

*All In:* a Forum on Health  
Care Coverage and  
Affordability

# New Insurance Options

# Gary Claxton

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Kaiser Family Foundation

# Brian Webb

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National Association of Insurance  
Commissioners

# Jessica Altman

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Pennsylvania Insurance  
Department

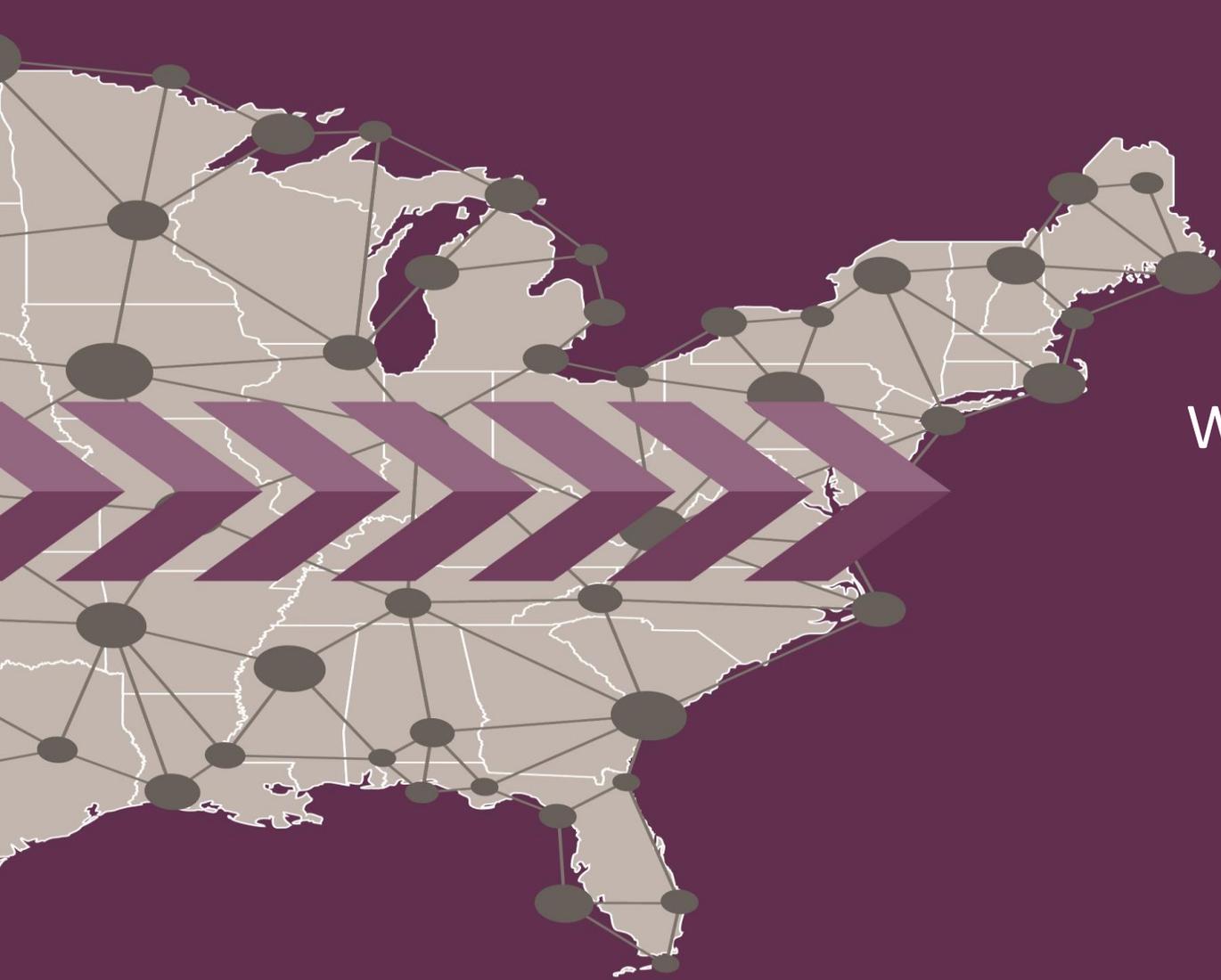
# New Insurance Options

State Innovation (1332)  
Waivers, Reinsurance, and  
Related Strategies

# Heather Howard

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State Health and Value Strategies  
Princeton University



# State Innovation (1332) Waivers, Reinsurance, and Related Strategies

Heather Howard

August 29, 2019

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*

# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this presentation was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# Agenda

- **1332 Basics**
- **What Can be Waived?**
- **Waiver Process**
- **States' 1332 Proposals**



## **1332: The Basics**

# What Can be Waived?

Section 1332 authorizes waivers of four components of the Affordable Care Act

## 1 *Subsidies*

States may modify the rules governing covered subsidies. States that waive premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies for alternative approaches.

## 2 *Exchanges and QHPs*

States can modify or eliminate QHP certification and the Exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.

## 3 *Employer Mandate*

States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable coverage to their full-time employees.

## 4 *Individual Mandate*

States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health coverage. Note: this requirement no longer needs to be waived.

# What Can't be Waived?

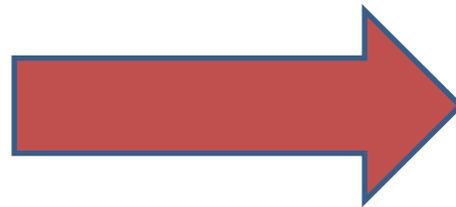
**States may not waive pre-existing conditions protections, guaranteed issue and related rating rules**

## *Fair play rules*

States may not waive non-discrimination provisions prohibiting carriers from denying coverage or increasing premiums based on health status. States are precluded from waiving rating rules that guarantee equal access at fair prices, including age rating and protections for individuals with pre-existing conditions

## What's in it for States?

- Flexibility to waive major ACA coverage provisions and try out solutions tailored to the state's specific needs.
- Opportunity to stabilize insurance market and reduce premiums.
- Access to federal funds that would otherwise be coming into the state through ACA programs.



# What Guardrails Apply to Waivers?

## Statutory Guardrails

### 1 *Scope of Coverage*

The waiver must provide coverage to at least as many people as the ACA would provide without the waiver.

### 2 *Federal Deficit*

The waiver must not increase the federal deficit.

### 3 *Affordability\**

The waiver must provide “coverage and cost sharing protections against excessive out-of-pocket” spending that is at least as “affordable” as Exchange coverage.

### 4 *Comprehensive Coverage\**

The waiver must provide coverage that is at least as “comprehensive” as coverage offered through the Exchange.

\*In 2018 guidance, the Departments of Health and Human Services and Treasury noted that waivers will be evaluated based on whether residents have access to comprehensive and affordable coverage under the waiver, even if they do not enroll in this coverage. This means that the guardrails will be satisfied if someone chooses to enroll in coverage with a lower premium even if that coverage is less comprehensive. States can thus seek a waiver to provide access to less comprehensive or less affordable coverage compared to the ACA.

# Updated Waiver Concepts and Guidance

**In fall 2018, the Departments of Health and Human Services and Treasury released:**

- **new guidance that sets forth their interpretation of Section 1332 waivers, and**
- **a discussion paper that outlines four waiver concepts that states might consider developing**

## Waiver Concept A: State Specific Premium Assistance

States could use the 1332 authority to waive the premium tax credit and use the funds towards a state premium subsidy, either creating a new state tax credit or subsidy or leveraging an existing program. For example, the state subsidy might be a per-member per-month amount based on age, and eligibility might be based on a new affordability standard (i.e., subsidies available if health coverage exceeds a certain percent of income). Eligibility determinations for the state subsidy would be the responsibility of the state, perhaps leveraging federal data sources currently used for Marketplace and Medicaid determinations.

## Waiver Concept B: Adjusted Plan Options

States could use the 1332 waiver authority to make subsidies available for plans that do not meet all ACA requirements or to expand the availability of catastrophic plans to broader groups of people. Making non-ACA-compliant plans eligible for subsidies could be done either with the premium tax credit by allowing additional plans to be plan to be sold on the Marketplace or with a state subsidy under Concept A. For example, a state could potentially receive pass-through funding and create a state subsidy for catastrophic plans; short term, limited duration plans; association health plans; and employer-based plans.

## Waiver Concepts C: Account- Based Subsidies

States could repurpose subsidy funds into a defined-contribution, consumer-directed account, similar to Health Savings Accounts, called “Health Expense Accounts” (HEAs).

## Waiver Concepts D: Risk Stabilization Strategies

States could develop waivers similar to those already approved, such as: a claims cost-based model (OR, MN, WI), a conditions-based insurance model (AK) or a hybrid model (ME). The discussion paper also notes that states could implement an actual high-risk pool, which, like the high-risk pools in place pre-ACA and high-risk pools in operation under the ACA (the Pre-existing Conditions Insurance Program) do not need to meet all the ACA requirements.



## Obtaining a Waiver

# Steps in Waiver Process



## State

- Consider state goals and determine if 1332 waiver is desirable
- Have sufficient state authority to implement the waiver
- Draft waiver application
- Hold pre-application hearing
- Include in waiver application:
  - Actuarial/economic analyses
  - Implementation timeline
  - Ten-year budget plan



## HHS and Treasury

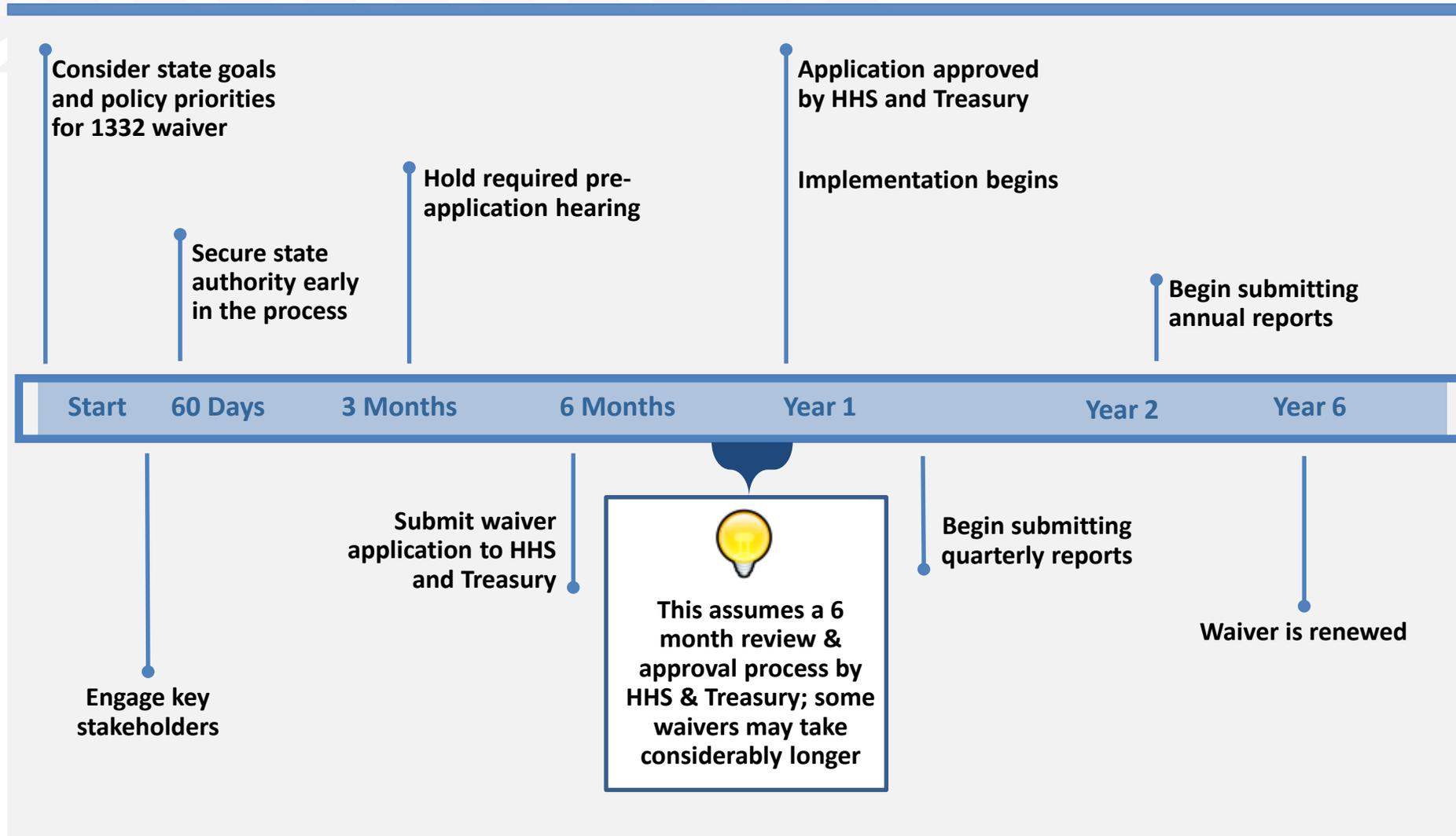
- Deem waiver application complete
- Conduct federal notice and comment period
- Review application within 180 days of deeming it complete
- Approve or reject application – approval may impose specific terms and conditions (STCs)



## Implementation

- Implement waiver per application provisions and STCs
- Submit quarterly and annual reports to Treasury and HHS
- Renew waivers every five years, because waiver term may not exceed five years

