

## MEMORANDUM

**To:** Colorado Health Insurance Exchange Oversight Committee  
**From:** Jeff Bontrager, Director of Research on Coverage and Access, Colorado Health Institute  
**Re:** 1332 Waivers and Exchange Strategies  
**Date:** July 13, 2015

States across the political spectrum – from Vermont to Arkansas – have explored reforming their health insurance markets using an innovation waiver created by Section 1332 of the Affordable Care Act (ACA).

The Colorado Health Institute (CHI) discussed several of these ideas during my presentation to the committee on June 5, 2015. In addition, CHI identified ways in which Connect for Health Colorado – the state’s health insurance marketplace – could be improved. The three key points were:

1. *Improvement* can be defined operationally, financially or by increasing access to affordable health insurance.
2. A 1332 waiver is a vehicle by which a state can make changes to its health insurance markets. Changes need not be limited to exchanges, nor are 1332 waivers the only vehicle. States already possess the means by which many changes may be made.
3. A state must first answer this basic question: **What are the most pressing challenges?**

We have identified intriguing examples of how states are addressing a range of challenges. There are only 12 other state-based exchanges, so the pool of ideas is limited. We have drawn ideas from states that both operate their own exchange and those that rely on the federal exchange (See Graph 1).

**Graph 1. Examples of Health Reform Ideas from the States**



The Colorado Health Institute drafted this memo in preparation for the committee’s meeting on July 15, 2015. We discuss ideas from other states as well as offer responses to questions submitted by committee members after the June 5 meeting.

**1. Operational Improvement of Connect for Health Colorado**

About 10 percent of consumers experience problems trying to enroll in health insurance through the state’s marketplace, according to Connect for Health Colorado. This may have to do with their eligibility, but often is related to technological glitches. These two challenges represent areas ripe for improving the operations of Connect for Health Colorado.

The Challenge
<p>Enrolling in health insurance can be confusing. Coloradans who get a raise or a pay cut can find their eligibility moving between different programs, such as Medicaid or private insurance subsidies through the exchange. Called “churn,” this can be devastating for the most vulnerable.</p>
Ideas from Other States
<p>Arkansas used a Section 1115 Medicaid waiver to create a “private option” for people newly eligible for Medicaid. The program enrolls people in a private insurance exchange plan, earmarking Medicaid funds to pay their premiums.</p> <p>Arkansas also pays for benefits that are traditionally covered by Medicaid but are not always offered in the program’s private plans. These are called “wraparound” benefits. Arkansas is exploring a 1332 waiver to identify alternatives to paying for these benefits or to the marketplace altogether. One option would be to provide tax credits and cost-sharing reductions in the private market outside the online exchange.</p>
Considerations
<p>While addressing churn wasn’t the primary reason Arkansas pursued the private option, it has turned out to be a help. Allowing people to remain in the same plan regardless of changes in their income is decreasing churn across programs.</p> <p>Research has shown that this type of plan may reduce the number of adults who churn across the Medicaid/exchange divide in states – like Arkansas – that did not expand Medicaid or maintained very limited eligibility for the program. It is unclear, however, how this option would work in states such as Colorado that have expanded Medicaid eligibility.</p> <p>Colorado’s legislature explored a similar idea in House Bill 14-1115. The bill would have required the state to explore a premium assistance pilot program to place new Medicaid enrollees in private insurance plans through Connect for Health Colorado. After passing a health committee, the bill failed in the House Appropriations Committee over concerns about its cost.</p>

