2017 Spring National Meeting
Denver, Colorado

HEALTH CARE REFORM REGULATORY ALTERNATIVES (B) WORKING GROUP
Saturday, April 8, 2017
3:30 – 5:00 p.m.
Colorado Convention Center—Room 102/104/106—Street Level

ROLL CALL

Ted Nickel, Chair  Wisconsin  Brendan Peppard  New Jersey
Roger Sevigny, Vice Chair  New Hampshire  Nicole Pickel  New York
Lori K. Wing-Heier  Alaska  Jon Godfread  North Carolina
Susan Jennette  Delaware  Mark O. Rabauliman  Northern Mariana Islands
Eric Johnson  Florida  James Mills  Oklahoma
Kathy McGill  Idaho  Johanna Fabian-Marks  Pennsylvania
Paulette Dove  Illinois  Kendall Buchanan  South Carolina
Greta Hockwalt  Indiana  Melissa Klemann  South Dakota
Julie Holmes  Kansas  Michael Humphreys  Tennessee
Robert Wake  Maine  Jan Graeber  Texas
Chlora Lindley-Myers  Missouri  Tanji Northrup  Utah
Matthew Rosendale  Montana  Osbert E. Potter  Virgin Islands
Martin Swanson  Nebraska  Molly Nollette  Washington
Mackay Moore  Nevada  Tom Glauser  Wyoming

AGENDA

1. Hear Opening Remarks—J.P. Wieske (WI)

2. Hear a Presentation on the Wisconsin Medicaid Program
   —Michael Heifetz (Wisconsin Department of Health Services)

3. Hear a Presentation on the New Hampshire Medicaid Program—Jennifer Patterson (NH)

4. Hear a Presentation on the Federal Affordable Care Act (ACA) Section 1332 Waivers—Representative TBD (OK) and Representative TBD (AK)

5. Discuss Any Other Matters Brought Before the Working Group—J.P. Wieske (WI)

6. Adjournment

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Agenda Item #1

Hear Opening Remarks—*J.P. Wieske (WI)*
Agenda Item #2

Hear a Presentation on the Wisconsin Medicaid Program—Michael Heifetz (Wisconsin Department of Health Services)
NAIC: Health Care Reform Regulatory Alternatives Working Group

Michael Heifetz, Medicaid Director
Presentation Outline

• Wisconsin’s Medicaid Program

• Wisconsin’s Commercial Market

• Wisconsin’s Coverage Structure: Then

• The Wisconsin Model: Now

• Federal Reform Considerations
Wisconsin’s Medicaid Program
Wisconsin Medicaid

Caseload by Eligibility Groups

GPR Costs By Eligibility Groups

<table>
<thead>
<tr>
<th></th>
<th>Caseload</th>
<th>GPR Costs</th>
<th>All Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>% of total</td>
<td>$</td>
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<tr>
<td>EBD</td>
<td>234,094</td>
<td>25%</td>
<td>$2,008M</td>
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<tr>
<td>Adults</td>
<td>335,729</td>
<td>36%</td>
<td>$856M</td>
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<tr>
<td>Children*</td>
<td>370,391</td>
<td>39%</td>
<td>$276M</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>940,214</strong></td>
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<td><strong>$3,139M</strong></td>
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*excluding CHIP funded children

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<tr>
<td>EBD</td>
<td>$1,787</td>
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<tr>
<td>Adults</td>
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<td>Children*</td>
<td>$155</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$696</strong></td>
</tr>
</tbody>
</table>
2018 Projected Medicaid Funding

Total Biennial Estimate $20 Billion

- **FED**: 54%
- **GPR**: 31%
- **SEG**: 6%
- **PR**: 9%

**SEG**: collections & recoveries; drug rebates; member cost-sharing

**PR**: provider assessments, CPE
2018 Projected Medicaid Enrollment

Children 42%

Parents and Caretakers 15%

EBD 21%

Preg. Women 2%

Childless Adults 13%

Other Full Benefit 2%

Limited Benefit 5%

Managed Care covers 2/3 of MA membership
Wisconsin’s Commercial Market
WI Commercial Market

• 18 Insurers in Individual Market
  (15 offering both on and off the Exchange; 12 in Medicaid and Exchange)

• National and Regional Players

• Integrated Health Systems

• No Dominant Insurer (by market share)

• Consumer- and Insurer-friendly Regulatory Dynamic
WI Commercial Market

Exchange Coverage by FPL

- >300% - ≤400% of FPL
- >250% to ≤300% of FPL
- >200% to ≤250% of FPL
- >150% to ≤200% of FPL
- ≥100% to ≤150% of FPL
- Other FPL
Wisconsin Coverage Structure
Then...

- BadgerCare Plus Core Plan Waiver
  - Program began in 2009
  - Adults without dependent children (“childless adults”) with incomes up to 200% FPL.
  - Enrollment capped; WAITLIST maintained.
  - Limited benefit plan: did NOT comply with EHB.
Now...The Wisconsin Model

- Cover all Wisconsin adult residents with income ≤ 100% FPL
- Residents with income above 100% FPL enter private market/exchange; subsidies available
- Reduce reliance on government: Dependence to Independence
- Only state in USA with no coverage gap (Kaiser Family Foundation)
- Simplify benefits design.
  - One comprehensive benefit package, for all members
  - Clearer for providers, members and administrators (state)
Federal Reform Considerations
Medicaid Reform & Wisconsin

- Block Grant, Per Capita or Hybrid
- Baseline
- Inflationary Indexing
- Equity
- Increased state flexibility (CMS/DHHS)
- Eliminate Federally Imposed Costs
- Timing/Phasing
Agenda Item #3

Hear a Presentation on the New Hampshire Medicaid Program—Jennifer Patterson (NH)
Agenda Item #4

Hear a Presentation on the Federal Affordable Care Act (ACA) Section 1332 Waivers
—TBD (AK) and TBD (OK)
FACT SHEET

FOR IMMEDIATE RELEASE
December 11, 2015

Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

HHS and Treasury Issue Additional Guidance on 1332 Waivers

On December 11, 2015, the Department of Health and Human Services and the Department of the Treasury posted guidance in the Federal Register for states interested in seeking a State Innovation Waiver under section 1332 of the Affordable Care Act. The guidance provides states with flexibility to pursue innovative waiver proposals while preserving the important protections of the Affordable Care Act, consistent with the statutory language. The guidance explains how the Secretaries will evaluate waiver applications, so that states have the information they need as they consider a waiver application. The Departments welcome comments on all aspects of the guidance and look forward to continuing to work with states and other stakeholders.