# Sample 1332 Implementation Timeline



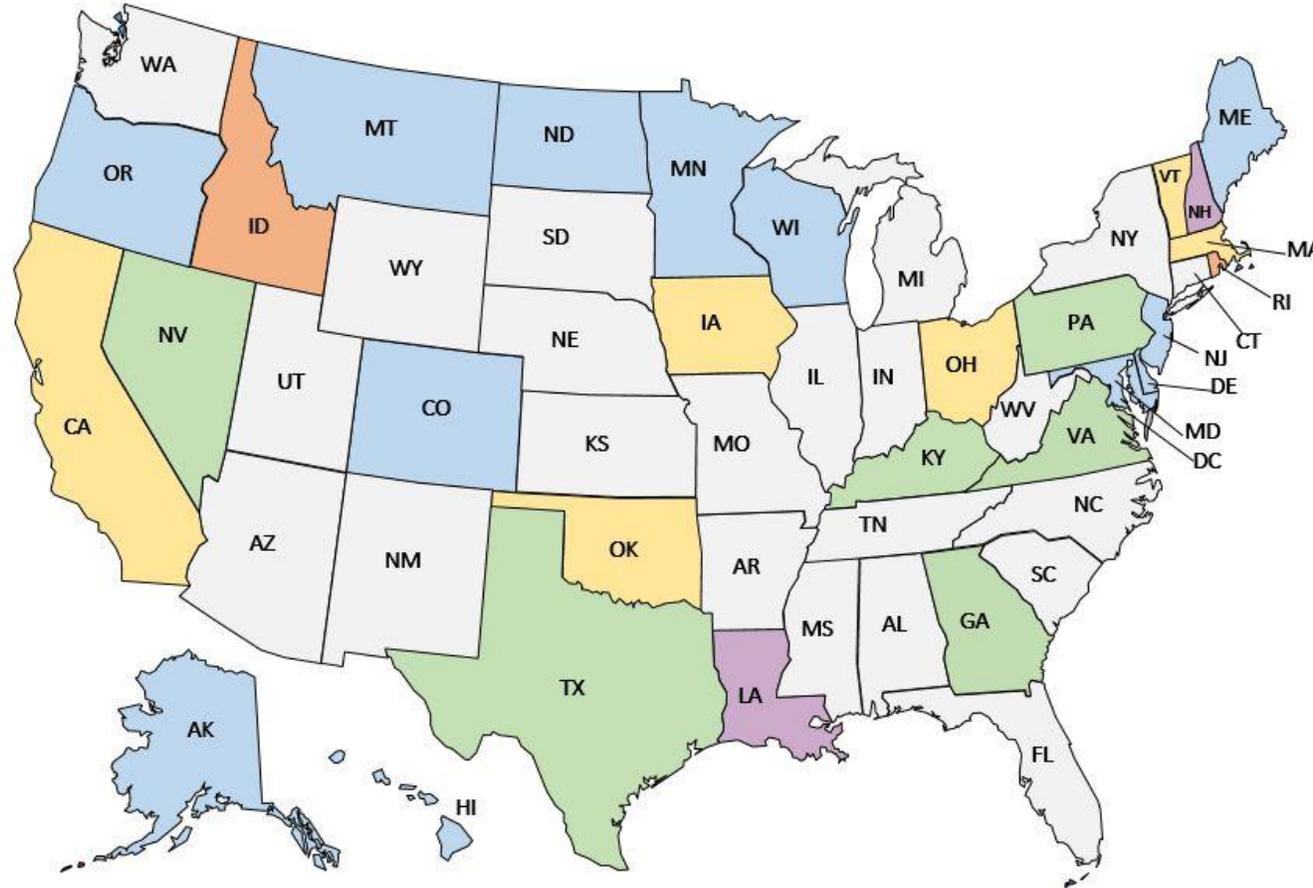
# SHVS Implementation Checklist

- ✓ Sketch out a calendar for activities
- ✓ Start conversations with carriers
- ✓ Secure expertise for actuarial and economic modeling
- ✓ Check-in with federal partners
- ✓ Start conversations with your legislature
- ✓ Review the process requirements
- ✓ Consider the program details



## Overview of State 1332 Activity to Date

# Status of 1332 Activity



- Waiver approved (12)
- Authorizing legislation passed, vetoed
- Waiver application submitted
- Authorizing legislation enacted
- Public draft of application

## Types of 1332 Waivers [Approved]

- Narrow/targeted
  - Hawaii fix for ERISA-sanctioned employer mandate
- Reinsurance program (AK, CO, DE, ME, MD, MN, MT, NJ, ND, OR, & WI )
  - Stabilizes individual market through state-funded reinsurance program for high cost claims
  - 1332 waiver allows state to recoup (“pass-through”) some of the savings that accrue to the federal government due to lower premiums

## Other State 1332 Proposals

State	Primary Elements	Status
CA	Permit immigrants currently banned from Exchanges to purchase unsubsidized Exchange coverage	Withdrawn 1/18/17
ID	<p>“Coverage Choice Waiver,” Idahoans making between 100% and 138% of the FPL could opt to get health insurance coverage either through Medicaid or via the state exchange</p> <p>Permit the sale of non-ACA compliant plans</p>	<p>Application submitted 7/15/2019</p> <p>3/8/18: CMS replied in a letter that it would enforce the ACA’s penalties against carriers that attempted to sell non-compliant plans</p>
IA	Reshape subsidy structure, changes in enrollment, and reinsurance	Withdrawn 10/23/17
MA	<p>Preserve Massachusetts’ unique premium rating practices for individual and small group markets.</p> <p>Waive cost sharing reduction (CSR) payments to insurers in Massachusetts and allow federal pass-through funding of those CSR payments and any advanced premium tax credit (APTC) payments resulting from lower premiums to partially finance a Premium Stabilization Fund (PSF).</p>	<p>Withdrawn 5/16/16 after CMS said waiver unnecessary to accomplish goals</p> <p>Application incomplete as of 10/23/17</p>
OH	Waive the individual mandate requirement	Waiver deemed incomplete on 5/17/18
VT	Eliminate health insurance exchange for small employers and maintain current system of direct enrollment with insurers	Application incomplete as of 6/9/16

## Other Potential 1332 Ideas

- Waive tax credits and replace with a state subsidy to address issues like (1) family glitch, (2) cliffs, (3) affordability, (4) reconciliation, and maybe (5) age rating
- Ban short-term plans
- Merge the individual and small-group markets
- Create a state public option or Medicaid buy-in
- Other measures that cut health care costs and therefore bring down silver premiums, like an all-payer rate system, or effective rate review



Thank You

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[www.shvs.org](http://www.shvs.org)

[SHVS resources for states on 1332 waivers](#)

# Chris Howard

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Maine Guaranteed Access  
Reinsurance Association



Introduction and Overview  
of  
Maine Guaranteed Access Reinsurance Association

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Forum on Health Care Coverage and Affordability in Maine

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August 29, 2019

# Original MGARA Model

Authorized by 2011 PL c. 90

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## **Non-Profit Corporation**

- 12 person board
  - 7 Superintendent Appointed Members
  - 5 Member Insurer Appointed Members
- Reinsurance Company
  - Mandatory Ceding
  - Discretionary Ceding
  - Fixed Attachment Points - 90% > \$7,500 & 100% > \$32,500

**Purpose** - To stabilize and reduce premiums in individual health insurance market by providing reinsurance to insurers in that market.

## **Funding**

- Reinsurance premiums paid by carriers ceding coverage to MGARA.
- \$4 per person per month assessment on all market segments.

**No Effect on Insureds Coverage / Reduced Premiums** - Ceding of coverage does not affect individual insured's coverage in any way.

# MGARA Early Years Results

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**During 18 months of operation in 2012-13, MGARA:**

- Collected about \$26.3 million in premium and \$41.2 million in assessments.
- Paid about \$66 million in reinsured health insurance claims.
- Kept premium increases about 20% lower than they otherwise would have been.

# Federal Transitional Reinsurance Program

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- ACA provided a national transitional reinsurance program which operated from 2014-16.
- Due to substantial overlap between the federal and state programs, MGARA's active operations were suspended effective January 1, 2014.

# 2017 Public Law c. 124

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- Authorized MGARA's reactivation subject to a successful application to the federal government for a Section 1332 innovation waiver.
- A Section 1332 Innovation Waiver was critical to MGARA re-start.

# Need for 1332 Innovation Waiver

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Federal Premium Tax Credits (PTCs) currently subsidize persons in the individual market with income from 100% to 400% of the federal poverty level. +/- 80% of Mainers insured in the individual market are in this demographic.

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The PTC program caps the net premiums paid by those persons on a sliding scale based on income. This means that when premiums decrease, federal support for Mainers receiving PTC assistance is reduced dollar-for-dollar.

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Therefore, absent a waiver, MGARA-reduced premiums would primarily benefit the federal government, not Maine's insurance consumers.

# MGARA Re-Start Process

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6/2/2017 - LD 659 enacted authorizing a 1332 Waiver Application

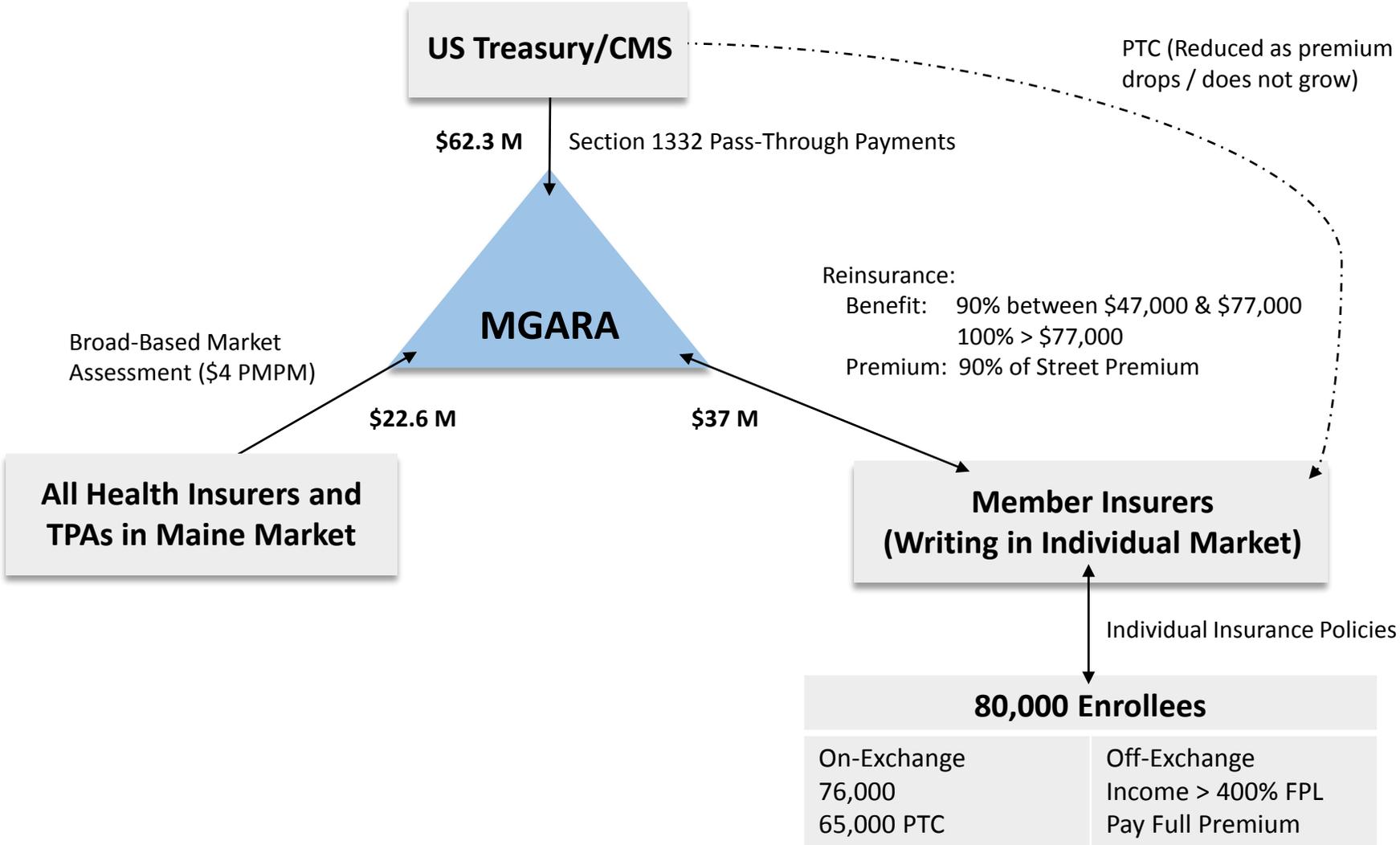
7/30/2018 - State receives CMS approval of 1332 Waiver

8/18/2018 - MGARA Board approves re-initiation of MGARA operations

12/15/2018 – MBOI approves MGARA Amended Plan of Operation

1/1/2019 – MGARA Restart

# 2019 MGARA Operating Model



# Major Changes to MGARA 2019

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Change	Description
<ul style="list-style-type: none"><li>1332 Pass-Through Payment Revenue</li></ul>	<ul style="list-style-type: none"><li>Takes back \$62.3 M windfall to US Treasury</li></ul>
<ul style="list-style-type: none"><li>Attachment Points</li></ul>	<ul style="list-style-type: none"><li>Attachment Pt 1 - @ \$47,000 MGARA reimburses 90% of claims to \$77,000.</li><li>Attachment Pt 2 - @ \$77,000 MGARA reimburses 100% of claims</li></ul>
<ul style="list-style-type: none"><li>Federal High-Cost Risk Pool</li></ul>	<ul style="list-style-type: none"><li>MGARA will have unlimited exposure on claims over \$77,000 to the reimbursement point under the Federal High-Cost Risk Pool.</li><li>For 2019, carriers are eligible under the Federal High-Cost Risk Pool for reimbursement of 60% of claims above \$1 million.</li></ul>

# No Change to MGARA 2019

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Staying Same	Description
<ul style="list-style-type: none"><li>Assessments</li></ul>	<ul style="list-style-type: none"><li>\$4 PMPM</li></ul>
<ul style="list-style-type: none"><li>Ceding Premium</li></ul>	<ul style="list-style-type: none"><li>90% of Street Premium</li></ul>
<ul style="list-style-type: none"><li>Mandatory Ceding Conditions</li></ul>	<ul style="list-style-type: none"><li>Maintain same 8 Mandatory ceding conditions as original MGARA plan</li></ul>
<ul style="list-style-type: none"><li>Discretionary Ceding</li></ul>	<ul style="list-style-type: none"><li>Expanded “window” for ceding to 120 days</li></ul>

# 2019 MGARA Financial Model

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Revenue		Percent of Revenue
Assessment (\$4 PMPM)	\$22,600,000	18.5%
Reinsurance Premium (90% Street Premium)	\$37,000,000	30.3%
1332 Pass-Through Payments (PTC Savings at US Treasury from MGARA)	\$62,300,000	51.1%
<b>Total Revenue</b>	<b>\$121,900,000</b>	<b>100%</b>

Expenses		
Reinsurance Claims	\$89,700,000	
Operating Expenses	\$700,000	
<b>Total Expenses</b>	<b>\$90,400,000</b>	

MGARA started 2019 with \$4.7M Fund Balance

# MGARA 2019 YTD

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1332 Grant Transfer to MGARA completed 6/26/19

\$23,910,080 drawn from MGARA's 1332 PMS account as of 8/15/2019.

a/o 6/30/2019:

Ceded lives	3227
Ceded premium	\$15,963,061
Assessment revenue	\$ 5,452,869
Claims incurred	\$34,542,973

# Reversing Historical Trend

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**Average rate increases since 2014:**

2014-15	-0.8%
2015-16	-1.2%
2016-17	+22%
2017-18	+21%
2018-19	+1 %*

**\*2018 -19 weighted average with effect of MGARA program:**

- **Anthem: - 4.3%**
- **Community Health Options: +0.9%**
- **Harvard Pilgrim: + 2.1%**

# MGARA 2019 Impact

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- MGARA estimated individual market premium reduction of about 9% in 2019 relative to what they would otherwise be with similar results each year of the program.
- MGARA estimated number of uninsured will be reduced by between 300 to 1,100 per year.
- Program makes no change in benefits to consumers.

