AFFORDABLE HEALTH INSURANCE WORKING GROUP
ACT 43, (HB 552 HD1 SD2 CD1), SESSION LAWS OF HAWAI'I 2017

Meeting Minutes

DATE: November 20, 2017

TIME: 9:00 AM

PLACE: Conference Room 229
State Capitol

Working Group Attendees:
Sen. Rosalyn Baker
Rep. John Mizuno
Virginia Pressler Director of Health
Linda Chu Takayama Director, Dept. Labor and Industrial Relations
Insurance Commissioner Gordon Ito.
Rep. Della Belatti
Judy Mohr Peterson, Director of Med-Quest Division

I. Introduction of Members and Staff present

II. Review and Appoval of Minutes from Previous Meeting

Minutes approved with no amendments

III. Working Group Roundtable Discussion and Presentations

Note: Full audio and video recordings of the Working Group Meeting, as well as the documents and presentations referenced are available on the Capitol Website and can be accessed at the following address: http://www.capitol.hawaii.gov/specialcommittee.aspx?comm=ahiwg&year=2017

Topics:

- Update on high-risk reinsurance program from Commissioner Ito. CMS will require a second legislative authorization to pursue a 1332 waiver, but Hawaii is allowed to work towards creation of the reinsurance program and on getting the legislative authorization concurrently. They are working with an actuarial firm to determine savings for the State.

- Update on Premium Supplementation Fund monies for small business. DLIR has received some federal funds for plan year 2017. Business should be able to access the funds shortly.

- Legislative options for reducing health costs, and backing up ACA into state law.

- Discussion of potential impacts of association health plans and potential outcomes of the (date) executive order on health insurance

- State-based individual mandate and outcomes of similar legislation in other states.
- Presentation by Dr. Peterson on Hawaii's Section 1115 Medicaid Waiver. *Presentation slides available online in the AHIWG materials section.*

- Discussion of the initiatives the State can pursue to deliver better care for less money and begin to bend the cost curve of health care.

IV. Next Steps and Announcements

- Discussion of plans to have legislative vehicles in place to deal with uncertainty at the federal level.
- This will be the last AHIWG meeting, but departmental directors will continue meeting to address the ongoing changes and challenges in the healthcare market going forward.
- The Legislative Reference Bureau will be drafting a final report summarizing the working group's findings that will be available around the beginning of the 2018 legislative session.

V. Questions

From questionnaire submitted to the Working Group by advocate-group *Save Medicaid Hawaii*. Questions are answered by the appropriate State agency depending on subject matter.

1) What can Hawaii do to maintain ACA protections in state law?If the Trump administration goes on to publish rules re: the Executive Order on Association Health Plans that allow the selling of sub-standard, bare bones (+ no contraception) health policies across state lines, how can we prevent HI Pre-Paid Health Act (PPHA) from being undermined? Can we require that any policy sold to Hawaii residents meets those requirements?
If allowed to, surely many Hawaii employers will move to shift costs by offering these substandard policies, undermining the risk pool and leaving our local insurers covering the older and sicker among us, and increasing costs to the state, a sure recipe for skyrocketing costs and collapse of the market in Hawaii.

Insurance Division's response: Once the draft rules are released, we recommend the Department of the Attorney General to review the rules to see if it would preempt or negatively impact PPHA. The Department of Labor and Industrial Relations should take a hard stance to say association plans must comply with PPHA. If the Trump administration attempts to enforce the executive order by saying these association plans do not have to comply with PPHA and can be sold in Hawaii, then the recommendation noted above should be considered.

2) What can the insurance commissioner and the Legislature do to stabilize the market it Hawaii?
In California (1) and other states, insurance commissioners have taken direct actions –would those actions help in Hawaii? Even with Trump ending ACA subsidies, we know insurance companies still must pay them by law, and so they will raise premiums, so the fed govt. will have to pay the increased premiums for those qualifying for subsidies (except for COFA, which state covers and feds do not). The immediate concern is for the rest of the market who do not get subsidies – and perhaps in employer market as well, who may all have to pay sudden and steep premium increases of up to 20%.

Insurance Division's response: Regarding the non-funding of the Cost Sharing Reduction (CSR), the two health insurers writing ACA individual plans have placed a "load" on the silver plans sold on the exchange to cover the loss of CSRs. Those who qualify for premium subsidies and cost-sharing reductions on the exchange will still receive them in 2018. The off-exchange silver plans do not have that load and are subsequently less expensive for those not qualified for subsidies. Additionally, we have initiated discussions on the creation of a high-risk reinsurance program. Draft legislation authorizing the consideration and submittal of a second Section 1332 Waiver has been drafted.

3) Should Hawaii move COFA adults back to Med-Quest? If the cost of the silver plan premium goes up 10 to 20%, and state is paying that for COFA adults, would it cost less and provide better coverage to allow them to re-enroll in Medicaid as they were before being dis-enrolled by Med-QUEST and the Governor in 2015? And by this we mean cost less - not simply the state or Med-QUEST budget - but for Hawaii's health care system as a whole. Out of 9,000 COFA adults who were insured before 2015, it appears that over 3,000 COFA adults are un-accounted for by # insured by HMSA and Kaiser today (2). What happened? Were they lost to the system during that chaotic transition? Could their lack of insurance be one of the drivers in increasing costs statewide?
Recommendation: Consider expanding current eligibility for MedQuest to include low income COFA adults (non-pregnant, non-disabled).

