

WSHIP AFTER THE ACA

A STUDY OF HIGH RISK POPULATIONS WITH WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP) COVERAGE AND BARRIERS THAT REMAIN IN ACCESSING COMPREHENSIVE COVERAGE ALTERNATIVES

A Report to the Governor and Washington State Legislature
Pursuant to RCW 48.41.240(5)

October 2015

The Affordable Care Act (ACA) has made coverage available to most Washington residents with pre-existing health conditions by requiring health insurance companies to offer coverage regardless of health status during annual open enrollment periods. This study provides an in-depth look at how the ACA has impacted WSHIP's role in meeting the needs of Washington residents with chronic or complex health conditions.

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LEGISLATIVE REQUEST – RCW 48.41.240(5)

48.41.250 Review of populations needing coverage through pool–Analysis and recommendations–Report. (5) The board shall revisit the study of eligibility completed in 2012 with another review of the populations that may need ongoing access to coverage through the pool, to be submitted to the governor and legislature by November 1, 2015. The eligibility study shall include the non-Medicare populations scheduled to lose coverage and Medicare populations, and consider whether the enrollees have access to comprehensive coverage alternatives that include appropriate pharmacy coverage. The study shall include recommendations to address any barriers in eligibility that remain in accessing other coverage such as Medicare supplemental coverage or comprehensive pharmacy coverage, as well as suggestions for financing changes and recommendations on a future expiration of the pool.

EXECUTIVE SUMMARY

ABOUT THIS STUDY

Leif Associates, Inc., a health care actuarial consulting firm, was engaged by the Washington State Health Insurance Pool (WSHIP) to review the populations that may need ongoing access to coverage through the pool and prepare this report in compliance with RCW 48.41.240(5).

Our approach to this study included three distinct components:

- Data analysis of the claims and enrollment of WSHIP members before and after the implementation of the Affordable Care Act (ACA)
- A survey of the members who remained in WSHIP in early 2015 and other interested parties
- A review of the individual health insurance options available in the commercial marketplace for Washington residents, both with and without Medicare

KEY FINDINGS

Barriers that Remain in Accessing Coverage. The study identified five barriers that remain for the high risk populations served by WSHIP:

1. **Third-Party Premium Restrictions.** Federal law requires carriers to accept payment from some third-party sponsors such as the Ryan White HIV/AIDS program, but discourages carriers from accepting payments from hospitals, other healthcare providers, and other commercial entities due to concerns about adverse selection. (45 CFR Part 156)
2. **Citizenship Requirements.** Undocumented immigrants are not eligible for coverage through the Health Benefit Exchange. There is some uncertainty about whether the private market will accept undocumented applicants, many of whom are low income and rely on third-party sponsors.
3. **Lack of Medigaps for Under Age 65.** Only two insurers currently offer plans in Washington. No plans are available to Medicare enrollees outside their 6 month guarantee issue period.
4. **Health Screening for Medigaps Past Guarantee Issue Period.** Medicare enrollees over the age of 65 who are past their 6 month guarantee issue period are subject to Medigap health screening and may be rejected or offered coverage with limitations.
5. **ESRD Patients Excluded from Medicare Advantage Plans.** Medicare Advantage Plans are not required to accept applicants with End Stage Renal Disease (ESRD).

Impact of the ACA on Populations Served By WSHIP. While the Affordable Care Act (ACA) has provided new options to most of the non-Medicare high risk population served by WSHIP, the study found no improvement in access to comprehensive coverage for high risk Medicare-eligibles in need of supplemental coverage.

RECOMMENDATIONS

The WSHIP Board recommends that WSHIP be continued beyond 12/31/17 to provide access to comprehensive coverage.

Specific recommendations are as follows:

- **Continue WSHIP Non-Medicare Coverage Beyond 12/31/17.** The Board recommends continuing WSHIP non-Medicare coverage for current enrollees, rather than terminating their coverage on 12/31/17 as required by current statute. The Board is concerned that some of the current WSHIP enrollees would be left without coverage because of their undocumented status or their inability to pay the premium without the assistance of third-party payers. The Board did not come to a unanimous decision about this recommendation.
- **Continue WSHIP Medicare Coverage.** The Board recommends keeping the WSHIP Medicare program open until additional options are available to address the barriers to accessing Medigap coverage.
- **Maintain WSHIP's Funding Mechanism.** The Board recommends keeping the current funding mechanism.
- **Expand Alien Medical Coverage for Undocumented Immigrants.** The Board recommends expanding the Alien Medical for Dialysis and Cancer Treatment program to cover additional serious health conditions and post-transplant care.

More details about the study and the Board's recommendations can be found in the report. We specifically direct your attention to pages 18 and 19, where the Board's statement of principles and recommendations can be found.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	I
ABOUT THIS STUDY.....	I
KEY FINDINGS	I
RECOMMENDATIONS	II
INTRODUCTION.....	1
STUDY METHODOLOGY	2
HOW WSHIP’S POPULATION PROFILE HAS CHANGED.....	3
THE COST OF WSHIP AND WHO PAYS	6
COMPARING WSHIP PLANS TO MARKETPLACE PLANS	7
BENEFIT LEVELS -- MEDICAL	7
BENEFIT LEVELS -- PHARMACY.....	8
AFFORDABILITY	9
ELIGIBILITY	10
AVAILABILITY	11
SUMMARY OF FINDINGS	12
CHALLENGES AND OPPORTUNITIES	13
COVERAGE OF UNDOCUMENTED IMMIGRANTS	13
THIRD-PARTY PREMIUM PAYMENT.....	14
AVAILABILITY OF MEDIGAP COVERAGE UNDER AGE 65	14
END STAGE RENAL DISEASE	15
FUNDING OF WSHIP	16
WSHIP BOARD OF DIRECTORS STATEMENT OF PRINCIPLES	18
RECOMMENDATIONS OF THE WSHIP BOARD OF DIRECTORS	19
APPENDIX -- SURVEY RESULTS	20
NON-MEDICARE MEMBERS	20
MEDICARE MEMBERS	20
INTERESTED PARTIES	21

INTRODUCTION

Since 1988, the Washington State Health Insurance Pool (WSHIP) has provided health insurance coverage for state residents who have been denied health insurance coverage because of their medical status and are unable to obtain the comprehensive coverage they need. WSHIP has served two distinct populations: (1) Uninsurable Washington residents who are not eligible for Medicare or Medicaid; and (2) Washington residents who are covered by Medicare but are unable to purchase Medicare Supplement or Medicare Advantage plans.