The Challenge
<p>Technical glitches with the Connect for Health Colorado website have made enrolling in coverage difficult for some Coloradans.</p>
Ideas from Other States
<p>Some states are selling their exchange technology to other states. For example, Maryland is purchasing Connecticut’s software.</p> <p>Other states – like Colorado – have invested in fixing their own software.</p> <p>Some states – like Nevada and Oregon – have decided to convert their exchanges to the federal platform, so they no longer need to manage their own technology.</p>
Considerations
<p>By using another state’s software, a state exchange may gain operational efficiency and avoid the cost of future fixes. On the other hand, states must consider the consequences of giving up autonomy over technical decisions, relying on another state’s contractors and ensuring compatibility with the state’s Medicaid system.</p> <p>Connect for Health Colorado is working to fix its technical issues in order to ensure a streamlined eligibility system with Medicaid. If these issues are corrected, Colorado may move into a position to lease its technology to other states.</p> <p>Nevada and Oregon have recently converted their exchanges to a Supported State-Based Marketplace (SSBM) model, joining New Mexico and, soon, Hawaii. This means that the state gives up its technical infrastructure in favor of the federal platform, HealthCare.gov. Unlike federal “partnership” exchanges, however, SSBM states retain control over consumer assistance programs and the ability to certify qualified health plans, develop a sustainability plan and set user fees.</p>

## 2. Financial Improvement of Connect for Health Colorado

Despite plans to increase revenue through higher user fees, Connect for Health Colorado’s expenditures continue to outpace its revenues. Plateauing enrollment, ongoing technical fixes and the high cost of customer service are contributing factors. The exchange’s board and staff continue to explore options to improve financial sustainability.

The Challenge
<p>Employer participation in the Small Business Health Options Program (SHOP) remains a largely untapped market. Stringent eligibility rules for tax credits can discourage small businesses from enrolling. Improved operations and enrollment in the SHOP could bring increased revenue for Connect for Health Colorado.</p>

#### Ideas from Other States

The District of Columbia has established a combined individual and SHOP exchange.

Some states, such as Maryland and Massachusetts, have implemented policies that require insurance carriers to offer products on the SHOP.

More broadly, states could use a 1332 waiver to provide incentives for small and large employers to offer health insurance. States could revise or remove the mandate for large employers. They could modify the eligibility requirements for small businesses to receive tax credits on the SHOP. Finally, a state could revamp or eliminate the SHOP.

We continue to research what ideas – if any – states are pursuing to improve their SHOP exchanges.

#### Considerations

Further analysis will help to determine the return on investment of maintaining the SHOP, revamping it or eliminating it.

States already can make many decisions about the SHOP without a waiver.

If major changes are made to the SHOP, a plan for transitioning current enrollees would be needed.

### 3. Improvement in Access and Affordability

Ensuring that Coloradans have access to affordable health insurance is a central component of Connect for Health Colorado’s mission. This issue may move to the forefront because of two factors: many health insurance carriers have requested rate increases for 2016 and Connect for Health Colorado is faced with enrolling harder-to-reach populations.

#### The Challenge

Small changes in a family’s income can have a big impact on how much they pay for health care. This is referred to as the “affordability cliff.” For example, if a higher wage moves someone from Medicaid – in which they generally pay nothing – to private insurance, they assume responsibility for premiums, co-pays and deductibles.

Financial assistance – in the form of tax credits and cost-sharing reductions – is available through the exchange. However, middle-income people may also experience a cliff when an increase in their income makes them ineligible for this financial assistance. This often occurs at 400 percent of the federal poverty level (FPL) – about \$97,000 for a family of four.

### Ideas from Other States

Minnesota has explored and implemented a number of options to decrease this cliff.

The state has implemented a Basic Health Program (BHP). The ACA gives states the option of creating a BHP that covers residents who aren't eligible for Medicaid and who have incomes up to 200 percent of FPL – approximately \$48,500 for a family of four. A state can structure the BHP to provide coverage similar to Medicaid or the Children's Health Insurance Program. The BHP would allow enrollees to retain the same coverage with only the cost-sharing (copays and deductibles) changing as income increases and decreases.

Minnesota also has identified a number of ways a 1332 waiver could be used to create seamless coverage. For example, a 1332 waiver could be coordinated with other waivers to eliminate sharp differences in out-of-pocket costs between Medicaid, the BHP and private insurance. Waivers could also standardize enrollment timelines and the way income is counted for different programs.