# MGARA 2020 Impact

Average Premium Reduction due to MGARA

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Companies	Ave. Premium Reduction
Anthem	7.7%
Harvard-HMO	7.2%
Maine Community Health Options	3.8%

# Audrey Morse Gasteier

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Massachusetts Health  
Connector



# Massachusetts's Experience with 1332 Waivers

AUDREY MORSE GASTEIER

Chief of Policy and Strategy

Massachusetts Health Connector

*All In: A Forum on Health Care Coverage and Affordability | August 29, 2019*

# Context Setting: The Merged Market and the Health Connector

**The Massachusetts Health Connector is the state's health insurance exchange, created in 2006 as a part of the state's health reform law. It is situated within the "merged market", which is a shared risk pool comprised of the nongroup and small group market segments.**

## *The Merged Market*

- Massachusetts "merged" its nongroup and small group markets into one shared risk pool in 2007
- Roughly 750,000 covered lives in the merged market (44% nongroup and 56% small group)
- Coverage offered by 10 health carriers, mostly local non-profit HMOs

## *The Health Connector*

- Created in 2006 as part of a set of state health reforms aimed at increasing access to health insurance in Massachusetts, and later adapted to incorporate the federal health reforms of the Affordable Care Act (ACA)
- Provides coverage to individuals and small businesses in the merged market
- Plays key role in Massachusetts' version of health reform, e.g., state individual mandate and "state wrap" program for residents <300% FPL ("ConnectorCare")
- Covers roughly 285,000 people (85% of total nongroup lives in state)
- Has had the lowest average individual premiums of any Exchange market in the country for three years running (2017-2019), despite otherwise high health care costs in the state



***Searching for Stability During Uncertainty:***  
**Our 2017 Experience with a Section 1332 Waiver**  
**Application**

# Background on Cost Sharing Reduction (CSR) Risk & Anticipated Impact

Throughout much of 2017, our state and others sought to plan against growing uncertainty about continued federal Cost Sharing Reduction payments, due to a pending lawsuit and uncommitted federal signals.

- In 2014, the then-majority in the US House of Representatives sued the Obama administration, alleging that the US Department of Health and Human Services' Cost Sharing Reduction (CSR) payments to carriers were unlawful because funding for them had not been properly appropriated in the ACA
- A May 2016 ruling by a federal judge in favor of the House would have ceased the payment of CSRs, but the Obama administration appealed the ruling. The case, later known as *House v. Price*, had continued in an unresolved status since the outset of the new federal administration in January 2017
- Uncertainty in insurance markets and Exchanges nationally began to intensify throughout 2017 spring and summer, with confusion about how to price for the possible cessation of CSR payments to carriers and how best to keep insurance markets stable and consumers who depend on CSRs protected
- CMS continued to make monthly payments to issuers through 2017, but on the evening of Thursday, October 12, CMS announced it would immediately halt CSR payments
- CSR payment cessation announcement was days, and in some cases hours, after many states had finalized 2018 rates, including Massachusetts

# Massachusetts's Preparations to Address Risk of CSR Withdrawal

Many states, including Massachusetts, spent much of 2017 working to address the uncertainty the CSR risk could cause in their markets using a range of tactics as carriers developed and filed rates for plan year 2018.

## Process considerations

- In Massachusetts, we met on a weekly basis with our carrier community and with our Division of Insurance as we considered options throughout late spring, summer, and early fall of 2017
- Sought to keep market and stakeholders calm, informed, and engaged in the process for considering options

## Approaches that were considered

- Proactive adjustment of 2018 rates, even before CSR decision made vs. “hold steady”
- Pursuing state funding or market assessment as a stop-gap
- 1332 waiver approach

## Additional questions with which we wrestled

- Which plans should have a load to account for CSR exposure? Just silver plans or just silver QHPs or all plans? Just on-Exchange or both on-and-off Exchange? Cordon off impact to just nongroup market vs. full merged market?

## What we decided

- During the summer of 2017, Massachusetts prepared a Section 1332 waiver to address its anticipated market instability that could occur if CSRs were to be halted or if the continued uncertainty of CSR payments were to persist. It simultaneously prepared its market for the possibility of having to use “silver loaded” rates for 2018.

# Massachusetts's 1332 Waiver: Premium Stabilization Fund Request

**Massachusetts submitted a 1332 waiver application on Sept. 8<sup>th</sup> to stabilize 2018 premiums in the face of CSR withdrawal.**

- Massachusetts requested authority to waive Cost-Sharing Reductions and instead establish a state Premium Stabilization Fund to eliminate instability in the market, thereby lowering premiums and consequently federal premium tax credit liability
- Massachusetts sought a “pass-through” of federal premium tax credit savings, with these funds seeding the Premium Stabilization Fund, which would in turn support issuers. The 1332 application sought to waive requirements to reduce cost-sharing [42 USC § 18071] and pass through of available funds to a state [permissible under 42 USC §18052(a)(3)]
- Massachusetts would then use these funds to pay carriers CSRs (instead of the federal government doing so), using the revenue that would soon come into the state’s market via higher APTC due to silver loading that Massachusetts would prefer not to do
- Because the state would not waive the requirement that issuers provide CSR-enriched plans, there would be no consumer-facing changes to coverage costs or benefits
- Massachusetts preferred a Congressional solution to market instability, but submitted this waiver with a request for “fast-track” review, as a potential solution if federal action did not materialize prior to 2018 rate finalization

Link to the September 8<sup>th</sup> submission of Massachusetts’s Section 1332 waiver request available at: <https://www.mahealthconnector.org/wp-content/uploads/Massachusetts-Request-for-1332-State-Innovation-Waiver-to-Stabilize-Premiums-090817.pdf>

# CMS Response to Massachusetts's 1332 Waiver Request

## CMS rejected Massachusetts's 1332 request, citing insufficient time in advance of plan year 2018.

- Given the short timeline between submission of the Massachusetts waiver request and the applicable plan year (which would begin on January 1, 2018), CMS determined that Massachusetts's waiver request was "incomplete".
- CMS's October 23<sup>rd</sup> 2017 response noted: *"Pursuant 45 CFR 155.1308(f), in order for an application to be deemed complete must comply with paragraphs (a) through (f) section under section 155.1308. Sub section (b) states that an application for initial approval of a section 1332 waiver must be submitted sufficiently in advance of the requested effective date to allow for an appropriate implementation timeline. Given that the waiver was submitted less than two months prior to the beginning of the 2018 open enrollment period and, if the application were deemed complete, the Federal public comment period would not end until after the beginning of open enrollment, the Departments have determined that there is not sufficient time to implement the proposed waiver."*

Link to the CMS response to Massachusetts's Section 1332 waiver request available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Preliminary-Determination-Incompleteness-MA.pdf>

# What Did Massachusetts End Up Doing?

**Reversing a prior decision to load unadjusted rates, Massachusetts ended up “silver loading” – increasing rates for silver, on-Exchange QHPs by 18 percent as compared to what rates would have otherwise been for 2018.**

- The DOI and the Health Connector ultimately opted to have carriers “silver load” for plan year 2018 – a practice that has continued into 2019 and 2020
- The Baker-Polito Administration covered Massachusetts carriers for the remaining quarter of 2017 for which the federal government did not pay CSRs – totaling to \$28M in state costs
- While many states have found that “silver loading” ultimately provided additional premium subsidy to lower-income eligible individuals, in Massachusetts our ConnectorCare program has largely shielded those unintended benefits to lower income individuals and has resulted in undue cost burdens to our unsubsidized population
- Silver-loading has introduced distortion and problematic consequences for pricing in our market that are not preferable over the long term
- We continue to explore opportunities to mitigate these continued impacts of CSR non-payment by the federal government, including consideration of submitting a similar Section 1332 waiver for a future plan year on a slower timeline



**Other Possible 1332 Waivers**

## **Under Possible Consideration: 1332 Waiver for State Administration of Small Business Tax Credits**

**The Health Connector has considered whether to pursue a 1332 waiver to administer ACA Small Business Tax Credits at a state level to make them more accessible to eligible small employers in the Commonwealth.**

- Federal small business tax credits available through the ACA are not currently being used for maximum impact - preliminary data indicates that uptake has been low
- These tax credits are designed to help the types of small employers data indicates are struggling most in the current employer-sponsored-insurance market: the smallest (<25 employees) and those with lower wage employees (average wages <\$50,000)
- The Health Connector has begun tentatively exploring whether a 1332 waiver of federal small business tax credit program [26 USC § 45R] to obtain pass through of available funds to Massachusetts [permissible under 42 USC §18052(a)(3)] would be a worthwhile endeavor
- With federal approval, Massachusetts would receive the federal funds currently available to eligible employers in Massachusetts and distribute them in a streamlined and administratively simplified manner to small businesses covered by Health Connector for Business



## Questions?

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State Innovation (1332)  
Waivers, Reinsurance, and  
Related Strategies

Break

Program will resume at  
11:15am

# Health Insurance Marketplace Options

# Trish Riley

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National Academy for State  
Health Policy

# Health Insurance Marketplace Options

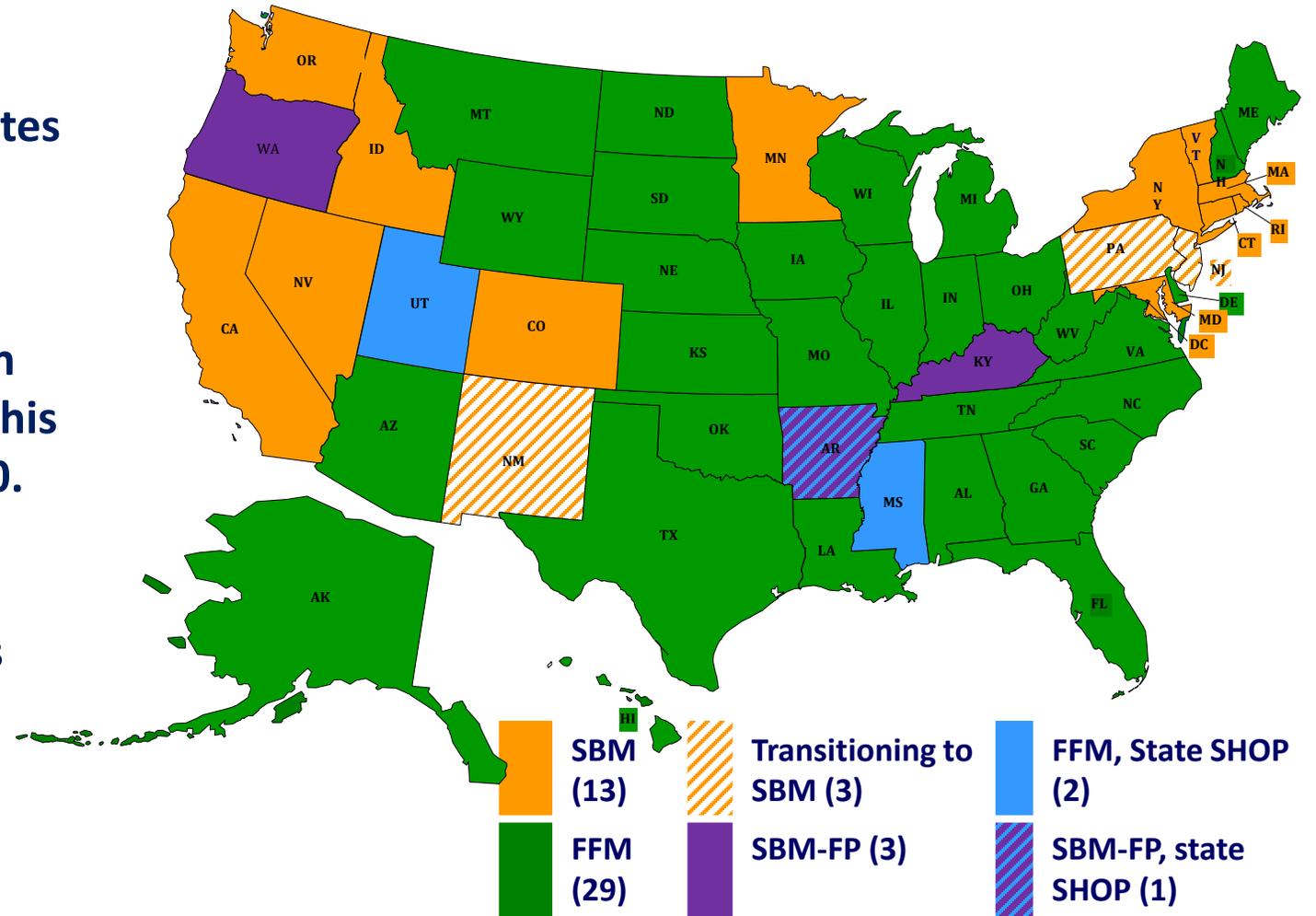
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**Trish Riley**  
[triley@nashp.org](mailto:triley@nashp.org)  
Executive Director



# Current Marketplace Models

- SBMs have more autonomy over their marketplaces and insurance markets. States with SBMs outperform FFM states on enrollment, affordability, and choice.
- Some states are exploring transition to an SBM model. NV will implement an SBM this year. NJ & PA will begin transition in 2020.
- The House has proposed legislation to provide \$200M in federal grants to states that wish to establish SBMs.



# Authority over key marketplace functions, by model

Marketplace Function	SBM	SBM-FP	FFM
<b>Plan Management</b>			
Set/ collect assessments	State	Both	Federal
QHP review & certification	State	State	Both
<b>Outreach &amp; Marketing</b>			
Navigator Program	State	State	Federal
Advertising	State	State	Federal
Agents/brokers	State	State	Federal
<b>IT/Operations</b>			
Integrated eligibility system	State	Federal	Federal
Application	State	Federal	Federal
Online tools (e.g., calculators)	State	Federal	Federal
Call Center	State	Federal	Federal
Set Special Enrollment Periods	Both	Federal	Federal

# SBM Governance Models

CA	Independent public agency	MA	Quasi-governmental entity
CO	Quasi-governmental entity	MN	Quasi-governmental entity
CT	Quasi-governmental entity	NY	Within Department of Health
DC	Independent public entity	RI	Division within the executive branch
ID	Independent public corporation	VT	Within Department of Vermont Health Access
MD	Independent public agency	WA	Non-governmental, public/private entity

# Financing the Marketplaces

- **Operational budget\***
  - **Total: \$3.7M-\$319.6M**
  - **Median: \$36.1M**

\*Based on fiscal year 2017. Data does not including information from New York.

