STATE OF UTAH

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January 13, 2017

The Honorable Representative Kevin McCarthy
Majority Leader, United States House of Representatives
2421 Rayburn House Office Building
Washington, D.C. 20515

Dear Majority Leader McCarthy,

Thank you for the opportunity to provide input on this critical issue that so directly affects the citizens of the State of Utah. Few issues affect states as broadly and significantly as healthcare. As you stated in your letter, our state health officials and community stakeholders have already begun actively working on a framework for the future of healthcare.

While Utah has many concerns about the Affordable Care Act, we urge Congress to act carefully and methodically on this issue. As of December 31, 2016, 186,093 Utahns had selected health insurance plans on healthcare.gov. According to the U.S. Census, since 2010, Utah's uninsured rate dropped to 10.5 percent, down from 14 percent. As we work to re-craft healthcare in our country we must be careful not to increase the rate of uninsured, particularly for our most vulnerable citizens.

We take management of our healthcare system very seriously in the State of Utah. Effective January 2013, Utah implemented an Accountable Care Organization service delivery model in our Medicaid program. As a result, Utah has saved $45 million in Medicaid expenditures and has been able to keep the annual increase in expenditures to less than 3 percent.

We are proud of the accomplishments of our Medicaid program and feel we have much to offer Congress in the redesign of our healthcare system at the national level. Consequently, our recommendations go beyond the Affordable Care Act since many current Medicaid provisions predate ACA. I am providing this feedback on behalf of the great State of Utah.

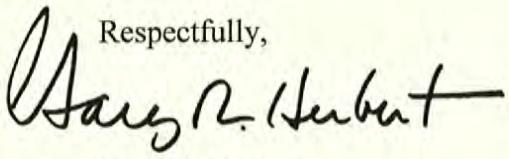
Utah has always been proactive in finding solutions to effectively address health care costs, including insurance. Timely innovation in health care delivery is essential, as such the State supports reform that recognizes the following principles:

- States are best suited to respond to the needs and demands of their markets, therefore states should have primary regulatory control over insurance.
- States are the most effective laboratories for finding ways to maintain healthy and competitive markets.
- States must have the ability to protect consumers, enforce state law, and drive meaningful reform.
- States should be given greater flexibility to develop and administer their own state Medicaid programs.
- States that have chosen not to fully utilize certain programs or expand enrollment should not be disadvantaged financially under any new federal funding methodology.
- States with high performing, low-cost health care systems should not be discriminated against in federal participation rate formulas.
- Multiple regulatory entities hinder effective reform, create onerous obligations, require duplicative work, and increase health care delivery costs.
- Reforms must be fiscally prudent but, should maintain or improve affordable access to health care for those that are currently covered.
- Reforms should maintain or improve the quality of health coverage that Utahns receive.
- Reforms should include measures that will bend the cost curve.
- Reforms should be finalized enough in advance of implementation to allow insurers to properly price products.

I acknowledge that a repeal and meaningful reform could take years to plan and implement. Utah's citizens cannot wait for such a lengthy process. Insurers need assurances of immediate market stability, and the time necessary for effective implementation. Therefore we encourage swift action on an interim basis as well as to lay the foundation for longer term goals. Please find attached to this letter specific recommendations from our state health officials, insurance officials and community stakeholders.

Again, thank you for the opportunity to provide you with this feedback. If you have any questions or need additional information regarding Medicaid or the ACA, please do not hesitate to contact my office.

Respectfully,



Gary R. Herbert
Governor

In response to your specific questions, the State of Utah provides the following:

ACA Recommendations:

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

We must return to a system of state-based regulation. The regulations issued by the Department of Health and Human Services (HHS) over the past six years have limited the ability for states to regulate their market and insurers to respond to market needs. The strict time frames imposed by HHS prohibits insurers from appropriately pricing or introducing products to meet the demands of the market.

The current instability in the market has limited the number of insurers in the market. In order to expand choice, the market must be stable enough to attract new insurers. Utah's insurers have operated at a loss since 2014. During 2015, insurers reported an average loss in net income of -8.8 percent. In order to lower premiums, actions must be addressed across the entire health care delivery system, taking into account: increasing costs associated with the delivery of health care; the exponential increases in prescription drug costs; cost-shifting to private-pay entities due to deficiencies with government program reimbursements; and health care providers' legal defense costs. Any cost cutting measures must be taken with caution to ensure the health care system continues to promote innovation.

