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STATE OF ALABAMA

January 13, 2017

The Honorable Kevin McCarthy
House Majority Leader
Congress of the United States
Washington, DC 20515

Dear Majority Leader McCarthy:

Thank you for the letter dated December 2nd that asked for recommendations on changes to the Affordable Care Act in an effort to improve quality and affordability in health insurance markets and in Medicaid.

I agree with you that Americans deserve more patient-oriented solutions, which would mean "more state choices and fewer federal mandates." States should be given the ability to reduce Medicaid benefits or enrollment, to impose premiums or other skin-in-the-game requirements for beneficiaries, or to reduce Medicaid spending in other ways if needed to match cuts in federal Medicaid revenues that may accompany reforms. Quality care would remain crucial, but a sustainable balance of revenues and spending also must exist.

Consumer choice also is vital. Repealing the Affordable Care Act without a clear replacement could raise concerns among insurers nationwide and cause some to withdraw from the market, limiting consumer choice.

Alabama's responses to your letter's questions are enclosed. I also would like to draw your attention to three specific recommendations related to health care:

- Adjust, by regulation or law, the Medicare Hospital Area Wage Index to reduce the wide gaps between states in hospital reimbursement rates paid by Medicare. The current wage index formula punishes hospitals by lowering federal payment rates as hospitals become more efficient. I also request deletion of the "Bay State boondoggle," the portion of the Affordable Care Act that changed the Area Wage Index to boost payments for a handful of states and cut them for others. Deleting that provision would help more than four-fifths of the nation's hospitals, according to the Alabama Hospital Association.

- Stop scheduled cuts in Medicaid Disproportionate Share Hospital (DSH) payments, cuts that would hurt hospitals that care for many indigent people, especially in states such as Alabama that have not expanded Medicaid under the Affordable Care Act. The scheduled cuts soon could reduce DSH payments to Alabama hospitals by more than $100 million a year, and about three-fourths of Alabama hospitals already operate in the red, according to the Alabama Hospital Association.

- Maintain federal funding for the Children's Health Insurance Program (CHIP) and maintain the Federal Medical Assistance Percentage (FMAP) increase now in place. Alabama has 150,000 people 18 and younger served by CHIP. Reducing the federal contribution to the regular state FMAP would cost Alabama about $90 million in Fiscal Year 2018 alone.

Please contact Dave White, my health policy advisor, at (334) 353-7480 or dave.white@governor.alabama.gov with any questions you may have.

Thank you for this opportunity to share some of the issues facing the State of Alabama. I look forward to working with you and others in Congress, and with the incoming President and his administration, to improve health-care quality, coverage, and sustainability for all Americans.

Sincerely,

Robert Bentley

Robert Bentley
Governor

cc: Senator Richard Shelby
Senator Jeff Sessions
Representative Robert Aderholt
Representative Mike Rogers
Representative Mo Brooks
Representative Martha Roby
Representative Terri Sewell
Representative Bradley Byrne
Representative Gary Palmer

Here are Alabama's responses to nine questions asked of governors and insurance commissioners in a letter dated December 2, 2016, from House Majority Leader Kevin McCarthy and five other leaders of the U.S. House of Representatives:

1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?

With the Affordable Care Act (ACA) and the Health Insurance Exchanges it created, oversight of the health insurance markets—from Exchange plans to short term medical plans—has shifted, with federal regulators taking unprecedented action in the business and regulation of insurance. The advent of the Federally Facilitated Marketplace (FFM) and the requirements that must be followed to offer a plan on the FFM raised costs for many insurers, and many have withdrawn from state markets. Repealing the ACA without a clear replacement could raise concerns among insurers nationwide, and cause more to withdraw from the market, limiting consumer choice. Alabama now has only one insurer offering qualified health plans on the FFM after two other insurers withdrew. A repeal without a replacement could result in no insurer on the FFM if this insurer also were to withdraw. Purchasing insurance on the FFM is the only way to receive cost-sharing reductions and premium tax credits to assist with the cost of health insurance. In Alabama, more than 125,000 people are eligible for the cost sharing subsidy/tax credits in the individual market. We must provide a smart and stable transition to the solutions developed so consumers are not jeopardized and markets are not destabilized.

