
Washington State Health Insurance Pool

WSHIP after the ACA: Purpose, Eligibility, and Funding

**A Report to the Washington State Legislature As Required by
ESSHB 2319 Affordable Care Act Implementation**

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Executive Summary

Leif Associates was engaged by the Washington State Health Insurance Pool (WSHIP) to assist the WSHIP Board of Directors in conducting a study of the ongoing role of WSHIP as required by the passage of ESSHB 2319. The requirements of the statute are as follows:

- (1) The Board shall review populations that may need ongoing access to coverage through the Pool, with specific attention to those persons who may be excluded from or may receive inadequate coverage beginning January 1, 2014, such as persons with end-stage renal disease or HIV/AIDS, or persons not eligible for coverage in the Exchange.
- (2) If the review indicates a continued need for coverage through the Pool after December 31, 2013, the Board shall submit recommendations regarding any modifications to Pool eligibility requirements for new and ongoing enrollment after December 31, 2013. The recommendations must address any needed modifications to the standard health questionnaire or other eligibility screening tool that could be used in a manner consistent with the federal law to determine eligibility for enrollment in the Pool.
- (3) The Board shall complete an analysis of current Pool assessment requirements in relation to assessments that will fund the reinsurance program and recommend changes to Pool assessments or any credits against assessments that may be considered for the reinsurance program. The analysis shall recommend whether the categories of members paying assessments should be adjusted to make the assessment fair and equitable among all payers.
- (4) The Board shall report its recommendations to the governor and the legislature by December 1, 2012.

The purpose of this report is to document the findings of the study and summarize the recommendations of the WSHIP Board of Directors.

Key Findings and Recommendations

1. Populations That Might Need Ongoing Access

The Board found that while the majority of persons currently covered by WSHIP will be eligible for comprehensive health insurance through the commercial market or through the Exchange, there are some populations that may still need assistance through WSHIP:

- Medicare Enrollees. The Patient Protection and Affordable Care Act (ACA) did not require guaranteed issue of Medicare Supplement policies for persons who are eligible for Medicare, regardless of whether they are over or under age 65. Almost 25% of WSHIP's current enrollment falls in this category. Without WSHIP this population may not have access to as comprehensive supplemental coverage as it does today.
- Other persons not eligible for adequate coverage through the commercial market or the Exchange. The Board was not able to determine specific disease categories that can be identified in advance as being likely to have inadequate coverage through the commercial market or the Exchange. A review of the essential benefits and potential cost-sharing limits for the coverage that will be available beginning in 2014 did not identify gaps in coverage or excessive cost-sharing that would present barriers for persons with exceptional needs. However, the Board also recognizes that there may be some persons, whether due to immigration issues or a lack of insurance carrier availability in a given geographic location or other reasons, who might not have access to coverage in the future. Given this uncertainty, the Board recommends leaving the law as it stands so long as WSHIP continues to serve other populations.



2. Modifications to Pool Eligibility Requirements and Standard Health Questionnaire

a. Medicare Eligibility

New Medicare Enrollment: The Board recommends maintaining the current general eligibility requirements for WSHIP's Medicare plans until such time as comprehensive coverage is available to persons covered by Medicare.

Ongoing Medicare Enrollment: The Board recommends that WSHIP continue coverage for current Medicare enrollees until such time as comprehensive coverage is available to persons covered by Medicare.

The board did not come to a unanimous decision about these recommendations.

b. Non-Medicare Eligibility

New Non-Medicare Enrollment: The Board recommends that the general eligibility requirements for WSHIP's non-Medicare plans be revised to read as follows until 12/31/2016:

- You must be a resident of Washington state;
- You must not be eligible for Medicare coverage, Medicaid coverage or health benefit plans offered through the Exchange or private market; and
- You live in a Washington state county where individual health benefit plans are not offered.

Ongoing Non-Medicare Enrollment: The Board recommends that WSHIP continue coverage for current non-Medicare enrollees until 12/31/2016.