\*\*Total applications received for individual market coverage during the 2017 open enrollment period.

\*\*\*Total effectuated enrollments as of February 2017, including covered lives enrolled through SHOP

State	Total Applications**	Total Enrollment***
CA	3,342,399	1,422,570
CO	165,513	127,499
CT	44,801	99,727
DC	27,293	82,843
ID	78,546	85,102
MA	79,852	248,696
MD	351,770	135,249
MN	134,965	92,325
NY	3,045,259	208,483
RI	59,822	34,107
VT	44,985	75,097
WA	646,413	184,695

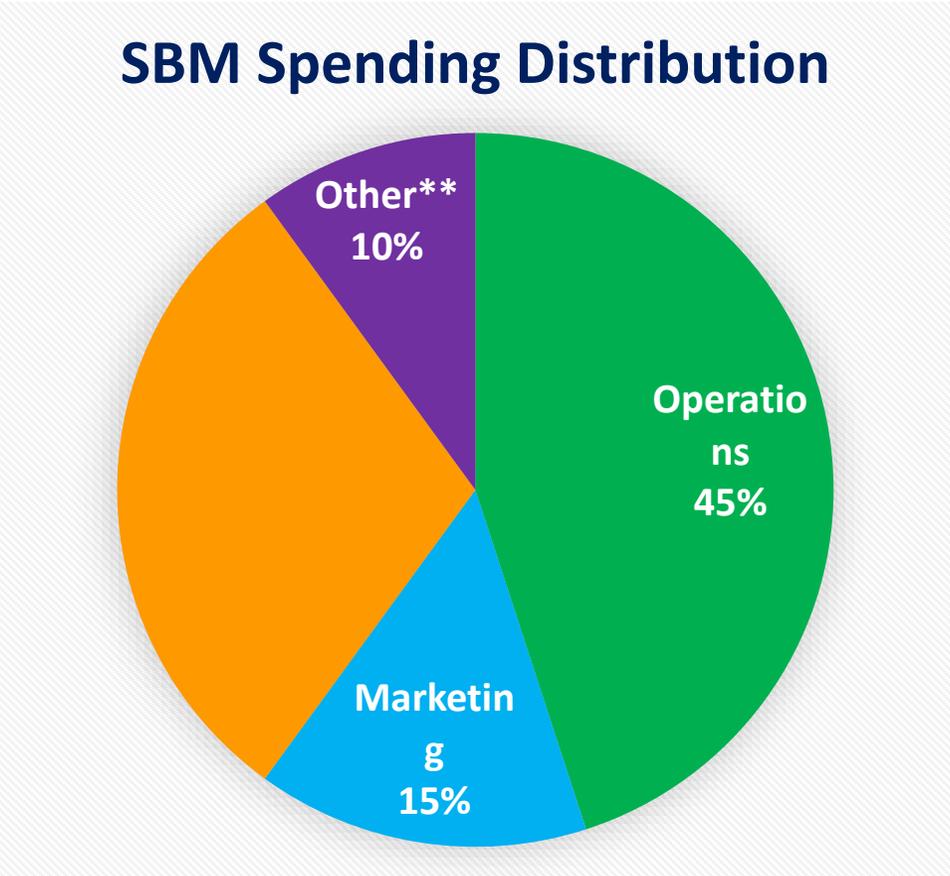
# Financing the Marketplaces

## SBM Assessment and Revenue Strategies (plan year 2019)

<b>CA</b>	3.75% assessment on plans offered through the marketplace	<b>MA</b>	2.5% assessment (marketplace plans) 3% on ConnectorCare plans
<b>CO</b>	3.5% assessment on marketplace plans.	<b>MN</b>	3.5% assessment (marketplace plans)
<b>CT</b>	1.65% assessment on plans inside and outside of the marketplace	<b>NY</b>	State appropriations
<b>DC</b>	0.9% broad-based assessment on all health carriers doing business in the District with annual premium revenues of at least \$50,000	<b>RI</b>	3.5% fee is assessed on all health and dental insurance premiums sold through the marketplace, the cost of which is spread across all health and dental insurance premiums in the individual and small group markets.
<b>ID</b>	1.99% assessment (marketplace plans)	<b>VT</b>	State appropriations
<b>MD</b>	2% assessment (on & off marketplace plans)	<b>WA</b>	2% assessment (on & off marketplace plans, existed prior to ACA) plus \$3.36 PMPM assessment on plans offered through the marketplace

# Financing the Marketplaces

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\*\*Other may include Human Resources, Legal, Training and recruitment, appeals, and money directed toward market stability measures including reinsurance.

# SBMs meet state-specific needs

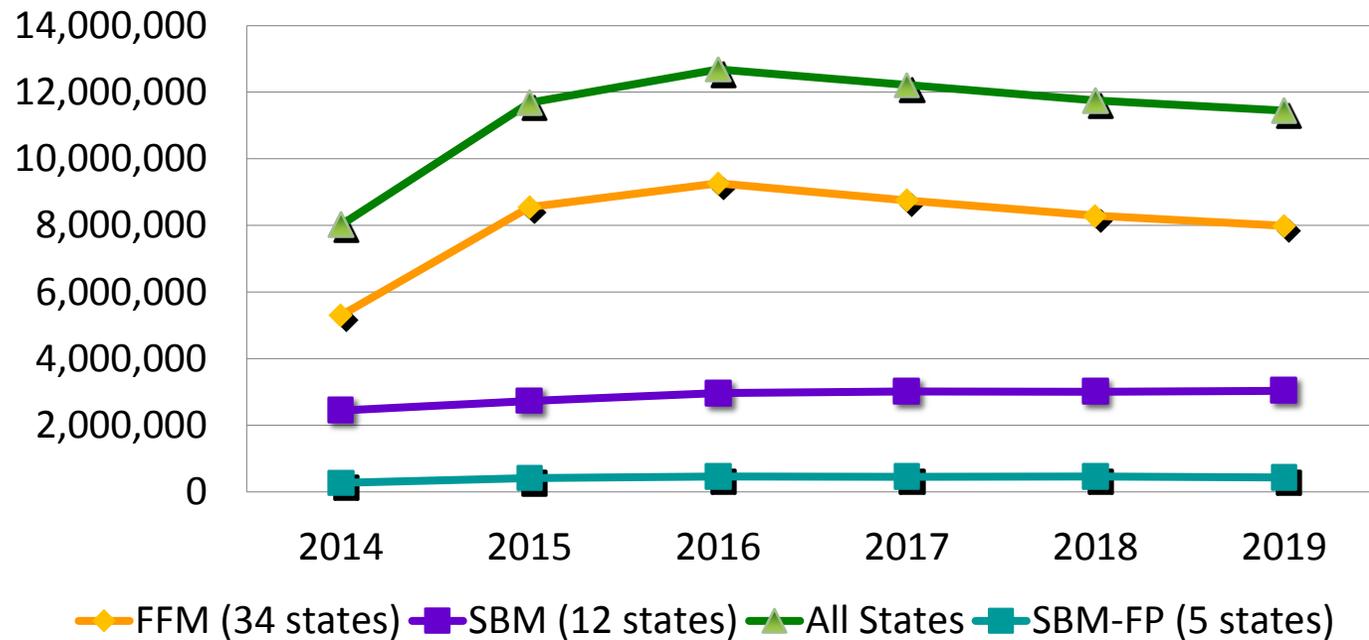
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- More autonomy over insurance markets-- Systems adaptable to state policy changes (incl. merged markets)
- Access to detailed market and enrollee data
- Tailored marketing and outreach strategies

# State-based marketplace (SBM) enrollment holds steady



Health Insurance Marketplace Enrollment  
(Plan Selections) 2014-19



Since 2016, enrollment has remained steady in SBM states.

- SBM enrollment rose slightly (0.9%) in 2019.
- Enrollment in the FFM dropped by 3.7% in 2019.

CMS Marketplace Open Enrollment Period Public Use Files, 2016-2019, available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html>; ASPE Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report <https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-2015-open-enrollment-period-march-enrollment-report>; Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period <https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-summary-enrollment-report-initial-annual-open-enrollment-period>

# Addressing affordability and insurance market changes

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- **Detailed data on enrollment enables active monitoring and analysis of markets**
- **Systems adaptable to state policy priorities—incl. standard plan design, custom special enrollment periods,**
- **Ability to drive consumers to better “fit” plans based on health needs**
- **Strengthened partnership with carriers**

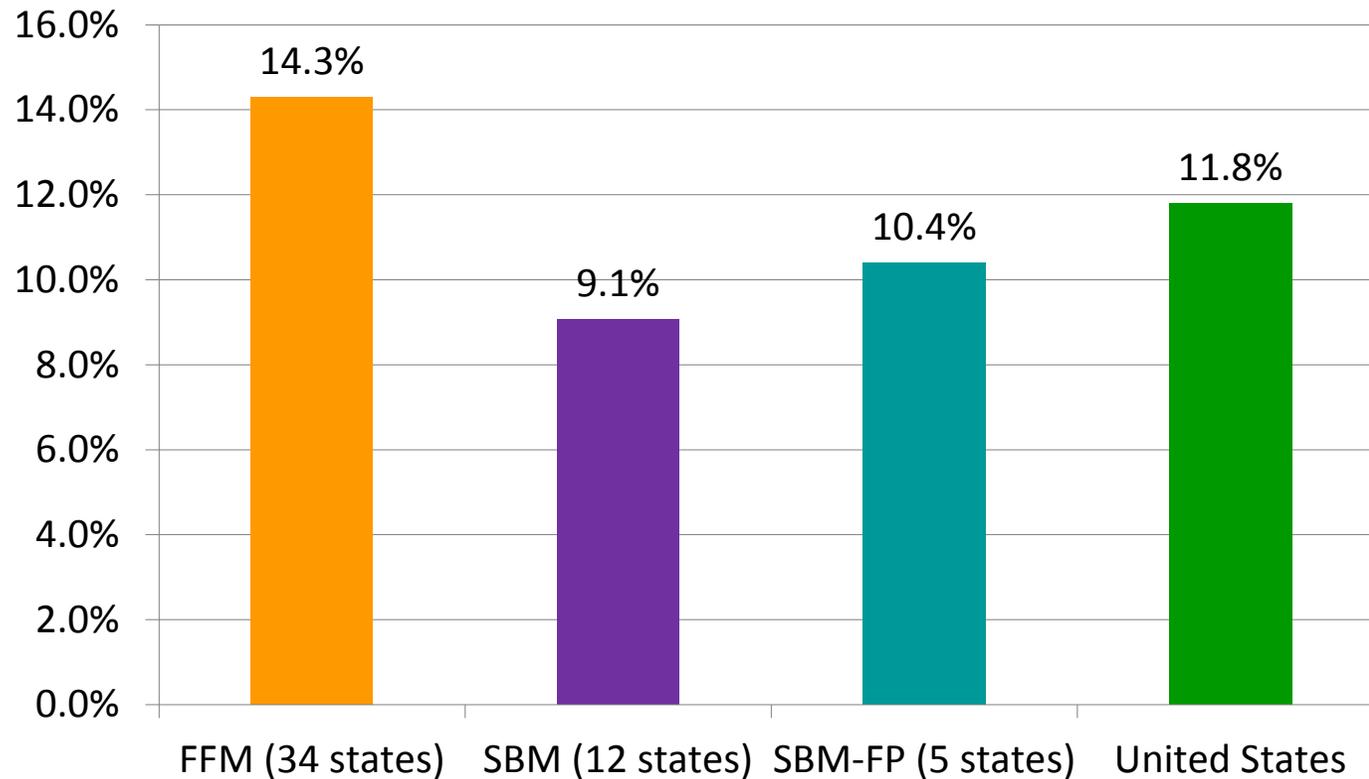
# Building and maintaining local partnerships

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- **Cross-agency collaboration incl. Medicaid coordination**
  - Integrated IT and benefit systems
- **Partnerships with non-traditional agencies (e.g. Dept. of Unemployment, state departments of revenue)**
- **Outreach partners (Navigators, Agents/brokers, Community leaders)**

# SBM states contain premium growth

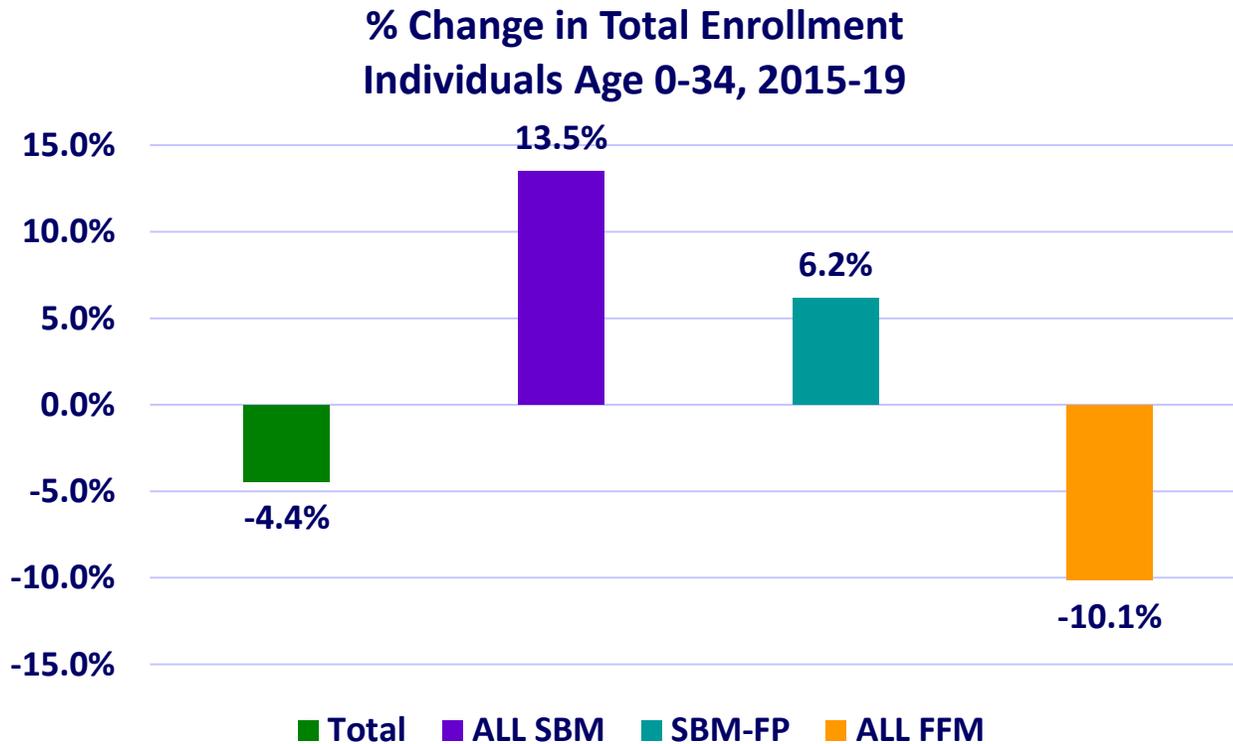
Compound Annual Growth Rate, 2014-19



- Since 2014, premiums have nearly doubled in FFM states, compared with 1.5-times in SBM states.
- This, in part, is due to SBM strategies to stabilize markets, including work to improve outreach and enrollment and to support policies intended to improve individual market risk (e.g., reinsurance).