With the implementation of the Affordable Care Act (ACA) in 2014, insurance companies are required to offer coverage to individuals with pre-existing conditions who are not eligible for Medicare. Legally present low-income residents are eligible for lower premiums and more generous benefits when purchasing through the Washington Health Benefit Exchange, regardless of their health. However, the ACA did not change the marketplace rules for Medicare Supplement (also known as Medigap) or Medicare Advantage plans. Additionally, state law does not require insurance companies to sell Medicare supplement plans to beneficiaries under age 65.

In anticipation of health reforms, WSHIP's eligibility rules for its non-Medicare plans were changed effective January 1, 2014 to limit enrollment to individuals enrolled in WSHIP prior to December 31, 2013 and individuals residing in a county where an individual plan is not offered during defined open enrollment or special enrollment periods. Because plans were offered in all counties in 2014 and 2015, WSHIP has been closed to new non-Medicare enrollment. Many of the WSHIP enrollees transitioned to new coverage options available through the Washington Health Benefit Exchange, private market, or expanded Medicaid. Out of the 3,000 non-Medicare members covered by WSHIP in 2013, approximately 560 enrollees elected to retain their WSHIP non-Medicare coverage which is scheduled to be discontinued on December 31, 2017. WSHIP's Medicare-eligible plan remains open to enrollees who are unable to obtain comprehensive supplemental coverage or a Medicare Advantage Plan, and there is no scheduled discontinuation date for the program which consistently covers approximately 1,000 Washington residents.

As we began this study, we asked ourselves why WSHIP's 560 non-Medicare and 1,000 Medicare members stay in WSHIP when there are new options for coverage in the marketplace.

The Study's Six Essential Questions

Do the populations served by WSHIP have access to comprehensive coverage alternatives?

Do those coverage alternatives provide appropriate coverage for high risk individuals?

What barriers still exist that prevent WSHIP members from securing other coverage?

If such barriers exist, how might they be dealt with to allow high risk Washington residents to purchase the coverage they need?

Should changes to WSHIP's eligibility requirements or financing be made?

Should WSHIP continue to provide coverage for high risk residents who are unable to obtain the coverage they need, and if so, for how long?

To answer that question, our analysis addressed six essential questions:

- *Do the high risk populations served by WSHIP have access to comprehensive coverage alternatives in the insurance marketplace?*
- *Do those coverage alternatives provide appropriate coverage for the medical and prescription drug expenses of high risk individuals?*
- *What barriers still exist that prevent WSHIP members from securing coverage in the insurance marketplace rather than through WSHIP?*
- *If such barriers exist, how might they be dealt with to allow high risk Washington residents to purchase the coverage they need?*
- *Should changes to WSHIP's eligibility requirements or financing be made?*
- *Should WSHIP continue to provide coverage for high risk residents who are unable to obtain the coverage they need, and if so, for how long?*

This study takes an in-depth look at both the non-Medicare and Medicare populations currently enrolled or eligible for coverage through the high risk pool and their access to coverage alternatives in the marketplace.

STUDY METHODOLOGY

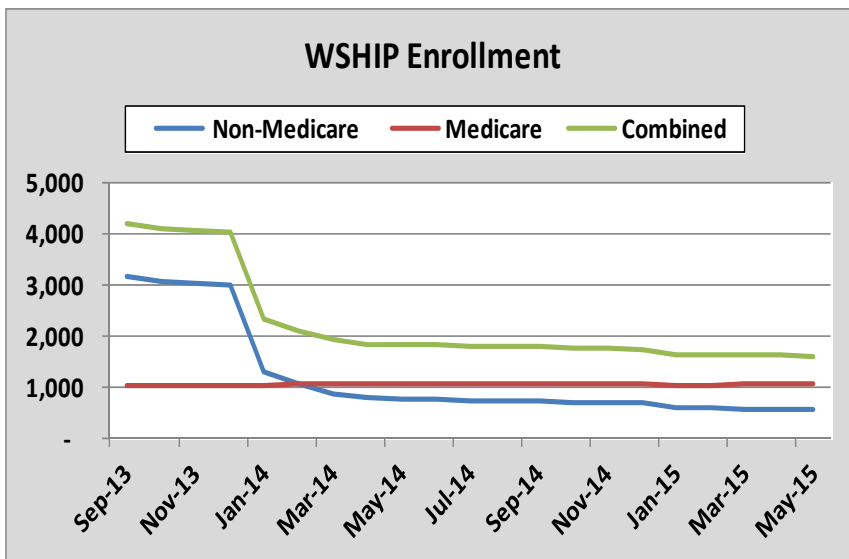
Our approach to this study included three distinct components:

1. **Analysis of Enrollment and Claims Data.** We secured enrollment and claims data for WSHIP members enrolled in May 2015. We secured similar data for members enrolled in September 2013. We compared the demographics and health expenses of the two populations to identify the profile of members who stayed in the pool and those who left during the 2014 and 2015 marketplace open enrollment periods.
2. **Survey of Enrollees and Interested Parties.** We worked with WSHIP to conduct a survey of the members who remain in WSHIP. Separate surveys were distributed for members not eligible for Medicare and those who were. We also conducted a survey of interested parties to get their input.
3. **Market Research.** We studied the plans available in the marketplace for Washington residents and secured additional information from public sources on the topics addressed in the study.

HOW WSHIP'S POPULATION PROFILE HAS CHANGED

Prior to the implementation of the Affordable Care Act, WSHIP covered slightly more than 4,000 Washington residents, the majority of whom were not eligible for Medicare and could not purchase health insurance in the individual market because of their health conditions. With the passage of the ACA, this barrier went away for most of the members.

