ROLL CALL

Ted Nickel, Chair     Wisconsin     Brendan Peppard     New Jersey
Roger A. Sevigny, Vice Chair     New Hampshire     Troy Oechsner     New York
Lori K. Wing-Heier     Alaska     Jon Godfread     North Dakota
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 Glause     Wyoming

NAIC Support Staff: Jolie H. Matthews

AGENDA

1. Consider Adoption of its Spring National Meeting Minutes—J. P. Wieske (WI)

2. Hear Updates on, and Status of, State Federal Affordable Care Act (ACA) Section 1332 Activity—J. P. Wieske (WI)
   • Hawaii—Arlene R. Ige (HI)
   • Minnesota—Fred Andersen (MN), Kristi Bohn (MN) and Peter Brickwedde (MN)

3. Hear a Presentation from the Council for Affordable Health Coverage (CAHC) on Potential Policies Related to the ACA Section 1332 Waivers and Other Waivers—Joel White (CAHC)

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

5. Adjournment
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Agenda Item #1

Consider Adoption of its Spring National Meeting Minutes—*J.P. Wieske (WI)*
The Health Care Reform Regulatory Alternatives (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Denver, CO, April 8, 2017. The following Working Group members participated: Ted Nickel, Chair, represented by J.P. Wieske (WI); Roger A. Sevigny, Vice Chair, represented by Jennifer Patterson (NH); Lori K. Wing-Heier (AK); Jennifer Vaughn (DE); Eric Johnson (FL); Kathy McGill (ID); Jennifer Hammer (IL); Karl Knable (IN); Julie Holmes (KS); Marti Hooper (ME); Mary Mealer (MO); Matthew Rosendale (MT); Jon Godfread (ND); Martin Swanson (NE); Gale Simon (NJ); Mackay Moore (NV); Troy Oechsner (NY); James Mills (OK); Kendall Buchanan (SC); Melissa Klemann (SD); Michael Humphreys (TN); Jan Graeber (TX); Tanji Northrup and Nancy Askerlund (UT); Osbert E. Potter represented by Cheryl Charleswell (VI); Molly Nollette (WA); and Tom Glaus (WY). Also participating were: Mary Ellen Breault (CT); and Al Redmer Jr. (MD).

1. **Heard Opening Remarks**

Mr. Wieske said the Working Group’s meeting should be considered an information-gathering session. He said that given the uncertainty regarding the repeal, replacement or repair of the federal Affordable Care Act (ACA), many states are interested in understanding what options they may have, such as pursuing a Section 1332 waiver or Medicaid 1115 waiver. As such, Mr. Wieske said the Working Group invited Wisconsin and New Hampshire to discuss their approaches regarding their Medicaid programs, and Alaska and Oklahoma to discuss their Section 1332 waiver activities.

2. **Heard a Presentation on the Wisconsin Medicaid Program**

Michael Heifetz (Wisconsin Department of Health Services, Medicaid Program) provided a current snapshot of Wisconsin’s Medicaid program. He also described the program’s past coverage structure and its current coverage structure. Mr. Heifetz said that in the past, under the BadgerCare Plus Core Plan (Plan), coverage was provided to adults without dependent children with incomes up to 200% of the federal poverty level (FPL). He said enrollment was capped, and a waitlist for coverage under the Plan was maintained. Mr. Heifetz said the Plan was a limited benefit plan, which did not comply with the essential health benefits (EHBs) under the ACA. He said the program’s current coverage structure, the so-called “Wisconsin Model,” covers all Wisconsin adult residents with an income of up to 100% of the FPL. Residents with an income above 100% of the FPL enter the private market through the exchange and can obtain subsidies. Mr. Heifetz said that according to the Kaiser Family Foundation, Wisconsin is the only state that did not expand Medicaid under the ACA with no coverage gap. He also explained that the program provides coverage under one comprehensive package for all participants.

Mr. Heifetz described Wisconsin’s commercial insurance market. He said there are 18 insurers in the individual market, with 15 offering both on and off the exchange health benefit plans. Mr. Heifetz noted that there is no dominant insurer by market share. He discussed potential federal reforms, such as changing the Medicaid program to a block grant funding. Mr. Heifetz stressed the importance of providing state flexibility.

Commissioner Redmer asked about Wisconsin’s uninsured rate. Mr. Heifetz said it is currently 6%.