Unweighted averages, based on average benchmark premiums as analyzed by the Kaiser Family Foundation. Data available at: <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

# SBMs target younger enrollees



- SBMs have tailored efforts, including marketing and outreach strategies, to engage younger enrollees.
- Younger enrollees, considered healthy and lower-cost, are essential to maintain a good risk mix and lower overall premiums.
- Total enrollment among young enrollees has risen by 13.5% in SBM states, while dropping by 10.1% in FFM states.

Enrollment is measured by plan selections. State-by-state data by age is unavailable for 2014; calculations for 2015 based on plan selections with available data on enrollment type. CMS Marketplace Open Enrollment Period Public Use Files, 2016-2019, available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html>; ASPE Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report <https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-2015-open-enrollment-period-march-enrollment-report>

# Lina Rashid

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CMS Center for Consumer  
Information and Insurance  
Oversight

# Mila Kofman

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DC Health Benefit Exchange  
Authority



**Mila Kofman, J.D.  
Executive Director  
DC Health Benefit Exchange Authority**

**August 29, 2019**



## DC Health Link: state-based online health insurance marketplace

- Private-public partnership (private Executive Board)
- Last state to start IT build, **1 of 4 state marketplaces opened for business on time** (& stayed open) Oct 1, 2013
- Small group & individual market through DC Health Link:
  - **100,000 covered lives** (private health insurance): 79,000 people in SHOP (5,000+ District small businesses covered; 11,000 Congress -- Members and designated staff in district offices and on the Hill); 17,000 residents (individual); 5,000 residents with individual dental insurance (market didn't exist before); more than 800 brokers (92% of small businesses have a broker)



## HBX Recent Awards and Recognition

- ✓ **2018 & 2016 Best Practices in Innovation:** Amazon Web Services (AWS) City on a Cloud international competition
  - for shared services with the Massachusetts Health Connector for Business & open source code in the cloud with agile development (works on all devices – don't need internet and computer access; daily deployments and no off-line for deployments)

**DC open source, cloud-based code is free (no licensing fees) and available to all states (State IT agencies and consultants can deploy in a state) (NASHP policy brief)**
- ✓ **2018 and 2017 Ranked #1 for consumer decision support tools (ranking of SBMs and FFM)**
- ✓ **Five PR News Awards in 2018 and 2019**
- ✓ **2017 AWS IT case study** on cloud solutions (<https://aws.amazon.com/solutions/case-studies/DC-HBX/>)
- ✓ **First in the nation SBM partnership.** Selected by the Massachusetts Health Connector to provide IT solution and on-going operations support for the MA SHOP (Feb 2017)



## 2019 HEALTH INSURANCE OPTIONS THROUGH DC HEALTH LINK

### **Plans:**

- 152 Small Group Plans
- 25 Individual Plans (includes 2 catastrophic)

### **Insurers:**

- 3 United HealthCare Companies (group only);
- 2 Aetna Companies (group only);
- CareFirst BlueCross BlueShield;
- Kaiser Permanente



## Why a state-based marketplace (SBM)?

### Leverage SBM to achieve local policy priorities:

- ✓ DC now has near universal coverage (96+% insured)
- ✓ Since DC Health Link opened for business, we've cut uninsured rate in ½

### Reflects local priorities (stakeholder working groups & consensus policy):

- ✓ **Empowered consumers** to make more informed decisions in a transparent unbiased on-line private market (e.g. Rx look up, CSR, one-on-one user testing)
- ✓ **Purchasing power of larger employers:** small businesses can offer their employees choice of insurance companies and coverage levels just like large employers (easy set up and one bill pay)
- ✓ **IT reflects local policies:** no tobacco rating; 90 days open enrollment period; additional special enrollment rights; verification locally tailored; enrollment data for targeted marketing and outreach for populations with low or lower insured rates; easy back and forth private and Medicaid (and small business and self employed); individual responsibility requirement (slide)
- ✓ **Remove barriers to care:** standard plans (slide)
- ✓ **Created a private market** for individual stand alone dental (includes Medicare enrollees)
- ✓ **Local affordability programs** like Massachusetts has (APTC wrap), quality and other state reforms like CA and NY include in their carrier contracts



## Reflects local priorities cont.

- ✓ IT roadmap based on customer, broker and navigator, and health plan feedback and priorities – customized EDI
- ✓ Advocate for all our customers (lowest possible rates and have saved millions for our customers; advocate for products, e.g. HSAs)
- ✓ Locally accountable to policymakers and customers we serve (state customers always a priority, e.g. *late night and holiday* emergencies)
- ✓ Local economy (small businesses and self-employed customers in our paid advertisement, local call center, vendors)
- ✓ Dialable budget (\$\$ marketing and navigators)



## **SBM Reflects local priorities: removing barriers to care through standard plans**

**Standard Plans Individual Marketplace** (73% of DC Health Link customers enrolled in standard design plans)

- ✓ **PRE-DEDUCTIBLE COVERAGE:** These plans cover primary & specialty care (including mental health) without limit on number of visits, urgent care, and generic Rx without first having to meet a deductible.
- ✓ Standard plans have the same benefits and same out-of-pocket costs (deductibles, copays, coinsurance) and make it easy for residents to compare plans based on quality & networks.



## **SBM Reflects local priorities: One Big Marketplace**

### **Full transparency to drive competition**

- ✓ Premium competition (for small businesses), e.g. first year 3 of 4 carriers refiled proposing lower rates (1 carrier refiled twice proposing lower rates and 1 carrier also added additional plans);
- ✓ Price points: 2013-2019 decreased rates or no change in some plans

### **Market power like large employers (100,000 covered lives)**

- ✓ Employer choice with predictable budget (defined contribution)
- ✓ Employee: choice of 1 carrier all metal levels OR All carriers 1 metal level (employer gets one bill)
- ✓ Nationwide and local networks

### **All QHP protections market-wide**

### **Equity: all product choices**

### **Full support for brokers, TPAs, and GAs (special portal and account management features)**

- ✓ 92% of employers have a broker
- ✓ Broker quoting tools; event partnerships, dedicated internal team; on site support



## New individual responsibility requirement: similar to federal requirement

- **Applies to 2019 tax year** (when federal fine decreased to \$0)
- **Applies to any “applicable individual”** (Similar to federal standards as of 12/15/2017)
- **Applies if go without coverage for ≥3 months** (per federal standards 12/15/2017)
- **\$\$ Fine similar to federal** (offset if federal is reinstated)

### Responsibility fine:

Whichever is greater: \$695 per adult/\$347.50 per child -- up to a cap of \$2085 per family OR 2.5% of family income that is over the filing threshold

Fine is capped at the average DC bronze level health plan (*HBX will publish annually*).



## New individual responsibility requirement

- **Exemptions:**
  - **Automatic** exemption (on DC income tax form): 222 FPL%; 324% FPL for under 21 (% adjusted by Mayor based on eligibility for Medicaid, CHIP & Immigrant Children’s Program)
  - **Individuals must apply** for affordability/hardship exemption (similar to federally administered exemptions)
- **Outreach requirement:** Office of Tax and Revenue (OTR) outreach to people who are subject to a penalty
- **\$\$ collected:** new Fund to help educate about coverage options and increase affordability of individual health insurance premiums



## **IT TAKES A VILLAGE**

- **DC Mayors and Councilmembers**
- **DC Health Link Business Partners**
- **DC Health Link Assisters, Navigators & Certified Application Counselors**
- **DC Health Link Certified Brokers**
- **DC Health Plans**
- **DC Government Agencies**
- **Faith-based Community**
- **Community Organizations**
- **Local Businesses**



greater**washington**  
hispanic chamber of commerce



**RAMW**

RESTAURANT ASSOCIATION  
METROPOLITAN WASHINGTON

**DC Chamber of Commerce**  
DELIVERING THE CAPITAL



PROTECTING THE CONSUMER'S FUTURE  
**NAHU**  
National Association  
of Health Underwriters  
AMERICA'S BENEFITS SPECIALISTS

# Health Insurance Marketplace Options

Break

Program will resume at  
12:45pm

# Controlling Costs

# Michael Chernew

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Harvard Medical School

# State Levers to Control Health Care Spending

Michael Chernew

# What is the Objective?

- Spending by the state
  - Medicaid
  - State employees
- Health care spending in the state
  - (including federal share)
- ➔ Spending by state residents
  - Premiums
  - Out of pocket
  - Taxes to support state spending

# Basic Recommendation

- Expand Medicaid
  - (I know you did this)
  
- (More broadly, maximize out of state \$)

# Spending Math

- Spending = Price \* Quantity
  - ➔ Any policy to control spending must address price, quantity, or the combination
  
- One person's spending is another person's revenue
  - ➔ Be prepared to accept lower revenue growth for providers

# Addressing Quantity

- Public health
  - Wonderful, but not a big saver
- Reduce low value care
  - Education, information initiatives
  - Support payment reform

# Addressing Price: Drugs

- Really important
- States worry less about broad implications
- 'negotiation' leverage
- Key issue is access
- Interplay with federal policy is central

# Addressing Price: Medical Services

- Impact of transparency is modest
  - May be counter productive
- Pro-competitive reforms are useful, but unlikely enough
  - Limit mergers
  - Address contracting issues

# Addressing Price: Medical Services

- Eliminate worst abuses
- Cap price
  - Start with out of network: that will have in- network impacts
- Regulate price growth
  - Rhode Island example
- May need total cost of care/ premium backstop

# Peter Hayes

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The Healthcare Purchaser Alliance  
of Maine



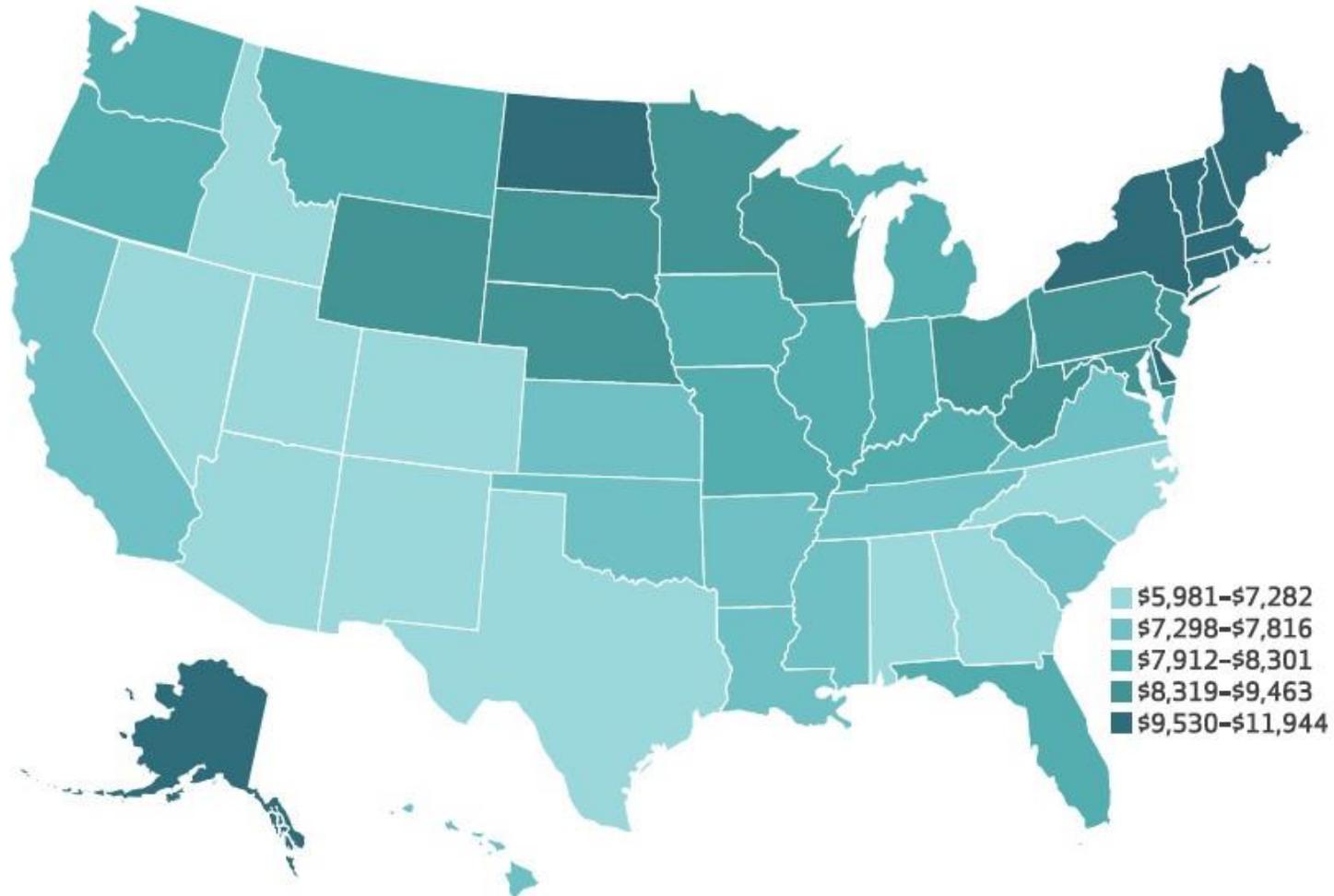
HEALTHCARE  
PURCHASER  
ALLIANCE  
OF MAINE

