State Health Reform Assistance Network
Charting the Road to Coverage
1332 State Innovation Waivers: Lessons Learned from the Basic Health Program

Manatt Health Solutions
November 2015
Overview
Today’s Focus

Discuss lessons learned from implementing the Basic Health Program (BHP) to inform 1332 planning across two key areas:

1. Federal Funding Methodology
2. Key Policy and Operational Issues
Federal Funding Methodology
How will CCIIO calculate the amount of federal funds available to the states under a 1332 waiver?

**Basic Health Program**

“The amount determined . . . is equal to 95 percent of the premium tax credits under section 36B of title 26, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.”

PPACA § 1331(d)(3)(A)(i)

**1332 Waiver for Innovation**

“The Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver.”

PPACA § 1332(a)(3)
Approach to Calculating BHP Funding

“The BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in general alignment with the methodology used by Exchanges.”

42 CFR 600(3)(A)

Determine 95% PTC/CSR funding on a per enrollee basis

Account for each enrollee’s:
- Age
- Income
- Coverage type (self-only or family)
- Geography
- Health status
- Income reconciliation

Consider Exchange experience with a special focus on enrollees < 200% FPL.

PPACA § 1331(d)(3)(A)(ii)
Overview of BHP Funding Methodology

Step 1
- Segment BHP population into “rate cells”
- Assign a reference premium for each rate cell

Step 2
- Determine estimated PTC for each rate cell

Step 3
- Determine estimated CSR for each rate cell

Step 4
- Determine a state’s total monthly federal payment
Segment BHP population into “rate cells” and determine a reference premium for each cell

Rate cells represent a unique combination of:

- Age range (0-20, 21-34, 35-44, 45-54, 55-64)*
- Geographic rating area
- Coverage category: Self-only vs. Family
- Household size (1, 2, 3, 4, 5)
- Income range by FPL (0-50%, 51-100%, 101-138%, 139-150%, 151-175%, 175-200%)

Reference premium based on the SLCSP for individuals with these factors

*For states that do not use age rating, the BHP payment rate will not vary by age in those states.
OPTIONAL: Apply adjustment factors for population health and/or premium trend to the reference premium

Rate cells represent a unique combination of:
- Age range (0-20, 21-34, 35-44, 45-54, 55-64)
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Reference Premium

Adjusted Reference Premium

Apply population health factor and premium trend factor, at state option

Note: Population Health Factor (PHF): PHF= 1 through 2018 (until subsequent methodology alters), unless state proposes state-specific adjustment.
Premium Trend Factor (PTF): State option to use the prior year’s premiums as the basis for the federal payments, in which case, the reference premium is adjusted for the PTF.
**Step 2** Determine estimated PTC for each rate cell

Rate cells represent a unique combination of:
- Age range (0-20, 21-34, 35-44, 45-54, 55-64)
- Geographic rating area
- Coverage category: Self-only vs. Family
- Household size (1, 2, 3, 4, 5)
- Income range by FPL (0-50%, 51-100%, 101-138%, 139-150%, 151-175%, 175-200%)

- Determine estimated PTC payment for individuals in each cell
- Adjust for Income Reconciliation Factor

= PTC

*Note: The PTC portion of each rate represents the average that all persons in the rate cell would receive.*
BHP Federal Funding Methodology, cont.

Step 3 Determine estimated CSR for each rate cell

- Rate Cells represent a unique combination of:
  - Age range (0-20, 21-34, 35-44, 45-54, 55-64)
  - Geographic rating area
  - Coverage category: Self-only vs. Family
  - Household size (1, 2, 3, 4, 5)
  - Income range by FPL (0-50%, 51-100%, 101-138%, 139-150%, 151-175%, 175-200%)

- Determine estimated CSR payment for individuals in each cell
- Adjust for:
  - Tobacco rating
  - Administrative costs
  - Induced utilization

= CSR

Note: The PTC portion of each rate represents the average that all persons in the rate cell would receive.
Step 4

Determine a state’s total monthly federal payment

Payment for Rate Cell X = (95% PTC + 95% CSR) x Projected # of Enrollees

+ 

Payment for Rate Cell Y = (95% PTC + 95% CSR) x Projected # of Enrollees

+ 

Payment for Rate Cell Z = (95% PTC + 95% CSR) x Projected # of Enrollees

Total Monthly Payment to State
Key Policy & Operational Issues
Population Health Factor

**BHP Approach**

- CMS assumes no health status differences between BHP and QHP enrollees (i.e., Population Health Factor = 1)

- States have the option to propose and implement a retrospective risk adjustment if they believe their BHP population to be less healthy than their Marketplace population.