3. **Heard a Presentation on the New Hampshire Medicaid Program**

Ms. Patterson said New Hampshire chose to expand its Medicaid program and established the Bridge to Marketplace Program (Program) in 2015. She said that New Hampshire has seen its individual market grow from about 52,000 to 107,000 in 2016. Ms. Patterson also noted that an indirect benefit with establishing this program is the strengthened relationship between the New Hampshire Department of Insurance (DOI) and the New Hampshire Department of Health and Human Services’ (DHHS) Office of Medicaid and Business Policy (OMBP). She said this new relationship also helped in responding to the opioid use issue. Ms. Patterson said that whatever federal changes are made, they will still enable the state to continue programs like New Hampshire has been able to establish. Mr. Wieske asked if the Program has helped with the typical churning issue where individuals move frequently between the Medicaid program and the commercial individual health insurance market or move off and on the individual health insurance market multiple times during a policy year. Ms.
Patterson said the Program has eased this situation. She said she believes that was one goal in establishing it, and it appears to be working.

4. Heard Presentation on Federal ACA Section 1332 Waivers

a. Alaska

Director Wing-Heier discussed Alaska’s reasoning for applying for a Section 1332 waiver. She said one reason Alaska decided to apply for a waiver was due to the loss of carriers willing to participate in the individual market. Alaska has only one carrier participating in 2017, and premium rates were skyrocketing. Director Wing-Heier said the Alaska DOI figured it had to do something to help stabilize the market. Premiums needed to be higher to prevent the exit of the one remaining insurer, and premiums needed to be lower to prevent healthier lives from leaving the market. She said the Alaska DOI established the Alaska Reinsurance Program (ARP) in June 2016. Director Wing-Heier explained how the ARP is funded through a budget appropriation from a 2.7% premium tax on all insurers. She said after the ARP was established, the one remaining insurer filed rates and was approved for a 7.3% rate increase, which was significantly lower than the previous 42% rate increase prior to the ARP’s establishment.

Director Wing-Heier said that although the ARP appeared to be working, the Alaska DOI had a problem because the Alaska legislature placed a two-year sunset on the ARP’s funding stream, which meant that the Alaska DOI had to find another source of funding. She explained that in the legislation enacting the ARP, a provision was added permitting the Alaska DOI to apply for a Section 1332 waiver. As such, to obtain the needed funding, the Alaska DOI decided to apply for a waiver. Director Wing-Heier said Alaska submitted its application in November 2016, and the federal Center for Consumer Information and Insurance Oversight (CCIIO) has accepted it, but it has not been approved. She said Alaska estimates that the reduction in the premium increase from 42% to 7.3% in 2017 saved the federal government $51.6 million in advance premium tax credits for 2018. As such, Alaska has requested that amount to be passed through to the state assuming the waiver is effective in 2018.

Mr. Wieske asked for comments. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) described the consumer protection provisions in the Section 1332 waiver process. Joel Ario (Manatt Health Solutions) cautioned that each state is different. He said premiums were high in Alaska. As such, there is more of a return to the federal government as Director Wing-Heier explained.

b. Oklahoma

Mr. Mills discussed Oklahoma’s activities related to its preparation for submitting a Section 1332 waiver application. He explained that Oklahoma is a direct enforcement state, and it did not pursue Medicaid expansion. Mr. Mills said Oklahoma’s exchange experience has not been good to date. Oklahoma has one insurer participating in the exchange this year. He said Oklahoma also has seen significant rate increases. Mr. Mills said that in 2016, the legislature enacted legislation, Senate Bill 1386, to address the challenges of Oklahoma’s health insurance market. He said contingent on the approval of a Section 1332 waiver, the legislation also gave the Oklahoma DOI authority to perform rate reviews for individual and small group market rate filings and qualified health plan (QHP) certification. Mr. Mills said Governor Mary Fallin established the 1332 Waiver Task Force (Task Force) to bring together a diverse set of stakeholders to develop potential strategies for addressing Oklahoma’s health insurance market challenges as part of pursuing the waiver. He said the Task Force has been meeting since August 2016 to discuss Oklahoma’s individual health insurance market challenges and design solutions to support these guiding principles in order to stabilize Oklahoma’s individual health insurance market.

