Health Care Coverage Studies

Under Am. Sub. H.B. 49 of the 132nd General Assembly, JMOC was asked to review the feasibility of implementing a plan that is similar to the Healthy Indiana Plan (HIP), a Medicaid Section 1115 waiver and a high risk insurance pool in Ohio. The first section of this paper will look at Ohio's experience with a Healthy Indiana-like waiver and review what provisions other states are seeking under Section 1115 for their healthy adult populations. The second section will look at high risk pools and reinsurance, the authority available under Section 1332, and how other states are using this new authority to support high risk pools and reinsurance programs.

Section 1115 Medicaid Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and welfare programs, which include certain Medicaid requirements. For many years, 1115 waivers have been used in the Medicaid program to waive certain federal requirements to provide states with an avenue to test and implement new approaches, including coverage expansions. Since the enactment of the Affordable Care Act and the Supreme Court decision that the expansion of Medicaid to low income childless adults was optional for states, these waivers have been used to narrow coverage to expansion adults. Section 1115 waivers are approved at the discretion of the Secretary of Health and Human Services through negotiations between a state and the Centers for Medicare and Medicaid Services (CMS). Section 1115 waivers are generally approved for five year periods and must be renewed.

Quick Review: Healthy Ohio

The budget for FY 2016-2017 called on the Department of Medicaid to submit an 1115 waiver. This waiver was known as Healthy Ohio. Modeled closely after the Healthy Indiana Plan, the waiver was written by current CMS Administrator, Seema Verma; however, the populations affected by Ohio's waiver were much broader than those approved in Indiana. It is important to note that the program design was largely specified in state statute, which limited the ability of the state to respond to changes requested by CMS. The Healthy Ohio waiver was ultimately denied by CMS in September 2016.

What Our Neighbors Are Doing

Indiana

Ohio is familiar with the Healthy Indiana Plan (HIP), as it based its Healthy Ohio Plan off of this model a few years ago. Indiana used this plan to expand Medicaid coverage to childless adults. CMS recently approved a renewal of this waiver for three years with new provisions included. CMS approval

maintained the core of the HIP program but incorporates new features like expansion of Gateway to Work initiative. This expansion will require community engagement activities for non-exempt HIP members. Like coverage through the Health Exchange, HIP requires premium contributions of 2% of income, ranging from $1 to $20 per month. Many states are now requesting requirements similar to those approved for Indiana. Within HIP, there are exemptions for those who are homeless, students, in active substance use disorder treatment, medically frail, over 59, or a parent or caretaker of school age children. The individuals who are required to maintain these hours can achieve them in several ways. For example, those participating may use a combination of work, community service, job training, homeschooling, or caregiving. The most recently renewed waiver includes a substance use disorder (SUD) component that will add new services and gain federal financial participation for services provided in an institution for mental disease (IMD). In other recent changes, Indiana has utilized their managed care entities to offer monetary bonuses, or gift cards, for participating in four key areas:

- Tobacco cessation
- SUD treatment
- Chronic disease management
- Employment-related incentives

These are outcome-based rewards that are capped at $300 per member annually.

Kentucky

In January 2018, the Kentucky Health waiver became the first state with an approved waiver that contained work requirements as a condition of eligibility. While this paved the way for other states to begin requesting similar requirements, Kentucky's waiver, which was to take effect July 1, was recently blocked by a federal court ruling. Another major component of the demonstration is an expansion of SUD treatment for all Medicaid enrollees. Much like Ohio, Kentucky is facing the same crisis with drug and opiate addiction. Kentucky Health is using this waiver to expand SUD services included services provided in an IMD. Other notable provisions of the waiver include:

- Monthly premiums of at least a $1.00 but not more than 5% of income;
- Coverage lockout for adults with incomes over 100% FPL who fail to pay premiums;
- State-funded account to enable enrollees to manage deductibles;
- Incentive programs that allow members to earn dollars to purchase additional benefits (vision, dental) and receive limited reimbursement for gym memberships;
- Retroactive eligibility is eliminated for most adults; and
- Non-emergent medical transportation (NEMT) services is waived for most expansion adults.