Maine Purchasers  
Perspective

*August 29, 2019, 2019*

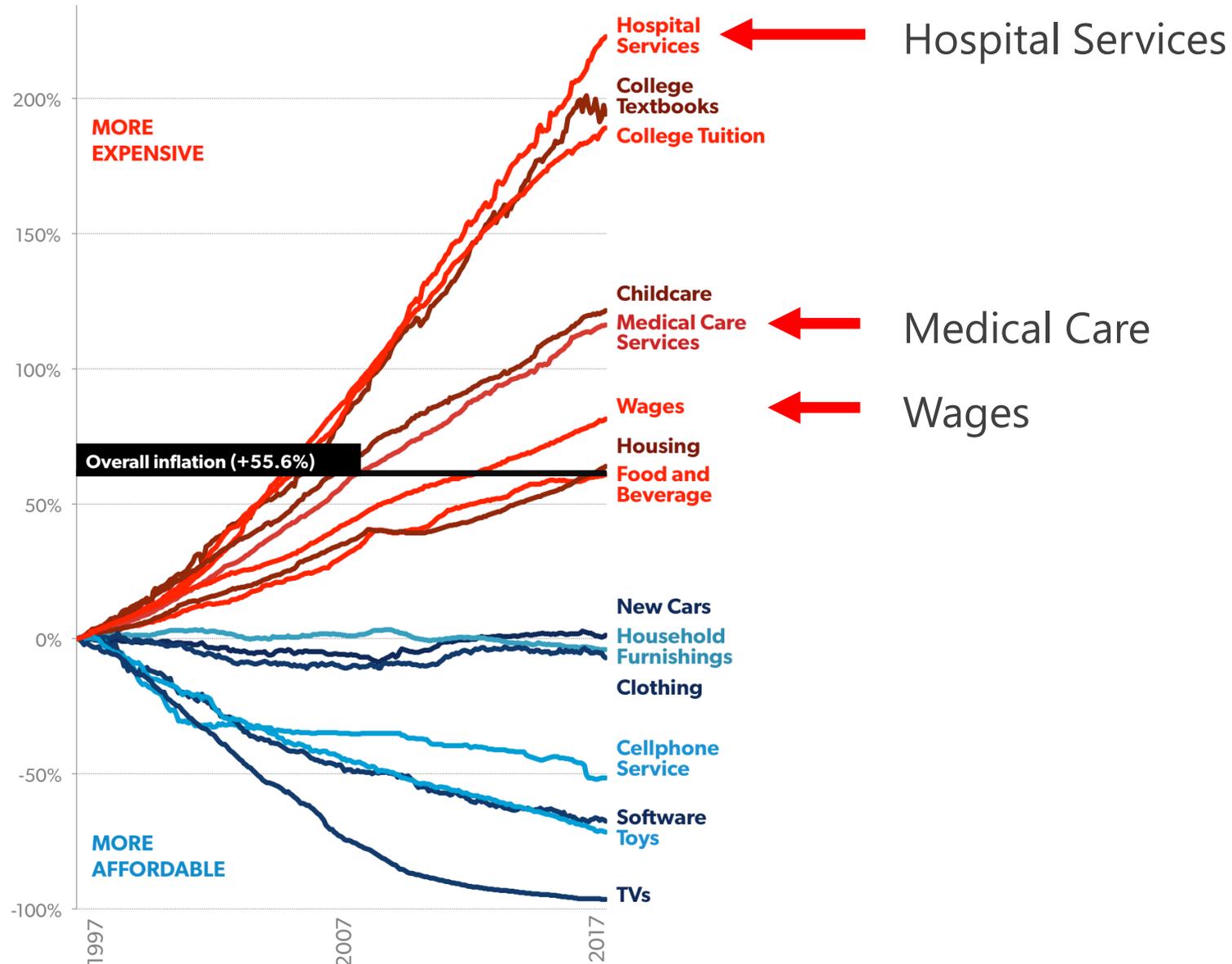
# Per Capita Spending by State (2014)

Per capita personal health care spending by state of residence, calendar year 2014



Maine is the highest cost state, in the highest cost region of the country

# Price Changes: 1997-2017

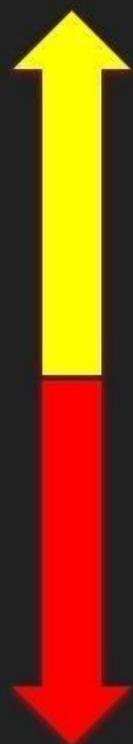


Takeaway: Markets with quality transparency and competition create higher value

# Why does this all matter?



## CATASTROPHIC MISALLOCATION OF RESOURCES



**+37%**

**HEALTHCARE  
SPENDING**



- 50% LOCAL AID**
- 31% PUBLIC HEALTH**
- 22% MENTAL HEALTH**
- 14% INFRASTRUCTURE, HOUSING & ECON. DEV.**
- 13% LAW & PUBLIC SAFETY**
- 12% EDUCATION**
- 11% HUMAN SERVICES**

**HEALTHCARE SPENDING DEVASTATES SOCIAL DETERMINANTS OF HEALTH  
(FY01 - FY14 - STATE OF MASSACHUSETTS)**

Rising healthcare costs eat into every aspect of our lives -- from infrastructure, to education, social support programs

# Purchaser Focus for High Value Care



HEALTHCARE  
PURCHASER  
ALLIANCE  
OF MAINE

- Transparency
  - Provider Cost and Quality
  - PBM's
- Providers of Excellence (CoE's)
- Patient Engagement
  - Shopper tools
  - Leveraging digital/virtual care
  - Chronic illness
- Different Reimbursement Models
  - Reference Based
  - Pay for Performance
  - Specialty Drug
  - Captives
- Data Analytics



# Prices, Not Utilization, Driving Costs

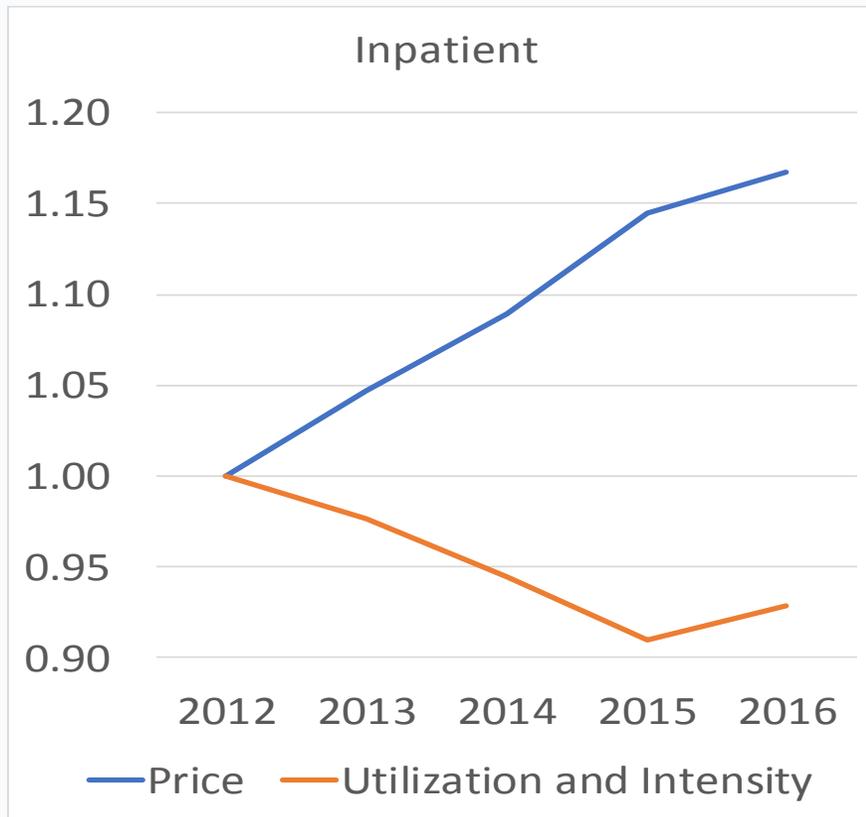


**Inpatient Use Continued to Decline but Prices Rose Substantially**

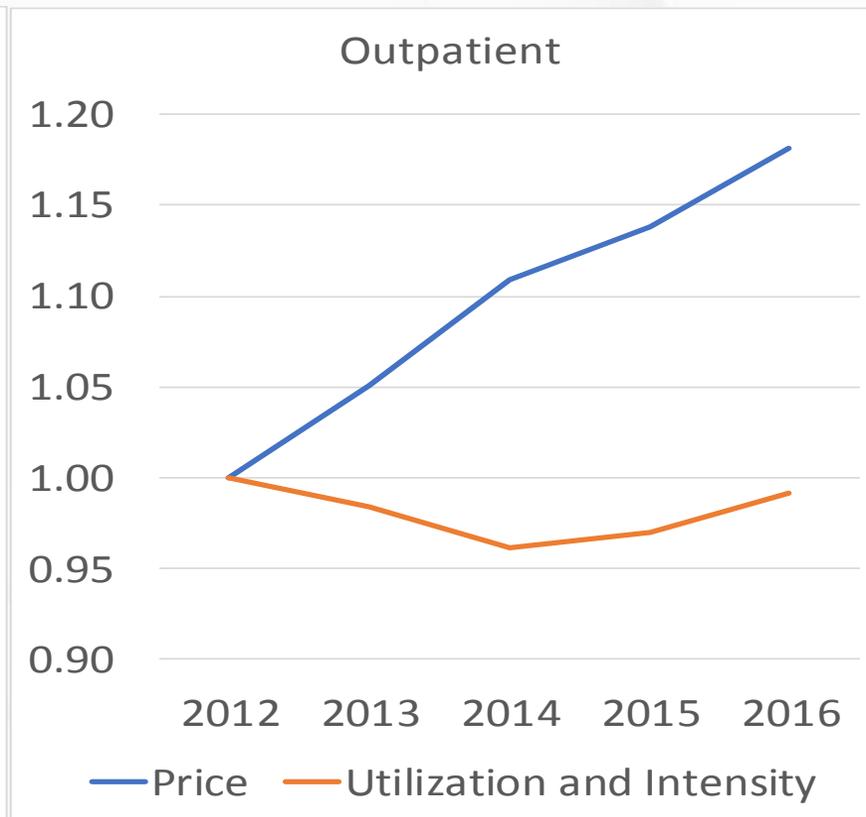


**Outpatient Prices Drove Spending Growth**

**Use trending back to baseline**



**Use trending back to baseline**



## The New York Times

***New York Times (5/9/2019)***

***“Many Hospitals Charge Double or Even Triple What Medicare Would Pay”***

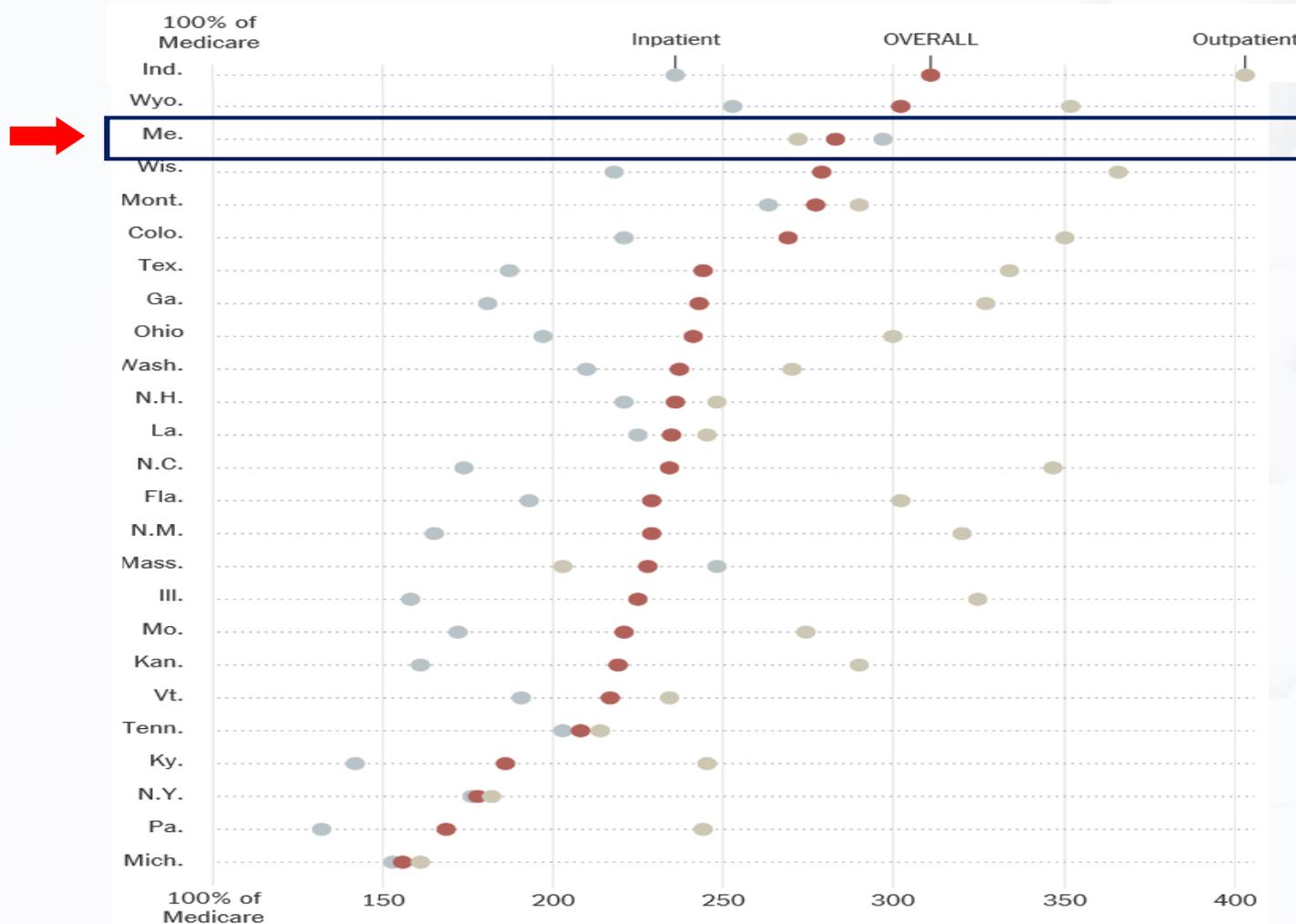
The RAND study shows “market forces are clearly not working,” said Richard Scheffler, a health economist at the University of California, Berkeley. “Prices vary widely and are two and a half times higher than Medicare payment rates without any apparent reason,” he said.

The disparity shows how competition has faltered in an opaque market where the costs of care are secret and hospital systems are increasingly consolidated, gaining outsized clout in price negotiations with employers, some experts say.

