to this process, other states have been able to complete the application process in a matter of a few months.

The primary benefit of using a Section 1332 Waiver for a reinsurance program is that when monthly premiums are lowered, the amount of federal tax credit dollars is also reduced. This produces savings to the federal government. With a Section 1332 Waiver, those federal savings can be passed back to Delaware to off-set a large portion of the cost of the state-sponsored reinsurance program.

Similar to the previous option involving a lower cost insurance product, most consumers (i.e., those consumers who are eligible for federal tax credits) would have very little, if any, change in their monthly premium since their portion is tied to their income. However, for individuals not eligible for federal tax credits, reinsurance would result in a lower premium and more affordable coverage. A key difference between reinsurance and reducing premiums through a provider networks option is that providers are not directly impacted by a state-sponsored reinsurance program.

While more robust actuarial modeling would be required, Oliver Wyman Actuarial Consulting presented to the Study Group three different reinsurance scenarios with provisional estimates of the impact of each scenario on premium costs and enrollment levels. The initial estimates assumed a targeted premium reduction of 10%, 15% and 20%, although other choices are also available to us. For example, in the presentation from Maryland regarding their Section 1332 Waiver/reinsurance program, we learned that Maryland targeted a 30% premium reduction. This is indicative of the various policy and design choices we would have to make if Delaware opted to pursue a state-sponsored reinsurance program (e.g., program structure, program administration, impact on insurers, etc.). Based on the estimates provided, a 20% premium reduction in Delaware equates to an approximately $40 million reinsurance program in 2020.

With a Section 1332 Waiver and retention of the federal dollar savings, the estimated cost to the State would only be approximately $5.2 million in 2020 with a potential range of $3.5 million to $7.0 million depending on key factors and pricing assumptions.

Funding to cover the State's net cost to enable the reinsurance program could come from a variety of different sources including, but not limited to: an assessment on insurers, general fund revenues, a State-based individual mandate penalty, a provider assessment or other sources of revenue from the General Assembly.

ENABLING INDIVIDUALS TO BUY INTO THE STATE EMPLOYEE GROUP HEALTH INSURANCE PLAN (GHIP)

Another option that was raised during a Study Group meeting was opening the State employee GHIP to non-State employees (or groups not otherwise eligible to obtain insurance through the GHIP). The impact on the premiums of an influx of new members would need to be modeled as changes to the premiums would likely be required if the risk profile changes materially. Similar to the Medicaid expansion option, if a disproportionate share of individuals with greater health care needs chooses to enroll in the GHIP, premiums could go up significantly and raise the costs to the State by a large amount. Conversely, if lower risk individuals opt for the GHIP, the remaining risk pool in the individual market would be markedly more instable and put pressure on the Exchange-based plans to raise premiums again. At present, estimates of the State's annual share of cost per each active individual in the GHIP is approximately $15,000. This amount is before assessing the impact on the cost of coverage of an influx of new risk. Based on this annual cost (which could vary if individuals were asked to pay more of the cost themselves), for every 1,000 individuals that would take up coverage through the GHIP, the cost to the State would be approximately $15 million. Unlike previous options discussed, there are no federal matching funds to off-set this new Delaware taxpayer expense.

4
PRELIMINARY RECOMMENDATIONS

Taking into consideration the different advantages and disadvantages of the options the Study Group has considered, including the level of complexity, range of costs to the State and time required to actually implement a beneficial change, Secretary Walker from the Department of Health and Social Services is proposing that Delaware further evaluate a Section 1332 Waiver to implement a State-sponsored reinsurance program for our individual health insurance market. The primary goals of this recommendation include:

- Reducing average monthly health insurance premiums by a significant level (e.g., a 20% to 30% reduction)
- Minimizing the level of uncertainty and the actual amount of a new State expenditure
- Maximizing the retention of federal dollars staying in Delaware through the receipt of pass-through savings to off-set State costs
- Working with our insurers on reinsurance pricing assumptions to obtain the best return-on-investment for our State

Should this recommendation be supported by the Study Group, several key program design decisions will be needed so that the corresponding actuarial modeling, Section 1332 Waiver application and stakeholder discussions can be completed in a timely manner. A list of key decision points and, where applicable, a preliminary recommendation is provided below for the Study Group's consideration. It is important to note that these design decisions are not wholly independent of each other. Instead, each decision point affects other decision points and therefore influences the final cost and impact of the reinsurance program on our market.

TYPES OF REINSURANCE PROGRAM STRUCTURES

There are three main structures that a reinsurance program can take. These include 1) condition-based programs that reimburse insurers for the claims of individuals with certain chronic conditions, 2) attachment point-based programs that reimburse insurers for a portion of claims between a specified lower and optional upper threshold and 3) percent of claims-based programs that reimburse insurers for a specified percentage of total annual claims. For each structure, there are several key considerations including:

- Care management/coordination: the level of incentive or disincentive for insurers to continue to focus on member care coordination

- Ease of administration: State versus insurer responsibilities to collect and analyze data and process payments. There is the potential that existing federal resources (e.g., EDGE files) could be used to lessen the State's administrative requirements.
- Impact on insurer pricing process: to what degree can lower insurer risk reduce premium prices, including potentially lower margin levels for insurers?
- Flexibility: in what manner can the State adjust the reinsurance program's parameters to align with intended goals?
- Timing of payments: when do the reinsurance payment calculations occur and is there an interim and final settlement or just a single final settlement?