Michigan

In 2013, Michigan legislators approved a unique model for their Medicaid expansion population. The Healthy Michigan program introduces reforms including premiums and higher cost sharing for those with incomes above 100% FPL, creation of health accounts to track expenses and cost-sharing contributions, and financial incentives for completing health risk assessments and engaging healthy behaviors that have since been incorporated into other state waivers. In the most recent HRA Report,

86% of beneficiaries who had completed the health risk assessment agreed to address risk behaviors such as tobacco use, drug abuse, nutrition, and exercise. The Healthy Michigan Plan also requires beneficiaries to contact a primary care provider within 60 days of choosing a health plan. Michigan has recently enacted legislation that would require the state to implement work requirements by 2020.

The chart that follows provides highlights of the states seeking Section 1115 waivers to tailor coverage for their able-bodied adult populations and the features being sought.

Proposed and/or Approved Features	**Indiana**	**Kentucky**	**Michigan**	**Arkansas**	**Arizona**	**Iowa**	**Wisconsin**	**Maine**
Premiums	√	√	√	√	√	√	√	√
Cost Sharing	√	√	√	√	√	√	√	√
Healthy Behaviors Incentive	√	√	√	√	√	√	√	
NEMT Waiver	√	√			√	√		
Work-Related Provision	√	√	**In Dev**	√	√		√	√
HSA-Like Account	√	√	√		√			
Retroactive Coverage Waiver	√	√		√		√		√

Ohio Work Requirement Waiver

In the most recent budget (HB 49), Ohio was required to submit a Medicaid waiver to CMS that included work requirements. The Ohio Department of Medicaid has posted this waiver on their website and accepted public comment from February 16th to March 18th.

For administrative simplicity, the waiver aligns work requirements and exemptions in the SNAP program for able bodied adults without dependents. Recipients must work or participate in a community engagement activity for a minimum of 20 hours per week. This applies as a condition of eligibility to adults enrolling in Medicaid through expansion. However, much like other states, Ohio's waiver has many exemptions for the work requirement. ODM anticipates that roughly 36,000 people currently enrolled in this population would be affected. Those who fail to meet the work requirement will have their Medicaid eligibility terminated.

The Department submitted their waiver at the end of April 2018 and is still awaiting approval. Currently, CMS has only given a firm no to the Kansas request for lifetime limits and Arkansas' attempt to drop eligibility from 138% FPL to 100% FPL.

High Risk Pool and Reinsurance Options Under Section 1332

With the availability of waivers under Section 1332 of the Affordable Care Act (ACA), many states are considering reinsurance and/or high risk pools as a strategy to stabilize premium cost growth in their individual health insurance markets to make coverage more affordable to more people.

High Risk Pools

High risk pools and reinsurance are not new concepts. High risk insurance pools were created to provide access to coverage for individuals with pre-existing and/or certain high cost health conditions who had been denied coverage in the individual insurance market. The first high risk pools began in Connecticut and Minnesota in the 1970s. High risk pools operate like insurance companies with their own benefit plan, rates, and networks.

Under the high risk insurance pool option, individuals with expensive health conditions would be placed together in the same risk group. Because of their underlying health risk, the cost of coverage is much higher in the high risk pool. To make coverage affordable, states provided additional funds to supplement premium revenue in the high risk pool.

By the end of 2011, 35 states operated a high risk pool with a combined enrollment of just over 226,000 people, which was well short of the eligible population.[1] The cost of claims and administration totaled about $2.6 billion in 2011 with enrollee premiums covering about half of that amount.[2] States used a variety of sources to cover the remaining amount including tobacco settlement funds, hospital taxes, and assessments on insurance premiums.

In 2005, Ohio considered but did not implement a high risk pool. The analysis done at the time[3] found that after five years the state's pool would have about 13,000 people enrolled. The report noted that the most likely enrollees would be individuals between the ages of 50 and 64 and those who are self-employed. With premiums set at 150% of the standard market rate (which would not be allowable under current community rating law), the state would need to supplement premiums by about $144 million per year. While this information is dated, it provides insight into the magnitude of what this type of program would cost to implement in the state.

