Health Insurance Reforms and Affordability

State Policy Seminar: Levers to Address Health Costs

June 6, 2022

Trivia!

Which health insurance payer covers the largest number of Americans?

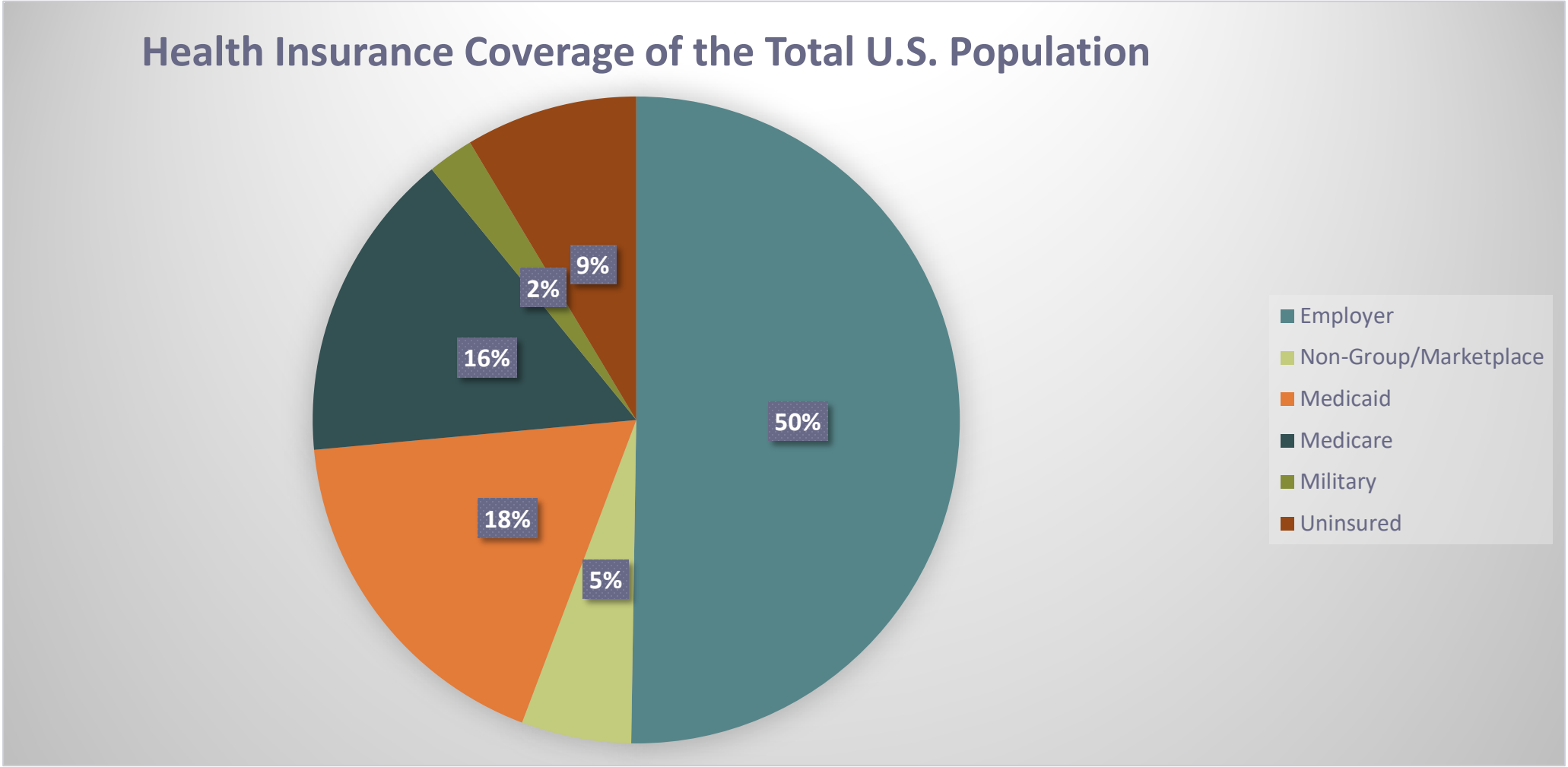
A. Medicaid

B. Medicare

C. Employer-Sponsored

D. Marketplace Coverage

Where do people get their health insurance?