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?***

Currently, Utah's large employer (50+ employees) group health insurance markets appear to be stable. However, to help stabilize the individual and small group markets, it is important that Congress allow for an appropriate transition period prior to the implementation of any new healthcare reform so as to allow the markets to respond effectively. Any change in the current system will create a ripple effect. As such, Congress and federal agencies must paint a clear pathway for the future. Careful consideration should be taken when cutting or revising specific provisions within the Patient Protection and Affordable Care Act (ACA).

The ACA limited insurers ability to underwrite a policy of insurance, restricting premium variation by age rating, limited to a ratio of 3:1, geographic location and smoking status. A flexible age ratio will encourage younger, healthier participants to sign up for health insurance coverage. With the requirement of guaranteed issuance of health insurance, younger healthier participants are vital for the stabilization of the risk pools.

To assure the individual health insurance market is not a dumping ground for bad risk, it is imperative that individuals enroll in programs designed for them. Unhealthy individuals are being steered into individual commercial health insurance markets when other, more appropriate, coverage is available. Enforcement, tied with severe penalties, should be

considered for entities who steer unhealthy individuals into the individual commercial health insurance market.

A repeal of the individual mandate alone, while still requiring insurers to guarantee issue coverage to everyone, will further erode the individual market by reducing the number of insurers who offer plans, limit the products offered, and increase in premiums. An individual mandate repeal must be balanced with appropriate measures to restrict individuals from gaming the system by accessing insurance only when care is needed. Insurers are not forced to issue homeowners insurance when the house is on fire. As such, an insurer should not be forced to issue health insurance only when an individual has an immediate and acute need for a medical procedure.

In order to stabilize the markets, special enrollment periods (SEP) must be strengthened. Insurers in Utah have indicated that more than 50% of their individual market participants are on a plan for less than a year. A process to verify eligibility for a SEP must be completed prior to enrollment. The SEP ties in closely with the need to also address pre-existing condition prohibitions. The current prohibition on pre-existing conditions, coupled with extensive enrollment periods either through the annual open enrollment or a SEP, allows for individuals to take advantage of the system. Consideration should be given to allow insurers the use of: a) a limited 12-month pre-existing exclusion with a 6-month look back period, coupled with a credit for previous coverage to protect those consumers who maintain continuous coverage; or b) a meaningful late enrollment penalty.

Congress must delay any change in the Cost Sharing Reductions until years end. A mid-year termination of the program would be disastrous. It could cause individual market insurers to drop out of the ACA marketplaces, and it is likely that many of our individual market enrollees would be forced to terminate coverage.

The most destabilizing program for our individual market over the past three years has been the risk corridor program. Congress needs to work together with federal agencies to assure similar fiascos do not occur again. Congress' change of the risk corridor program, a year after products had been sold, coupled with HHS's refusal to allow insurers to re-price products, collapsed many of the Consumer Operated and Oriented (co-op) plans, in addition to placing numerous insurers in hazardous financial condition. Insurers must have the ability to appropriately price products. For 2014 and 2015, Utah insurers expected $282,000,000 in risk corridor payments to offset the unknown risks associated with the ACA, but only received $18,000,000.

The extended 90-day grace period for an individual to remit premium payments to an insurer leaves many insurers without receipt of premium payments. Reducing the grace period from 90 days to 30 days, which is standard industry practice for most other insurance products, would also assist in stabilizing the individual market.

The vast regulations that have been finalized since the passage of the ACA should be reviewed. What we believe is an arbitrary overstep of authority is the recent application of the nondiscrimination provisions of Section 1557 of the ACA in the recent regulations

finalized by HHS. HHS's Office of Civil Rights is applying these regulation to insurer products unrelated to the ACA, requiring that if an insurer receives federal monies under the ACA (such as cost sharing reduction reimbursements), then none of the insurer's other business may have rates that vary by gender. Many insurers who participate in the ACA market also offer several other different products that are rated by gender, such as: Medicare supplement, disability income, or vision products. An insurer's products, unrelated to the ACA, should be not affected by the regulations of the ACA.

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

Please see our guiding principles and recommendations outlined above.