State Innovation Waivers allow states to receive federal funding to implement alternative models of health care coverage that provide high quality, affordable coverage to their residents. In order for a State Innovation Waiver to be approved, a state’s alternative model must provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver; provide coverage to a comparable number of residents as would be provided absent a waiver; and not increase the federal deficit.

In 2012, the Departments published regulations (published at 77 FR 11700) that set forth the process for states to submit applications and describe what an application from a state must contain. These waivers may take effect as early as January 1, 2017.

HIGHLIGHTS

- **Coverage:** To meet the coverage requirement, a comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. The assessment of whether a proposal meets the coverage requirement also takes into account the effects on vulnerable residents,
including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues.

- **Affordability:** To meet the affordability requirement, health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver. Affordability refers to state residents’ ability to pay for health care and may generally be measured by comparing residents’ net out-of-pocket spending for health coverage and services (i.e. premiums, deductibles, co-pays, and co-insurance) to their incomes. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. The assessment of whether a proposal meets the affordability requirement also takes into account the effects on vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues.

- **Comprehensiveness:** To meet the comprehensiveness requirement, health care coverage under the waiver must be forecast to be at least as comprehensive overall for residents of the state as coverage absent the waiver. Comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs) as defined in section 1302(b) of the Affordable Care Act, or Medicaid and/or CHIP standards as appropriate. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver.

A waiver must not decrease the number of individuals with coverage that satisfies the requirements of EHB, the number of individuals with coverage of any one category of EHB, or the number of individuals with coverage that includes services authorized under the state’s Medicaid and/or CHIP programs.

The assessment of whether a proposal meets the comprehensiveness requirement also takes into account the effects on vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues.

- **Deficit Neutrality:** Under the deficit neutrality requirement, the projected federal spending net of federal revenues under the waiver must be equal to or lower than projected federal spending net of federal revenues in the absence of the waiver. The estimated effect on federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees), that would result from the proposed waiver. The effect on federal spending includes all changes in Health Insurance Marketplace financial assistance and other direct spending, such as changes in Medicaid spending that result from the changes made through the State Innovation Waiver. Projected federal spending under the waiver also includes all administrative costs to the federal government associated with the waiver.
**Impact of Other Program Changes:** The assessment of whether a State Innovation Waiver proposal satisfies the statutory criteria set forth in section 1332 takes into consideration the impact of changes to Affordable Care Act provisions made by a proposed State Innovation Waiver. The assessment does not consider the impact of policy changes that are contingent on further state action, such as state legislation that is proposed but not yet enacted. It also does not include the impact of changes contingent on other federal determinations, including approval of federal waivers pursuant to statutory provisions other than section 1332 (e.g., section 1115 Medicaid or CHIP demonstrations). In addition, savings accrued under either proposed or current section 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed waiver meets the deficit neutrality requirement.

**Funding Available to States:** The amount of federal funding provided to states to implement their waiver is the Secretaries’ annual estimate of the federal cost (including outlays and forgone revenue) for Marketplace financial assistance provided pursuant to the Affordable Care Act that would be claimed by participants in the Marketplace in the state in the absence of the waiver, but will not be claimed as a result of the waiver. The amount is calculated annually.

**Public Input:** The notice clarifies that the minimum length of public notice and comment periods for waiver applications is 30 days.

The Departments welcome comments on this guidance and will consider issuing additional guidance in the future if additional clarifications are necessary.

States may submit State Innovation Waiver applications to stateinnovationwaivers@cms.hhs.gov.


For more information, please visit: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-31563.pdf

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About the 1332 State Innovation Waiver Application Process

States have the option to seek a State Innovation Waiver under Section 1332 of the Affordable Care Act to pursue innovative strategies to provide high quality, affordable health care coverage while retaining the statute’s basic protections. The U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury are responsible for reviewing waiver applications.

States may submit State Innovation Waiver applications to stateinnovationwaivers@cms.hhs.gov.

Public Input Process Prior to Submission of an Application

Prior to submitting a State Innovation Waiver application to HHS for review and consideration, a state must provide public notice and a comment period sufficient to ensure a meaningful level of public input on the application. During the public comment period, the state must conduct public hearings regarding the state’s application. In addition, a state with one or more federally recognized tribes within its borders must conduct a separate process for meaningful consultation with the tribes as part of the notice and comment process.

Application Requirements

The final regulations specify what information needs to be included in an application for a State Innovation Waiver. Critical elements of that application include (but are not limited to):

- The list of provisions the state seeks to waive, including the rationale for the specific requests;
- Data, assumptions, targets, and other information sufficient to determine that the proposed waiver will provide coverage that is at least as comprehensive as would be provided absent the waiver, will provide coverage and cost sharing protections that keep care at least as affordable as would be provided absent the waiver, will provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver, and will not increase the Federal deficit;
- Actuarial analyses and actuarial certifications to support State estimates that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement;
- 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 providing the state authority to implement the proposed waiver; and,
- A detailed plan as to how the state will implement the waiver, including a timeline.
The regulations provide more detail about each of the application elements and should be consulted carefully as states develop applications.

HHS may also request, or a state may propose, additional information to aid in the review of the application.