Source: Kaiser Family Foundation, 2020

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

Plan for Today's Session

- States' role regulating coverage
- Policy options to insure affordability of insurance coverage
  - Joel Ario, Manatt
- Q&A / Discussion

Private Insurance: Legislative Levers

Cost Growth Benchmarking

Price Transparency

Marketplace Stabilization

Surprise Billing

Public Option

Rate Review

State vs. Federal Role: Private Insurance Regulation

States Can Regulate

- Marketplace plans (individual and small group)
- Marketplace alternatives (e.g., short-term, limited-duration plans, association health plans, health care sharing ministries)
- Fully-Insured Employer-Sponsored Plans
  - Employer pays a premium to a health insurance company
  - Approx. 40% of covered workers

States Can't Regulate (Preempted by ERISA)

- Self-Insured/Self-Funded Employer-Sponsored Plans
  - Employer pays most of the health care costs of employees as the claims occur
  - Approx. 60% of covered workers

National Conference of State Legislatures
State Policy Seminar: Levers to Address Health Costs

June 6, 2022

Joel Ario, Managing Director

Manatt Health

Agenda

- Cost Benchmarking
- Transparency
- Marketplace Stability
- No Surprises Act
- Public Option
- Rate Review

Cost Benchmarking

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Why States are Pursuing Cost Containment

States are taking a lead role on health care cost containment for multiple reasons.

- **Unsustainable cost growth** – health care cost growth impacts states in multiple ways, including crowding out other spending in state budgets
- **Consumer affordability –** consumers bear the brunt of cost growth in unaffordable premiums and/or large deductibles and other cost sharing
- **Lack of federal progress** – the federal government has helped states expand coverage but has not been as helpful a partner in containing costs
- **Laboratories of democracy** – states have flexibility to experiment with different approaches to cost containment