Mr. Mills described Oklahoma’s individual insurance market. He said that in 2015, Oklahoma had the fourth highest mortality rate, experienced premium increases in excess of 75% on average for plan year 2017, and only 31% of eligible individuals are purchasing coverage on the exchange for plan year 2016. Mr. Mills said the Task Force explored the reasons for these issues and determined that some were due to: 1) low enrollment; 2) churning between the Medicaid program and the commercial market; 3) lack of competition; 4) plan design; and 5) lack of state oversight with respect to rate review and other oversight responsibilities. He said the Task Force issued a report with draft recommendations for stabilizing Oklahoma’s individual health insurance market. Mr. Mills said the Oklahoma legislature has approved them. He said Oklahoma likely will pursue sequential Section 1332 waivers and/or amendments to an initial waiver to implement the changes over time. Mr. Mills said it is anticipated that an initial waiver allowing the state to assume more responsibility over rate review and
QHP qualification will be submitted in July 2017, with implementation in 2018, and the second phase waiver most likely will be implemented in 2019.

Having no further business, the Health Care Reform Regulatory Alternatives (B) Working Group adjourned.

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Agenda Item #2

Hear Updates on, and Status of, State Federal Affordable Care Act (ACA) Section 1332 Activity—J.P. Wieske (WI)

- Hawaii—Arlene R. Ige (HI)
- Iowa—Andria Seip (IA)
- Minnesota—Fred Andersen (MN), Kristi Bohn (MN) and Peter Brickwedde (MN)
Section 1332 Innovation Waiver
Presentation to NAIC Health Care Reform Regulatory Alternatives WG
Minnesotans access health insurance in many ways

Minnesota Health Insurance by Market (2015)

- Uninsured, 4.3%
- MinnesotaCare, 1.9%
- Medicare, 16.6%
- TRICARE, 1.0%
- Individual Market, 5.4%
- Small Group Market, 4.8%
- Large employer - insured, 12.6%
- Large employer - self insured, 37.8%
- Medical Assistance, 15.6%
Minnesotans who buy their own insurance need help

• About 170,000 Minnesotans get healthcare coverage through the individual market
  • Minnesotans without access to coverage through an employer, basic health plan (MinnesotaCare), Medicare, Medicaid
  • Contractors, farmers, realtors, daycare providers
• Premiums increased significantly in 2016 and 2017
Rising costs have destabilized Minnesota’s individual market

• The rate of premium increases has been dramatic
  • Driven by high-cost claims and healthy people leaving the market
  • In 2015, claim costs exceeded premiums collected by 38%
    • In 2014, individual market rates were particularly low in MN vs. other states
  • 50% of individual market claim amounts have been incurred by 2.2% of enrollees
  • Costs are passed on to all individual market enrollees in the form of higher premium rates
National events also affected Minnesota’s individual market

• Federal programs provided stabilizing assistance but not in amounts originally promised and are no longer in effect

• Minnesota insurance companies reacted with rate increases, narrower provider networks and market exit

• Minnesota isn’t unique - Similar issues occurring in other states
Why Minnesota chose to subsidize individual market

- Those earning too much money to get federal tax credits were facing substantially higher premium rates
- Higher rates were mainly caused by costs associated with highest-cost claims
- Addressing high-cost claims lowers premiums
The MPSP will use some Federal money to fund the reinsurance program

• Because reinsurance will lower premiums, it also will lower federal tax credits Minnesotans use to make their insurance more affordable
  • Higher premiums = higher federal tax credits; lower premiums = lower Federal tax credits

• Minnesota’s waiver seeks to retain the foregone federal tax credits and use those federal funds to help support the MPSP
  • Budget neutral for the federal government, as required under 1332
  • Using money that would otherwise come to Minnesota if the reinsurance program didn’t exist
Establishment of Minnesota’s reinsurance program is contingent on approval of the state’s 1332 waiver

- For the MPSP to work, Minnesota needs an approved waiver

- With an approved waiver, the MPSP will:
  - Decrease premiums from what they otherwise would be absent the program
  - Not change employer-based insurance, Medicare, or Medicaid
  - Have no impact on MN’s basic health plan, MinnesotaCare
The amount of federal funding for the MPSP could be significant

- The federal government can be expected to pay 35%-50% of the $271 million expected annual cost of the MPSP
  - Equates to over $100 million per year in federal support
  - MPSP parameters are $50K attachment point, $250K cap, and 80% coinsurance
  - Parameters were backed into based on MN legislature’s desire to have $271 million program
    - State funding from general fund and health care access fund; insurer tax considered
  - Parameter/cost calculations were based on past claims data and projected trend
  - Final cost TBD (depending on total enrollment, high-cost enrollment, etc.)
Timeline – legislation through current