**Application Review Process**

Upon receipt of a State Innovation Waiver application, HHS and the Department of the Treasury (the Departments) will work with the state on the review and approval process. The Departments (in coordination with other agencies as applicable) will follow the process outlined below:

1. The Departments will conduct a preliminary review within 45 days of submission to determine if the application is complete. 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.

2. 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.

3. Following the preliminary determination that a state’s application is complete, the Departments will provide for a public notice and comment period.

4. 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.
2. In §121.1, under Category XI, revise paragraph (b), effective December 29, 2015 to read as follows:

§121.1 The United States Munitions List.
  *(b) Electronic systems, equipment or software, not elsewhere enumerated in this sub-chapter, specially designed for intelligence purposes that collect, survey, monitor, or exploit, or analyze and produce information from, the electromagnetic spectrum (regardless of transmission medium), or for counteracting such activities.

3. In §121.1, under Category XI, revise paragraph (b), effective August 30, 2017, to read as follows:

§121.1 The United States Munitions List.
  *(b) Electronic systems or equipment, not elsewhere enumerated in this sub-chapter, specially designed for intelligence purposes that collect, survey, monitor, or exploit or analyze and produce information from, the electromagnetic spectrum (regardless of transmission medium), or for counteracting such activities.

Brian H. Nilsson,
Deputy Assistant Secretary for Defense Trade Controls, Bureau of Political-Military Affairs, U.S. Department of State.

Billings Code 4710–25–P

DEPARTMENT OF THE TREASURY
31 CFR Part 33

DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Part 155
[CMS–9936–N]

Waivers for State Innovation

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS; Department of the Treasury.

ACTION: Guidance.

SUMMARY: This guidance relates to Section 1332 of the Patient Protection and Affordable Care Act (ACA) and its implementing regulations. Section 1332 provides the Secretary of Health and Human Services and the Secretary of the Treasury with the discretion to approve a state’s proposal to waive specific provisions of the ACA (a State Innovation Waiver), provided the proposal meets certain requirements. In particular, the Secretaries can only exercise their discretion to approve a waiver if they find that the waiver would provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver, would provide coverage that is at least as comprehensive and affordable as would be provided absent the waiver, and would not increase the Federal deficit. If the waiver is approved, the state may receive funding equal to the amount of forgone Federal financial assistance that would have been provided to its residents pursuant to specified ACA programs, known as pass-through funding. State Innovation Waivers are available for effective dates beginning on or after January 1, 2017. They may be approved for periods up to 5 years and can be renewed. The Departments promulgated implementing regulations in 2012. This document provides additional information about the requirements that must be met, the Secretaries’ application review procedures, the amount of pass-through funding, certain analytical requirements, and operational considerations.

DATES: Comment Date: Comments may be submitted at any time.

ADDRESSES: In commenting, please refer to file code CMS–9936–N. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments to this document on http://www.regulations.gov. Follow the “Submit a comment” instructions.

2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9936–N, P.O. Box 8016, Baltimore, MD 21244–8016.

3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9936–N, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses:


(b) Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed.

For information on viewing public comments, see the beginning of the SUPPLEMENTARY INFORMATION section.


SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Statutory Requirements

Under Section 1332 of the Affordable Care Act (ACA), the Secretaries of Health and Human Services (HHS) and the Treasury as appropriate may
exercise their discretion to approve a request for a State Innovation Waiver only if the Secretaries determine that the proposal meets the following four requirements: (1) The proposal will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state’s residents as would be provided absent the waiver; (3) the proposal will provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and, (4) the proposal will not increase the Federal deficit. The Secretaries retain their discretionary authority under Section 1332 to deny waivers when appropriate given consideration of the application as a whole, including the four requirements. As under similar waiver authorities, the Secretaries reserve the right to suspend or terminate a waiver, in whole or in part, any time before the date of expiration, if the Secretaries determine that the state materially failed to comply with the terms and conditions of the waiver, including any of the requirements discussed in this guidance.

Final regulations at 31 CFR part 33 and 45 CFR part 155, subpart N require a state to provide actuarial analyses and actuarial certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to support the state’s estimates that the proposed waiver will comply with these requirements.1

A. Coverage

To meet the coverage requirement, a comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Coverage refers to minimum essential coverage (or, if the individual shared responsibility provision is waived under a State Innovation Waiver, to something that would qualify as minimum essential coverage but for the waiver). For this purpose, “comparable” means that the forecast of the number of covered individuals is no less than the forecast of the number of covered individuals absent the waiver. This condition generally must be forecast to be met in each year that the waiver would be in effect.

The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. (For example, while a State Innovation Waiver may not change the terms of a state’s Medicaid coverage or change existing Medicaid demonstration authority, changes in Medicaid enrollment that result from a State Innovation Waiver, holding the state’s Medicaid policies constant, are considered in evaluating the number of residents with coverage under a waiver.)

Assessment of whether the proposal covers a comparable number of individuals also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues. Reducing coverage for these types of vulnerable groups would cause a waiver application to fail this requirement. Even if the waiver would provide coverage to a comparable number of residents overall. Finally, analysis under the coverage requirement takes into account whether the proposal sufficiently prevents gaps in or discontinuities of coverage.

As provided in 31 CFR part 33 and 45 CFR part 155, subpart N, the waiver application must include analysis and supporting data that establishes that the waiver satisfies this requirement, including information on the number of individuals covered by income, health status, and age groups, under current law and under the waiver, including year-by-year estimates. The application should identify any types of individuals who are less likely to be covered under the waiver than under current law. The state should also provide a description of the model used to produce these estimates, including data sources and quality, key assumptions, and parameters. The state may be required to provide micro data and other information to inform the Secretaries’ analysis.

B. Affordability

To meet the affordability requirement, health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.

Affordability refers to state residents’ ability to pay for health care and may generally be measured by comparing residents’ net out-of-pocket spending for health coverage and services to their incomes. Out-of-pocket expenses include both premium contributions (or equivalent costs for enrolling in coverage), and any cost sharing, such as deductibles, co-pays, and co-insurance, associated with the coverage. Spending on health care services that are not covered by a plan may also be taken into account if they are affected by the waiver proposal. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. This condition generally must be forecast to be met in each year that the waiver would be in effect.