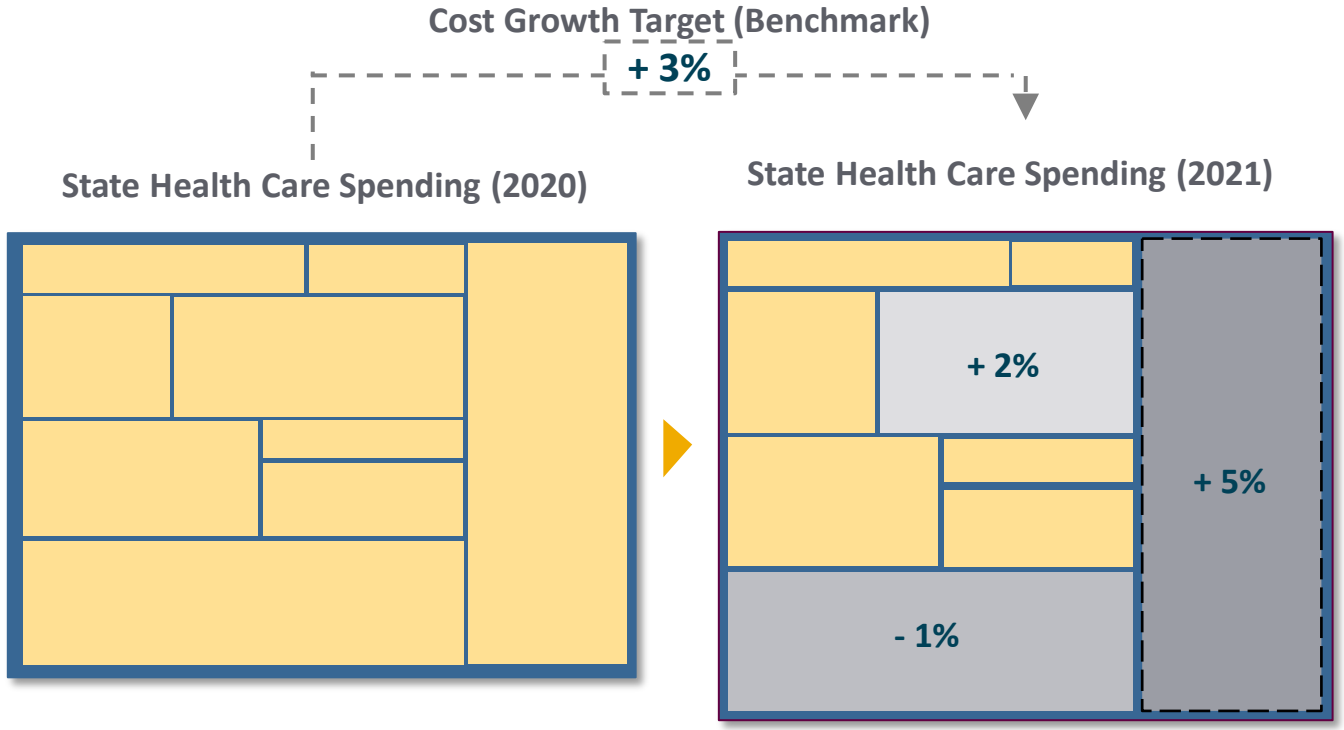
Health Care Cost Growth Benchmarking

Health care cost growth benchmarking programs are data-driven, transparency-focused cost-containment initiatives that measure state health care spending growth in relation to established targets.

How Does a Benchmarking Program Work?

- **Data Collection and Measurement.** States collect data directly from public and private payers, monitoring health care spending across all lines of business, to measure total health care spend.