- **4/4/17:** State legislation directs Commerce to seek 1332 waiver
- **4/28/17:** Draft waiver and actuarial analysis posted publicly on Commerce website
- **May 2017:** Several public hearings in MN
- **5/30/17:** Submission of waiver to CMS
- **6/30/17:** Submission deemed “complete” by CMS
- **6/30/17-7/30/17:** Federal comment period
Minnesota experience – 1332 process

• All waiver and actuarial analysis work was performed internally by Department staff
  • Est. 1,000 hours of total work
  • Most work performed before CMS released 1332 checklist
  • Checklist will be very helpful to states in future
• Keys for efficient process:
  • Understand what federal government is seeking
    • For federal budget-neutral analysis:
      • Establish targets / template for easy analysis of key aspect:
        • Comparison of future Federal spending (to state enrollees), before and after the program
        • e.g., 2nd lowest silver rates and number of tax credit recipients by rating area
    • Work with CMS on legislation/contingency requirement
• Questions or comments?
Agenda Item #3

Hear a Presentation from the Council for Affordable Health Coverage (CAHC) on Potential Policies Related to the ACA Section 1332 Waivers and Other Waivers—Joel White (CAHC)
Addressing Market Uncertainty and Stability Through Waivers
WHERE WE ARE AND WHERE ARE WE HEADED?
The ACA made massive changes to health markets – some positive and some negative.

- It created new consumer protections, corrected market imbalances, and reduced the number of uninsured Americans to historic lows.
- Yet, overreach by the ACA has also contributed to high and growing health insurance premiums.
- Plan choice and competition have declined.
- ACA’s enrollment risk pools are seriously unbalanced.

**Result:** An unstable and expensive market that is driving away many of the healthy consumers needed to hold coverage costs down.

**Further:** Massive uncertainty created by political turmoil has made a bad situation much worse.
ACA EXCHANGE ENROLLMENT: ROUGHLY 11M SIGN-UPS AFTER 2017 OPEN ENROLLMENT

ACA Insurance Exchange Enrollment
2014 - 2017

*Approximate enrollment total.
2017 ENROLLMENT PROJECTIONS, IN MILLIONS

2017 EXCHANGE ENROLLMENT PROJECTIONS, IN MILLIONS

- CBO, March 2010: 23
- CBO, January 2017: 10

2013 POTENTIAL EXCHANGE POPULATION VS. 2017 ENROLLED POPULATION, BY AGE

1 Number of potential eligible exchange enrollees determined using 2013 American Community Survey data on the Uninsured and Non-group populations prior to implementation of the health insurance exchanges. Analysis includes the 38 states relying on healthcare.gov in 2016.

As of July 26, 2017 – Map from CMS does not account for recent agreement in certain states for insurer participation or for potential future exits from insurers.
Average Second Lowest Cost Silver Plan Premiums for a 27-Year Old (Before Tax Credits), 2014-2017

*Data are for the 39 states utilizing HealthCare.gov only.

Average National Deductibles for Individual Exchange Coverage*

<table>
<thead>
<tr>
<th>Year</th>
<th>Average National Silver Individual Exchange Coverage Deductibles*</th>
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</thead>
<tbody>
<tr>
<td>2014</td>
<td>$2,907</td>
</tr>
<tr>
<td>2015</td>
<td>$2,927</td>
</tr>
<tr>
<td>2016</td>
<td>$3,117</td>
</tr>
<tr>
<td>2017</td>
<td>$3,572</td>
</tr>
</tbody>
</table>

* Individual Silver is the most popular Exchange plan.

Source for Individual Market: Data.HealthCare.gov via HealthPocket’s Infostat Reports.
1) **Political Uncertainty:** Uncertainty in congressional and executive action over CSR funding and health reform raises premiums and decreases market participation.

2) **Medical Cost Trend:** Health spending is expected to grow by 6.5% in 2018.*

3) **Risk Pool:** Risk pools are likely to continue to be smaller, sicker, costlier, and less predictable with high rates of churn.

4) **Less Competition:** Consolidation in the provider space relative to insurers leads to higher negotiated rates and/or narrower networks. Choice among insurers has decreased.