Waivers are evaluated not only based on how they affect affordability on average, but also on how they affect the number of individuals with large health care spending burdens relative to their incomes. Increasing the number of state residents with large health care spending burdens would cause a waiver to fail the affordability requirement, even if the waiver would increase affordability for many other state residents. Assessment of whether the proposal meets the affordability requirement also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues. Reducing affordability for these types of vulnerable groups would cause a waiver to fail this requirement, even if the waiver maintained affordability in the aggregate.

In addition, a waiver would fail the affordability requirement if it would reduce the number of individuals with coverage that provides a minimal level of protection against excessive cost sharing. In particular, waivers that reduce the number of people with insurance coverage that provides both an actuarial value equal to or greater than 60 percent and an out-of-pocket maximum that complies with section 1302(c)(1) of the ACA, would fail this requirement. So too would waivers that reduce the number of people with coverage that meets the affordability requirements set forth in section 1916 and 1916A of the Social Security Act, as codified in 42 CFR part 447, subpart A, while holding the state’s Medicaid policies constant.

As provided in 31 CFR part 33 and 45 CFR part 155, subpart N, the waiver application must include analysis and supporting data that establishes that the waiver satisfies this requirement. This includes information on estimated individual out-of-pocket costs by income, health status, and age groups, absent the waiver and with the waiver.

The expected changes in premium contributions and other out-of-pocket costs for insured individuals who would have been eligible for Medicaid are considered, as well as the change in premiums and cost-sharing associated with the waiver.

For this purpose, “comparable” means that would qualify as minimum essential coverage (or, if the individual shared responsibility provision is waived under a State Innovation Waiver, to something that would qualify as minimum essential coverage but for the waiver).
costs and the combined impact of changes in these components should be identified separately. The application should also describe any changes in employer contributions to health coverage or in wages expected under the waiver. The application should identify any types of individuals for whom affordability of coverage would be reduced by the waiver.

The state should also provide a description of the model used to produce these estimates, including data sources and quality, key assumptions, and parameters. The state may be required to provide micro data and other information to inform the Secretaries’ analysis.

C. Comprehensiveness

To meet the comprehensiveness requirement, health care coverage under the waiver must be forecast to be at least as comprehensive overall for residents of the state as coverage absent the waiver.

Comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs) as defined in section 1302(b) of the ACA, or, as appropriate, Medicaid and/or CHIP standards. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver.

Comprehensiveness is evaluated by comparing coverage under the waiver to the state’s EHB benchmark, selected by the state (or if the state does not select a benchmark, the default base-benchmark plan) pursuant to 45 CFR 156.100, as well as to, in certain cases, the coverage provided under the state’s Medicaid and/or CHIP programs. A waiver cannot satisfy the comprehensiveness requirement if the waiver decreases: (1) The number of residents with coverage that is at least as comprehensive as the benchmark in all ten EHB categories; (2) for any of the ten EHB categories, the number of residents with coverage that is at least as comprehensive as the benchmark in that category; or (3) the number of residents whose coverage includes the full set of services that would be covered under the state’s Medicaid and/or CHIP programs, holding the state’s Medicaid and CHIP policies constant.

That is, the waiver must not decrease the number of individuals with coverage that satisfies EHB requirements, the number of individuals with coverage of any particular category of EHB, or the number of individuals with coverage that includes the services covered under the state’s Medicaid and/or CHIP programs.

Assessment of whether the proposal meets the comprehensiveness requirement also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues. A waiver would fail the comprehensiveness requirement if it would reduce the comprehensiveness of coverage provided to these types of vulnerable groups, even if the waiver maintained comprehensiveness in the aggregate. This condition generally must be forecast to be met in each year that the waiver would be in effect.

As provided in the final regulations at 31 CFR part 33 and 45 CFR part 155, subpart N, the waiver application must include analysis and supporting data that establishes that the waiver satisfies this requirement. This includes an explanation of how the benefits offered under the waiver differ from the benefits provided absent the waiver (if the benefits differ at all) and how the state determined the benefits to be as comprehensive.

The state should also provide a description of the model used to produce these estimates, including data sources and quality, key assumptions, and parameters. The state may be required to provide micro data and other information to inform the Secretaries’ analysis.

D. Deficit Neutrality

Under the deficit neutrality requirement, the projected Federal spending net of Federal revenues under the State Innovation Waiver must be equal to or lower than projected Federal spending net of Federal revenues in the absence of the waiver.

The estimated effect on Federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees), that would result from the proposed waiver. Estimated effects would include, for example, changes in: The premium tax credit and health coverage tax credit, individual shared responsibility payments, employer shared responsibility payments, the excise tax on high-cost employer-sponsored plans, the credit for small businesses offering health insurance, and changes in income and payroll taxes resulting from changes in tax exclusions for employer-sponsored insurance and in deductions for medical expenses.

The effect on Federal spending includes all changes in Exchange financial assistance and other direct spending, such as changes in Medicaid spending (while holding the state’s Medicaid policies constant) that result from the changes made through the State Innovation Waiver. Projected Federal spending under the waiver proposal also includes all administrative costs to the Federal government, including any changes in Internal Revenue Service administrative costs, Federal Exchange administrative costs, or other administrative costs associated with the waiver.

Waivers must not increase the Federal deficit over the period of the waiver (which may not exceed 5 years unless renewed) or in total over the ten-year budget plan submitted by the state as part of the State Innovation Waiver application. The ten-year budget plan must describe for both the period of the waiver and for the ten-year budget the projected Federal spending net of Federal revenues under the State Innovation Waiver and the projected Federal spending net of Federal revenues in the absence of the waiver.