The following chart shows the changes in the WSHIP enrollment from September 2013 (just prior to the first marketplace open enrollment) to May 2015 (just after the second marketplace open enrollment).



Lower Enrollment
but Sicker, More
Costly Health Status

Non-Medicare claims jump
61% to \$5,000 pmpm

Medicare claims remain
stable at \$827 pmpm

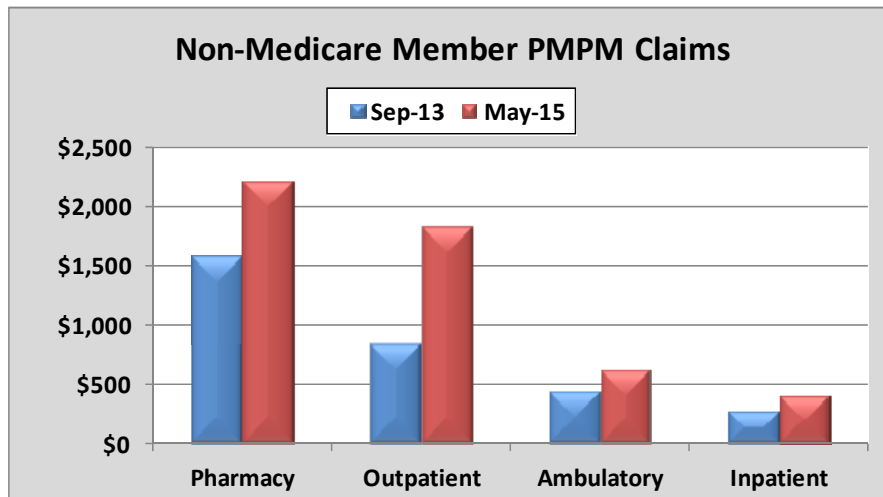
Dialysis is major cost driver

Significant Decrease in Non-Medicare Enrollment. Our analysis of enrollment showed the following:

- Non-Medicare Members. There was a significant drop in enrollment (from approximately 3,000 to less than 1,000) during the 2014 open enrollment. Since then, there has been a gradual loss of membership of about 2% per month, with an additional 15% leaving during the 2015 open enrollment. These former WSHIP members are believed to have secured coverage through the commercial market or expanded Medicaid. Current membership (April 2015) is 560 members.
- Medicare Members. Medicare membership stayed consistently at approximately 1,000 members during the entire time period.
- Combined Membership. The combined membership dropped from just over 4,000 to approximately 1,600 members during this time period.

Changes in Health Status. To compare the health status of the WSHIP population before and after the implementation of the ACA, we analyzed the prior twelve months of claim data for members enrolled at two points in time, September 2013 and May 2015. We looked at the claims separately for the non-Medicare and Medicare populations, since the Medicare plans are supplemental and therefore have a significantly different health cost than members with non-Medicare comprehensive coverage.

A comparison of the population health costs on a per member per month (PMPM) basis during the two time periods is shown below for the non-Medicare population. Our analysis is based on allowed claims (the amount paid by both WSHIP and the member) in order to see the patterns in total health care expenses.



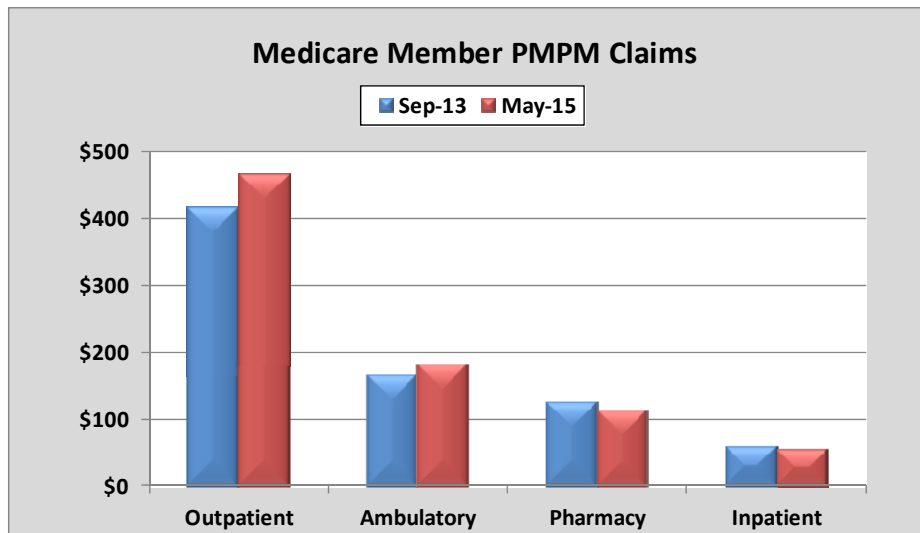
Non-Medicare Claims Jump 61%. Our analysis of non-Medicare claims showed that the total health care expenses for these members rose from approximately \$3,100 to \$5,000 per member per month during this 20-month period, an increase of 61% (40% on an annual basis). The biggest increases came from outpatient and pharmacy claims, but significant increases were seen in all major categories of claims. This is an indication that the population remaining in WSHIP has a significantly worse health status than the earlier population. The \$1,900 increase in the PMPM claims came from the following sources:

	Year Ending 9/2013	Year Ending 5/2015	Change
Pharmacy	\$1,583	\$2,210	\$627
Outpatient Hospital	\$833	\$1,824	\$991
Ambulatory	\$441	\$620	\$179
Inpatient Hospital	\$276	\$397	\$121
Total	\$3,133	\$5,051	\$1,918

As seen in the table above, the biggest increases came from outpatient hospital and pharmacy claims. Pharmacy claims make up 44% of total claims, while outpatient hospital claims represent 36%. Looking closer at the outpatient claims, we saw the following:

	Year Ending 9/2013	Year Ending 5/2015	Change
Hemodialysis	\$335	\$869	\$535
Drugs	\$110	\$285	\$174
Surgery	\$80	\$105	\$25
Emergency Room	\$48	\$94	\$46
Other	\$260	\$471	\$211
Total	\$833	\$1,824	\$991

We also analyzed the claims of members with Medicare, as shown in the chart below.