5) **Regulatory Overreach:** Few tools remain for insurers to effectively limit costs in the current environment.

*Source: PwC. Medical Cost Trend: Behind the Numbers 2018.*
STATE WAIVERS
States may apply to waive certain aspects of the ACA and IRC

Provided Certain Guardrails are Affirmed

01. QHPs
   - EHBs
   - Annual out of pocket costs
   - Actuarial value

02. MARKETPLACE
   - Alternate enrollment options
   - Enrollment periods
   - Risk pools

03. FINANCIAL ASSISTANCE
   - Tax credits
   - Cost sharing reduction subsidies
   - Family contributions

04. MANDATES
   - Individual mandate
   - Employer mandates

01. COMPREHENSIVENESS

02. UNINSURED

03. AFFORDABILITY

04. NO DEFICIT INCREASE
• States are entitled to funds the federal government would have spent to help provide coverage in the absence of a waiver, including funds spent on subsidies and CSRs

• If a state is able to reduce costs for subsidies and CSRs, then the state can receive “pass through” funding to reduce state costs and/or increase benefits
• Before a state may apply, it must pass legislation enacting the state plan.

• Secretaries (HHS and IRS) retain approval discretion.

• 180 days to review and approve or deny.

• Limited to 5 years, with possibility of renewal.

• Medicaid and Marketplace Waivers can be submitted simultaneously…but, savings and costs cannot be shared among programs.
### RECENT STATE INTEREST

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Description</th>
<th>Status</th>
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<tbody>
<tr>
<td></td>
<td>Pass through funding partially finances the state reinsurance program. The state reinsurance program saw great success last year and has inspired other states.</td>
<td>Approved 7/11/2017</td>
</tr>
<tr>
<td></td>
<td>Allow undocumented immigrants to purchase coverage without premium subsidies</td>
<td>Proposal Withdrawn</td>
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<td>Revert to state law with respect to employer coverage, and waive requirements small business tax credit only be available through SHOP.</td>
<td>Approved 12/30/16</td>
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<td></td>
<td>Stopgap plan, replace income based credits with flat credits, eliminate cost-sharing subsidies. Federal pass-through funds finance new reinsurance and premium subsidies</td>
<td>Under review</td>
</tr>
<tr>
<td></td>
<td>New reinsurance program funded by state and federal pass-through.</td>
<td>Under review</td>
</tr>
<tr>
<td></td>
<td>Allow direct enrollment for small group rather than through SHOP.</td>
<td>On hold</td>
</tr>
</tbody>
</table>
• Restrictive interpretation of waivers under 2015 guidance

• Trump Administration has signaled it supports more applications, faster approval, and creative risk pooling strategies.

• It is likely to have looser interpretations of conditions needed to meet approval for:
  • “at least as comprehensive”
  • “at least as the same coverage levels” and
  • “at least as affordable”