With the implementation of the ACA, insurance carriers were no longer allowed to reject applicants for individual health insurance due to their health status, which eliminated the need for high-risk pools to cover the uninsurable. The ACA created a temporary high risk insurance pool to provide coverage to individuals with pre-existing medical conditions who had been denied coverage. This program was intended to preserve the individual insurance market until implementation of the health exchange and

[1] Karen Pollitz, "High Risk Pools for Uninsurable Individuals," Kaiser Health, February 2017.
[2] Liz Leif and Cecil Bykerk, "The Next Generation High Risk Pool: Can this be a Lifesaver for the Individual Market?" The Actuary Magazine, July 2017.
[3] Leif Associates Inc., State of Ohio High Risk Pool Feasibility Study, June 2005.

premium assistance in 2014; however, the program ran low on funding and was closed to new enrollment in March 2013.

Reinsurance

Reinsurance, also known as stop-loss coverage, is basically insurance for insurers. Reinsurance is commonly used by employers with self-insured plans to protect against very high claims. Unlike in a high risk pool where members are segregated, in a reinsurance program insurers are reimbursed for a proportion of claims for a member once the member's claims exceed a predetermined threshold (also known as an attachment point) up to a cap. Reinsurance programs serve only a financial function and do not duplicate plan functions like benefit design and network management, which lowers administrative costs. Reinsurance programs are invisible to plan members.

The ACA created a transitional reinsurance program that ran from 2014 to 2016 to compensate marketplace insurers for taking on high-risk beneficiaries. The law set aside a total of $20 billion, funded largely by a tax on insurers, for the years 2014 through 2016. In 2014, the $10 billion collected from health insurers was used to reimburse individual insurers for 80 percent of a member's health claims between $45,000 and $250,000. According to an analysis by the American Academy of Actuaries, this program reduced premiums in 2014 by 10 to 14 percent.[4] The amounts levied for the reinsurance program decreased to $6 billion for 2015 and to $4 billion for 2016, reducing the program's impact on premiums.

Section 1332: A New Option for States in 2017

Section 1332 allows states to seek authority from the Secretaries of Health and Human Services and the Treasury to waive certain requirements of the Affordable Care Act. Under this authority that became available to states in January 2017, states can seek to:

- Modify or eliminate the tax penalties on individuals who fail to maintain health coverage;
- Modify or eliminate the penalties on large employers who fail to offer affordable coverage to their full time employees;
- Modify the covered benefits and subsidies including reallocating premium tax credits and cost sharing reductions; or
- Replace state marketplaces or supplant the plan certification process with alternative ways to provide health plan choice, determine eligibility for subsidies, and enroll consumers in plans.

To receive federal approval, states seeking 1332 waivers must meet certain guardrails. These guardrails[5] include:

- Coverage must be at least as comprehensive as coverage without the waiver;
- Coverage and cost sharing protections must be at least as affordable as without the waiver;
- Coverage must be provided to at least as many residents as without the waiver; and

[4] "Drivers of 2015 Health Insurance Premium Changes," American Academy of Actuaries Issue Brief, June 2014.
[5] 42 U.S. Code § 18052

- The waiver must not increase the federal deficit.

A key benefit to states through the waiver is the ability to use the premium tax credits and cost sharing subsidies that the federal government would have paid through higher premiums to reduce exposure to high cost members, lowering premium costs for all.

To assist states, CMS has created a specific checklist for states to follow when seeking a 1332 waiver to create a reinsurance program or high risk pool. This checklist can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf.

Review of State 1332 Waivers to Stabilize the Individual Marketplace and Reduce Premiums

According to NCSL, 35 states have considered or passed legislation to initiate the 1332 waiver application to date.[6] Proposals to reduce premium growth using reinsurance have been the most commonly requested and approved authority sought by states. To date, three states, Alaska, Minnesota, and Oregon have received approval to operate reinsurance programs under Section 1332. Two other states, Maine and Wisconsin have submitted reinsurance proposals and are awaiting action. The chart that follows highlights key elements of these reinsurance proposals as well as state proposals in development and proposals that have been withdrawn.

