LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

March 11, 2020

The Honorable Jerome Zeringue, Vice Chairman
Joint Legislative Committee on the Budget
Baton Rouge, La. 70802
zeringuej@legis.la.gov
Sent via email

The Honorable Mack White, Chairman
Louisiana State Senate
Baton Rouge, La. 70802
whitem@legis.la.gov
Sent via email

RE: Act 412 Report

Dear Representative Zeringue and Senator White,

Act 412 of the 2019 Regular Legislative Session (Act 412) tasked the Louisiana Department of Insurance (LDI) with the establishment of the Louisiana Guaranteed Benefits Pool (LGBP), a risk-sharing program designed reduce premiums for health insurance products offered in the individual market by defrayal of the claims cost of high-risk insureds in that market. In designing the LGBP, LDI surveyed stakeholders and other states to determine best practices and engaged leading actuarial firm Lewis & Ellis, Inc., to conduct an actuarial analysis of the cost of the program. The result of this work is the report that follows, including both the program design specification and actuarial analysis required by Act 412.

LDI has identified a number of key takeaways:

- The LGBP program is projected to reduce individual market premiums by 35-40% -- a premium reduction of approximately $300 per month

- This premium reduction is sufficient to drive significant return to the individual market by moderate-income Louisianans, particularly those with preexisting conditions who are currently priced out of the market by the income-only focus of the current federal subsidy system.

- While the LGBP program is targeted at protecting individuals with preexisting conditions rather than directly addressing the loss of income-based subsidization, it provides a critical first step to affordability while preserving more than half of the funding available under Act 412 to further enhance affordability for low- to moderate-income Louisianans.

- LDI suggests a number of affordability-focused programs for further evaluation at the end of this report. An effective example of such program could serve to complement the LGBP program and provide stronger individual market protections than exist today. After accounting for the cost of the LGBP, a further $230 million annually would be available to fund this complementary program. Additionally, because the Health Insurance Provider Fee judgment was not needed to fund the LGBP, a further $172 million from this judgment could be used to further enhance an affordability complement.

I. Background

Act 412 is designed to provide a framework for replacing the core protection of the Patient Protection and Affordable Care Act of 2010 (ACA) in the event that the ACA is ruled unconstitutional by the Supreme Court of the United States. The ACA is structured as three interrelated central provisions: core substantive protections, federal subsidization, and the individual mandate. The first provision – core substantive protections – defines the menu of minimum health benefits all policies must cover, provides a wide array of protections for individuals with preexisting conditions, requires that insurers must determine rates at a community level rather than based on health factors of a particular insured, and prohibits annual and lifetime coverage limits. This provision prohibits many of the pre-ACA strategies insurers used to manage their risk in the individual market – health underwriting, preexisting condition exclusions or waiting periods, and "skinny" benefit design. As a result, these requirements are popular with consumers but also cause a significant increase in premiums.

The second provision of the ACA – federal subsidization – is critical to keeping individual market health insurance affordable despite the costly requirements imposed through the first provision. This market is heavily subsidized through a combination of advance premium tax credits (APTCs) – which reduce insured's cost to maintain insurance – and cost sharing reduction requirements (CSRs) – which reduce the patient's cost of care.[1] APTCs are generally available, on a sliding scale, to individuals earning between 100% and 400% of the federal poverty level (FPL), while CSRs are available to individuals earning between 100% and 250% of FPL. These subsidies work jointly to counteract the inflationary effect of the ACA's substantive insurance requirements and also to enhance the affordability of individual market health insurance to individuals with low to moderate income.

Act 412 seeks to preserve many of the ACA's core substantive protections. In doing so, it recognizes the need to replace the second provision with a sufficiently robust funding mechanism to keep insurance affordable. A preliminary stage of this funding work was the design and actuarial analysis of the LGBP. This program – which is designed to reduce premiums by "de-risking" the high-risk lives in the individual market while preserving as much funding as possible to structure a complementary program to address affordability for low- and moderate-income individuals – is described in more detail below.

