



A Robert Wood Johnson Foundation program

State Health Reform Assistance Network

Charting the Road to Coverage

Support
provided by



Robert Wood Johnson
Foundation

1332 State Innovation Waivers: Lessons Learned from the Basic Health Program

Manatt Health Solutions
November 2015

Agenda

- **Overview**
- **Federal Funding Methodology**
- **Key Policy & Operational Issues**
- **Discussion**

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

Introduction to BHP & 1332 Federal Funding



How will CCIO 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:

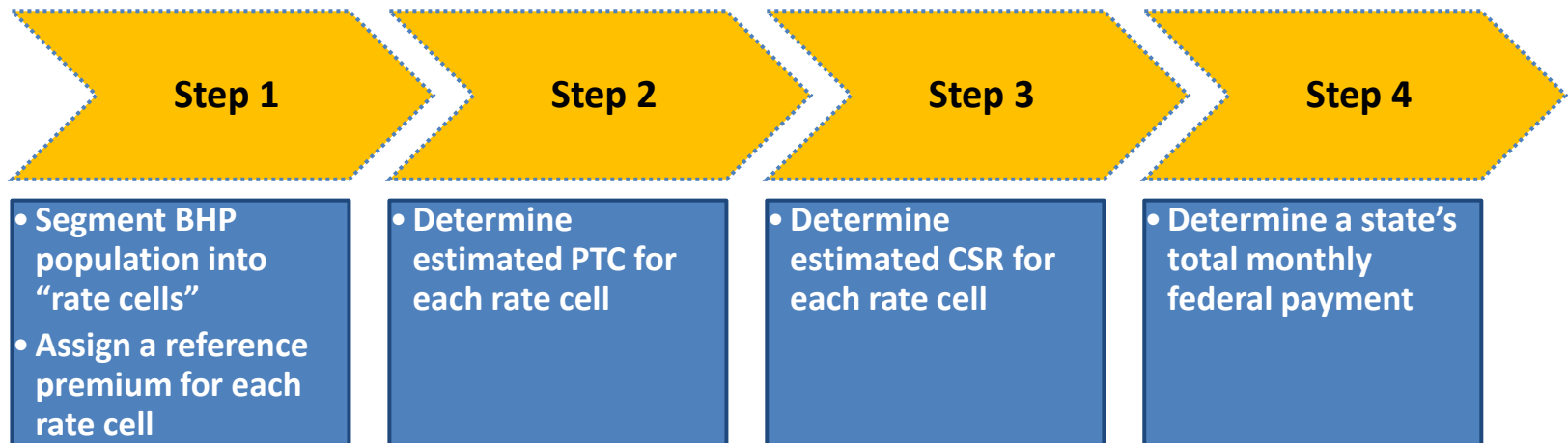
- Age
- Income
- Coverage type (self-only or family)
- Geography
- Health status
- Income reconciliation



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

PPACA § 1331(d)(3)(A)(ii)

Overview of BHP Funding Methodology



BHP Federal Funding Methodology

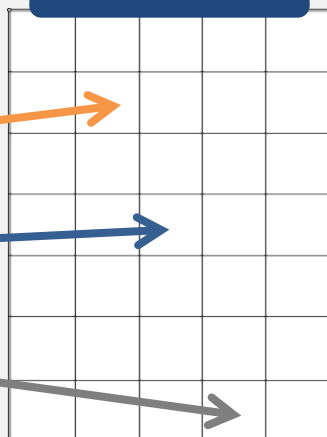
Step 1

Segment BHP population into “rate cells” and determine a reference premium for each cell

BHP Population



Rate Cells



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%)