Medicare Claims Remain Stable at \$827 pmpm. The Medicare members have a much lower claim level than the non-Medicare members (\$827 compared to \$5,000) because the benefits WSHIP provides are a supplement to what Medicare pays. The cost of these benefits does not typically change much from year to year. Outpatient facility expenses make up 57% of the total cost.

Dialysis Continues to Be Major Cost Driver. As with the non-Medicare members, the largest component of the outpatient facility costs for Medicare members is hemodialysis, which accounts for more than a third of the outpatient cost.

THE COST OF WSHIP AND WHO PAYS

Funding for WSHIP comes from three sources:

1. Premiums paid by the participants

WSHIP participants in non-Medicare plans pay a monthly premium that is based on plan, age, tobacco use, and county of residence. Discounts are available but the rate can never be less than 110% of standard market rates.

WSHIP participants in Medicare plans also pay a monthly premium that is based on plan and whether the member is over or under age 65. Discounts are available subject to the same rules as the non-Medicare plans.

Premiums pay less than 30% of WSHIP's costs. The other 70% of the needed funds come from assessments paid by the state's health insurance carriers.

2. Premiums paid by third-parties

WSHIP allows third-parties to pay the premium for WSHIP members. Of the current members, nearly 60% have their premium paid by other parties:

- Evergreen Health Insurance Program pays the premium for approximately 280 (about half) of the non-Medicare WSHIP members. They are a non-profit organization that provides assistance to people with low to moderate incomes who have a diagnosis of HIV/AIDS.
- Kidney Organizations or Foundations pay the premium for over 50% of the Medicare members and a few of the non-Medicare members. This includes sponsorships by the American Kidney Fund's Health Insurance Premium Program (HIPP). The American Kidney Fund (AKF) is a national non-profit program serving people with kidney disease. According to their website, HIPP is funded 100% by voluntary contributions from dialysis providers.

Low-income non-Medicare Washington residents can secure free or discounted coverage through Medicaid or the Health Benefit Exchange if they are legally present in the United States. We believe that most of the persons for whom WSHIP premium is paid by a third-party organization are undocumented residents who are unable to afford to pay for health insurance without assistance and cannot participate in Medicaid or the Health Benefit Exchange.

3. Carrier Assessments

The premiums paid by members and third-party payers pay only a portion of the cost of the WSHIP program. In 2014, the total claim and administration expense for WSHIP totaled about \$52 million, but the member premiums plus a small amount of federal grants and other income

totaled only about \$15 million. The shortfall was assessed to health insurance carriers who operate in the state.

COMPARING WSHIP PLANS TO MARKETPLACE PLANS

BENEFIT LEVELS -- MEDICAL

NON-MEDICARE

WSHIP Medical Benefits Are More Generous. WSHIP's benefits are more generous than what is generally available in the marketplace.

- WSHIP offers plans with \$500 deductibles and \$1,000 maximum out-of-pocket for medical benefits. We were unable to identify any individual health products in the 2015 marketplace with out-of-pockets this low. About 67% of WSHIP members are in this generous level of benefit.
- WSHIP offers PPO plans and an indemnity plan (the indemnity plan does not channel members to preferred providers). No comparable indemnity plans were available in the marketplace in the 2015 open enrollment. About 11% of WSHIP members are in WSHIP's indemnity plan.

In the 2015 individual marketplace, there were sixteen carriers that offered ACA-compliant health insurance plans during the open enrollment period that started October 15, 2014 and continued until February 15, 2015. ACA-compliant plans are required to provide benefits in ten categories of care. Essential health benefits are defined at the state level by referencing a benchmark plan, which for the period 2014 through 2016 is the Regence BlueShield Innova plan. The ACA-compliant plans also cover habilitative benefits and pediatric dental and vision.

Cost sharing for medical benefits in the marketplace is set at the metal levels of 90% (Platinum), 80% (Gold), 70% (Silver), or 60% (Bronze). Low income individuals can choose plans with up to 94% actuarial value. The actuarial value of the WSHIP \$500 deductible plan is approximately 90%.

MEDICARE

WSHIP Medicare Plan is modeled as a Plan F. This is the most commonly sold Medicare Supplement Plan. WSHIP has two Medicare plans:

1. Medicare Basic. This plan was introduced in 2006, when Medicare Part D was put in place. The Basic plan does not cover drugs, other than those covered under Medicare Part B. Members in this plan can get drug coverage by purchasing a Prescription Drug Plan (PDP) from one of the many plans offered in the individual market during open enrollment each year. There are approximately 820 members in this plan.

2. Medicare Basic Plus. This plan was closed to new enrollees in 2006 when the Basic Plan was introduced. In addition to supplementing the medical benefits, this plan also supplements the pharmacy benefits provided by the PDP plan purchased by the member. The number of members covered in this plan has dropped to about 260 members.

BENEFIT LEVELS -- PHARMACY

NON-MEDICARE

WSHIP Pharmacy Benefits Are More Generous. WSHIP's pharmacy benefits are also more generous than what is available in the marketplace. WSHIP offers pharmacy benefits with annual out-of-pocket maximums of \$500. About 67% of WSHIP members have this generous pharmacy benefit. The others are in plan designs with \$850, \$1,000, or \$5,000 maximum out-of-pocket limits.

Under federal regulations, ACA-compliant plans are required to cover the greater of one drug per category and class or the same number of drugs in each category and class as the State's EHB benchmark plan. Due to some concerns about the drug count standard (such as how newly-approved drugs would be added), HHS is adopting a new approach beginning in 2016 that will require that plans have a pharmacy and therapeutic (P&T) committee that will ensure that the plan's formulary drug list covers a sufficient number and type of prescription drugs. A health plan's formulary drug list is required to cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states and must not discourage enrollment by any group of enrollees. The formulary drug list must also ensure appropriate access to drugs in accordance with widely accepted national treatment guidelines and general best practices.