- **Assessment Against the Benchmark.** Total health spend is then assessed against an established cost growth target.
- **Accountability.** Payers and providers that exceed targets may be subject to public inquiry or penalty.

State Cost Growth Benchmarking Programs and Data



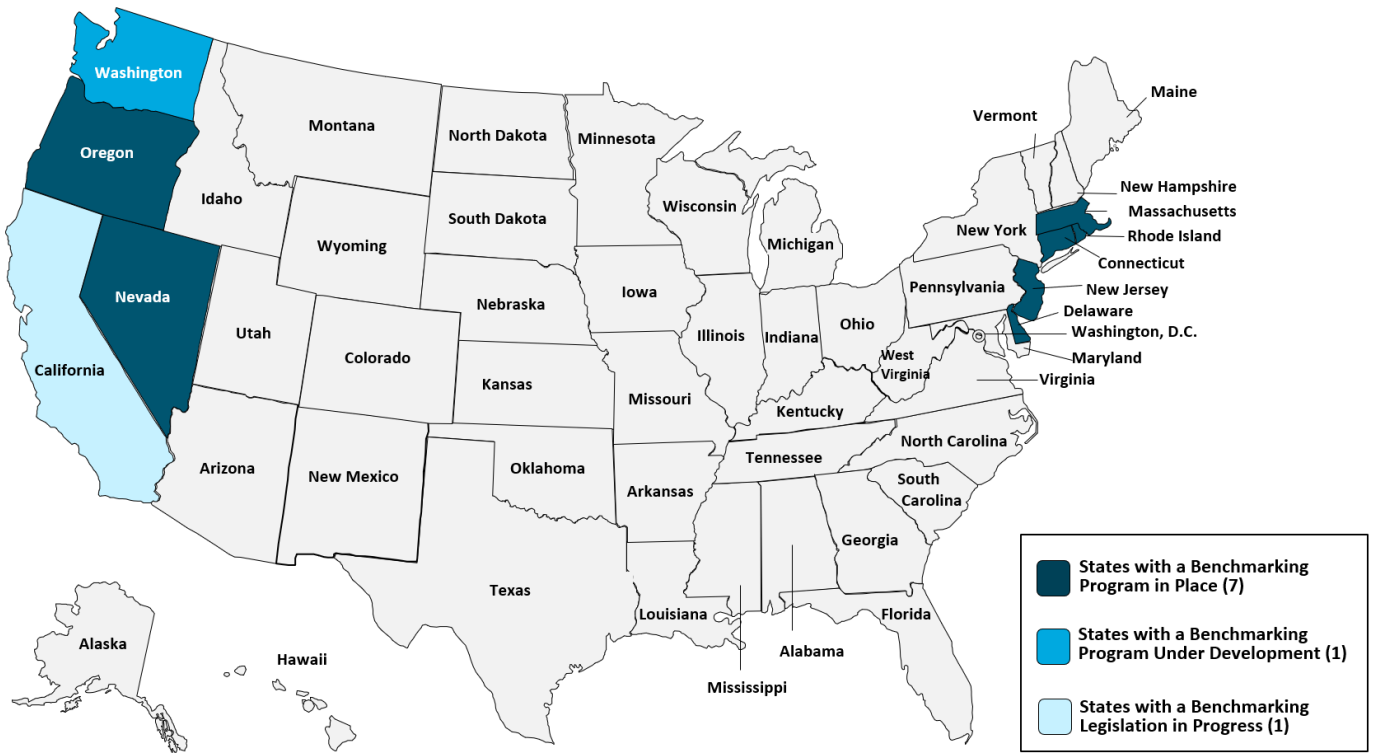
More information available on Manatt's Cost Containment Update