The ten-year budget plan should assume the waiver would continue permanently, but should not include the waiver, or savings attributable to any period outside of the ten-year budget window. A variety of factors, including the likelihood and accuracy of projected spending and revenue effects and the timing of these effects, are considered when evaluating the effect of the waiver on the Federal deficit. A waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement.

The state should also provide a description of the model used to produce these estimates, including data sources and quality, key assumptions, and parameters. The state may be required to provide micro data and other information to inform the Secretaries’ analysis.

As provided in 31 CFR part 33 and 45 CFR part 155, subpart N, a state must submit evidence to demonstrate deficit neutrality, including a description of the analysis used to produce its estimate of the impact of the waiver on the Federal deficit. The description must include detailed information about the model, data sources and quality, key assumptions, and parameters. The state may be required to provide micro data and other information to support actuarial and economic analyses, so that the Secretaries can independently verify that the waiver meets the deficit neutrality requirement.
II. Impact of Other Program Changes on Assessment of a Waiver Proposal

The assessment of whether a State Innovation Waiver proposal satisfies the statutory criteria set forth in Section 1332 takes into consideration the impact of changes to ACA provisions made pursuant to the State Innovation Waiver. The assessment also considers related changes to the state’s health care system that, under state law, are contingent only on the approval of the State Innovation Waiver. For example, the assessment would take into account the impact of a new state-run health benefits program that, under legislation enacted by the state, would be implemented if the State Innovation Waiver were approved.

The assessment does not consider the impact of policy changes that are contingent on further state action, such as state legislation that is proposed but not yet enacted. It also does not include the impact of changes contingent on other Federal determinations, including approval of Federal waivers pursuant to statutory provisions other than Section 1332. Therefore, the assessment would not take into account changes to Medicaid or CHIP that require separate Federal approval, such as changes in coverage or Federal Medicaid or CHIP spending that would result from a proposed Section 1115 demonstration, regardless of whether the Section 1115 demonstration proposal is submitted as part of a coordinated waiver application with a State Innovation Waiver. Savings accrued under either proposed or current Section 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed State Innovation Waiver meets the deficit neutrality requirement. The assessment also does not take into account any changes to the Medicaid or CHIP state plan that are subject to Federal approval.

The assessment does take into account changes in Medicaid and/or CHIP coverage or in Federal spending on Medicaid and/or CHIP that would result directly from the proposed waiver of provisions pursuant to Section 1332, holding state Medicaid and CHIP policies constant.

As the Departments receive and review waiver proposals, we will continue to examine the types of changes that will be considered in assessing State Innovation Waivers.

Nothing in this guidance alters a state’s authority to make changes to its Medicaid and CHIP policies consistent with applicable law. This guidance does not alter the Secretary of Health and Human Services’ authority or CMS’ policy regarding review and approval of Section 1115 demonstrations, and states should continue to work with CMS’ Center for Medicaid and CHIP Services on issues relating to Section 1115 demonstrations. A state may submit a coordinated waiver application as provided in 31 CFR 33.102 and 45 CFR 155.1302; in such a case, each waiver will be evaluated independently according to applicable Federal laws.

III. Federal Pass-Through Funding

The amount of Federal pass-through funding equals the Secretaries’ annual estimate of the Federal cost (including outlays and forgone revenue) for Exchange financial assistance provided pursuant to the ACA that would be claimed by participants in the Exchange in the state in the calendar year in the absence of the waiver, but will not be claimed as a result of the waiver. The calculation of the amount of pass-through funding does not account for any other changes in Federal spending or revenues as a result of the waiver, including Federal administrative expenses for making the payments (note, however that changes to Federal spending on administrative expenses is considered in determining whether a waiver proposal meets the deficit neutrality requirement). The estimates take into account experience in the relevant state and similar states. The amount is calculated annually.

The waiver application must provide analysis and supporting data to inform the estimate of the pass-through funding amount. For states that do not utilize a Federally-facilitated or state Partnership Exchange this includes information about enrollment, premiums, and Exchange financial assistance in the state’s Exchange by age, income, and type of policy, and other information as may be required by the Secretaries.

For further information on the demographic and economic assumptions to be used in determining the pass-through amount, see Section IV below.

IV. Economic Assumptions and Methodological Guidelines

The determination of whether a waiver meets the requirements under Section 1332 and the calculation of the pass-through funding amount are made using generally accepted actuarial and economic analytic methods such as micro-simulation. The analysis relies on assumptions and methodologies that are similar to those used to produce the baseline and policy projections included in the most recent President’s Budget (or Mid-Session Review), but adapted as appropriate to reflect state-specific conditions.

The analysis is based on state-specific estimates of the current level and distribution of population by the relevant economic and demographic characteristics, including income and source of health coverage. It generally uses Federal estimates of population growth, economic growth as published in the Analytical Perspectives volume released as part of the President’s Budget (https://www.whitehouse.gov/omb/budget/Analytical_Perspectives) and health care cost growth (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/) to project the initial state variables through the ten-year Budget plan window. However, in limited circumstances where it is expected that a state will experience substantially different trends than the nation as a whole in the absence of a waiver, the Secretaries may determine that state-specific assumptions will be used.

Estimates of the effect of the waiver assume, in accordance with standard estimating conventions, that macroeconomic variables like population, output, and labor supply are not affected by the waiver. However, estimates take into account, as appropriate, other changes in the behavior of individuals, employers, and other relevant entities induced by the waiver, including employer decisions regarding what coverage (and other compensation) they offer and individual decisions regarding whether to take up coverage. The same state-specific and Federal data, assumptions, and model are used to calculate comprehensiveness, affordability, and coverage, and relevant state components of Federal taxes and spending under the waiver and under current law.

The analysis and information submitted by the state as part of the application must conform to these standards. The application must describe all modeling assumptions used, sources of state-specific data, and the rationale for any deviation from Federal forecasts. A state may be required to provide to the Secretaries copies of any data used for their waiver analyses that are not publicly available so that the Secretaries can independently verify the analysis produced by the state.

