

Jeffrey A. Meyers, Director
Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street, Thayer Building
Concord, NH 03301-3857

October 31, 2014
Via email

Re: New Hampshire Health Protection Program
Premium Assistance Section 1115 Research and Demonstration Waiver

Dear Mr. Meyers:

Anthem Health Plans of New Hampshire (“Anthem”) appreciates the opportunity to provide comment on the NH Premium Assistance Section 1115 Research and Demonstration Waiver released on October 1, 2014. We are committed to being a valued health partner to the state and to delivering quality products and services to NH citizens and we look forward to continued discussions with the state as health reform efforts continue.

Overview: It is our hope that the comments below represent thoughtful considerations for the state as the Medicaid Premium Assistance program evolves. Timely decision making, program and process clarity, and access to critical data are key elements in ensuring issuer participation and readiness. Anthem has summarized our comments into seven main categories. Recommendations and considerations are based on a comprehensive review of the NH waiver document, our current experience offering QHP coverage through NH’s marketplace, and our understanding of similar premium assistance programs across the country – programs that are either in place or planned.

Timing is critical: The premium assistance program is slated to be offered through the NH exchange for coverage year 2016. In order to offer new products by the 2016 open enrollment period, carriers will be required to develop QHP plans and rates in the first quarter of 2015 and file QHP plans and premiums in the second quarter of 2015, with certification occurring soon after. Additionally, carriers will need to implement IT system changes to add capabilities needed to participate in the program, such as the processing of enrollment transactions and financial payments from the Medicaid agency. Thus, the following items need to be finalized by December 31 of this year:

- Product parameters (i.e. plan design for the plans with eliminated and lower cost-sharing) and understanding of how the individual market risk pool will be impacted with the newly added population;

- Financial and payment parameters for premium payment and cost-sharing reductions that will be applied for the Medicaid premium assistance population;
- Access to Medicaid claims utilization data for 2014 for the expansion population to help determine cost impact to the individual market;
- Modifications to the QHP certification process to reflect the additional plan variations for the Medicaid population;
- Detailed understanding of the readiness tasks (e.g. for IT/systems) for program elements such as enrollment and financial transactions from the Medicaid agency;
- A close to final draft of the 3-way contract that would need to be in place between the issuer, Medicaid agency, and federal exchange.

Should this information be delayed and a January 1, 2016 implementation date not be achievable, the program would need to be delayed at least until January 1, 2017 due to the fact that contracts and rates for exchange coverage are fixed for the entire calendar year.

Approach to administering QHP plan variations for Medicaid beneficiaries should mirror existing process for individual market consumers eligible for cost-sharing reductions (CSRs):

In order for QHP issuers to reduce or eliminate cost-sharing for Medicaid beneficiaries enrolling in QHPs, issuers must be able to load additional QHP plan variations in their systems beyond what exist today for the CSR-eligible population. Such a process is the only clean way to ensure Medicaid beneficiaries experience the lower/eliminated cost-sharing to which they are entitled. This is the same way issuers currently administer CSRs for the individual market population, and it is critical to build on this process and avoid unnecessary complexity. Enrollment in the new plan variations would be treated as an eligibility issue for the 0-138% FPL in the same way enrollment into CSR plans is treated as an eligibility issue for the 100-250% FPL population today.

Financial terms of covering Medicaid beneficiaries in QHPs: Carriers considering participation in the Medicaid Premium Assistance program require further clarity regarding how rates in the individual market will be adjusted with the addition of the Medicaid population and budget neutrality requirements, and also how cost-sharing reductions will be calculated. Specifically, the following must be considered:

- **Risk pool adjustments:** Issuers will need data for Medicaid beneficiaries and must be allowed to make appropriate adjustments to the individual market risk pool that will include Medicaid beneficiaries.
- **Induced utilization:** Just having the Medicaid agency pay premiums and cost-sharing in existing contracts will not be sufficient to cover costs due to the concept of “induced utilization” where utilization increases when cost-sharing is reduced. Thus, the “cost-sharing reductions” paid by the Medicaid agency must reflect that additional dynamic. Including “induced utilization” is consistent with how the federal government administers such reductions for the standard exchange population.

As noted above, to fully understand the dynamics of the expansion population and to incorporate that dynamic into rates, complete Medicaid data would be needed from the Medicaid agency by December 31 of this year.

Carrier Participation: Offering of Medicaid Premium Assistance QHPs should be voluntary for commercial QHP carriers. Such would ensure all parties are ready to serve the low-income population.

Certification process: Clarity is needed regarding the 3-way contracting requirements and process between the issuer, Medicaid Agency, and the exchange.

Transparency around “budget neutrality” and shared responsibility: A key consideration for the state and all stakeholders will be how the state achieves “budget neutrality” in the context of the Medicaid waiver, given provider rates for Commercial products are typically higher than Medicaid. We ask that this critical part of the discussion be transparent with all stakeholders.

Administration of additional Medicaid benefits: Clarity is needed regarding the services that will continue to be covered by Medicaid (e.g. Non-emergency transportation, EPSDT, adult vision) on a fee-for-service basis through the Medicaid agency. Carriers need to understand the customer service process and appeals process for the benefits that are not administered as part of the QHP.

Thank you for this opportunity to offer our comments as the state moves forward with its efforts to establish the New Hampshire Health Protection Program, and specifically the Medicaid Premium Assistance Program. We look forward to working with the state as the specific elements of the program are refined. Should you have any questions or wish to discuss our comments further, please contact Sherri Panaro, Director Change Management; 603-541-2114; sherri.panaro@wellpoint.com.

Sincerely,



Sherri Panaro
Director, Change Management
Anthem Blue Cross Blue Shield