As part of our analysis, we compared the top 25 drugs by plan cost for the non-Medicare members in 2014 to the formularies of Premera, Group Health, and Regence. The top 25 drugs represent 76% of WSHIP's total drug spend in 2014. We found that 19 of the top 25 drugs were classified as preferred drugs on one or more of the three carriers' formularies. This included all of the HIV drugs. Of the remaining six drugs, two were on at least one of the carriers' non-preferred lists, and three were covered by the carriers' medical rather than pharmacy benefits (this affected 4 patients). We also looked at the top 25 drug list for the first quarter of 2015, which included five additional drugs, all of which were considered preferred drugs by one or more of the three carriers.

MEDICARE

WSHIP Medicare Basic Plan Does not Provide Pharmacy Benefits. In the Basic plan, pharmacy coverage is not provided by WSHIP. Medicare Prescription Drug Plans (PDP) are available during open enrollment each year for WSHIP's Medicare-eligible members to purchase. A few drugs are covered by WSHIP's Medicare plan, but only those that are covered by Medicare Part B.

WSHIP Basic Plus Plan Wraps Around Part D Coverage. In the Basic Plus plan which is currently closed, WSHIP provides supplemental coverage to the Medicare PDP plans purchased by the member. WSHIP historically provided pharmacy coverage in its Medicare plans, even when Medicare did not. At the time Medicare Part D was implemented in 2006, there was concern that the standard Part D plan design left significant gaps in coverage for current enrollees who currently had comprehensive pharmacy coverage through WSHIP. The Basic Plus plan filled the Medicare Part D gaps by paying the Medicare deductible, copays and coverage gap for drugs covered by Medicare Parts B and D, plus 80% for some drugs not covered by Medicare. In 2014, WSHIP's cost for this supplemental drug benefit averaged \$395 PMPM, for a total of \$1.3 million.

Beginning in 2010 with the passage of the ACA, the design of the standard Medicare Part D benefit began to change, with a ten-year phase-in aimed at closing the coverage gap. This is being accomplished through a combination of Part D enrollee contribution, Medicare contributions, and drug manufacturer contributions. By 2020, Part D enrollees will be responsible for just 25% of their prescription drug costs in the coverage gap rather than the 100% in the original Part D benefit design.

AFFORDABILITY

NON-MEDICARE

Premiums for WSHIP participants are based on a standard risk rate with an additional markup. The standard risk rate is based on the individual health insurance rates available in the commercial market. The markup currently used for the non-Medicare plans is 10% for members in PPO plans and 50% for members in Standard (indemnity) plans. The PPO plans use a contracted provider network and differentiate cost sharing between network and non-network providers. The Standard plans do not use a provider network and cost sharing is the same regardless of the provider that is used. About 90% of the non-Medicare members are in the PPO plans.

Discounts are allowed for persons who have been in WSHIP for three years, had 18 months of coverage before joining WSHIP, or are below 300% of Federal Poverty Level (FPL), although rates can never go below 110% of the standard risk rate. In 2014, the average rate paid by WSHIP non-Medicare members was 113% of standard market rates adjusted for benefit differences.

Individuals purchasing health insurance coverage through the Health Benefit Exchange are eligible for discounts that limit their premium to no more than 9.5% of income if their household income is 400% of the Federal Poverty Level (FPL) or less. Persons who are not legally present in the United States cannot purchase through the Exchange, but can purchase directly from an insurance carrier during the open enrollment period.

MEDICARE

WSHIP's Medicare plan rates are calculated in the same way as non-Medicare rates, by referencing Medicare Supplement rates available in the market. Medicare enrollee premium rates are marked up

10% for members under age 65 and 50% for members over age 65. Discounts are available, and the average rate paid by WSHIP Medicare members is 115% of standard market rates adjusted for benefit differences. About 70% of the Medicare members are under age 65.

ELIGIBILITY

NON-MEDICARE

WSHIP Non-Medicare Plans are Currently Closed to New Enrollment. Eligibility for WSHIP's non-Medicare plans is limited to individuals enrolled in WSHIP prior to December 31, 2013 and individuals residing in a county where an individual plan is not offered during defined open enrollment or special enrollment periods. Because plans are offered in all counties, WSHIP has been closed to new non-Medicare enrollment.

The ACA requires health insurance carriers operating in the individual market to issue coverage to any applicant during an open enrollment period each year. After the open enrollment is closed, individuals can enroll in coverage if they have a life event that qualifies them for a Special Enrollment Period, such as getting married, having a baby, or losing other health coverage.

MEDICARE

Medicare Plans are Currently Open to New Enrollment. To be eligible for WSHIP's Medicare plans, the following requirements must be met:

- Residence in the state of Washington
- Enrolled in Medicare Parts A and B
- Evidence of rejection for medical reasons, restrictive riders, an up-rated premium, or a pre-existing conditions limitation of a Medicare Supplement insurance policy, or not have comprehensive Medicare Supplement coverage available; and
- Must not have access to a reasonable choice of Medicare Advantage plans.

Reasonable choice is defined as having a choice of HMO or PPO Medicare Part C plans offered by at least three different carriers that have had provider networks in the person's county of residence for at least five years. In addition, the plan options must include coverage at least as comprehensive as a Plan F Medicare Supplement plan combined with Medicare Parts A and B. The plan options must also provide access to adequate and stable provider networks that make up-to-date provider directories easily accessible on the carrier's website and in hardcopy if requested. Finally, if no HMO or PPO includes the healthcare provider with whom the individual has an established relationship and from whom the individual has received treatment within the past 12 months, the individual does not have access to reasonable choice. Using this definition, nine Washington counties (Clark, Cowlitz, King, Lewis, Pierce, Snohomish, Spokane, Thurston, and Whatcom) met the criteria as having reasonable choice in 2015.

Interestingly, approximately 70% of WSHIP's Medicare members live in counties that are defined as having reasonable choice of Medicare Advantage plans in 2015.

Medicare Advantage plans are available without medical underwriting each year during an open enrollment period. Medicare enrollees who are under age 65 who have End Stage Renal Disease (ESRD) cannot purchase Medicare Advantage plans.