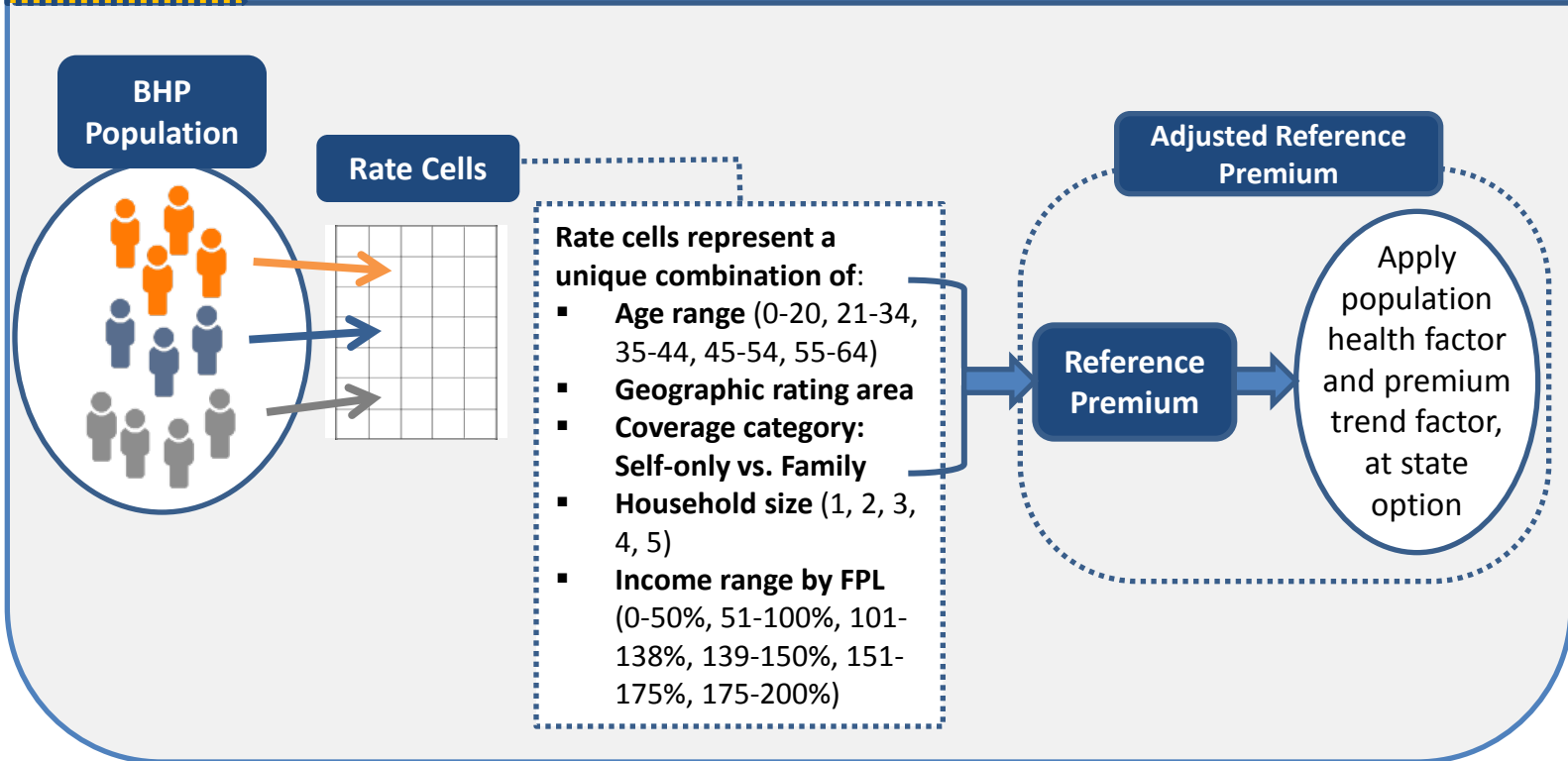
Reference premium based on the SLCSP for individuals with these factors

**For states that do not use age rating, the BHP payment rate will not vary by age in those states.*

BHP Federal Funding Methodology, cont.

Step 1a

OPTIONAL: Apply adjustment factors for population health and/or premium trend to the reference premium



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.

BHP Federal Funding Methodology, cont.

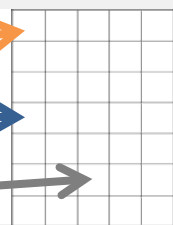
Step 2

Determine estimated PTC for each rate cell

BHP Population



Rate Cells



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.

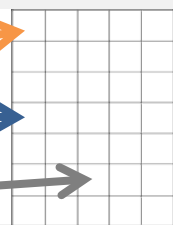
Step 3

Determine estimated CSR for each rate cell

BHP Population



Rate Cells



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.

BHP Federal Funding Methodology, cont.

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 determining household size and income.
- For filer households, use Marketplace rules to determining 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

Marketplace:

- First day of the following month if QHP selected between 1st-15th or first day of second following month if QHP selected between 16th 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)



Key Insights

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

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

Webinar Topic	Date
1332 State Innovation Waivers: What's Next for States	4/20/15 
1332 State Innovation Waivers: What Can be Waived?	5/29/15 
1332 State Innovation Waivers: Getting off the Ground	7/13/15 
1332 State Innovation Waivers: Coordinating 1332 and 1115 Waivers	8/24/15 
1332 State Innovation Waivers: Issues Related to Coordinated Waivers	10/6/15 
1332 State Innovation Waivers: Learning from the Basic Health Program	TODAY 
Topic TBD	TBD-- December

Thank you!

Deborah Bachrach DBachrach@Manatt.com

Patti Boozang PBoozang@Manatt.com

Melinda Dutton, MDutton@Manatt.com

Arielle Traub, ATraub@Manatt.com

Heather Howard, Heatherh@princeton.edu

Daniel Meuse, Dmeuse@princeton.edu