The general eligibility requirements for WSHIP's non-Medicare plans currently require that an individual be rejected for coverage by an insurance carrier based upon the results of the Standard Health Questionnaire. This requirement will not be relevant in 2014, because insurance carriers will not be allowed to reject applicants for health reasons.

Under Age-19 Enrollment: The Board recommends removing the eligibility requirement concerning children under age 19 from WSHIP's eligibility rules as access to WSHIP outside of open enrollment periods will not be needed in 2014.

The current eligibility requirement for children under age 19 says that any person under the age of nineteen who does not have access to individual plan open enrollment or special enrollment, as defined in RCW 48.43.005, or the federal preexisting condition insurance pool, at the time of application to the pool is eligible for the pool coverage. After 2014, the under 19 population will have the same open enrollment periods as the rest of the population.

c. Modifications to the Standard Health Questionnaire

The Board recommends that the Standard Health Questionnaire be eliminated for purposes of determining future WSHIP eligibility and that WSHIP no longer have the responsibility to maintain it.

The Board recognizes that the ACA prohibits the practice of health screening to determine eligibility for health insurance coverage. Thus the Standard Health Questionnaire does not have an ongoing purpose. The Board recognizes that other ACA-compliant tools might continue to be used by insurance carriers to identify and monitor the health status of insureds in support of care management and wellness programs.



3. Pool Assessments

a. Relationship of Reinsurance Assessments and Pool Assessments

The Board recommends that carrier assessments for the Pool and for the federal reinsurance program be kept separate and distinct.

Subsequent to the passage of ESSHB 2319, final rules on the federal reinsurance program were released. These final rules make it clear that a state may not use the reinsurance contributions for any purpose other than reinsurance.

b. Potential Changes to Categories of Members for Assessments

The Board recommends adjusting the category of members paying WSHIP assessments to include TPAs for self-funded plans if a cost-effective mechanism can be developed by the state to determine and regulate TPA assessments and the Pool is anticipated to remain open.

The Board has long believed that the most appropriate means of funding WSHIP would be a broad assessment mechanism that includes both fully insured and self-insured health insurance programs. Currently, only fully insured comprehensive, multiple employers welfare associations (MEWAs), and stop loss insurance carriers are assessed, although state law allows for assessment of self-funded plans as soon as authorized by federal law. While the ACA requires assessment of Third-Party Administrators (TPAs) on behalf of self-funded plans for reinsurance contributions, those collections will be made by the federal government, not the states. Current legal review, however, indicates that an amendment of the WSHIP act to extend WSHIP member assessments to TPAs (as distinguished from self-funded plans) should not result in pre-emption under the federal ERISA statute. In 2011, the cost of WSHIP assessments was \$1.75 pmpm for every person covered in the insured market. Adding TPAs as members of WSHIP would reduce that amount to a payment of \$1.16 pmpm, thus making WSHIP assessments more fair and equitable among all payers.

The board did not come to a unanimous decision about this recommendation.

Study Challenges

Unknown Exchange Implementation Details

Because many of the decisions about how the Exchange will function have yet to be made, we have had to make many assumptions about what the market will look like in 2014. We have assumed that the Exchange will be operational by January 1, 2014. We have also made assumptions with regard to the benefit plan designs that will be available in the commercial market and in the Exchange. While details are beginning to emerge, much remains to be fleshed out. We have used the information currently available to us, with the knowledge that additional information may be released later that could alter the study recommendations.

Definition of Inadequate Coverage

While the law called for an analysis of populations that might not have access to adequate coverage in 2014, a definition of inadequate coverage was not provided. In evaluating the adequacy of coverage, we compared what we assume the coverage will be in 2014 to that currently provided by WSHIP to see if there were significant differences. The underlying assumption in this comparison is that WSHIP currently provides adequate coverage to its enrollees. Access to reasonable choice of certain categories of



providers is another potential aspect of inadequate coverage. Information about provider networks available in the Exchange and the private market beginning in 2014 is not currently available.