MQD RESPONSE: While it is the case that the Marketplace premiums will be going up, at this time the COFA adults' premiums are still mostly covered by their Advanced Premium Tax Credits. Thus, the additional premium costs that we (the state via MQD) are covering above the individual's premium tax credits are still far less than covering the entire premium if they were covered by MQD without any federal match. As far as what the overall costs are for the population that is uninsured, MQD has worked with hospitals and our clinical team as individuals show up receiving "one-time emergent" services. As individuals are identified, they are put on our list for individual outreach to sign them up for coverage during open-enrollment. Unfortunately, the only point of entry into the marketplace for most of these individuals in during the annual open enrollment period which is 45 days from November 1 – December 15, 2017 for 2018 coverage.
Until or unless the COFA can be covered under Medicaid with federal Medicaid match, it is highly unlikely that their costs would be a reason to cover the population.

4) Should Hawaii consider a Public Option? Would our overall system cost be lower if we created a public option via Medicaid, as Minnesota and New York have done, as the Nevada legislature attempted to do, and as Sen. Schatz has proposed?
Recommendation: Study other models and seriously consider Hawaii becoming a national leader by offering its residents a Public Option.

MQD response: It is our understanding that at one time, Hawaii did study implementing a public option, which is associated with the Marketplaces. If the Workgroup and/or legislature would be interested in this, MQD could work with the other state agencies to do preliminary research. As an FYI, in October of this year, Sens. Michael Bennet (D-Colo.) and Tim Kaine (D-Va.) on introduced a bill to add a government-run "public option" plan to the ACA, modeled on Medicare and called "Medicare X, Choice Act of 2017." While this bill is not likely to move in the current political climate in DC, at least a third of all Democratic Senators have signed on.

The public option is different than what Nevada and Sen Schatz has proposed – which is some form of "Medicaid Buy-In". MQD has done some very preliminary research on this topic. However, there are

many details that are unknown that affect the pros/cons of using such an approach. As with the public option, if there is interest, MQD could do some additional preliminary research.

5) Can we reduce administrative costs for providers under MedQUEST?
Can the state negotiate with insurers under the MedQuest system for unified procedures among health plans that will reduce admin overhead and cost for health providers? For example: (1) a unified drug formulary for common conditions and (2) standardized referral forms.
The state of Hawaii has contracts with multiple insurance companies under MedQuest. Each has a different set of rules that primary care providers must follow to cover services for their patients; for example: each has different drugs they will cover for the same condition, and different referral forms for specialists. Complying with these myriad requirement increases the # staff providers must hire to comply. Out-of-state companies are the hardest to deal with, and cost the most in provider and staff time – this ultimately adds to the cost we are all paying for care
Recommendation: In the state RFP for the next round of contracts for MedQuest insurers empower MedQuest to use its negotiating power to require one set of rules for all insurers, such as a unified drug formulary for common conditions & standardized forms for referrals.

MQD Response: Administrative burden is a common complaint from providers. MQD has made some changes to requirements over the years, and will continue to consider options to streamline while still allowing for the unique capabilities of each health plan.

6) Can Hawaii do anything to reduce Drug Costs?
Is there any action Hawaii can take under state law to negotiate re: drug prices say for Med-QUEST, State Hospital, or prison systems? One of the big cost increase drivers in recent years in Medicaid and Medicare is pharmaceuticals, such as high cost Hepatitis C meds.
Under Med-QUEST now the 5 health plans can negotiate prices with the drug companies and this is one reason the formularies keep changing - giving providers headaches as they try to keep up with what patient can be prescribed what medicines - and raising costs. New drugs are offered at low prices, then the prices are raised once the company gets enough market share.
Is the QUEST population in Hawaii too small to benefit from having 5 companies competing? Under Governor Lingle (2002-2010), Quest was opened up to Mainland based health plans with the stated purpose of increasing competition and decreasing costs. Is there any evidence this has been the result? Would limiting the QUEST plans to the 3 largest give those plans more bargaining power with drug companies?

MQD Response: Increasing drug costs has been a concern for MQD over the past several years. We have implemented several changes to our rates for high-cost drugs to try and mitigate costs. Regarding the size of the health plans and the costs of drugs – the size of the plan nationally does increase their ability to negotiate prices. In general, this is seen in our rates, and is one of the reasons that the MQD increases tied to price and utilization have been lower than for other health care sector plans. That being said, we will continue to explore options that would help contain costs.

7) Who is looking at Hawaii's health system as a whole and planning for the future?

The AHIWG has made an impressive start, but its mandate will soon expire. There appears to be no entity in the state that is looking at the health system as a whole without a vested interest in one corner of it. Can an independent body or state healthcare advisory group study and make recommendations re: realistic models for moving towards universal coverage in Hawaii?

Recommendation: Empower and fund the Hawaii Health Authority (HHA) - or a newly created entity such as a Hawaii healthcare task force/advisory group – to take over this task once AHIWG wraps up its work this fall.

Insurance Division's response: Various state agencies continue to meet to discuss various options to address the ACA and the Trump administration's changes. However, there should be a healthcare task/advisory group to develop and implement programs that will help bend the health care cost curve.

VIII. Adjournment