[6] http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx

State	Approval Status	Description	Source of state funds	Total Annual Program Cost	State Annual Program Cost	Start Date	Impact on Premiums	Impact on Enrollment	Other Information	Sources
Alaska	Approved	The Alaska Reinsurance Program covers claims in the individual market for individuals with one or more of 33 identified high cost conditions to help stabilize premiums. Insurers offering individual health care insurance plans (except grandfathered or transitional plans) are required to cede claims for consumers with specified conditions beginning January 1, 2017.	Premium taxes - redirected from state's general fund	$60M	$11M	CY 2018 (AK ran state funded program in 2017)	Premium reduction of 20% in individual market	Enrollment increase of 1,650	The increased enrollment is expected to come from Alaskans above 400% FPL who are younger and healthier compared to the current individual market.	https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html
Minnesota	Approved	The goal of Minnesota's reinsurance program, known as the Minnesota Premium Security Plan (MPSP) is to reduce premiums in the individual market. The MPSP is an attachment-point reinsurance model similar to the temporary federal reinsurance program that was in place from 2014 through 2016. The parameters for 2018, which are specified in state law, set an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000. The state notes that it has an above-national-average percentage of individual market enrollees who do not qualify for federal premium tax credits. The reinsurance program will allow more people to afford coverage but also indirectly allow for lower rates by attracting a healthier risk pool.	General fund	$271M	$71M	CY 2018	Premium reduction of 25% in FY 2018	Enrollment increase by 20,000 to 30,000 people		https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf
Oregon	Approved	The Oregon Reinsurance Program (ORP) will bring certainty and stability to Oregon's individual health insurance market by reimbursing insurers for high cost claims to spread risk across the broader Oregon health insurance market, thereby lowering premiums. The program is also expected to encourage insurers to maintain and possibly expand geographic coverage areas. In 2018, the ORP will reimburse 50 percent of claims between a proposed attachment point of $95,000 and a cap of $1 million. Reinsurance payments will be made at the close of the plan year.	0.3% assessment in 2018 on health insurance premiums, to 0.9% in 2019, and 1.5% in 2020; plus one time fund transfers from two expiring state funds	$90M	$36M	CY 2018	Premium reduction of 7.5% in 2018; 7.0% in 2019	Enrollment increase of 1.7% in 2018; 1.6% in 2019; and 1.4% per year after		Sources: CMS: waiver application, approval letter, pass through funding letter; Oregon Department of Consumer and Business Services: https://dfr.oregon.gov/business/insurance-industry/health-ins-regulation/Pages/reinsurance-main.aspx
Wisconsin	Submitted	Under the Wisconsin Healthcare Stability Plan, qualified health plans will be reimbursed for a percentage of an enrollee's claims between an attachment point and a cap. For 2019, QHPs will be reimbursed for enrollee claims above $50,000 up to a cap of $250,000. By law, the reinsurance rate must be between 50% and 80%. The reinsurance rate will be set at 50% for 2019.	General Fund	$200M	$34M	CY 2019	Premium reduction of 10.6%	Enrollment increase of 0.8%		https://oci.wi.gov/Documents/Regulation/WI%201332%20Waiver%20Application%20and%20All%20Attachments.pdf
Maine	Submitted	Maine's waiver would restart the state's reinsurance program known as Maine Guaranteed Access Reinsurance Association (MGARA) that was suspended in 2014. MGARA makes payments to an insurer when an eligible claimant's accumulated claims incurred during the calendar year exceed an initial attachment point. The proposed initial attachment point for the program in 2019 is $47,000. The program will pays 90% of an enrollee's claims between $47,000 and $77,000 and will pay 100% for claims above $77,000 in a year. Under the MGARA program, insurers must cede 90% of a premium for any covered member with one of eight currently designated medical conditions (certain cancers, COPD, congestive heart failure, HIV/AIDS, renal failure, and rheumatoid arthritis).	$4 PMPM assessment on commercial health plans	$93M	$22.6M in assessments and $37M in ceded premiums	CY 2019	Premium reduction of 9%	Enrollment increase of 1.1% in 2019, 0.9% in 2020, and 0.3% to 0.8% for the remaining 8 yrs. of waiver	Estimates assumed individuals with incomes between 100 and 138% of FPL will move to Medicaid, which was expected to start in November 2017.	https://www.maine.gov/pfr/insurance/mgara/Complete%20Maine%201332%20Waiver%20Application%20and%20Exhibits.pdf