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?***

Many small employers in Utah have moved to self-funded arrangements in order to reduce costs by circumventing the requirements of the ACA. Due to this loophole, the healthiest small groups opt for self-insuring, leaving the less healthy groups to seek coverage in the commercial market, destabilizing the small group market. All employers should have the same opportunities to craft the plans necessary based on the needs of their group, without undue burdens. The flexibility provided to self-funded employers, should also be made available in the commercially insured employer market.

Tax subsidies, if they are to be made available by Congress, for small employers that offer health coverage should be applicable whether the coverage is purchased in or out of the SHOP.

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

Transparency in the actual cost of services is necessary. An informed consumer can make better choices for use of the health care dollars when they are able to make comparisons prior to services being rendered. For example, if a person has a blood test done through a hospital lab it can cost 5 or 6 times what it would cost at another company whose business focuses on blood work. Or, consider a drug with two different delivery methods - one taken twice a day, and the other only once a day, but the cost for the once a day is double. If people had cost information readily available, they could be incentivized to choose the lower cost options.

A method to increase transparency previously moved forward in many states via All-Payer Claim Databases (APCD). For APCDs that have been in existence for several years, most now have quantifiable data that can assist in transparency. Recent court decisions prohibit states from mandating self-funded employers, or their administrators, to submit claims data to state APCDs. This could severely impact the credibility of the data and its subsequent use. Lawmakers should carefully assess what this means for increased transparency and consider the merits of mandated data-sharing. .

There needs to be better transparency and competition in the pricing of prescription drugs, a large cost driver in health insurance premiums. In recent years, there have been dramatic increases in the price of generic prescription drugs. Analysts should assess what kind of market failures are contributing to these price spikes.

Other factors to consider when addressing affordability are: 1) providing hospitals the ability to control their costs; 2) treatment of patients in appropriate health care settings; 3) promoting healthcare quality improvement mechanisms; and 4) reforms so health care providers can provide best practices rather than practice to prevent lawsuits.

6. ***Does your state currently have or plan to enact authority to utilize a Section 1332 Waivers for State Innovations beginning January 1, 2017?***
   - ***a. If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovations Waivers for benefit year 2017?***
   - ***b. If allowed, would your state utilize a model waiver for expedited review and approval similar to 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?***

The State of Utah currently does not have plans in place to utilize a Section 1332 waiver. Hopefully any new reforms Utah considers would not need a waiver under the new administration.

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?***

Yes, the State of Utah may be interested in operating a high risk pool. Our State successfully operated a high risk pool before it was no longer allowed by federal law.

Whether or not Utah would establish a high-risk pool depends on the shape of the insurance regulatory market. Prior to the ACA, Utah utilized a high-risk pool subsidized through state funds. There are many benefits to the market for the establishment of high-risk pools. However, without other reforms a high-risk pool is likely to be an unaffordable option. States should be able to tailor their high-risk pool with cost saving measures that may include: a) prohibiting the dumping of employees from employer-based plans; b) enforce an individual's responsibility to maintain continuous coverage, or be subject to an appropriate pre-existing exclusion or penalty; and c) ability to set policy maximums to constrain the losses.

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?***

Utah strongly recommends that the states have at least a 2 year transition period before any new structure takes effect.

The State of Utah's Legislature meets annually for a 45 calendar day session. The 2017 General Session of the Utah State Legislature is scheduled to begin on Monday, January 23, 2017. The Governor has the authority to call a Special Session of the Legislature, but our past practice has been to only call special sessions on consensus items. Given the gravity of change being considered, great consideration would need to be given on whether a Special Session of the Legislature would extend beyond the typical single day special sessions we've held in the past.

Federal regulations require insurers to file products in early spring for the following calendar year. For example, 2018 plan and rate filings must be submitted no later than May 3, 2017. These timeframes hinder an insurer's ability to appropriately price products or respond to market forces. While developing 2018 rates, insurers will lack 2016 reinsurance and risk adjustment data, which isn't scheduled to be released by HHS until June 30, 2017.

