NASHP Leaders' Summit: Views on the Current Congressional Debate

In signaling that it will craft its own health reform proposal, the U.S. Senate opens the door for new approaches to address cost, coverage, and access. In tandem, state officials are assessing the impact of potential changes and weighing their options. The National Academy for State Health Policy (NASHP) recently "took the pulse" of state health policy leaders, representing the geopolitical diversity of the states, to collect their thoughts about reform. Through a short survey, meetings, and a focus group of leaders representing insurance, Medicaid, governors' offices, legislatures, and health insurance exchanges, these states identified both practical approaches and questions regarding the impact of possible Congressional action. This snapshot briefly summarizes the concerns of that disparate group of state officials, all engaged in implementing health reform.

The Real Issue – The Cost of Health Care

State leaders, who participated, recognize that work remains to achieve greater affordability of coverage – both for consumers and payers. At the heart of the debate over the Affordable Care Act (ACA) is the question of federal outlays – how much should the federal government spend and for what? Absent from the debate is a concerted focus on reducing the underlying costs of health care – an issue state leaders identify as a prerequisite for sustainable reform. States articulated support for on-going investments in payment and delivery reform to spur innovation and efficiency. They warned of the consequences of hospital and provider consolidation, as well as issuer consolidations that reduce competition and drive up prices, and implored the federal government to act, and to support state action, on other cost drivers such as pharmaceutical pricing. The proposal to eliminate funding for the Public Health and Prevention Fund was viewed as antithetical to efforts to lower costs and improve health as investments in public health and prevention can reduce the burden of chronic illness and disability over time.

What About Medicaid?

Medicaid's role in providing coverage for low-income persons was widely acknowledged, as was the need to assure a strong partnership between the state and federal governments who share program administration and funding. Proposals to block grant or fund Medicaid using a per capita cap raised questions about whether that funding structure could adequately fund the program over time, particularly for those states that have expanded coverage, and result in cost shifts to states. Concerns were raised as well from non-expansion states who feared they could be penalized and receive less funding based on their decision not to expand eligibility.

The implications of any proposed roll-back in Medicaid expansion would need to be carefully weighed both for its real impact on people who are at risk of losing coverage, the resulting cost shift to states and other payers, and for administrative impact. Notably, eligibility systems for Medicaid expansion populations would need to be retooled. A number of states that operate integrated eligibility systems for Medicaid and the tax subsidies through their state based insurance exchanges would need to address the impact on exchange operations and budgets, if expansion is eliminated.

States identified potential tools they would like to leverage to address Medicaid cost drivers. Although every state did not embrace each of these options, the list includes greater flexibility in program design, the ability to negotiate better pharmaceutical pricing, increased capacity to vary services based on geographic and regional needs, and better ability to direct the care and achieve savings from those dually eligible for Medicare and Medicaid. Some states sought flexibility to lower Medicaid expansion eligibility to 100 percent FPL from 138 percent but others warned that this population tends to have health needs, that Medicaid provides more cost effective coverage and that placing them in the marketplaces would expose low income individuals to higher costs and could have an adverse impact on premiums in the marketplace. States welcomed the openness of the administration to support 1115 and States welcomed the openness of the administration to support 1115 and other waivers that advance innovation and cost effectiveness. States were also quick to note that any change made to the program will require adequate time and resources to implement; the larger the policy and financing changes, the greater the demand on states to implement them.

What to do about the Individual market?

The urgency to address the individual market is a high priority that requires both short and longer-term solutions. States expressed concern about the impact of uncertainty on the stability of the individual market. Without immediate assurances that cost sharing reductions (CSR) will be fully funded, for example, states expect the result will be significant premium increases, fewer people covered, and higher costs to the federal government as tax credits will rise to offset that increase. States worry about whether the individual market will be intact by the time any proposals to stabilize it are enacted.

Market volatility has resulted in some issuer withdrawal or "coverage deserts" with fears that more withdrawals could come as issuers approach rate filing deadlines. States stressed the importance of policies that prevent plan exit as the primary vehicle for reform but recognized that there may be a need for short-term, temporary strategies. To address market withdrawal, some debated the potential of an "emergency waiver", enabled through the Department of Health and Human Services, to provide temporary solutions such as flexibility over use of the Advance Premium Tax Credit (APTC) to purchase grandfathered and grandmothered plans on the exchanges or opportunities to qualify Medicare Advantage, state employee health plans or Medicaid managed care plans as APTC eligible. Others considered the proposal to provide APTC for off-exchange plans but noted it could have limited utility in some markets where plans have withdrawn not just from the exchanges but the entire individual market. Some considered extending the income limit for Basic Health Plans (BHP) to 400 % FPL, and leveraging APTC funding to purchase these plans (potentially already feasible through use of a 1332 waiver). Others expressed concerns over these strategies if structured in a way that could inadvertently penalize issuers that have "played by the rules," underscoring that strategies may need to be developed on a state-by-state basis.