The State of Play on Cost Growth Benchmarking Programs

To date, eight states have established cost growth benchmarking programs aimed at enhancing health system transparency and cost growth accountability, with several other states following suit with pending legislation or similar cost-containment efforts.

Five new states have joined the original three (Massachusetts, Rhode Island and Delaware) in advancing benchmarking programs since 2021:

- ***Nevada*** and ***New Jersey*** established their cost growth targets in late 2021
- ***Connecticut*** established its cost growth and primary care targets and began measuring total health care spending
- ***Oregon*** hosted its first annual health care cost trends hearing in April 2022
- ***Washington's*** Health Care Cost Transparency Board continues to meet and advance program recommendations
- ***California*** is seriously considering benchmarking legislation this year

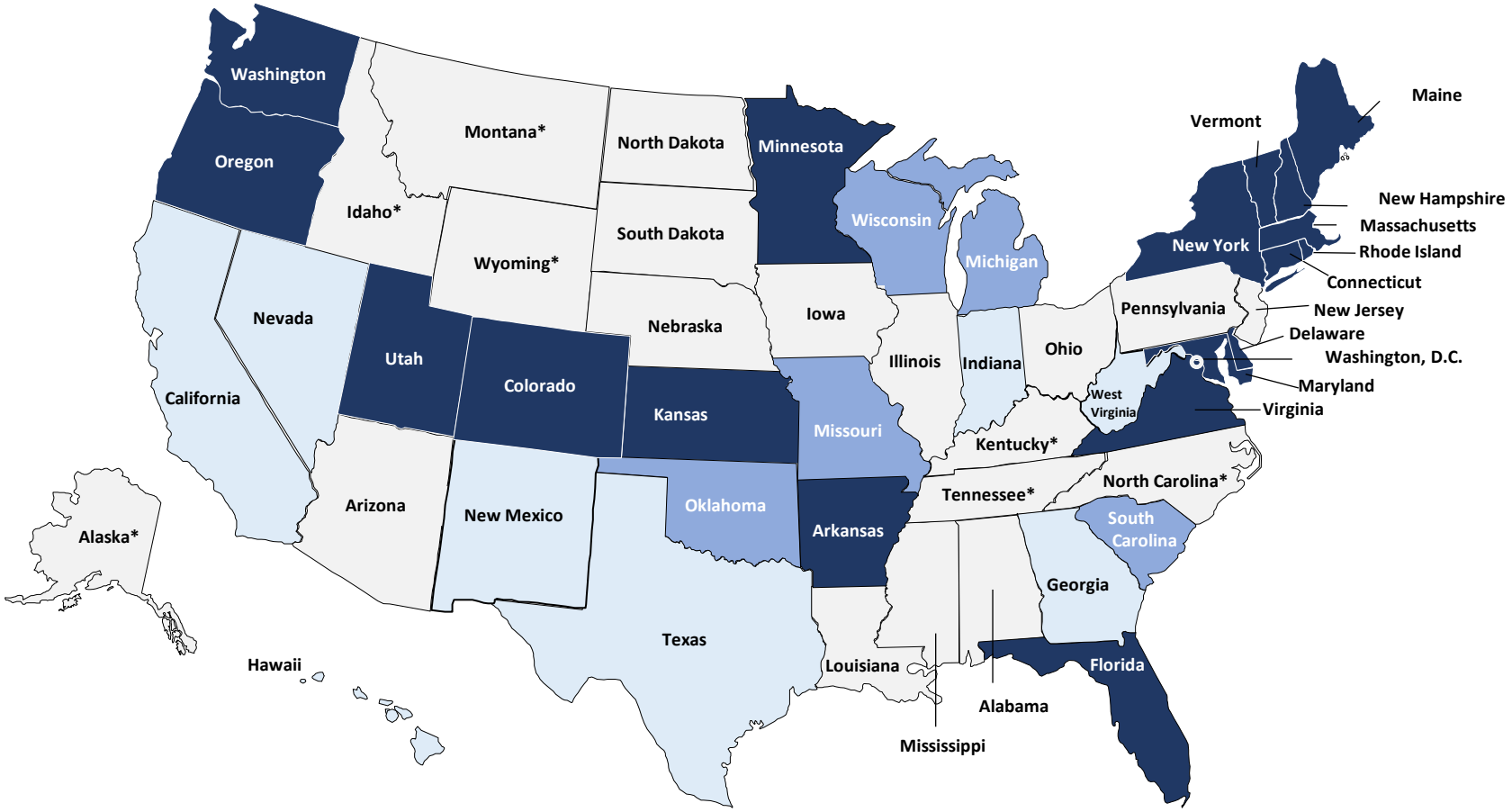


Transparency

Federal and State Transparency Initiatives Will Fuel Cost Containment

- The Biden Administration has built on Trump Administration regulations that require detailed disclosures by hospitals and insurers about their actual pricing policies
  - Hospital rule took effect on 1/1/21 and requires user friendly disclosures on shoppable services and machine-readable files on all hospital pricing for each payer
  - Insurer rule will take effect on 7/1/22 and require disclosure of discounted rates paid to each hospital with real time disclosure to consumers of their cost sharing obligations
- At least 18 states have established All Payer Claims Databases (APCDs) that provide detailed information on claims costs
  - APCDs are increasingly considered a cornerstone resource for state health data organizations (HDOs)
  - State HDOs may use APCDs in combination with other data resources (e.g., health information exchange data; hospital discharge databases, hospital financial reporting, cost growth benchmarking) to develop more contextualized or actionable reporting

The APCD State of Play



At least 18 states have fully-operational APCDs, with many other states actively developing or seriously considering establishment

- States with an existing APCD (18 states)
- States implementing an APCD (8 states)
- States with an existing MPCD / voluntary reporting (5 states)
- * States with strong interest (7 states)
- States with no activity (12 states and DC)

Source: Map courtesy of the APCD Council, a program of NAHDO and UNH. APCD Interactive State Report Map. July 2021.

What Types of Information Can APCDs Provide?

APCDs offer policymakers, regulators, and researchers a unique tool to better understand how our systems of health are performing for our populations.

APCDs have been - or have the potential to be - used to:

- **Create a baseline understanding of state residents'** coverage, service utilization, costs, and health, and how those measures have changed over time.
- **Support regulatory oversight of payers and providers,** from compliance with network adequacy requirements to projections for how mergers or expansions may impact consumer costs to supporting system transparency.
- **Identify health system failures** - including coverage disruptions, excessive cost growth or provider price variation, irregular billing practices, and health disparities - and inform the design of strategies to address them.
- **Facilitate an understanding of "whole person" needs** through their ability to internally link member data (e.g., Medicare/Medicaid dual-eligible analyses) or bridge health and social/public health data sources (e.g., COVID-19 long-hauler analyses, opioid impact analyses).