Regulations issued by HHS have forced most plans years to a January 1 effective date, with calendar year deductible and coinsurance accumulators. This is very problematic not only for the insurance industry, but also for our nation's health care delivery system. Due to the deductible and coinsurance calendar year maximums, there is a rush to get care in the last three months of the calendar year. This puts unnecessary pressure on the health care delivery system. This cyclical problem places additional strain on the insurance industry to maintain a staff with adequate knowledge. The strain also is felt by the insurance agents, many of whom are already burdened with Medicare open enrollment products. Unfortunately, we see too many persons employed as temporary seasonal staff to assist with these enrollment periods. Such employment is unsustainable for the individual, but it also affects the quality of assistance consumers can receive as they enroll in their healthcare plans.

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?***

Utah adopted some 2010 federal reforms through administrative code which can be easily amended or repealed.

Medicaid Recommendations:

Our first preference is to allow each state to develop and implement their own plans, funded with block grants from the federal government and appropriately matched with state dollars. Absent these reforms, then we request the following modifications to Medicaid:

Allow States Flexibility to Redefine Mandatory Benefits

- Revisit mandatory vs. optional benefits categorization in Medicaid, especially regarding long-term care and community based services
- Allow states more flexibility to redefine required essential health benefits for Medicaid
- Allow states to implement prioritization of benefits if reductions are necessary to stay on budget (i.e., Oregon model)

Maintain Core Program Functionality in Block Grant Options

- Establish per member per month amounts by eligibility group
- Don't disadvantage states that haven't yet fully utilized certain programs, including expansion
  - States like Utah that have been fiscally prudent and careful not to act too quickly should not be penalized in the allocation of funding in the future. All states should begin any new process on a level playing field.
- Retain current funding structure for Medicaid (FMAP) with a transition path towards any new funding structure (PMPM, block grant, etc.)
  - States can't transition overnight. States should be given at least a two year transition period.
- Consider options that would enhance funding during a recession and decrease funding during an economic expansion
- Allow value based purchasing models to continue in order to determine if they can demonstrate true changes in health care quality and costs
- The use of provider taxes to generate revenue for the use in the Medicaid program should still be an option available to states.

Provide Greatest Flexibility to States Regarding Medicaid Coverage for Parents and Adults without Children

- Allow work requirement as a condition of eligibility for able bodied individuals
- Allow Medicaid benefits to be benchmarked to a commercial health plan
- Allow meaningful premiums and copays for all income levels
- Allow states to impose enrollment caps if costs exceed budget

Generally retain existing protections for aged, blind, disabled, children, and pregnant women

- Reevaluate the EPSDT (Early Periodic Screening, Diagnosis and Treatment) benefit for children. EPSDT requires states to provide comprehensive and preventative health services for Medicaid beneficiaries under the age of 21 with few limitations.
  - Consider limiting benefits to what is available in the private market. Currently, children on Medicaid have more access to services and benefits than children who are covered under good commercial plans.

Reduce Burdensome Bureaucracy Imposed by the Centers for Medicare and Medicaid Services

- Place an immediate moratorium on Medicaid regulations issued by CMS in the past 12 months while repeal and replace is being considered
    - It makes no sense for states to waste valuable time and resources implementing regulations that may be repealed or amended shortly after the required implementation date.
- Simplify the CMS waiver and amendment process – consolidate waiver types and authorities, establish mandatory timelines within which CMS must respond back to states with an approval or denial.

Rollback ACA changes to the Children's Health Insurance Program (CHIP) and

- As a result of ACA many children were moved from CHIP to Medicaid even though families preferred to keep their children on CHIP. In Utah, CHIP was a very cost effective program that acted as a bridge between Medicaid and the commercial market. Families and providers often preferred CHIP to Medicaid. ACA extended many Medicaid requirements to CHIP.
- CHIP authorization and funding should be extended for at least five years.

Reconsider Use of Medicaid Funds for Other Programs

- Eliminate ACA requirements that moved a significant number of CHIP children to Medicaid – especially the increase in the minimum Medicaid income level
- Consider moving responsibility for Medicare Part B premiums and Part D clawback from states to the federal government, especially under block grant options
- Ensure changes to Medicare don't disproportionately impact states through Medicaid dual covered.
- Reevaluate if Medicaid is the best program to provide funding for the country's various social service needs (e.g., school-based services, care for relocated disaster victims, etc.)

Public Health

Recognize Repeal Could Result in a Significant Reduction in Public Health Funding

- Assure that the Prevention and Public Health Fund which is now part of the ACA is preserved to fund community-wide disease prevention programs.

Key State Contacts:

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