The following are some of the topics we ask you to consider as you develop plans to replace the ACA:

- **Eliminate the Federal Marketplace and its accompanying federal rules.** Discontinuing the FFM will diminish the federal intrusion into the sale and regulation of health insurance. States have historically regulated this area, from market conduct examinations to forms compliance review and rate review. By eliminating the Federal Marketplace, many of the requirements placed on insurers in offering products would be significantly lessened. If the FFM is eliminated, some or all of the taxes and fees created under the ACA could also be eliminated, as the costs for the FFM and duplication of states' regulatory authority would no longer be necessary. Even if Marketplace exchanges continue as part of a replacement plan, Congress should require a significant reduction in federal regulations in areas of network adequacy, quality reporting, benefit offering requirements, grace periods, rate review, and the many other requirements developed since the ACA became law.
- **Let the states determine what plans offer creditable coverage for purposes of federal assistance.** The ACA dictated the essential health benefits that a health insurer must cover. We recommend that states be allowed to establish their own "standard" plans to be considered "creditable coverage" for purposes of qualifying for any federal assistance/tax credits. These plans should not be limited for sale only on the FFM to qualify for any federal assistance or tax credits. Once a state has designated plans as eligible for federal assistance or a tax credit that should be sufficient. Accordingly, states should determine open enrollment periods and special enrollment periods, grace periods for payment of

premiums, and other marketplace requirements currently determined by federal regulations for the FFM.

2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group and large group health insurance markets?

Dual federal and state regulatory oversight has proved burdensome to insurers. Here are some additional issues to consider, as well as those highlighted in question 1, as Congress and the incoming administration seek to stabilize the markets:

- **Continue guaranteed issue and replace the individual mandate with incentives for enrollment.** Guaranteed issue must be balanced with effective solutions to maintain continuous creditable coverage of healthy individuals and ensure sustainability. Eliminate the individual mandate and replace it with incentives for enrollment similar to Medicare Part B, where an individual pays a higher premium for a later enrollment, or add a waiting period for pre-existing conditions, or both. The increased premium and/or waiting period would provide strong incentives for healthy individuals to enroll in creditable coverage while offsetting increased costs to provide coverage for those who do not enroll until they are sick. It was the individual market that traditionally presented a challenge for underwriting when the ACA was created. Many people who did not purchase health insurance in the individual market were people who could not find an affordable plan due to their pre-existing conditions or high risk factors. With the elimination of pre-existing condition exclusions under the ACA, the individual market has become the national high-risk pool, one of the reasons premiums have increased. As a result, high premiums in the individual market have been a deterrent for healthy enrollees throughout the country. Additionally, high claims costs have not been spread over a broad population as originally intended. We believe coverage must be made affordable as we also avoid adverse selection.
- **Verification of enrollment eligibility.** Make sure people are truly eligible when they enroll in "creditable coverage" plans, whether in an initial enrollment, open enrollment or a special enrollment period, to ensure that late enrollees are identified or the special enrollment period truly applies to the circumstances. Additionally, if an individual appears to be eligible for a public program such as Medicare or Medicaid, he or she should be referred to that program. There have been instances of "steering" individuals with chronic conditions, such as end-stage renal disease, from Medicare to private insurers simply because providers knew that the reimbursement amount would be higher. Steering and gaming of the system result in higher premiums for all, and in some cases, affect the future eligibility of the insured into the public program. Congress should take the steps necessary to ensure that such steering and gaming of the system end, so consumers are enrolled in the correct "credible coverage" plans.
- **Eliminate the Small Business Health Options Program (SHOP).** Small business markets were relatively stable prior to the implementation of the ACA in 2010. Let small

businesses make the decisions as to whether to offer insurance coverage and what type of insurance coverage suits their needs and those of their employees.

- **Allow states to define "creditable coverage" for federal assistance with premiums.** As previously discussed, states should have the authority to define what plans would be considered "creditable coverage" for purposes of any federal assistance/tax credits. If premium tax credits or other assistance are considered to help lower-income and middle-class families purchase insurance, the formula should consider the age, income, and geographic location of all individuals seeking enrollment into the plan.
- **Eliminate the requirements of the Essential Health Benefits and strict plan designs.** By allowing insurers to offer plans with a variety of co-pays and deductibles, networks based on state-established parameters, and benefits, choice would return to the markets. States should have the authority to establish the basic minimum coverage to be considered "creditable coverage" for tax credits or federal assistance. This minimum coverage should require catastrophic coverage, or basic hospital, medical, and surgical care only. Consumers would then be free to select or add the other insurance coverages (such as pharmaceutical coverage or maternity care) that they determine best meet their needs. Congress could also let people put into their health savings accounts any federal assistance received for having creditable insurance coverage.
- **Expand the age-rating factor range.** Allow states to determine age-rating factors. For instance, states may elect to expand age ratings from 3:1 to 5:1.
- **Eliminate risk adjustment for small group.** Modify the federal risk adjustment formula (if the program continues) to address flaws in the methodology that create competitive disadvantages in the insurance market. The small group market should be exempt from risk adjustment.