II. Executive Summary

The LGBP will apply to lives covered by nongrandfathered health insurance products in the individual market. The program serves to replace the "pay for" function of the ACA by offering a mechanism to reduce premiums by mitigating the impact of high claim cost often associated with the ACA's core substantive provisions. It is important to note that the LGBP will not serve as a

[1] CSRs have technically been unfunded since 2017, but still operate as a subsidy of on-Exchange individual market participants as the law continues to require the reductions to be made by the insurance company and the "value" of these reductions are now included in the product's premium cost and largely funded through APTCs. Most states, including Louisiana, have since maximized the APTC funding of CSRs through a process known as "silver loading."

total replacement of the ACA's current subsidy structure. As the LGBP mechanism and actuarial analysis was developed, it was clear that a risk pool design was appropriate as a replacement of the ACA's risk-based subsidization but not as a replacement of the ACA's income-based subsidization. As such, the LGBP was structured to serve two functions: 1) to efficiently use post-ACA resources to reduce premiums based on the risk of the insured population; and 2) to maximize the "preserved" post-ACA resources available to address the loss of income-based subsidization. A number of options to achieve this latter purpose will be discussed later in this report.

The LGBP operates as a reinsurance/high-risk pool hybrid often known as an "invisible high-risk pool." The program defines a set of "triggering conditions." Even if an insured has one of these triggering conditions, the individual remains enrolled in his traditional insurance and the insurer continues to reimburse health care providers for his care. Once the insurer enrolls an individual with a triggering condition, the insurer cedes 98% of the individual's monthly premium to the LGBP and the LGBP covers all claim reimbursement costs incurred by the insurer for that individual. This structure limits the insurer's exposure in covering a defined set of conditions, reducing potential costs and the premium necessary to cover those costs.

In order to cover its share of claim costs, the LGBP – as with a reinsurance program – requires a stable source of funding. This will be generated through two mechanisms: turnover of premium of covered lives with triggering conditions and an appropriation from the replacement for the ACA's federal subsidization provision.[2] Based on the attached analysis by Lewis and Ellis, this program would cost an additional $209 million net of premium turnover and would reduce monthly premiums in the nongrandfathered individual market by approximately $300. In 2019, aggregate APTCs for enrollees in Louisiana totally approximately $439 million. As this program's activation is predicated on the replacement of this APTC funding by federal and/or state appropriations, the LGBP program would leave an additional $230 million in unallocated funding with which the state could seek to address the loss of income-based subsidization to reduce the uninsured rate of low- and moderate-income individuals currently covered through the individual market.

III. Program Parameters

As required under Act 412, the following are the parameters of the LGBP program:

1) The criteria for individuals to be eligible for participation in the program.

Individuals enrolled in nongrandfathered individual market plans are automatically covered by the program.

[2] Act 412 is only "activated" in the event that "adequate appropriations are timely made by the federal or state government in an amount that is calculated in a similar manner as the tax credit in Section 1402 of the Patient Protection and Affordable Care Act."

2) The development and use of health status statements with respect to eligible individuals.

If approved, LDI will propose a rule to establish a standardized form to be included as a component of an individual market health insurance application form to assess the existence of a triggering condition.

3) The standards for qualification, including but not limited to all of the following:

a. The identification of health conditions that automatically qualify individuals as eligible individuals at the time of application for health insurance coverage.

Based on a review of programs adopted by other states and feedback from critical stakeholders in Louisiana, the LGBP's premium turnover and claims coverage function is triggered by the existence of conditions within the following condition categories as defined by the HHS-Hierarchical Condition Categories risk adjustment model:

HIV/AIDs;
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock;
Metastatic Cancer;
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia;
Non-Hodgkin's Lymphomas and Other Cancers and Tumors;
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease;
Mucopolysaccharidosis;
Lipidoses and Glycogenosis;
Amyloidosis, Porphyria, and Other Metabolic Disorders;
End-Stage Liver Disease;
Acute Liver Failure/Disease, Including Neonatal Hepatitis;
Intestinal Obstruction;
Chronic Pancreatitis;
Inflammatory Bowel Disease;
Rheumatoid Arthritis and Specified Autoimmune Disorders;
Hemophilia;
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn;
Sickle Cell Anemia (Hb-SS);
Thalassemia Major;
Coagulation Defects and Other Specified Hematological Disorders;
Anorexia/Bulimia Nervosa;
Paraplegia;
Quadriplegic Cerebral Palsy;
Cerebral Palsy, Except Quadriplegic;
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy;
Multiple Sclerosis;
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders;

Cystic Fibrosis;
End-Stage Renal Disease;
Premature Newborns, Including Birthweight 2000-2499 Grams;
Stem Cell, Including Bone Marrow, Transplant Status/Complications;
Amputation Status, Lower Limb/Amputation Complications;
Chronic Hepatitis (Unspecified);
Chronic Hepatitis (Chronic Viral Hepatitis C); and
Chronic Hepatitis (Except Chronic Viral Hepatitis C).

b. A process pursuant to which health insurance issuers may voluntarily qualify individuals who do not automatically qualify as eligible individuals at the time of application for coverage.