Details About the Undocumented Population

Being legally present in Washington and the United States will be a requirement for securing coverage through the Exchange. However, there is only limited information about how many undocumented Washington residents are currently enrolled in WSHIP and whether the commercial insurance market will begin to screen applicants on the basis of citizenship. Thus there is little information available that will allow for accurate projections of whether this segment of Washington residents will have access to coverage outside of WSHIP.

Details About Income Levels

Information about the income levels of WSHIP members is limited. Thus it is difficult to project whether current WSHIP enrollees will move quickly to the Exchange in order to take advantage of federal subsidies or move to Medicaid if they become eligible, whether they will seek coverage through the commercial market, or whether they will linger in WSHIP's plans if they are allowed to do so.



Populations Currently Served by WSHIP

Total Population

The WSHIP State Pool enrollment and claims information presented below is for the period 1/1/2011 through 12/31/2011. Enrollee counts represent unique members covered at any time during the period.

- Number of Enrollees = 4,772; Average Age = 48.4
- Medicare Enrollees = 1,096; Non-Medicare Enrollees = 3,676
- Medicare Enrollees Under 65 = 771; Over 65 = 325
- Medicare Enrollees Average Claim PMPM: Medical = \$515; Rx = \$216
- Non-Medicare Enrollees Average Claim PMPM: Medical = \$1,170; Rx = \$1,179
- Advocacy Group Sponsorship = 2,168 Enrollees
- Medical Claims Paid = \$46.8 Million
- Rx Claims Paid = \$43.9 Million

HIV/AIDS

Many of the WSHIP enrollees with HIV/AIDS will be eligible for expanded Medicaid, so this group of people will likely gain access to Medicaid as quickly as possible. According to Mark Baker at Evergreen Health Insurance Program (EHIP), approximately 40% to 50% of EHIP's 1,200 WSHIP enrollees and 350 PCIP enrollees have incomes under 150% FPL. Approximately 620 to 775 of their WSHIP and PCIP participants may qualify for expanded Medicaid.

- Number of Enrollees = 1,611
- Medicare Enrollees = 95; Non-Medicare Enrollees = 1,516
- Medicare Enrollees Under 65 = 83; Over 65 = 12
- Medicare Enrollees Average Claim PMPM: Medical = \$165; Rx = \$571
- Non-Medicare Enrollees Average Claim PMPM: Medical = \$542; Rx = \$1,911
- Advocacy Group Sponsorship = 1,510 Enrollees
- More than One High Risk Condition = 233 Enrollees
- Medical Claims Paid = \$9.14 Million
- Rx Claims Paid = \$32.2 Million

Kidney Disease

Most of the WSHIP enrollees with End Stage Renal Disease (ESRD) are on Medicare (466 Medicare eligible compared to 42 non-Medicare eligible); this population will be affected by Medicaid to the extent that they meet the expanded eligibility requirements, assuming the expansion is available in Washington.

- Number of Enrollees = 508
- Medicare Enrollees = 466; Non-Medicare Enrollees = 42
- Medicare Enrollees Under 65 = 350; Over 65 = 116
- Medicare Enrollees Average Claim PMPM: Medical = \$876; Rx = \$38
- Non-Medicare Enrollees Average Claim PMPM: Medical = \$13,291; Rx = \$902
- More than One High Risk Condition = 111 Enrollees
- Medical Claims Paid = \$9.04 Million
- Rx Claims Paid = \$582,000

Hemophilia

There are 41 non-Medicare eligible enrollees with Hemophilia on WSHIP and they will be eligible for the Exchange or expanded Medicaid as long as they meet the eligibility requirements for the respective programs.