### Considerations

In preparation for a 1332 waiver request, Minnesota is considering legislation (SF 813) requiring an analysis of three proposals: 1) a free-market insurance-based competition approach; 2) a universal health care plan; and 3) an alternative to be decided by the Commissioner of Health.

### The Challenge

Health insurance markets require a mix of healthy people and sick people in their risk pools to make them financially viable. Healthier people may elect to forego insurance – and take a tax penalty – if they think they don't need it or can't afford it. Colorado has seen a disproportionate number of exchange enrollees in an older, and presumably sicker, cohort. While the age distribution is similar to enrollment nationally, enrollment of younger, healthier people is not up to the proportion suggested for a viable market.

### Ideas from Other States

States could use a waiver to offer high-deductible, low-premium plans with greater cost-sharing than is currently allowed under the ACA. These plans could be coupled with health savings accounts (HSAs) to cover deductibles and co-pays.

We are not aware that any states are pursuing this option under a 1332 waiver. Indiana enrolls low-income adults in its Healthy Indiana Plan (HIP), a high-deductible health plan and HSA. The program was established in 2008 under a Medicaid 1115 demonstration waiver.

### Considerations

Because the HIP was established under a waiver, Indiana is unable to leverage the ACA's federal funding for Medicaid expansion.

Having healthier people enroll in risk pools may lower health insurance premiums in the long term.

Greater enrollment in high-deductible health plans will likely lead to a higher percentage of people who cannot pay their copays and deductibles when seeking care — in other words, a higher underinsurance rate.

A transition plan would be needed if a state that had expanded Medicaid or its exchange moves to this model.

### Additional Questions from Committee Members

During the course of this research, committee members raised these questions:

1. *Should Colorado explore ways for Medicaid enrollees to opt into using allotted Medicaid funds to purchase private insurance?*

(See discussion on Arkansas above.)

2. *How can we use a 1332 waiver to establish a health insurance system that is not employment based?*

Theoretically, moving from an employer-based system would be possible. Vermont's Green Mountain Care program attempted to do this. The state sought to create a universal coverage program that was not employment-based. Under the program, employers could have continued to offer coverage to their employees if they desired. The state sought a 1332 waiver to remove the penalty on large employers, among other modifications to the ACA, because the mandate would be unnecessary if all Vermont residents had access to Green Mountain Care.

The plan was tabled after analysis indicated that the first year alone would cost Vermont taxpayers \$2.6 billion over and above the federal government's share of about \$1.7 billion.

3. *What would it mean for Colorado to transition to a) a federal partnership model and b) a federally-facilitated exchange model? What would Colorado lose by doing so? What would the state gain?*

(See discussion on federally-supported exchanges on Page 3.)

4. *Is Colorado changing the definition of “small employer” from 50 or fewer to 100 or fewer employees? If not, is that something the state should pursue as it looks at ways to improve SHOP participation? Also, are Colorado employers currently allowed to use a “defined contribution” model and/or offer multiple plans?*

Colorado’s SHOP is open to businesses with 50 or fewer employees. By 2016, the ACA requires SHOP exchanges be open to businesses with 100 or fewer employees. In Colorado, employers participating in the SHOP can offer a contribution toward their employees’ health insurance costs in the form of a percentage or fixed dollar amount.

Colorado elected to allow employers to offer choices of plans from adjacent metal tiers. For example, if an employer selected a bronze plan as its “reference plan,” employees could choose from bronze and silver plans.

## **Conclusion**

Colorado made a bold move in 2011 when the legislature decided the state would build its own exchange. Only a handful of states made this decision. Colorado chose its own “Colorado way” in order to create an insurance marketplace that brought choice to consumers and ensured that the exchange would embrace free-market principles.

Implementation of a project of this magnitude is almost always accompanied by challenges — both anticipated and unanticipated. As Colorado moves to so mitigate those issues, discussions about how to best move forward are both necessary and healthy for our state and the policy community.

CHI emphasizes that prioritizing Colorado’s challenges is central to the path forward. This memo lays out options based on work in other states. We thank you for the opportunity to contribute to this important discussion.

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