APCD data can be segmented to support numerous use cases, including:

- Member characteristics
- Plan/coverage types
- Provider types
- Service category

Marketplace Stability

ACA Marketplaces at Record Enrollment with Clouds on Horizon

- ACA Marketplaces have matured into a stable source of health coverage for nearly 15 million people not covered by employer plans (160M), Medicaid (80M), or Medicare (60M)
  - 17 states plus DC run their own State-Based Exchanges (SBMs)
  - Remaining 33 states rely on Healthcare.gov
- Enhanced federal subsidies have made coverage more affordable for past two years, but these subsidies are at risk of not being renewed
  - 7 states supplement federal subsidies, but only at the margins
- Early signals suggest double-digit rate increase requests in many states for 2023 with medical trend/inflation ending three years of relatively flat rates
- End of Public Health Emergency (PHE) will knock up to 15 million people off Medicaid roles, creating new challenges and new opportunities for ACA Marketplaces
- State investments in consumer outreach and easy enrollment programs generally pay off in healthier risk pools and lower premiums

No Surprises Act

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The No Surprises Act (NSA) Has Three Major Components

Surprise Billing Prohibition

- Prohibits balance billing for
  - Emergency Services at OON facilities
  - Non-Emergency Services provided by OON physicians at network facilities
- "Emergency Services" include "post-stabilization" services
- Federal process to determine patient cost share
- Federal Independent Dispute Resolution (IDR) Process to determine OON Rate when state law does not apply

Provider Obligations

- Consumer notices on website, posted and provided to patient
  - Complexities relate to placement, translations, sharing of notice obligations
- Must determine insured status and whether patient will submit to insurance
- Good Faith Estimates (GFEs)
- Notice, estimate and consent in certain cases to balance bill
- Continuity of care
- Patient-provider dispute resolution

Payor Obligations

- Prompt payment requirement (within 30 days for clean claims)
- Initial payment = amount payor reasonably intends to be payment in full
- Continuity of coverage (90 days after termination of provider contract)
- Deductibles and MOOPs on ID cards
- Advanced EOB (deferred)
- Price comparison tool (deferred)
- Regularly update provider directories

Many States Have Taken an Active Role in NSA Implementation

State Enforcement	Cooperative Agreement	Federal Enforcement

Specified Law in Texas

- **Texas will continue to enforce its 2019 law** on balance billing and dispute resolution
- **Texas Medical Board and Texas Board of Nursing** for provider enforcement
- **Texas Health and Human Services Commission** will regulate healthcare facilities
- **Texas Dept. of Insurance** for health plans

Cooperative Enforcement in Pennsylvania

- **PA Insurance Dept (PID)** is lead state agency to coordinate state and federal enforcement
- **PID offers web-based complaint handling** process to help consumers access state and federal assistance on case-by-case basis
- **Other state agencies include:** Depts of Health (facilities and ambulance), State (provider licensure), and Drug and Alcohol Programs (some provider oversight)
- **Coordination with federal gov't** for providers/facilities, self-funded plans, FEHBP