# State Medicare Comparison

## Hospital Prices

A study shows that employers in many states are paying much more than Medicare prices for hospital services



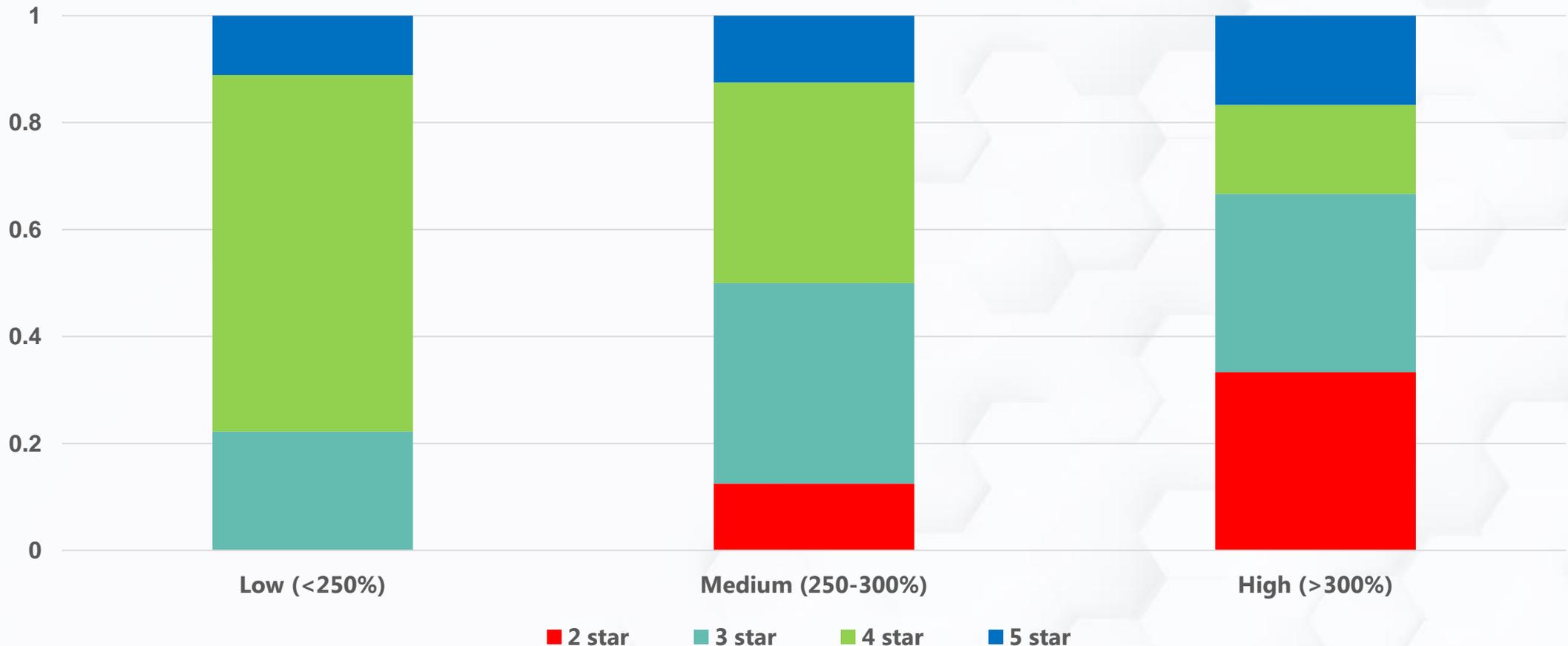
# Variation by Health Systems

SYSTEM	# of HOSPITALS	AVG PRICE (% MEDICARE)
MaineHealth*	6	263%
Northern Light	4	336%
Central Maine	3	229%
Covenant	2	295%
Independent**	9	238%
<b>State Average</b>		<b>283%</b>
<b>National Average</b>		<b>241%</b>

\* Includes Franklin and Southern Maine, which were incorrectly categorized as independent in RAND data.

\*\*Includes Maine General.

## Star Ratings by Price Group (Outpatient) Maine Hospitals



# Cost Implications for One Large Maine Employer

	ANNUAL COST	SAVINGS	% SAVINGS
Current IP/OP Spend (2018) @283% Medicare	\$122M	----	----
Estimated Spend @200% Medicare	\$86M	\$36M	30%
Estimated Spend @150% Medicare	\$65M	\$57M	47%
(20% margin) → Estimated Spend @135% Medicare	\$58M	\$64M	52%
(breakeven) → Estimated Spend @115% Medicare	\$50M	\$72M	59%

150%-200% of Medicare is the best value, according to the Rand study, based on quality and cost and supported by Maine results.

# Transparent PBM, Pass-Through Savings

- Transparent—client has access to all records (claims, payments, etc.)
- No spread pricing; employer pays the same amount paid to the pharmacy
- Employer gets 100 percent of rebates (incl. ZBD claims)
- Variable copay program
- Acquisition plus pricing for specialty drugs
- No aggregators
- ProCare gets a flat PEPM admin fee



**100%  
REBATES**



**ELIMINATE  
SPREAD**



**NETWORK/  
FORMULARY  
CHANGE**

SAVINGS OPPORTUNITIES

# It's the prices, stupid!



**\$9,050**

## CHEMOTHERAPY SESSION

New England Cancer Specialists in Topsham

**CHEMOTHERAPY SESSION**  
Waldo County General Hospital in Belfast

**\$20,000**



## It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

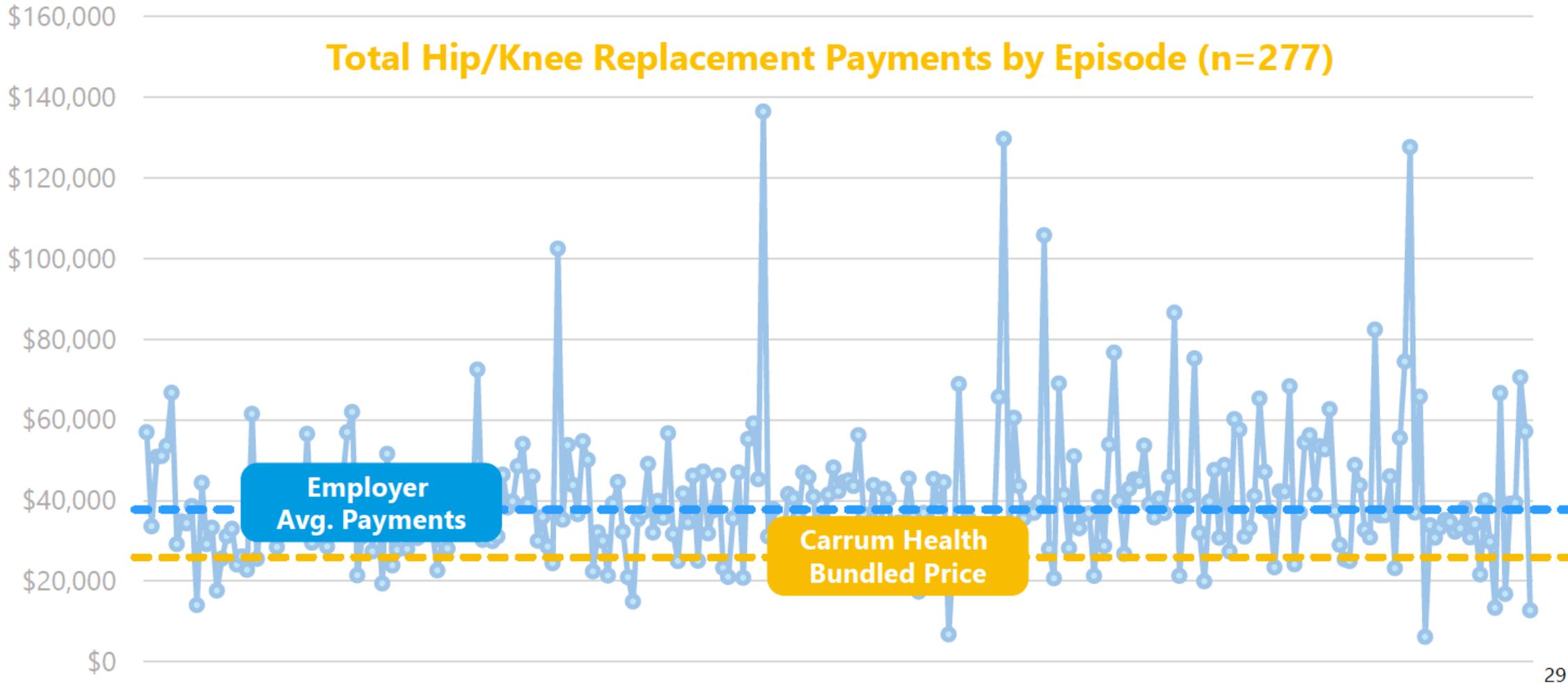
# Case Study: NH Health Trust

- Non-profit, employee benefits pool serving municipal, school and county governments
- 47K covered lives across New Hampshire

## 2015-2017 Savings

<b>\$7.3M</b> Gross Savings	<b>\$797,900</b> Incentives Paid	<b>\$554</b> Avg. Savings Per Claim
<b>20%</b> Employees Registered	<b>81%</b> Registered Users Shop	<b>21%</b> Redirection Rate
<b>8:1 ROI</b>		

# Variation is Rampant, Costs are High



One large purchaser saw a **615% variance** in the cost of knee replacements in Maine

# Carrum Repricing Outcomes

	CLIENTS			
	A	B	C	D
Year 1 per bundle savings	22%	22%	13%	34%
5-year total net savings	\$9-10 million	\$12 million	\$2-3 million	\$600-700 K
Year 5 PEPM net savings	\$21	\$12	\$15	\$12
Year 5 ROI	10:1	6:1	7-8:1	6:1
Current variation in cost	615%	558%	255%	NA



**Healthcare Purchaser  
Alliance of Maine**

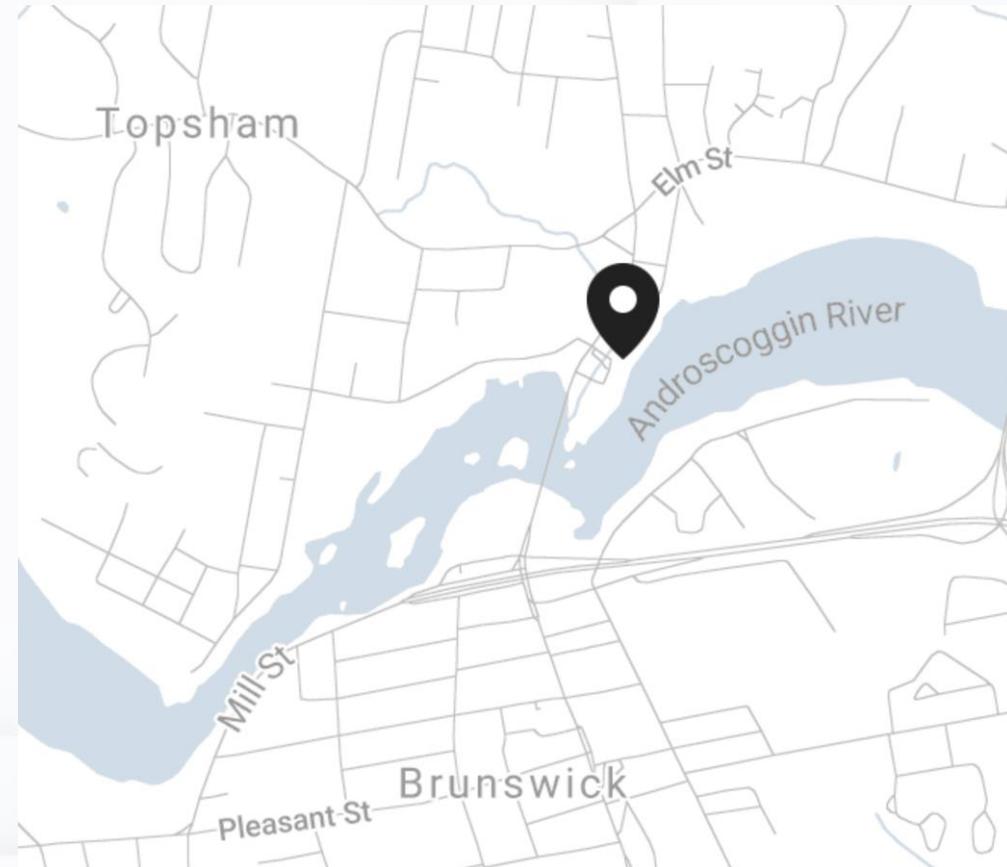
11 Bowdoin Mill Island, Suite 260

Topsham, ME 04086

207.844.8106

[info@purchaseralliance.org](mailto:info@purchaseralliance.org)

[www.purchaseralliance.org](http://www.purchaseralliance.org)



# Karynlee Harrington

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Maine Health Data Organization &  
Maine Quality Forum



# Panel Discussion: Controlling Costs

Karynlee Harrington | Executive Director | Maine Health Data Organization | Maine Quality Forum | August, 2019



## Maine Health Data Organization (MHDO)

Governing Statute:  
Title 22 Chapter 1683

## Maine Quality Forum (MQF)

Governing Statute:  
Title 24-A Chapter 87

**MHDO**-Established in 1995 to create and maintain a useful, objective, reliable and comprehensive health information data warehouse that is used to improve the health of Maine citizens, **and** to promote the transparency of the cost and quality of healthcare, including prescription drugs, in collaboration with the Maine Quality Forum.

MHDO is mandated to make data publically available and accessible to the broadest extent consistent with the laws protecting individual privacy, and proprietary information.

Acceptable uses of MHDO Data defined in Rule include, but are not limited to, **study of health care costs**, utilization, and outcomes; benchmarking; quality analysis; longitudinal research; other research; and administrative or planning purposes.

**MQF**-Established in 2003 to monitor and improve the quality of healthcare in the State of Maine.

# MHDO Data Sets

## Over 1 Billion Health Care Records and Growing....

- All Payer Claims Data-medical, **pharmacy** and dental claims (includes commercial, voluntary self-funded ERISA & public payers)
- Maine Hospital Inpatient and Outpatient Encounter Data
- Hospital Physician Practice Data (primary and specialty care)
- Maine Hospital Quality Data
- Maine Hospital Financial & Restructuring Data
- **NEW Rx Data coming in 2020 from prescription drug manufacturers, wholesale drug distributors and pharmacy benefit managers**
  - Details on the new law can be found here:

<http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0350&item=3&snum=129>

# CompareMaine

## More Information Better Decisions

CompareMaine was developed by MHDO & MQF in partnership with Human Services Research Institute; NORC, Wowza, the MHDO's Consumer Advisory Committee and other interested parties. CompareMaine was launched in the fall of 2015.

- Allows for the comparison of average costs (defined as median total payments) for over 200 procedures by health care facility by the top 5 health plans and a statewide average for all commercial payers and self-funded ERISA plans that submit data to MHDO. Over 22,000 cost estimates on the site.
- Integrates seven quality measures: Patient Experience, Preventing Serious Complications, Preventing Healthcare Associated Infections (2 measures), Preventing Falls with Injury, Preventing Pressure Ulcers and Unplanned Hospital-Wide Readmissions.
- Cost data on the site is updated 2/year
- External review process allows for those payers and facilities reported on the opportunity to review the cost data and comment before data is publicly released.