   During design of the program, LDI determined the initial implementation should not include a provision for insurers to cede additional conditions not specified in the list above. This limits adverse insurer behavior and keeps financial risk more predictable. Individuals developing a triggering condition subsequent to initial enrollment become subject to the turnover and reinsurance components of the LGBP at the beginning of the next coverage period – i.e. the following calendar year.

4) The percentage of premiums paid to health insurance issuers for health insurance coverage by eligible individuals that shall be collected and deposited to the credit and available for the use of the program.

   The premium turnover percentage is 98%.

5) The threshold dollar amount of claims for eligible individuals after which the program will provide payments to health insurance issuers and the proportion of the claims above the threshold dollar amount the program will pay.

   To maximize the ability of the program to protect preexisting condition coverage, the LGBP is designed to provide first-dollar coverage for individuals with triggering conditions and to cover all claim cost.

IV. Additional Considerations

As noted in the Executive Summary of this report, the LGBP addresses much of the cost of core protections implemented by Act 412 but is not the vehicle for replicating the affordability subsidies for low- to moderate-income individuals currently enrolled in individual market insurance. As the attached actuarial analysis shows, the next issue for the state to consider is how and to what extent to protect these individuals who could otherwise be left unable to afford continued coverage. Implementation of the LGBP program would leave approximately $230 million annually from the amount currently allocated to subsidize the individual market under the ACA to address this affordability issue. The state could choose to evaluate one or more of a number of options:

1) Continued Income-Based Subsidy
This approach would largely mirror what is currently in the ACA. With the LGBP and this approach in effect simultaneously, the state would essentially be following the model already adopted by 12 states under the ACA whereby Section 1332 Waiver reinsurance programs are used to reduce overall premiums while APTCs are used to provide income-based subsidies. This approach would ultimately mean the state has chosen to replace the federal ACA with a state-based version of a very similar program.

2) Provider-Based Subsidy
Rather than funding the individual purchase of insurance, the state could choose to shift the subsidy dollars to a network of providers in exchange for guaranteed coverage of the formerly insured population. This is essentially an Accountable Care Organization (ACO) model – one or more large hospital systems could accept a monthly or annual payment in exchange for providing all necessary care for a defined population. The promise of this approach is it incentivizes the health care system to avoid unnecessary care – the payment to the system is a fixed capitated amount regardless of the number of services provided – and to minimize waste and complications. Potential complications include the need to oversee participants to ensure adequacy of care and the need for sufficiently sophisticated health care systems throughout the state.

3) Risk- and Income-Based Cross-Subsidies
As the report details, the premium benefits created by the LGBP are enjoyed across all income groups. The state could choose to "recapture" some of this benefit from high-income enrollees and divert it back to low-income individuals to provide a further income-based subsidy. This option could be combined with any of the other insurance-based options in this section and would operate similarly, but with a stronger subsidy of low-income individuals at the cost of somewhat higher premiums for higher-income individuals.

4) Modified Income-Based Subsidy
The state could look to implement a modified version of the current ACA subsidy. For example, rather than subsidize such that premiums are reduced to a percent of income, the state could choose to subsidize a flat percent of premiums that adjusts based on income. Such an approach could put more pressure on insurers to keep premium growth more in line with income growth but also would require more adjustment over time.

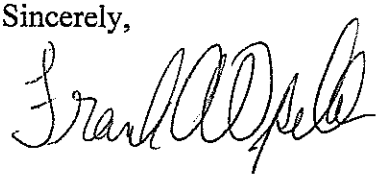
5) Uninsured Subsidy
Finally, the state could choose to allow low- to moderate-income individuals to become uninsured and subsidize their care through traditional mechanisms. This would include Disproportionate Share Hospital (DSH) funding and the LSU public-private partnerships. This approach is the simplest to model but encourages individuals to delay care, access the health care system through suboptimal channels, and likely increases long-run costs.

V. Conclusion

LDI submits this report in satisfaction of its obligation under Act 412. Upon approval by the Joint Legislative Committee on the Budget, LDI will implement the program and begin identifying covered individuals. It is critical to note, however, that the active portions of this program do not become effective until both: a) the attorney general notifies the commissioner of insurance that the ACA has been held unconstitutional by a final judgment of a court of competent jurisdiction; and b) adequate funding exists through appropriation by a combination of federal and state legislative bodies to replace the ACA's subsidy structure. In the interim, LDI welcomes further comment and stands ready to investigate the noted additional considerations at the pleasure of the committee.

If you have questions or concerns, please contact me.

Sincerely,



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