State	Approval Status	Description	Source of state funds	Total Annual Program Cost	State Annual Program Cost	Start Date	Impact on Premiums	Impact on Enrollment	Other Information	Sources
Maryland	In Development	In 2019, insurance carriers who provide individual health benefit plans will be reimbursed for 80% of an enrollee's claims between an attachment point (not yet set) and a cap of $250,000. The reinsurance program applies to plans sold on or off the exchange.	2.75% assessment on health plans, which is equivalent to the federal Health Insurance Fee (HIF) that was suspended by Congress for 2019.	$462M	$365M	CY 2019	Premium reduction of 30% in CY 2019	Increase of 5.8% in 2019		https://www.marylandhbe.com/wp-content/uploads/2018/06/Final_Maryland%201332%20State%20Innovation%20Waiver%20to%20Establish%20a%20State%20Reinsurance%20Program%20-
New Hampshire	In Development	New Hampshire's reinsurance plan would reimburse insurers for 40% of an enrollee's claims incurred between an attachment point of $45,000 and a cap of $250,000.	Assessment on health plans	$44.9M	$31.8M	CY 2018	Premium reduction of 7.2% to 7.4%		New enrollment will come from those over 400% FPL.	https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf
New Jersey	In Development	New Jersey recently enacted an individual mandate, which mirrors the former federal requirement, and includes an annual penalty of 2.5 percent of a household's income or a per-person charge — whichever is higher. The goals of the reinsurance program are to stabilize the individual market and make coverage more affordable. The program will cover a proposed 60% of claims incurred between an attachment point of $40,000 and a cap of $215,000.	General Fund and shared responsibility tax (from state individual mandate)	$323.7M	$105.8M	CY 2019	Premium reduction of 15%	Enrollment increase of 2.7% in 2019; 2.6% in 2020; 2.6% in 2021		https://www.state.nj.us/dobi/division_insurance/section1332/180627updateddraftapplication.pdf
Iowa	Withdrawn	Through the Iowa Stopgap Measure 1332, Iowa proposed to abolish its health insurance exchange, offer a single standard silver plan with standard cost sharing, offer flat per member premium credits based on age and income, and create a reinsurance program. The program would reallocate not only federal premium tax credits but also cost sharing credits available to participants with incomes below 200% FPL to reduce the cost of coverage for all in the individual market. Under the reinsurance program, plans would be reimbursed for 85% of claims for an enrollee between $100,000 and $3,000,000.		$422M	$0	CY 2018	Total premium reduction of 42%	Prevent 18,000 to 22,000 people from leaving the individual market	The state withdrew its 1332 application in October 2017 after it became clear that it would not receive federal approval in advance of the open enrollment period for 2018.	https://iid.iowa.gov/documents/state-of-iowa-1332-waiver-submission
Oklahoma	Withdrawn	As part of a coordinated 1332/1115 waiver application, the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP) would change current eligibility for coverage subsidies from 100-400% of FPL to 0-300% and standardize subsidies based on age and income; create two benefit options: a standard plan that covers 80% of medical costs and a high-deductible plan that covers less but can be used with a health savings account; scale back essential health benefits; allow insurers to charge older enrollees five times as much as younger enrollees (current limit is three); and implement a reinsurance program that would reimburse insurers 80% of an enrollee's claims above $15,000 and up to $400,000.	State assessment on insurers	$325M	$16M	CY 2018	Premium reduction of 34.1%	Enrollment increase of 14.7%	The state withdrew its 1332 application in October 2017 after it became clear that it would not receive federal approval in advance of the open enrollment period for 2018.	https://www.ok.gov/health2/documents/1332%20State%20Innovation%20Waiver%20Final.pdf

Conclusion

Ohio is currently awaiting a decision from CMS on its 1115 waiver to implement work requirements. Aside from the provisions outlined in this paper, it is unclear what additional flexibilities CMS may be willing to approve under Section 1332 or combined Sections 1115/1332.

It appears likely that CMS would approve a reinsurance program in Ohio, but it is important to note that all of the reinsurance programs approved to date require the use of state-generated funds. Ohio policymakers will have to weigh the potential reductions in premiums and gains in enrollment against other uses for state funds.