V. Operational Considerations

A. Federally-Facilitated Exchanges

The Centers for Medicare & Medicaid Services (CMS) operates the Federally-
facilitated Exchange (FFE) platform. Certain changes that affect FFE processes may make a waiver proposal not feasible to implement at this time. Until further guidance is issued, the Federal platform cannot accommodate different rules for different states. For example, waivers that would require changes to the calculation of Exchange financial assistance, non-standard enrollment period determinations, customized plan management review options, or changes to the design used to display plan options are generally not feasible at this time due to operational limitations. In addition, the Federal platform cannot accommodate changes to its plan management templates in the near term. States contemplating a waiver that requires such changes may consider establishing their own platform administered by the state.

As noted in Section I.D. of this guidance, costs associated with changes to Federal administrative processes are taken into account in determining whether a waiver application satisfies the deficit neutrality requirement. Regulations at 31 CFR part 33 and 45 CFR part 155, subpart N require that such costs be included in the 10-year budget plan submitted by the state.

VI. Public Input on Waiver Proposals

Consistent with the statutory provisions of Section 1332, regulations at 31 CFR 33.112 and 45 CFR 155.1312 require states to provide a public notice and comment period for a waiver application sufficient to ensure a meaningful level of public input prior to submitting an application. As part of the public notice and comment period, a state with one or more Federally-recognized tribes must conduct a separate process for meaningful consultation with such tribes. Because State Innovation Waiver applications may vary significantly in their complexity and breadth, the regulations provide states with flexibility in determining the length of the comment period required to allow for meaningful and robust public engagement. The comment period must be sufficient to ensure a meaningful level of public input and in no case can be less than 30 days.

Consistent with HHS regulations, waiver applications must be posted online in a manner that meets national standards to assure access to individuals with disabilities. Such standards are issued by the Architectural and Transportation Barriers Compliance Board, and are referred to as “section 508” standards. Alternatively, the World Wide Web Consortium’s Web Content Accessibility Guidelines (WCAG) 2.0 Level AA standards would also be considered as acceptable national standard for Web site accessibility. For more information, see the WCAG Web site at http://www.w3.org/TR/WCAG20/.

Section 1332 and its implementing regulations also require the Federal Government to provide a public notice and comment period, once the Secretaries receive an application. The period must be sufficient to ensure a meaningful level of public input and must not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to state compliance. As with the comment period described above, the length of the comment period should reflect the complexity of the proposal and in no case can be less than 30 days.
January 17, 2017

VIA ELECTRONIC MAIL: lori.wing-heier@alaska.gov
Mrs. Lori K. Wing-Heier
Director
Alaska Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-2567

Dear Mrs. Wing-Heier:

Thank you for your submission on January 3, 2017 of Alaska’s application for a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA). Alaska would waive requirements of the ACA and implement the Alaska Reinsurance Program (ARP) for 2018 and future years. The Department of Health & Human Services (HHS) and the Department of the Treasury (the Departments) have completed a preliminary review of the application in accordance with 45 CFR 155.1308(c), and we have made a preliminary determination that your application is complete.

Pursuant to 45 CFR 155.1308(d), the date of this letter marks the beginning of the Federal public notice process and 180-day Federal decision-making period. Public comments on the application will be accepted by the Departments from January 17, 2017 until February 16, 2017, and more information can be found on the CCIIO website.¹ The decision of the Secretaries of HHS and the Treasury will be issued within 180 days in accordance with 45 CFR 155.1308(e) and other applicable regulations. We look forward to working with you on your application and will be in touch if we need additional information. Please do not hesitate to contact us if you have any questions.

Sincerely,

Kevin J. Counihan
Chief Executive Officer, Health Insurance Marketplaces
Director, Center for Consumer Information & Insurance Oversight

Cc: Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Department of the Treasury

Saving the Individual Market in Alaska: The Alaska Reinsurance Program

Presented by:

Cecil Bykerk, Executive Director
Alaska Comprehensive Health Insurance Association
Agenda

- Alaska’s Individual Market
- Alaska’s High Risk Pool
- The Alaska Reinsurance Program
- Operational Details
- Current Status
Alaska’s Individual Market History

2014 and 2015
• Aetna, Assurant, Moda, Premera, State Farm

2016
• Aetna, Assurant, Moda, Premera, State Farm

2017
• Aetna, Assurant, Moda, Premera, State Farm
Rising Health Insurance Costs

- Alaska has the highest health care and health insurance costs in the nation
- Alaska’s individual market has approximately 22,000 enrollees
  - About 18,000 individuals are enrolled in the Exchange and 90% of them get a subsidy
- Alaska expanded Medicaid, which now covers 165,000 people (26,000 through expansion)
- Average cost in Exchange is $863 per month in 2016 vs nationwide average of $396
- Average subsidy in the Exchange is $750 per month vs a nationwide average of $291
- Premium costs in 2016 went up by over 38% for the two remaining carriers when the other three dropped out
- Premium costs with one carrier remaining were expected to have gone up by an additional 42% in 2017

Source: www.healthinsurance.org/alaska-state-health-insurance-exchange
The Dilemma

Premiums need to be lower to prevent healthier lives from leaving the market, leading to death spiral.

Premiums need to be higher to prevent exit of the one remaining insurer, leading to market collapse.
Alaska Comprehensive Health Insurance Association (ACHIA)

- High risk pool established in 1992
- Still open, need legislative action to close
- Enrollment reached peak of over 500 enrollees in 2012 (total state population = 737,000)
- Current enrollment around 130
- Top diagnosis ESRD, over half of claims
- 40% of enrollees in Medicare plans (Med Supp or carve-out)
- Funded by assessments
- Third-party payment allowed
- Citizenship is not required but must be Alaska resident
- Rates at 125% SRR, no discount program
The Alaska Reinsurance Program (ARP)

- House Bill 374 introduced by the Governor (I) and passed Republican controlled Legislature in June 2016
- State fiscal environment: AK budget deficit $3 to $4 billion
- HB 374:
  - Amends definitions allowing Division of Insurance to establish a reinsurance program for high risk residents
  - Permits DOI to apply for Section 1332 state innovation waiver
- Reinsurance program funding for 2017-2018 is appropriated by the Legislature from existing 2.7% premium tax on all insurers (not just health insurers) in Alaska (otherwise goes to General Fund)
  - Original bill funding based on high risk pool assessment - still in place
- $64 million was collected in 2015 by this tax
- For 2017, $55 million has been allocated to the reinsurance fund to cover claims for high cost insureds in the individual market
- Once passed, Premera filed rates and was approved for 7.3% rate increase (down from estimated 42%) attributed to the new reinsurance program
How Will It Work?