Longer-term, state officials acknowledged that the solution to "coverage deserts" is not in stop-gap remedies, but in development of policies what will create stable and efficient markets for people without employer coverage. Officials questioned the impact of current proposals on individual market risk pools, affordability, and access to coverage in their states.

Officials generally supported the need for tax credits that are: 1) federally-financed, 2) advanceable, 3) refundable, 4) rated based on age, income, and geographic variation and/ or indexed to account for health care costs. The majority supported the need for some federal protections so that individuals with pre-existing conditions have access to affordable coverage options, as well as for the enforcement of some form of shared responsibility requirement. Generally, officials support the maintenance

of many insurance protections including the prohibition of annual and lifetime caps on benefits, institution of guaranteed issue and renewability protections, and the prohibition on rescissions. Some expressed support for state flexibility to vary the definition of essential health benefits as a state option, while others raised cautions about the need for well-defined actuarial value parameters to assure existence of a baseline value against which plans can be designed and evaluated. State officials from whom we heard were interested in the American Health Care Act's (AHCA) concept for a State and Patient Stability Fund to provide state funding to offset the impact of high cost users and minimize impact on premiums. That fund would need to be sufficiently and permanently funded, not time limited and require no more than a small and consistent match from states.

As currently proposed, the Stability Fund provides $138 billion to fund one of nine strategies intended to stabilize insurance markets or reduce health care costs. Based on prior experiences implementing similar programs, states expressed serious concerns over the adequacy of the funding pool. Even if adequately funded, officials raised concerns over the structure of the Fund, especially the required state match, and that funding is only allocated for the program through 2026, which may ultimately render it a non-starter if states cannot finance the program over time. Several officials also expressed a desire for simplification of the program noting that the breadth of programmatic options described leads to confusion and competition over an already inadequate funding pool. There was strong support to narrow or consolidate Fund options - or allow states the option to do so—directing its primary use to strategies like reinsurance or other mechanisms to reduce premiums and/ or out-of-pocket costs.

Finally, officials discussed a greater need for solutions that focus on shifting market dynamics such as the cost of care and access to coverage. Some officials supported inclusion of provisions that could help consumers afford costs at point of care. Cost sharing reductions provide one such vehicle. Alternatively, it may be possible to design and offer income-adjusted, pre-funded Health Savings Accounts to cover point-of-care costs. Some officials called attention to how the changes to Medicaid may change the dynamics of private markets—shifting individuals formerly under Medicaid into vulnerable private insurance pools. Some supported providing state flexibility in the use of tax credits, including the capacity to coordinate with Medicaid.

Will states have a sufficient runway for implementation?

States repeatedly returned to the operational issues and timelines associated with any reform, noting that "state flexibility" also means state responsibility and the resulting administrative requirements and costs. Bound by balanced budget requirements and the responsibility for day-to-day operation of programs, states need to carefully consider how any new law will be practically implemented. Broadly speaking, with most state legislatures now out of session, policy changes requiring action from state legislatures may have to be on hold until 2018, limiting the capacity of states to begin implementing any changes before 2019. New policies that require infrastructure changes or new capacity may be especially formidable, requiring time to procure services, secure funding, and issue change orders for current vendors. States are still engaged in efforts to implement mental health parity and managed care regulations in Medicaid and building initiatives to respond to the opioid crisis. How new policies will be phased in demands careful planning by states as they will need to sustain current programs, coordinate transitions and contemplate and prevent unintended consequences. Both the state and the federal governments need time to develop, design and implement new policies.

Finally, an overriding concern for the state leaders we heard from is that the environment of uncertainty and confusion surrounding the current health reform debate has a detrimental and destabilizing impact on individuals and markets. Transparency, timelines, and clear messaging would help states as they assure the integrity, efficiency and responsiveness of state coverage initiatives while analyzing the impact of potential policy changes.

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