Medicare Supplement plans (also known as Medigap policies) can be purchased during a one-time 6-month open enrollment period at the time a person turns 65 and enrolls in Medicare Part B. Outside of open enrollment, the insurance companies are generally allowed to use medical underwriting and screen out less healthy applicants. Federal law doesn't require insurance companies to sell Medigap policies to people under 65. There are 29 states that require Medigap insurance companies to sell policies to applicants under age 65, but Washington is not one of them.

AVAILABILITY

NON-MEDICARE

During the 2015 open enrollment period which ended February 15, sixteen carriers offered individual health insurance either on or off the Health Benefit Exchange. Coverage was available in all counties. Plans were available at all metal levels, representing coverage at the 60%, 70%, 80%, and 90% levels of coverage. Many Silver plans were offered, with cost sharing reduction plans available for persons with incomes up to 400% FPL.

Individual coverage cannot be purchased outside of the open enrollment period.

MEDICARE

In April 2015, there are twenty-five insurance companies offering Medicare Supplement policies in Washington for persons age 65 and older. Two companies (United American and the Washington State Health Care Authority) offer plans to disabled persons under age 65.

In the 2015 Medicare Advantage open enrollment period, fifteen insurance companies offered HMO or PPO Medicare Advantage plans in Washington. Out of the 39 counties in the state of Washington, there were fifteen counties in which three or more Medicare Advantage plans were available. There were nine additional counties with two Medicare Advantage plans available. Nine counties had one plan available, and six counties had none.

SUMMARY OF FINDINGS

The major findings of this study are as follows:

NON-MEDICARE COVERAGE

- WSHIP has lost approximately 80% of its members since the start of 2014 when insurers began to insure individuals without regard to health status. As of April 2015, there were 560 members remaining in WSHIP Non-Medicare plans.
- Approximately half of the remaining members are undocumented low-income HIV/AIDS patients whose premium is paid by a third-party payer.
- Another major condition prevalent in the remaining membership is kidney disease, which is evidenced by a dramatic increase in prevalence of dialysis costs.
- Our analysis of individual health insurance plans available in the market showed there is adequate coverage available for both medical and pharmacy coverage and there are many options to choose from.
- We believe the remaining barrier for this population is:
 - There is some uncertainty whether insurance carriers will accept undocumented applicants and whether they will accept third-party payments for low-income undocumented high risk individuals with conditions such as kidney disease.

MEDICARE COVERAGE UNDER AGE 65

- WSHIP had 728 Medicare members under age 65 as of April 2015.
- These members are in WSHIP because it is the only place they can get a Medicare Supplement policy.
- Many of the members are ESRD patients who are not eligible for Medicare Advantage plans.
- Many of the ESRD patients are low-income and have their premiums paid by a third-party payer.
- We believe the remaining barriers for this population are:
 - Washington does not require Medigap carriers to issue policies on a guarantee issue basis to disabled persons under the age of 65.
 - Medicare Advantage plans are not required to take ESRD patients.

MEDICARE COVERAGE OVER AGE 65

- WSHIP had 347 Medicare members over age 65 as of April 2015.
- These members were eligible to purchase a Medicare Supplement policy during their initial open enrollment period but failed to do so.
- These members can also purchase a Medicare Advantage policy during the annual open enrollment, unless they are ESRD patients.
- We believe the remaining barrier for this population is:
 - Medicare Advantage plans are not required to take ESRD patients.

CHALLENGES AND OPPORTUNITIES

COVERAGE OF UNDOCUMENTED IMMIGRANTS

The Affordable Care Act provides access to comprehensive coverage for all Washington residents who are not covered by Medicare. This is accomplished through guaranteed access to coverage regardless of health status during annual open enrollment periods. Low-income residents who are legally present and purchasing through the Health Benefit Exchange are able to get financial assistance in the form of advanced premium tax credits and lower out-of-pocket expenses.

Low-income undocumented immigrants are not eligible for the financial assistance available to U.S. citizens through the Health Benefit Exchange. For a portion of them, this problem has been solved by enrolling in WSHIP with the assistance of a third-party organization that pays the premium. Although it is uncertain exactly how many undocumented immigrants are currently covered in WSHIP's non-Medicare plans, it is believed to be more than half.

If the WSHIP non-Medicare plans are closed at the end of 2017 as currently scheduled, the coverage options for low-income high-risk undocumented immigrants will be diminished. We explored other options available for these individuals.

The Alien Medical Programs (AMP). Immigrants with certain emergency medical conditions who meet the Medicaid eligibility requirements except for immigrant status qualify for these programs regardless of their date of arrival in the U.S. The programs cover only services necessary to treat the emergency condition.

1. **Alien Emergency Medical (AEM).** This program covers only services necessary to treat an emergency condition that are provided in a hospital setting (inpatient admission, emergency room, or outpatient surgery) or by a physician immediately prior to a hospital admission. This program is federally funded.
2. **Alien Medical for Dialysis and Cancer Treatment.** This program covers healthcare for undocumented immigrants who require: (1) dialysis to treat acute or end stage renal disease; (2) chemotherapy, radiation or surgery to treat cancer; or (3) anti-rejection medication following solid or non-solid transplants.
3. **State-Funded Long-Term Care Services Program.** This program provides care to individuals residing in their own homes or in nursing facility, adult family home, assisted living facility, or residential care facility.

All low-income children under 19 and low-income pregnant women are eligible for medical assistance regardless of immigration status, provided they meet other program requirements.

The Commercial Market. Undocumented immigrants can purchase health insurance from insurance carriers outside the Health Benefit Exchange without health screening during the annual open enrollment period.

THIRD-PARTY PREMIUM PAYMENT

Most of the undocumented immigrant population currently enrolled in WSHIP's non-Medicare plans have their premiums paid by third-party organizations. An issue that surfaced during this study was whether it was possible for the organizations to pay premiums for an individual purchasing coverage in the commercial market.

Effective on March 14, 2014, issuers of qualified health plans are required by HHS to accept premiums and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other Federal and State government programs that provide premium support for specific individuals, and Indian tribes, tribal organizations, and urban Indian organizations. This standard applies to all individual market qualified health plans, regardless of whether they are offered inside or outside of the Health Benefit Exchange.