• HHS’ analysis of the Cruz Amendment to the Senate repeal and replace bill hints at this.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Current Law/Situation</th>
<th>Problem</th>
<th>Solution</th>
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</thead>
<tbody>
<tr>
<td>Timeline</td>
<td>180 day approval</td>
<td>Too slow</td>
<td>Require faster approval</td>
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<tr>
<td>Approval Process</td>
<td>Waivers can be denied and curtailed</td>
<td>Slow process that gives less certainty to states to plan</td>
<td>Mandate approval or allow additional flexibility</td>
</tr>
<tr>
<td>Guardrails Too Stringent</td>
<td>• Scope of Coverage</td>
<td>Flexibility is insufficient to allow for much</td>
<td>Repeal guardrails, opt out of more of ACA (EHBs)</td>
</tr>
<tr>
<td>Pass-Through</td>
<td>Pass through funding is not allowed to cross</td>
<td>Limits the scope and ability for simultaneous waiver applications</td>
<td>Allow simultaneous waivers to be budget neutral as a whole, not just individually</td>
</tr>
<tr>
<td>HealthCare.gov</td>
<td>Most states rely on HC.gov</td>
<td>HHS will not tailor HC.gov to accommodate individual states; no other options</td>
<td>Allow states to use funding through user fees dedicated to HC.gov for additional enrollment options</td>
</tr>
<tr>
<td>IRS Rules</td>
<td>IRS rules govern subsidies</td>
<td>IRS will not accommodate individual states action on subsidies</td>
<td>States may use block grant approaches</td>
</tr>
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<td>State Legislation</td>
<td>Requires state legislation authorizing the</td>
<td>Limits the ability of states to submit waivers, particularly in states with biannual legislative sessions; slows process</td>
<td>Replace requirement for state legislation with a lower barrier requirement</td>
</tr>
<tr>
<td>Issue</td>
<td>Current Law</td>
<td>House</td>
<td>Senate</td>
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<tr>
<td>Areas That Can Be Waived</td>
<td>• Mandates</td>
<td>• Current law</td>
<td>• Current law</td>
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<td></td>
<td>• Benefits</td>
<td>• Community rating</td>
<td>• Community rating</td>
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<td></td>
<td>• Market</td>
<td>(provides $8 billion for</td>
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<td></td>
<td>Rules</td>
<td>states that waive this)</td>
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<td>• Exchanges</td>
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<td>Tests</td>
<td>• Comprehensive</td>
<td>• Budget Neutral</td>
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<td>• Scope of</td>
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<td>Coverage</td>
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<td></td>
<td>• Affordability</td>
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<td>• Budget</td>
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<td></td>
<td>Neutral</td>
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<tr>
<td>Process</td>
<td>• 180 day review</td>
<td>• 45 day review</td>
<td>• 45 day review</td>
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<td></td>
<td>• No additional federal funds</td>
<td>• 8 year approval</td>
<td>• Secretary “shall” approve</td>
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<tr>
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<td>• Pass through funding</td>
<td>• Secretary “shall” approve</td>
<td>• 8 year approval</td>
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<td>• 5 year approval</td>
<td>• State attestation that they reduce premiums and increase affordability</td>
<td>• $2 billion annually 2017-2019</td>
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<td>• Stability/ innovation funds</td>
<td>• Stability/ innovation funds</td>
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IDEAS TO STABILIZE MARKETS, IMPROVE ENROLMENT AND LOWER COSTS
Unbalanced risk pools require risk mitigation strategies
Will require more or repurposed funds
Increased funding reduces premiums on a linear basis
Waivers provide opportunities to establish risk strategies
States can take the lead and implement quickly
<table>
<thead>
<tr>
<th><strong>Stabilize Pools</strong></th>
<th>Establish invisible or other risk mitigation strategy</th>
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<tbody>
<tr>
<td></td>
<td>Fund through pass-through and/or state funds</td>
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<td><strong>Market Rule Flexibility</strong></td>
<td>Plans that sell ACA compliant plans may sell alternate, subsidy eligible plans</td>
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<td>Single risk pool</td>
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<td></td>
<td>Alter risk adjustment and subsidy benchmark to account for new plan types (will need to argue for block grant of subsidies)</td>
</tr>
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<td>Allow continuous coverage discounts and other positive incentives for people to obtain and retain coverage</td>
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<td><strong>Consumer Driven Subsidies</strong></td>
<td>Create a fund for a “glide-path” from Medicaid expansion to private coverage and to supplement tax credits for low-income people whose subsidies would be higher under the ACA</td>
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<td>Convert CSRs to consumer-driven accounts funded by pass-through payments (similar to Indiana’s POWER Accounts in their 1115 waiver)</td>
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<td>Could be used to cover both premiums and cost-sharing</td>
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<td><strong>Alternative Exchanges</strong></td>
<td>Allow subsidy off exchange</td>
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<td></td>
<td>Portion of user fees for HealthCare.gov to fund alternate enrollment pathways</td>
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<td>Federal data hub maintains eligibility functions</td>
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WHAT CAN THE ADMINISTRATION DO?

• Issue new guidance to allow additional flexibly for states, particularly in meeting criteria for approval (e.g. scope of coverage)

• Count savings in all markets to count towards pass-through funding, allowing simultaneous waiver applications to be budget neutral as a whole

• Allow 1115 and 1332 super waivers

• Provide model templates for states to use based on other successes
• Waivers can stabilize markets in the absence of Congressional or Administration action

• One size fits some isn’t working everywhere. We should recognize and be OK with that

• We expect to see additional flexibility added with the potential for greater federal funds to implement and incentivize waivers in the future

• Our members are ready to help states explore options that best suit the needs of their individual markets
THANK YOU

Joel White
President
Joel.white@cahc.net
202-744-1806
Agenda Item #4

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