3. What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?

The Medicaid program is a complex and interrelated program. While the ACA does have some useful features, it does inflict a number of burdensome requirements that are costly and inefficient. Here are suggested improvements to regulatory requirements that are administratively burdensome and limit the State's flexibility in managing its program to be more efficient and cost effective:

Allow states flexibility to establish their own eligibility rules, for more efficiency in the program.

Eligibility-specific requirements that we suggest be eliminated include ACA § 2202 – Hospital Presumptive Eligibility, and ACA § 2001 – Maintenance of Effort (MOE) Standards mandating states to continue coverage for specific eligibility groups.

Key administrative changes. While not an all-inclusive list, below are proposed administrative changes that could assist states in reducing costs and improving health outcomes:

- Simplify the burdensome State Plan Amendment and Waiver processes.
- Limit state reporting (finance, quality, etc.) to the Centers for Medicare and Medicaid Services (CMS) to an annual event as opposed to quarterly.
- Repeal burdensome requirements which result in unfunded mandates on states. For example, 42 C.F.R. Part 431, Subpart E regarding Medicaid notices and appeals to be effective January 20, 2017, will cause a significant administrative burden on the states and may result in unnecessary and duplicative information for beneficiaries.
- Re-evaluate or limit the burdensome requirements and system changes of ACA § 1557. For example, limit published materials to the top languages at the state's discretion as opposed to the federally mandated top fifteen languages.
- Limit federal recoupments from the states in relation to fraud and abuse if the state is unable to collect from an entity or an individual.
- Allow states the ability to determine and operate the Medicaid Management Information System (MMIS) in the most practical and cost efficient way for the state. For example, the CMS modularity mandate for the claims payment system is estimated to increase operational costs 300 percent or more with no identifiable benefit.

Benefit Program Re-design. If a block grant (determined on a global or per-capita basis) reduces the current federal funding of the Medicaid program, states should be allowed to determine the most efficient benefit packages for beneficiaries. For example, allowing states the following freedoms could assist states in reducing costs and improving health outcomes:

- The ability to provide incentives or penalties for recipients based on health behaviors, such as increased co-pays, limitation of coverage, or premiums for non-adherent patients.
- The power to set co-pay amounts and charge premiums for the state's Medicaid population.
- Flexibility to offer housing alternatives for the long-term care population. In some instances, beneficiaries do not have alternatives to institutional long-term care.
- The ability to purchase drugs for the lowest prices available in the United States or elsewhere. Medicaid agencies are in need of assistance with the steady increases of drug costs.

As Governor Robert Bentley said, the freedom to reduce spending to match any reductions in revenue would be absolutely vital for Alabama's Medicaid program and, we presume, the Medicaid programs in other states.

Financial Changes. While not an all-inclusive list, the following decisions by the federal government could help states reduce costs and improve health outcomes:

- Eliminate the planned ACA reductions in Disproportionate Share Hospital payments (DSH) in the states that have not expanded Medicaid (ACA § 2551).
- Continue to provide Children's Health Insurance Program (CHIP) federal funding, and maintain the Federal Medical Assistance Percentage (FMAP) increase now in place.

- Maintain the ability of states to use provider contributions, such as provider taxes, intergovernmental transfers, and certified public expenditures, to qualify for matching federal Medicaid funds. Medicaid state-share matches are a significant element in our state's ability to fund the Medicaid program. Reducing Alabama's ability to use those funding methods would hurt our Medicaid program.
- Reinstate the enhanced FMAP rate for physician bump payments.
- Allow states to decide how they will pay providers (rates, managed care, fee for service, etc.) without requiring federal permission.
- Provide incentives to the state for improved health-care quality metrics.
- Adjust the methodology for calculating Medicare Part B premium cost-of-living adjustments. As the methodology stands now, it puts a disproportionate burden on the state's Medicaid program by increasing the state's contribution.