**Consumer Perspective**
- Individuals will still purchase their coverage through the existing private carrier(s)
- Premiums will be lower than without this program (in 2017, about 24%)
- Additional funding matters are all behind the scenes

**Carrier Perspective**
- Individual carriers have to cede all risk for certain policyholders retrospectively to the reinsurance pool
- Carrier will be reimbursed for all the claims of a ceded individual
- All premiums collected for the ceded individual will be forwarded to the reinsurance pool
- Otherwise, the carrier continues traditional administration of the benefit plan
Which Individuals Can Be Ceded?

- Eligible individuals are identified through the claim process of having one of 33 conditions
- Conditions were identified through a study of 2015 market claims

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<tr>
<td>Percent Remaining</td>
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Eligible Condition Categories

- Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
- Acute Liver Failure/Disease, Including Neonatal Hepatitis
- Amputation Status, Lower Limb/Amputation Complications
- Amyloidosis, Porphyria, and Other Metabolic Disorders
- Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
- Anorexia/Bulimia Nervosa
- Cerebral Palsy, Except Quadriplegic
- Chronic Hepatitis
- Chronic Pancreatitis
- Coagulation Defects and Other Specified Hematological Disorders
- Cystic Fibrosis
- End Stage Renal Disease
- End Stage Liver Disease
- Hemophilia
- HIV/AIDS
- Inflammatory Bowel Disease
- Intestinal Obstruction
- Lipidoses and Glycogenosis
- Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
- Metastatic Cancer
- Mucopolysaccharidosis
- Multiple Sclerosis
- Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
- Non-Hodgkin’s Lymphomas and Other Cancers and Tumors
- Paraplegia
- Parkinson’s, Huntington’s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
- Premature Newborns, Including Birthweight 2000-2499 Grams
- Quadriplegic Cerebral Palsy
- Rheumatoid Arthritis and Specified Autoimmune Disorders
- Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
- Sickle Cell Anemia
- Stem Cell, Including Bone Marrow, Transplant Status/Complications
- Thalassemia Major
Operational Details

- ACHIA will serve as the reinsurance entity
- Detailed plan of operations to address program administration and accounting
- Carriers are required to cede claims of eligible high risk residents to the program
- ACHIA will reimburse carrier quarterly for ceded claims
- Claims and expenses will be paid from premium and then from the $55 million
- If claims are expected to exceed available funds, a proportional payment will be made to carriers
- There will be an annual true-up of claims and risk adjustment transfers
**Annual True-Ups**

### Claim True-Up
- Between April 15 and June 15 of each year
- True-ups for:
  - Crediting of premium and non-premium revenue received after the end of the benefit year
  - Retroactive reductions necessary to prevent a deficit for the benefit year
  - Retroactive increases necessary to ensure each claim for reimbursement is reimbursed proportionately (if more than one carrier in the market)

### Risk Adjustment True-Up
- Between June 30 and August 15 following any year in which there was more than one carrier in the individual market
- True up will require a recalculation of the federal risk adjustment transfers to account for the impact of removing ceded risks who were not the financial responsibility of the ceding carrier
Current Status

- Regulations have been written and approved
- A plan of operations has been approved by the ACHIA board
- Program was implemented January 1, 2017
- In November 2016, the state requested a Sec 1332 State Innovation Waiver and has been accepted but not approved yet
- The reduction in the premium increase from 42% to 7.3% in 2017 is estimated to have saved the federal government $51.6 million in Advance Premium Tax Credits for 2018
- Alaska has requested that amount be passed through to the state
- Waiver would be effective in 2018
April 5, 2017

Commissioner Ted Nickel (WI)
Chair, Health Care Reform Regulatory Alternatives (B) Working Group
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners
444 North Capitol Street, NW
Suite 700
Washington, DC 20001

RE: Federal Affordable Care Act Section 1332 Waivers

Dear Commissioner Nickel:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. More than 2,200 of our members reside in Oklahoma.

ASHA would like to offer comments to the National Association of Insurance Commissioners’ (NAIC) Health Care Reform Regulatory Alternatives Working Group related to Federal Affordable Care Act (ACA) Section 1332 waivers for the individual and small group markets.

Under Section 1332 of the ACA, states can apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high-quality, affordable health insurance while retaining the basic protections of the ACA. State Innovation Waivers allow states to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as what would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit.

Specifically, this letter will address recommendations found in the Oklahoma 1332 Task Force Concept Paper:\footnote{1} to:

- re-evaluate and reduce the essential health benefits package
- establish HSA-like consumer health accounts; and
- encourage the use of telehealth.\footnote{2}

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**Re-evaluate and reduce the essential health benefits (EHB) package**

The Secretary of the U.S. Department of Health and Human Services (HHS) may grant a request for a waiver if it is determined that the state plan will provide coverage that is at least as

\footnotetext{1}{https://www.ok.gov/health/documents/1332%20Waiver%20Concept%20Paper.pdf}
\footnotetext{2}{https://www.law.cornell.edu/uscode/text/42/18022}
comprehensive as the coverage defined in section 18022(b) of Title 42 of the United States code.\textsuperscript{3} The statute requires that benefits shall include at least 10 categories of coverage for essential health benefits (EHB), including rehabilitative and habilitative services and devices. Any efforts to re-evaluate the EHB package should maintain—at a minimum—coverage for these services. In the February 2015 Benefit and Payment Parameters Final Rule, the Centers for Medicare & Medicaid Services (CMS) defined “habilitation services and devices” using the definition of “habilitation services” from the NAIC’s Glossary of Health Coverage and Medical Terms, and explicitly added habilitation devices, as follows:

“Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”\textsuperscript{4}

The Uniform Glossary developed by the NAIC and adopted by HHS accompanies the Summary of Benefits and Coverage provided to millions of consumers with employer-sponsored and individual plans and also uses the NAIC definitions for habilitation and rehabilitation, which include speech-language pathology.\textsuperscript{5,6}

ASHA noticed under Appendix H of the Oklahoma 1332 Task Force Concept Paper that for both habilitation services and rehabilitation services, speech-language pathology is not listed in the explanation section as a covered service. Failing to specifically include coverage for speech-language pathology for habilitative services and devices would deny medically necessary treatment to children and adults with chronic and progressive conditions such as autism, cerebral palsy, congenital deficits, and developmental disabilities. Individuals who require habilitative services and devices rely on their health care coverage to keep, learn, or improve skills and functioning for daily living so that they can live as independently as possible. Often, skills acquired through habilitative services and devices lead to breakthroughs in functional ability that would not have been possible without access to timely and appropriate habilitation benefits. This reduces long-term disability and dependency costs to society. Rehabilitation services are provided to individuals with neurological and medical conditions, such as acquired brain injury or disease, stroke, and head and neck cancers. Individuals with acquired brain injury or disease may require speech-language treatment, cognitive rehabilitation, or swallowing treatment to regain or improve function for daily living.

One of the criticisms of the EHB requirement is that it significantly increases premiums; however, evidence suggests that factors, such as community rating, may actually have more of an effect on premiums than EHBs.

\textsuperscript{3} https://www.law.cornell.edu/uscode/text/42/18022
\textsuperscript{5} https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/
\textsuperscript{6} https://www.healthcare.gov/sbc-glossary/#medically-necessary
Establish HSA-like consumer health accounts

ASHA understands that Oklahoma is proposing that advance premium tax credits and cost sharing reduction funds be combined and repurposed to fund the HSA-like consumer health accounts. However, we are concerned that for these HSA-like consumer health accounts, Oklahoma is not proposing to establish a minimum actuarial value (AV) floor unlike the standard minimum AV of 80% for traditional plans. If adopted, individual market insurers will be allowed to offer plans with higher deductibles and out-of-pocket costs; thereby, reducing the value of coverage for consumers. This is of particular importance because the Oklahoma 1332 Task Force Concept Paper reveals that Oklahomans do not typically understand out-of-pocket expenses and coinsurance.

Encourage the use of telehealth

Telehealth technologies can increase patient access to medical care, particularly in remote or underserved areas. Telehealth encompasses activities ranging from health promotion and education, advice, reminders, interventions and monitoring of interventions. State regulatory barriers that inhibit the adoption of telehealth should be reduced. These barriers include reimbursement ineligibility, and variations and restrictions in state licensure rules.

Audiologists and speech-language pathologists have demonstrated the capability to provide effective care through telehealth technologies for more than a decade and in various work settings. Telehealth venues include medical centers, rehabilitation hospitals, community health centers, outpatient clinics, universities, patients' homes, and residential health care facilities. There are no inherent limits as to where telehealth can be implemented as long as the services comply with national, state, institutional, and professional regulations and policies. Telehealth is being used in the assessment and treatment of a wide range of clinical disorders, including articulation disorders, autism, dysarthria, fluency disorders, language and cognitive disorders, dysphagia, and voice disorders.

In closing, while Section 1332 waivers present an opportunity for states to develop innovative approaches for health care coverage specific to their residents, ASHA wants to ensure that all Americans continue to have access to high-quality, affordable health care that meets their needs. We appreciate your consideration of our comments on this important topic. Please contact me, Daneen Grooms, ASHA’s director of health reform analysis and advocacy, at 301-296-5651 or by e-mail at dgrooms@asha.org, if you require additional information or clarification.

Sincerely,

Daneen P. Grooms, MHSA
April 6, 2017

Commissioner Ted Nickel (WI)
Chair, Health Care Reform Regulatory Alternatives (B) Working Group
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners
444 North Capitol Street, NW
Suite 700
Washington, DC 20001

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Specifically, this letter will address recommendations found in the Oklahoma 1332 Task Force Concept Paper to:
- Re-evaluate and reduce the essential health benefits package
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- Encourage the use of telehealth.

**Re-evaluate and reduce the essential health benefits (EHB) package**

The Secretary of the Department of Health and Human Services (HHS) may grant a request for a waiver if it is determined that the state plan will provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of Title 42 of the United States code. The statute requires benefits
shall include at least 10 categories, including coverage of rehabilitative and habilitative services and devices. Any efforts to re-evaluate the EHB package should maintain at a minimum coverage for these services. In the February 2015 Benefit and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined “habilitation services and devices” using the definition of “habilitation services” from the NAIC’s Glossary of Health Coverage and Medical Terms plus explicitly adding habilitation devices, as follows:

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In closing, while Section 1332 waivers present an opportunity for states to develop innovative approaches for health care coverage specific to their residents, OSHA wants to ensure Oklahomans continue to have access to high-quality, affordable health care that meets their needs. We appreciate your consideration of our comments on this important topic. Please contact Sarah Baker at 405-201-8134 or by e-mail at sbakerslp@hotmail.com, if you require additional information or clarification.

Sincerely,

Suzanne Kimball, AuD, CCC-A  
President, Oklahoma Speech-Language-Hearing Association

Sarah Baker, MS CCC-SLP  
Habilitation Advocate for Oklahoma  
Private Practice Chair-OSHA
Agenda Item #5

Discuss Any Other Matters Brought Before the Working Group—J.P. Wieske (WI)