## CompareMaine

### More Information Better Decisions

- The categories of procedures include: office visits, PT & OT, mental & behavioral health, OB/GYN, radiology & imaging, lab services, inpatient/outpatient surgical procedures, Chiropractic services and infusion therapy
- Over 150 facilities on site include hospitals, surgical centers, diagnostic imaging centers, labs & clinics.
- Costs represent the median payments (carrier and member) & breakdowns the total into professional and facility payments when applicable.
- In most cases CompareMaine reports the costs for a single procedure, however, some diagnostic procedures may involve a main procedure and several related services.
- We use a Grouper tool which is clinically based logic to create groupings of claims for ten surgical procedures reported on CompareMaine.

## Commercial Data in APCD for the time period July 1, 2017- June 30, 2018

CPT Code	Procedure Name	Min Average Payment	Max Average Payment	% Diff. in Payment	Maine State Average
45380	Colonoscopy with biopsy for noncancerous growth	\$1,334	\$5,188	289%	\$2,866
59400	Vaginal delivery	\$6,405	\$15,592	143%	\$12,418
27447	Knee replacement	\$27,118	\$53,962	99%	\$37,373
45378	Colonoscopy without biopsy for encounter for preventive health services	\$1,132	\$3,626	220%	\$1,668
27130	Hip replacement	\$27,830	\$46,754	68%	\$37,353
47562	Gallbladder removal	\$10,410	\$23,048	121%	\$14,030
59510	C-section (Cesarean delivery)	\$13,718	\$28,775	110%	\$21,001
70551	MRI scan of brain	\$381	\$2,153	465%	\$987
73721	MRI scan of leg joint	\$303	\$2,590	755%	\$906
72148	MRI scan of lower spinal canal	\$290	\$2,826	874%	\$1,021

## CompareMaine & Variation in Payments for Top Ten Most Commonly Searched Procedures

Payment data are from current release of CompareMaine- V7 representing average payments for the time period July 1, 2017 through June 30, 2018. Data Source: MHDO APCD

# CompareMaine Cost Trends Over Time

Interactive dashboard that shows how average total costs reported on CompareMaine have changed over time.

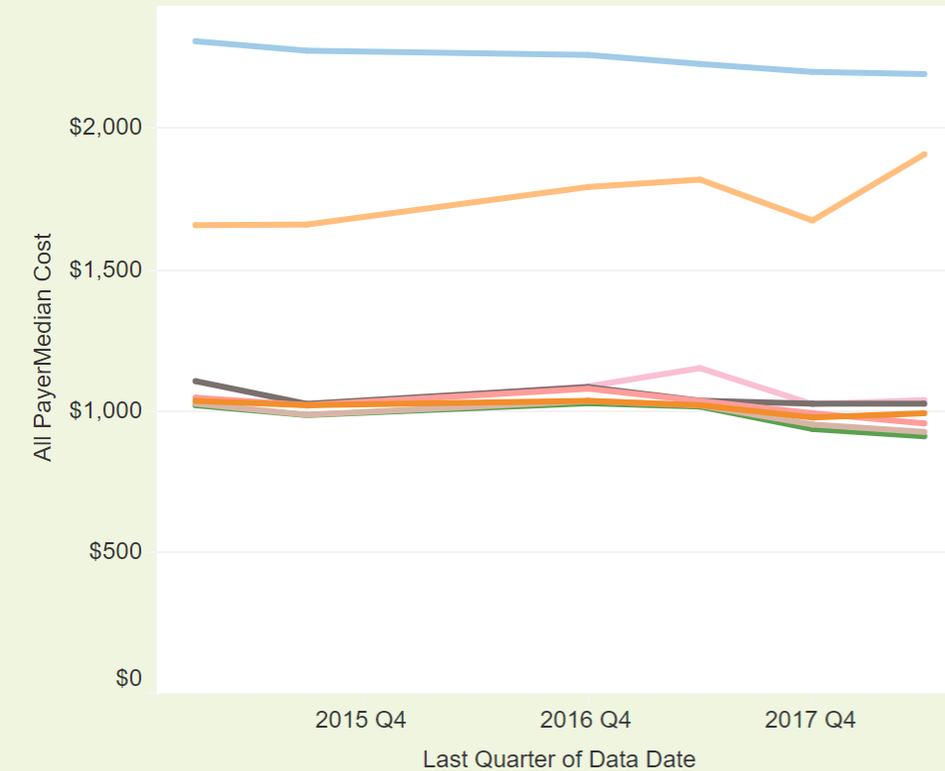
<https://www.comparemaine.org/?page=trends>

## CompareMaine Trends Over Time

Facility ...  Insuran...

Category  Sub-Category  Procedure(s)

### All Payers Statewide Costs Over Time



CPT Code(s)  
 70551  70553  72141

### Percent of Cost Changes Between CompareMaine Releases

Procedure Code	CM1	CM2	CM4
70551	0%	-1%	1%
70553	0%	0%	4%
72141	0%	-1%	3%
72148	0%	-4%	3%
72195		0%	3%
73221	0%	-2%	2%
73721	0%	-2%	2%
77059	0%	-1%	0%

# Pharmacy Paid Amount as a % of Medical Paid, 2009-2018 (as reported in APCD)

Source:  
<https://mhdo.maine.gov/tableau/data.cshtml>

## Commercial Insurance

2009: 23%

2010: 23%

2011: 24%

2012: 24%

2013: 27%

2014: 28%

2015: 29%

2016: 39%

2017: 36%

2018: 36%

Select a date range to see what data are available.

January 2009  March 2019

### What volume of claims are available?

Type of Insurance	Dental	Medical	Pharmacy
Commercial Insurance 	8,162,847	67,294,571	68,175,846
MaineCare (Medicaid)	1,835,109	109,529,805	54,375,156
Medicare		70,644,341	
Medicare Advantage*		20,205,400	85,518,060

Please note that claims that were incurred in more than one month may be counted more than once. This table is meant to provide an estimate of the volume of claims for the selected period.

\*Medicare Advantage category includes a large proportion of Medicare Part D in the pharmacy category. All of these Part D claims are paid through a commercial plan and may not necessarily be part of a Medicare Advantage plan.

### How much was paid?

Type of Insurance	Dental	Medical	Pharmacy
Commercial Insurance	\$2,263,093,864	\$24,574,076,104	\$7,060,798,183
MaineCare (Medicaid)	\$310,752,478	\$20,018,139,855	\$2,463,758,046
Medicare		\$20,757,481,360	
Medicare Advantage*		\$4,843,362,159	\$5,990,728,542

Please note that the paid amount includes the total cost for the insurer and any out-of-pocket expenses (e.g., prepaid for medical and copay, coinsurance, and deductible amounts for dental, medical and pharmacy).

\*Medicare Advantage category includes a large proportion of Medicare Part D in the pharmacy category. All of these Part D claims are paid through a commercial plan and may not necessarily be part of a Medicare Advantage plan.

## LD 1406, An Act To Promote Prescription Drug Price Transparency New Law in 2018

### Annual Requirements

By December 1, 2018 and annually thereafter, the MHDO must provide a report containing the following information about prescription drugs, both brand name and generic:

- The 25 most frequently prescribed drugs in the State;
- The 25 costliest drugs as determined by the total amount spent on those drugs in the State; and
- The 25 drugs with the highest year-over-year cost increases as determined by the total amount spent.

The MHDO produces these reports with the pharmacy data it collects from payers and is included in its all payer claims database (APCD).

MHDO will use the findings in these reports as well as the new information from the manufacturers to identify the data which the Pharmacy Benefit Manger's (PBM's) and/or Wholesale Distributors must report to the MHDO.

## Top 25 Costliest Drugs in the State (July 1, 2017 to June 30, 2018)

Brand or Generic		Payer Type					
Brand or Generic		Overall					
Rank	NDC	Drug Name	Drug Class(es)	Number of Prescriptions	Number of Prescription Users	Cost	Cost Per Prescription
<b>Top 25 Overall</b>				<b>426,721</b>	<b>103,316</b>	<b>\$444,063,697</b>	
<b>State Total</b>				<b>13,495,455</b>	<b>953,866</b>	<b>\$1,873,338,844</b>	
1	00074433902	Humira Pen	Gastrointestinal Drugs; Miscellaneous Ther..	12,047	2,091	\$74,465,813	\$6,181
2	58406044504	Enbrel	Miscellaneous Therapeutic Agents; Miscell..	4,769	868	\$27,498,401	\$5,766
3	00003089421	Eliquis	Blood Formation, Coagulation, and Thromb..	37,903	10,824	\$24,495,569	\$646
4	00088221905	Lantus Solostar	Hormones and Synthetic Substitutes	39,349	11,702	\$22,740,706	\$578
5	64406000602	Tecfidera	Not Available	2,362	382	\$21,014,747	\$8,897

Top 25 Costliest Drugs in the State of Maine (July 2017-June 2018)

Screenshot of tableau report posted on MHDO website: <https://mhdo.maine.gov>

## Top 25 Most Frequently Prescribed Drugs in the State (July 1, 2017 to June 30, 2018)

Brand or Generic				Payer Type			
Brand or Generic				Overall			
Rank	NDC	Drug Name	Drug Class(es)	Number of Prescriptions	Number of Prescription Users	Cost	Cost Per Prescription
<b>Top 25 Overall</b>				<b>1,117,282</b>	<b>439,375</b>	<b>\$138,265,986</b>	
<b>State Total</b>				<b>13,495,455</b>	<b>953,866</b>	<b>\$1,873,338,844</b>	
1	16729018317	Hydrochlorothiazide	Cardiovascular Drugs; Electrolytic, Caloric,...	87,695	33,174	\$403,290	\$5
2	12496120803	Suboxone	Central Nervous System Agents; Miscellan..	81,586	6,207	\$16,793,975	\$206
3	59310057922	Proair Hfa	Autonomic Drugs; Respiratory Tract Agents	80,239	45,379	\$5,835,927	\$73
4	00173068220	Ventolin Hfa	Autonomic Drugs; Respiratory Tract Agents	76,841	36,557	\$5,556,465	\$72
5	55111015810	Omeprazole	Gastrointestinal Drugs	58,212	22,959	\$892,031	\$15

Top 25 Most Frequently Prescribed Drugs in the State of Maine (July 2017-June 2018)

Screenshot of tableau report posted on MHDO website: <https://mhdo.maine.gov>

## Top 25 Drugs with the Highest Year-Over Year Increases in the State (July 2017-June 2018)

Screenshot of tableau report posted on MHDO website: <https://mhdo.maine.gov>

### Top 25 Drugs with Highest Year-Over-Year Increases in the State (July 1, 2017 to June 30, 2018)

Brand or Generic				Payer Type				
Brand or Generic				Overall				
Rank	NDC	Drug Name	Drug Class(es)	Number of Prescriptions	Number of Prescription Users	Cost	Increase	Cost Per Prescription
<b>Top 25 Overall</b>				<b>161,810</b>	<b>46,143</b>	<b>\$187,790,534</b>	<b>\$65,401,309</b>	
1	00003089421	Eliquis	Blood Formation, Coagulation, a..	37,903	10,824	\$24,495,569	\$7,508,762	\$646
2	57894006103	Stelara	Miscellaneous Therapeutic Agen..	878	284	\$18,443,244	\$6,800,721	\$21,006
3	57894019506	Zytiga	Antineoplastic Agents	402	108	\$4,609,010	\$4,601,939	\$11,465
4	00002771559	Basaglar Kwikpen	Hormones and Synthetic Substit..	7,648	2,643	\$4,711,233	\$4,146,607	\$616
5	00002143480	Trulicity	Hormones and Synthetic Substit..	8,134	1,852	\$8,592,739	\$3,608,322	\$1,056

# LD 1162, An Act To Further Expand Drug Price Transparency

## New Law in 2019

## Requirements

- MHDO must develop a data submission rule prior to April 1, 2020 to collect pricing information from:
  - Manufacturers
  - Pharmacy Benefit Managers
  - Wholesale Distributors
- MHDO must produce an annual report beginning November 1, 2020; and submit to the Legislature and post on MHDO's website.
- Report must include: information on trends in the cost of prescription drugs, analysis of manufacturer prices and price increases, the major components of prescription drug pricing along the supply chain **and** the impacts on insurance premiums and cost sharing and any other information the MHDO determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the State of Maine.

## Other MHDO Reports

### Hospital Financial Reports

Annual Summaries of hospital financial data over a five year span, as reported by Maine's non-governmental hospitals. Profitability, Liquidity, Capital Structure, Asset Efficiency and other common ratios are provided in these reports.  
[https://mhdo.maine.gov/hospital\\_financials.htm](https://mhdo.maine.gov/hospital_financials.htm)

**Profitability Ratios:** Provides information on the ability of the organization to produce a profit. Six measures of profitability are included: Operating Margin, Non-operating Revenue Margin, Total Margin, Return on Equity, Net Operating Income (Operating Surplus or Loss), and Total Surplus/Deficit (Total Surplus or Loss)

**Liquidity Ratios:** Measures an organization's ability to meet short-term obligations, collect receivables, and maintain cash position. Five measures of liquidity are included: Current Ratio (Without Board Designated and Undesignated Investments), Days in Accounts Receivable, Days Cash on Hand (Current), Days Cash on Hand (Including Board Designated and Undesignated Investments), and Average Payment Period (Current Liabilities)

**Capital Structure Ratios:** Measures how an organization's assets are financed, and its capacity to pay for new debt. Four capital structure ratios are included: Equity Financing, Debt Service Coverage, Cash Flow to Total Debt, and Fixed Asset Financing

**Asset Efficiency Ratios:** Measures the relationship between revenue and assets. Two asset efficiency ratios are included: Total Asset Turnover and Fixed Asset Turnover

**Other Ratio/Data Elements:** Average Age of Plant (Depreciation Only), Net Plant, Property, & Equipment, Cash & Investments (Current Assets), Current Assets Whose Use is Limited, Trustee-held Investments, Board-Designated & Undesignated Investments, Fund Balance-Unrestricted, Temporarily Restricted Net Assets, Permanently Restricted Net Assets, Total Gross Patient Service Revenue, Net Patient Service Revenue, Total Non-operating Revenue, Bad Debt (Provision for Bad Debt), Free Care (Charity Care), Total Operating Expenses, Total Advertising Expenses, & Salaries and Benefits

# Controlling Costs

# The National Context

Governor Janet Mills