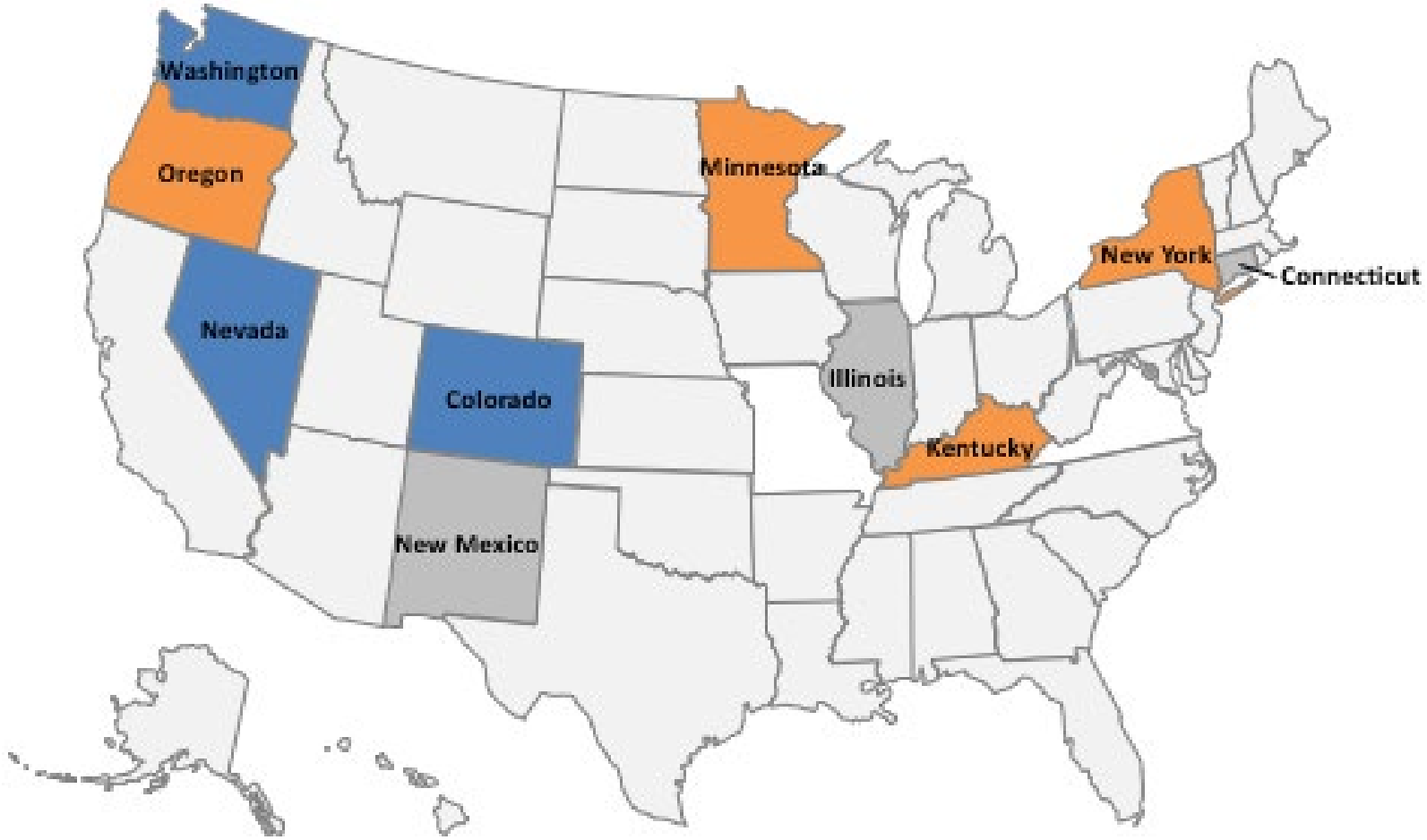
CMS Enforcement in Alabama

- **CMS will directly enforce all** NSA provisions because Alabama does not have a relevant state law and has not elected to enter a CEA
- **Alabama could decide to enforce certain provisions in future** through new laws and/or CEA

Public Option

The State of Play with Public Options and Basic Health Plans (BHPs)

- An increasing number of states have adopted or are considering public options and BHPs or a hybrid of the two.



Public Option

Basic Health Plan

Actively Considering Public Option/BHP

Washington is Strengthening its Public Option

- **Washington residents were offered the nation's first public option plans during the 2021 open enrollment period (OEP).**
  - **Target provider reimbursement rates** were set at an aggregate cap of 160 percent of Medicare rates with some variations
- In 2021 and 2022, Washington enacted legislation to **strengthen the public option** by:
  - **Requiring public options in all counties** by 2023.
  - **Requiring hospitals to participate** in counties without a public option.
  - Authorizing state officials to seek a **Section 1332 waiver.**
  - **Promoting standardized plans** by limiting non-standardized plan offerings.