- MN opted to develop and implement risk adjustment protocol as part of payment methodology; NY opted not to pursue risk adjustment.

**Key Insights**

- Payment methodology flexibility is helpful to states operating in an uncertain environment but also complicates the payment process.

- In the absence of Marketplace data, actuarial analysis was crucial to states in predicting their expected BHP populations.

- Analysis of potential variables and models for 1332 waivers will be able to build off of 2014-2016 Marketplace data.
Prospective Payments to States

**BHP Approach**

- CMS determines BHP payments to states on a prospective, state-specific, quarterly basis, multiplying payment rates by projected BHP enrollment.

- Payments are adjusted retrospectively based on actual enrollment but are not corrected for any other factors (except in states pursuing optional risk adjustment).

- Additional payments are deposited into the BHP Trust Fund, while reductions are applied to the state’s prospective payment in the upcoming quarter.

**Key Insights**

- Prospective methodology provides states with predictability.

- Quarterly payments allow for incremental adjustment rather than one annual adjustment of the entire amount.

- 1332 does not require states to set up a Trust Fund.
Risk Pool

BHP Approach

• The BHP population is excluded from the individual Marketplace.

• States conducted analyses to determine the impact this would have on the relative health of their Marketplace population.

Key Insights

• If a state uses its 1332 waiver to implement an alternative coverage vehicle for a subset of its Marketplace population, there will be risk pool implications.
Funding for Program Administration

BHP Approach

• 1331(d)(2) requires that BHP federal funding “only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for” BHP enrollees.

• States must identify other (non-federal) funding sources to cover BHP program administration costs.

Key Insights

• Nothing in the 1332 requirements appears to impose the same prohibition on states.
Non-Filer Households

**BHP Approach**

- CMS permits BHP enrollees to be non-filers.
- For non-filer households, use Medicaid rules to determine household size and income.
- For filer households, use Marketplace rules to determine household size and income.

**Key Insights**

- Flexibility critical but complicated to administer.
- NY used Medicaid non-filer rules with retrospective sampling and CMS is evaluating potential payment adjustments.
Medicaid/Marketplace Alignment

**BHP Approach**
- To the extent possible, CMS aligned BHP rules with Medicaid and/or Marketplace rules.
- Where Marketplace and Medicaid rules conflicted, CMS sought to align BHP with one program or the other, or where possible, provide States with flexibility to choose how to align.

**State Flexibility**
- Most E&E features, including:
  - Authorized Representatives
  - CACs
  - Eligibility Verification
  - Eligibility Effective Date
  - Enrollment Period
  - Eligibility Appeals
  - Eligibility Redeterminations

- Some enrollee premiums & cost sharing features, including:
  - Premium Grace Periods
  - Reenrollment Standards

**Key Insights**
- 1332 waivers provide an opportunity to align Marketplace rules with Medicaid rules.

**Marketplace:**
- First day of the following month if QHP selected between 1\textsuperscript{st}-15\textsuperscript{th} or first day of second following month if QHP selected between 16\textsuperscript{th} and last day. 45 CFR 155.420(b)(1)

**Medicaid:**
- First day of the month if individual was eligible any time during that month. 42 CFR 435.915(b)
Launch & Coverage Transitions

BHP Approach

- Permitted to phase-in enrollment in 2015 only.
- MN employed block renewal process for January 1, 2015.
- NY opted for phased-in approach:
  - Transition Period (April 1-Dec 31, 2015) for lawfully present non-citizens with household incomes 0-133% FPL
  - Full Launch (January 1, 2016)

Key Insights

- High potential for disruption (among consumers, IT systems, etc.)
- Phased-in approach allows time for coverage conversion, near-term use of federal funding, and additional time for system build, staff training, and enrollee verification.
- Assistors and consistent messaging critical to all coverage transitions.
Discussion/Questions?
Next Steps
## Next Steps

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Thank you!

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