The federal requirements do not prevent qualified health plans from refusing to accept payments of premium from third-party payers other than those specified. HHS has expressed concern that third-party payments of premium provided by hospitals, other healthcare providers, and other commercial entities could skew the insurance risk pool and create an unlevel competitive field in the insurance market. HHS encourages qualified health plans to reject these payments.

Approximately half of the WSHIP non-Medicare enrollees are HIV/AIDS patients who are sponsored by Evergreen Health Insurance Plan using Ryan White funds. These enrollees can transition into the individual market with continued premium support from EHIP.

Many of the non-EHIP WSHIP members are sponsored by the American Kidney Fund and other organizations. Qualified health plans are not likely to accept payment of premium from third-party organizations for these members. If these members are legally present, they are likely to be eligible for reduced premium through advanced tax credits in the Health Benefit Exchange. If they are not legally present, they will be eligible for the Alien Medical Programs described in the preceding section.

AVAILABILITY OF MEDIGAP COVERAGE UNDER AGE 65

Medicare beneficiaries that are age 65 and older have a right under federal law to guaranteed issue of a Medigap policy during the first six months after they enroll in Medicare Part B and at certain later times when they qualify for an open enrollment. These guaranteed issue and open enrollment provisions of the federal law are not extended to Medicare beneficiaries under age 65. States are allowed to adopt their own laws about access to Medigap coverage for the under age 65 population. Many states have adopted such laws in various forms. The state of Washington is not one of them.

In Washington, there are twenty-five carriers offering Medigap policies, but only two carriers will currently issue to persons under age 65. They are United American and the Washington State Health Care Authority (HCA). Rates for both carriers are significantly higher for under age 65 coverage.

The states that have passed laws requiring availability of Medigap policies under age 65 use a variety of approaches. Here are some examples:

Eligible Population Under 65

- Twenty-five states extend eligibility to under age 65 persons without further qualification.
- Three states (CA, MA, and VT) cover persons under age 65 but specifically exclude those with ESRD.
- A few other states use qualifiers such as involuntary loss of coverage, age 50 and older, or a 6-month pre-existing condition wait.
- A few states (MN, MT, OR, TX, WI) allowed a special open enrollment period when their high risk pools closed.

Initial Access

- Initial access is almost universally allowed during a 6-month open enrollment period after enrollment in Medicare Part B.
- A few states shorten the enrollment period to 2 months after disenrollment from employer coverage.
- One state (NY) allows year-round enrollment.

Required Plans

- Twenty states require a carrier to offer the same plans to persons over and under age 65.
- Other states specify which plans must be offered under age 65, generally some combination of Plans A, B, C, or F.

Rating Provisions

- Eighteen states do not put restrictions on the rates for under age 65.
- Eight states require the same rate to be charged for under and over 65.
- A few states allow a lower rate under 65 but not a higher rate.

END STAGE RENAL DISEASE

End Stage Renal Disease (ESRD) is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Most cases of ESRD are caused by diabetes or high blood pressure.

A person with ESRD may be eligible for Medicare. Medicare benefits on the basis of ESRD are for all covered services, not only those related to the kidney failure condition. Medicare coverage usually

starts on the fourth month of dialysis when the beneficiary participates in dialysis treatment in a dialysis facility. In certain circumstances, Medicare coverage can start sooner for an ESRD patient. If the person has Medicare only because of ESRD, Medicare coverage will end 12 months after the person stopped dialysis treatments, or 36 months after the person had a kidney transplant.

ESRD patients are generally not eligible for Medicare Advantage plans, thus they have a need for supplemental coverage to cover the amounts not covered by original Medicare. If the patient is under age 65, they will likely not be able to purchase a Medigap plan. Patients are responsible for the remaining 20% of charges not covered by Medicare.

Financial help for low-income ESRD patients is available from the Kidney Disease Program. This is a state-funded program administered by the Health Care Authority. It contracts with dialysis providers and serves on average about 600 ESRD patients. Financial help for paying Part B Medicare and other insurance premiums is available from the American Kidney Fund for dialysis patients with insufficient income and savings.

In a study of WSHP’s dialysis costs performed by Leif Associates in 2013, we found that WSHP’s average annual cost per Medicare-eligible dialysis patient was about \$5,400. For non-Medicare patients it was about \$86,000.

In WSHP’s current population as of May 2015, there are 585 patients with a diagnosis of ESRD and an additional 163 with a diagnosis of kidney disease. The breakdown of the ESRD members by Medicare and non-Medicare, compared to the total WSHP population, is as follows:

	Enrollees with ESRD	Total Enrollees	Percent of Enrollees
Medicare Under 65	407	716	57%
Medicare Over 65	148	339	44%
Non-Medicare	30	551	5%
Total	585	1,606	36%

FUNDING OF WSHIP

WSHIP funding is currently provided by premiums and carrier assessments. All health plans in the state are assessed proportionally based on their membership in the preceding calendar year, including one-tenth of the stop loss plan members. In 2014, the assessed lives totaled 3.1 million.

With no change in eligibility, we expect a 2017 assessment of approximately \$40 million. In 2018, if the non-Medicare plan is terminated, the assessment would be reduced to \$11.7 million. Based on this assessment need, we considered the following funding options:

1. **Continue current funding approach.** Based on 2014 assessed lives and a continuation of non-Medicare coverage, we estimate the assessment would equate to \$12.85 per assessed life per year or \$1.07 per life per month. If the non-Medicare coverage is terminated 12/31/17 as

currently scheduled, we estimate the assessment would be reduced to \$3.74 per assessed life per year or \$0.31 per life per month.

2. **Discontinue carrier assessments.** If assessments were discontinued and no other external funding source was found, the premium would need to be raised to allow the program to be self-supporting. Based on current and projected premium levels, revenue from premium is expected to be approximately \$11.8 million if the non-Medicare coverage is continued and \$5.2 million if it is not. Given that the premium provides only about 30% of the current funding, the premium increase needed to replace the carrier assessments would make the program unaffordable.

WSHIP BOARD OF DIRECTORS STATEMENT OF PRINCIPLES

In developing recommendations for addressing the barriers that remain for accessing coverage and the future of WSHIP, the Board of Directors felt it important to document the principle beliefs which form the basis for their recommendations. They are summarized here.