Recommendation: For relative ease of administration, familiarity level of insurers and State flexibility, we are recommending an **attachment-point reinsurance program**. The specific attachment points would be determined as part of the actuarial modeling in consideration of the program design goals. For illustration purposes, to achieve a 25% average premium reduction, the reinsurance program may need to cover 85% of claims costs that exceed $100,000 in a given year. Through the actuarial modeling process an iterative evaluation of options can be explored, and the option best suited to the State's goals can be selected. Having flexibility to reconsider program design on an annual basis may be important to allow for regular reassessment and improvements.

AVERAGE PREMIUM REDUCTION LEVEL

As noted previously, a decision will need to be made regarding the targeted level of average premium reduction that can be achieved through the reinsurance program. Other states have achieved premium reductions ranging from 7.5% (Oregon) to 30% (Maryland). The higher the premium reduction, the larger the reinsurance program and cost to the State becomes. A greater reduction in premiums increases the affordability level with the goal of increasing enrollment (particularly among relatively healthy individuals), which can then create more positive momentum going forward as premiums benefit from a larger and more diverse risk pool. However, human behavior is difficult to predict even in sophisticated simulation models so thoughtful consideration needs to be given to the level of change required to effectuate positive results.

Recommendation: A general thought is that small changes generate small results. If Delaware pursues a reinsurance strategy, it would behoove the State to pursue a larger change to generate more substantial and beneficial outcomes (i.e., more people having access to affordable health insurance). Therefore, we are recommending the State pursue a reinsurance program that will **reduce average premiums by 20% to 30%**. The specific figure will be dependent on actuarial modeling of different scenarios and sources of available funds, but the

general recommendation is to obtain the largest premium reduction that can be supported in a fiscally appropriate and sustainable manner.

STATE SHARE OF THE COST OF REINSURANCE

A Section 1332 Waiver will enable the State to retain federal dollars that would otherwise revert back to the federal government by virtue of premiums in the individual market being reduced. However, the amount of federal pass-through savings is unlikely to cover the full cost of the new reinsurance program. Per the presentation provided to the Study Group, a preliminary range in State costs to support a 20% reinsurance program is $3.5 million to $7.0 million in 2020. These costs would be higher if the reinsurance program targeted a 30% premium reduction.

Recommendation: We recommend **evaluating the sources of potential State funding relative to the amount of dollars needed to achieve the targeted premium reduction and decisions made based on this objective evaluation**. The overall goal of improving affordability and stability applies not only to our health insurance market and the insurers therein, but also to the State's finances, competitiveness and attractiveness to businesses and individuals to visit or live in our state.

FUNDING OPTIONS FOR STATE SHARE OF REINSURANCE

Commensurate with the amount of the State's share required to support the reinsurance program, a source of State funding will be needed. There are two strategies to consider in identifying a source of State funds: a one-time source of funding or a longer-term source of funding. As we heard from the representative from Maryland's program, Maryland opted to apply a state assessment fee on insurers in lieu of the federal health insurer tax that had been suspended for a year. This will be a one-time state assessment on Maryland's carriers, yet it is intended to provide state funding for their reinsurance program for up to three years (which the Maryland representative indicated would give the state time to develop a longer-term solution to their health care cost challenges).

If the federal government again suspends the federal health insurer tax, Delaware may be able to pursue a similar strategy as Maryland; but as a state, we can consider an assessment on insurers regardless of what the federal government does or does not do. Implementing an annual assessment on certain health care providers can also be source of ongoing funds to pay for the reinsurance program. The General Assembly has the choice to appropriate funds from elsewhere in the State's budget at their discretion or consider taxes/fees on things such as hotels and alcohol. We also learned that approximately $8.1 million in tax penalties attributed to the ACA's individual mandate was collected from Delaware residents by the federal government in 2016. The ACA's penalty for not having Minimum Essential Coverage is now $0, so much like the suspension of the federal health insurer tax, Delaware could explore a state-mandate and corresponding penalty to fund the State's share of the reinsurance program.

Recommendation: With the suspension of the federal individual mandate penalty and in consideration of the preliminary estimates of the cost of a reinsurance program, we recommend that the State **develop a state-based individual mandate with a corresponding penalty structure** intended to raise enough funds to cover some or all of the State's expected share of the cost of the reinsurance program. To the extent the State needs less funds than what the federal government collected in 2016, this should be factored into the design of the state-based individual mandate and corresponding penalty structure. If the General Assembly appropriates funds in support of this initiative, the State-based individual mandate penalty amounts could potentially be further reduced for other healthcare related issues. The study group strongly recommends that additional strategies to improve health outcomes and reduce health disease burden remain a focus beyond the scope of SCR70.

CONCLUSION

Addressing the challenges of high health care costs and the related cost of insurance is not unique to Delaware. The fact that several other states have already obtained approval of a Section 1332 Waiver for a reinsurance program, including one state developing a state-based individual mandate to fund its program (New Jersey), and more states are looking at a Section 1332 Waiver as a way to reduce health insurance premiums, indicates that there is viability in this option. We need to determine what is best for our state. The work of the SCR 70 Study Group is contributing to that discussion. The preliminary recommendations in this report are intended to spur further discussion by the Study Group. The final report that we are required to submit will reflect the collective input from the entire Study Group. More work remains to make Delawareans happier, healthier and more productive.