In addition, some financial changes to Medicare would greatly benefit Alabama hospitals, which are integral to providing care to Medicaid beneficiaries and other Alabamians. We recommend that the federal government adjust, by regulation or law, the Medicare Hospital Area Wage Index to reduce the wide gaps between states in hospital reimbursement rates paid by Medicare. The current wage index formula punishes hospitals by lowering federal payment rates as hospitals become more efficient. It is unfair and should be changed.

4. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?

The small business markets were relatively stable prior to the implementation of the ACA in 2010. Let small businesses decide whether to offer insurance coverage and what type of insurance coverage suits their needs and those of their employees. While premiums have increased since the inception of the ACA, they have not risen as quickly or as greatly in the small group market as they have in the individual market. This is a testament to the stability of the small-group market prior to the ACA. The premium increases experienced now in the small-group market are a direct result of the federal duplication of state regulation and the federal intrusion into the type of insurance plans that may be offered to small businesses and what coverage is required.

5. What key long-term reforms would improve affordability for patients?

Our Medicaid program already is affordable for beneficiaries. It is free for qualified recipients, except for some minimal co-pays.

As for the insurance market, insurers and providers may be best placed to answer the question. During the last few years, the Department of Health and Human Services has held several forums that highlighted insurers and providers working together to control costs, which in turn helps consumers: not just from a health-outcome standpoint, but from financial and affordability standpoints. Health-care costs themselves have continued to rise. Yes, more people have access to health insurance now as a result of the ACA; however, the ACA did not fully address the spiraling costs tied to providing health care. The rising costs of health care must also be

effectively addressed for any replacement plan to provide market stability, affordability and sustainability.

6. Does your state currently have or plan to enact authority to utilize a Section 1332 Waiver for State Innovation beginning January 1, 2017?

No.

a. **If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waiver for benefit year 2017?**
b. **If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?**
c. **If allowed, which requirements would your state seek to waive under a 1332 waiver?**
d. **If allowed—and if applicable—what changes would be necessary to current guidance to accelerate your state's ability to pursue a 1332 waiver?**

7. As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?

A high-risk pool with managed care is needed in some form. Premiums in the private insurance market are substantially reduced when the small percentage of insureds with the highest costs and health-care claims are moved into a high-risk pool. In Medicare, for example, a small percentage of insureds create the highest claims costs. It is a similar situation under the ACA. The high-risk pool would need to be funded through several different mechanisms to be sustainable. The high-risk pool would need federal funds as Alabama, like many states, would be unable to fully fund the program, even with assessments on insurers and premiums paid by the high risk enrollees. Basic program guardrails could be established on the federal level to ensure that criteria were in place to ensure that the sickest patients were truly the ones in the program and that insurers are not "dumping" potential high-risk enrollees into the federally funded system. By requiring assessments on insurers and higher premiums for enrollees in the high-risk pool, perhaps such enrollments could be deterred. Any high-risk pool must be based on actuarially sound principles.

8. What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements, should we consider while making changes?

The Alabama Legislature meets once a year, within the first six months of the calendar year. Special legislative sessions may be called by the Governor. In the insurance industry, companies need time to address any new requirements to the insurance marketplace. We would anticipate that approximately 18 months at a minimum would be needed for companies to develop plans,

rates, forms, and networks, and to meet any other regulatory requirements a replacement plan would bring. We anticipate that the clock for the development of new plans would start after a replacement law was passed and its following regulations completed. If the ACA is repealed and replaced, there must be a transition period, which must include adequate time to adapt to the replacement solution.

That timeline also applies for Medicaid. For changes affecting Medicaid's budget, the state would need at least 18 months' lead time. Changes affecting federal payments to the state should also be made clear to the state 18 months prior to effective dates, including any changes to the Federal Medical Assistance Percentage, Disproportionate Share Hospital allocations, and Medicare Part B premiums and related insurances, for instance.

9. Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?

Regarding insurance, Alabama has not adopted specific legislation on all 2010 reforms. The State currently has a Collaborative Enforcement Agreement with the Department of Health and Human Services to enforce 2010 reforms.

On Medicaid, the State has changed several Medicaid regulations to comply with the federally required 2010 federal reforms. These changes center mostly on eligibility, such as changes on income standards and eligibility groups. Repeal of these changes would require time and money, particularly with computer programming.