- The WSHIP Board serves at the will of the legislature and seeks a clear updated statutory statement of intent that establishes the role of WSHIP in filling the few remaining gaps in ensuring the availability of comprehensive or supplemental health insurance to all residents of Washington.
- The WSHIP Board believes the current statement of intent established in statute at RCW §48.41.020 is no longer fully relevant given the changes that have occurred with the passage of the Affordable Care Act. The current language is as follows:

It is the purpose and intent of the legislature to provide access to health insurance coverage to all residents of Washington who are denied health insurance. It is the intent of the Washington state health insurance coverage access act to provide a mechanism to ensure the availability of comprehensive health insurance to persons unable to obtain such insurance coverage on either an individual or group basis directly under any health plan.

- The WSHIP Board believes that even after the passage of the Affordable Care Act (ACA) a few barriers remain that prevent certain residents of Washington from accessing comprehensive health insurance, specifically low-income undocumented immigrants, Medigap insurance for persons under age 65, and Medigap insurance for persons over age 65 who did not purchase during their open enrollment period.
- The WSHIP Board recognizes that the statutory statement of intent does not mention affordability of coverage, and believes further that it was not the intent of the legislature to make WSHIP a mechanism to secure coverage for persons who have access to coverage in the insurance market but cannot afford to pay for it.

RECOMMENDATIONS OF THE WSHIP BOARD OF DIRECTORS

The WSHIP Board of Directors respectfully submits these recommendations for the future role of WSHIP and addressing the remaining barriers to accessing coverage.

Recommendation 1: Continue WSHIP Non-Medicare Coverage Beyond 12/31/17.

The WSHIP Board recommends continuing WSHIP non-Medicare coverage for current enrollees, rather than terminating their coverage on 12/31/17 as required by current statute. The Board is concerned that some of the current WSHIP enrollees would be left without coverage because of their undocumented status or their inability to pay the premium without the assistance of third-party payers. The Board did not come to a unanimous decision about this recommendation.

Recommendation 2: Continue WSHIP Medicare Coverage.

The WSHIP Board recommends the continuation of WSHIP's role in providing coverage to Washington residents who are covered by Medicare both over and under age 65 who cannot get Medicare Supplement coverage and lack reasonable choice of Medicare Advantage plans.

Recommendation 3: Maintain WSHIP's Funding Mechanism.

The WSHIP Board recommends keeping the current funding mechanism.

Recommendation 4: Expand Alien Medical Coverage for Undocumented Immigrants.

The WSHIP Board recommends the state consider expanding the Alien Medical for Dialysis and Cancer Treatment program to cover other serious medical conditions and post-transplant care.

APPENDIX -- SURVEY RESULTS

Leif Associates, in conjunction with the WSHIP staff and Benefit Management Inc., conducted surveys of current WSHIP members and other interested parties. The surveys were posted on the WSHIP website and were available either electronically or on paper.

NON-MEDICARE MEMBERS

Ninety-seven WSHIP enrollees responded to the survey, a response rate of approximately 17%, with members in the Standard plans having a higher response rate (29%) than the PPO plans (16%). Here are the highlights of the responses:

- Just under half of the members (48%) considered options available during the 2015 open enrollment but decided to stay with WSHIP. Respondents were asked to mark to all of the reasons that applied. The top three reasons were:
 - I like my WSHIP coverage and didn't really want to change (74%)
 - My WSHIP coverage for doctor and hospital care is more generous (38%)
 - My WSHIP coverage for prescription drugs is more generous (31%)
- Just over half of the members (52%) did not consider options available during the 2015 open enrollment. Respondents were asked to mark all of the reasons that applied. The top three reasons were:
 - I didn't think I was eligible for coverage in the insurance market because of my health conditions (28%)
 - I didn't think I was eligible for coverage in the insurance market for reasons other than my health (20%)
 - I didn't know about the open enrollment period (13%)

MEDICARE MEMBERS

Three hundred sixteen WSHIP enrollees responded to the survey, a response rate of approximately 28%, with members in the Basic Plus plan having a higher response rate (53%) than the Basic plan (20%). Here are the highlights of the responses:

- Only 38% of the members considered insurance options through the commercial insurance market during the last open enrollment. The top three reasons given for staying with WSHIP were as follows:
 - I like my WSHIP coverage and didn't really want to change (46%)
 - I found out I am not eligible for coverage in the insurance market (38%)
 - My WSHIP coverage for doctor and hospital care is more generous (38%)

- The other 62% of the members did not consider insurance options through the commercial insurance market during the last open enrollment. The primary reasons given were as follows:
 - I knew I could keep my WSHIP coverage in 2015 and had no interest in changing (68%)
 - I don't think I am eligible for coverage through the insurance market because of my health conditions (36%)

INTERESTED PARTIES

The survey was also distributed to others who might be interested in commenting on the current and future need for WSHIP. Responses were received from 137 persons, including representatives of insurers, providers, broker/agents, and other entities. Of the respondents, 18% pay premiums for WSHIP members and 22% provide health services for WSHIP members. Slightly more than half of the respondents were insurance carriers. Some provider organizations responded more than once.

- 55% of the respondents believe WSHIP non-Medicare coverage should not be continued beyond 2017. For the 45% of respondents who felt WSHIP should be continued, the major reasons given were these:
 - The insurance market does not offer enough plan options for these enrollees (57%)
 - The plans available in the market are too expensive for these enrollees (51%)
- 55% of the respondents believe WSHIP Medicare under age 65 coverage should be continued. 76 % of the respondents who felt WSHIP coverage should not be continued for these enrollees stated that they believe the market provides adequate choice and there is no reason to keep WSHIP available.
- 55% of the respondents believe WSHIP over age 65 should not be continued. For the 45% of respondents who believe WSHIP coverage should be continued, the major reasons given were these:
 - The insurance market does not offer enough Medicare Supplement plan options for these members (59%)
 - Some people need to get coverage outside of the open enrollment period and there is nowhere to get it other than WSHIP (46%)
 - Medicare Advantage plans are not available to persons with ESRD (44%)