Nevada Passes the Nation's Second Public Option

- **In June 2021, Nevada enacted a law establishing the nation's second public option:**
  - **Medicaid managed care organizations (MCOs) and/or commercial health insurers will be contracted** to offer a Marketplace public option in 2026 (MCOs are required to bid).
  - **Premiums for public option must be at least 5 percent lower than ACA benchmark premiums** with increases limited by Medicare index.
  - **Providers participating in other public programs will be required to enroll** in at least one public option provider network.
  - State officials are authorized to seek **a Section 1332 waiver.**
  - **Implementation is slated for 2026.**

Colorado and Oregon Have Their Own Unique Programs

Colorado Passes the Colorado Option

- **In June 2021, the Colorado Governor signed into law the Colorado Option**, which:
  - **Requires carriers to offer standardized health care plans beginning 2023.**
  - **Requires plans to achieve premium reductions of 5, 10, and 15 percent,** respectively, beginning in 2023 through 2025.
  - Authorizes state officials to seek a **Section 1332 waiver.**
- **Carriers that fail to meet premium reduction and/or network adequacy requirements may be subject to a public hearing** prior to approval of carrier final rates, and the **insurance commissioner has authority to set certain provider reimbursement rates**.

Oregon Adopts a Bridge Plan

- **In March 2022, the Oregon legislature approved a Bridge Plan to provide continuity of coverage** to people losing Medicaid in the PHE unwinding
- **The State is currently pursuing a Basic Health Plan** to provide long term Medicaid-like coverage to those in the 138-200 % FPL range
- **The State is considering the establishment of a State-Based Marketplace (SBM) and a 1332 waiver to enhance its coverage options in 2025 or later**

Rate Review

Rate Review Overview

48 of 50 states have "Effective Rate Review Programs" and are responsible for enforcing federal and any additional state rate review standards.

- **CMS updates rate filing templates each year and has created new opportunities for public involvement**
- **Accountability is strongest for large rate increases:**
  - Rates that exceed 15% require specific justification; states can change threshold
- **Rates can be deemed "unreasonable" if they are:**
  - Excessive,
  - Unjustified, or
  - Unfairly discriminatory

This includes evidence that a rate may trigger an MLR rebate. Insurers issued $2.1B in rebates in 2021 (almost five times the $447M in 2017).

- **CMS posts rate filing** information for all 50 states online
- **State practices vary** with some states posting proposed rates early in process and others only posting final rates.

Ratereview.healthcare.gov

Oregon has adopted transparency practices that offer a strong model for other states to consider, including a consumer-friendly website, early posting of proposed rates, online public hearings, and explanations of rate adjustments made by the regulator.

Colorado Regulator Can Set Provider Rates in Rate Review

The Colorado Option sets premium reduction targets, requires public hearings for carriers that fail to meet premium requirements, and empowers the insurance commissioner to set provider reimbursement rates on a case-by-case basis.

Premium Reduction Targets

The Colorado Option requires premiums to be:

- By 2023, **at least 5 percent lower** than carrier 2021 plan offerings.*
- By 2024, **at least 10 percent lower** than carrier 2021 plan offerings.
- By 2025, **at least 15 percent lower** than carrier 2021 plan offerings.

For 2026 and beyond, **premiums may not exceed medical inflation** relative to the previous year.

DOI Enforcement

- **Carrier notice** this spring if carriers fail to achieve 5 percent reduction for 2023.
- **Public hearings in spring 2024** if carriers fail to meet 10 percent reduction and/or network adequacy requirements.

Commissioner has broad powers to address reasons for carrier failure, including:

- Mandating hospital/provider participation.
- Rate setting.

***Note:** Adjusted for medical inflation (applies for all premium targets set 2023-2025).

Thank You

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