- Number of Enrollees = 71
- Medicare Enrollees = 30; Non-Medicare Enrollees = 41
- Medicare Enrollees Under 65 = 23; Over 65 = 7
- Medicare Enrollees Average Claim PMPM: Medical = \$737; Rx = \$452
- Non-Medicare Enrollees Average Claim PMPM: Medical = \$12,546; Rx = \$1,125
- Advocacy Group Sponsorship = 21 Enrollees
- More than One High Risk Condition = 44 Enrollees
- Medical Claims Paid = \$5.02 Million
- Rx Claims Paid = \$570,000

Cancer

Of the enrollees in WSHIP with cancer, 308 are Medicare eligible and 663 are not Medicare eligible. All of the 663 enrolled who are not Medicare eligible will be eligible for the Exchange or expanded Medicaid as long as they meet the eligibility requirements for the respective programs.

- Number of Enrollees = 971
- Medicare Enrollees = 308; Non-Medicare Enrollees = 663
- Medicare Enrollees Under 65 = 195; Over 65 = 113
- Medicare Enrollees Average Claim PMPM: Medical = \$521; Rx = \$302
- Non-Medicare Enrollees Average Claim PMPM: Medical = \$2,288; Rx = \$1,060
- Advocacy Group Sponsorship = 271 Enrollees
- More than One High Risk Condition = 331 Enrollees
- Medical Claims Paid = \$17.5 Million
- Rx Claims Paid = \$8.32 Million

Populations That May Still Need to be Served by WSHIP

Medicare Supplement

Under Age 65

The Medicare Supplement plan that WSHIP offers is one of only three Medicare Supplement plans offered to disabled people under age 65 in Washington State. According to the Statewide Health Insurance Benefit Advisors (SHIBA), there are two commercial Medicare Supplement plans offered for disabled people under age 65, the United American Plan B and the Washington State Health Care Authority (HCA) Blue Cross Premera Plan F, and both plans require a health screening.ⁱ WSHIP does not use medical screening for those applying for WSHIP's Medicare Supplement plans and is the only option for those applying for supplemental coverage outside of their 6 month open enrollment window.

The Medicare eligible under age 65 disabled population also has another coverage option through Medicare Advantage plans. The open enrollment period for a Medicare Advantage begins once the applicant is enrolled in Medicare Parts A and B and lasts for a 7 month period that begins 3 months before their 25th month of disability and ends 3 months after their 25th month of disability, but this does not apply if the applicant has ESRD.ⁱⁱ There is also an annual open enrollment for Medicare Advantage Prescription Drug Plans (MA-PDs) from October 15 to December 7 each year, for coverage starting January 1 of the following year.ⁱⁱⁱ

Most people who are under 65 and qualify for Medicare have a 24-month waiting period before they can enroll in Medicare. In 2008, 32% of under 65 Medicare beneficiaries surveyed reported that they went without coverage during their waiting period and another 25% lacked supplemental coverage altogether. They faced sizable financial barriers to care as they struggled with the costs associated with Medicare coverage and the costs of required services not covered by Medicare. Health care costs are a burden on



this population because many of the people who are disabled and under 65 are on a fixed income that does not allow for much flexibility. The ACA promises substantial help to those in Medicare's waiting period and starting in 2014, people with disabilities, along with all other Americans, will be subject to an individual mandate,^{iv} so it seems as though the gaps in coverage and some of the financial barriers will be alleviated by the ACA. But, as the details of plan designs offered in the Exchange are still unknown, there is a chance that some necessary services may not be covered and supplemental plans may still be needed for certain enrollees. WSHIP may still be able to serve as an option for supplemental coverage for the under age 65 disabled population.

Over Age 65

An individual can apply for a Medigap policy (supplemental coverage) during the first six months after turning 65 and enrolling in Medicare Part B. During this time, insurance companies cannot refuse to sell a Medigap policy due to disability or other health problem, or charge a higher premium than they charge other people who are 65 years old.^v Once the open enrollment period closes, an applicant can be denied coverage or charged more because of health reasons.

End Stage Renal Disease

Supplemental coverage is especially important for the population that suffers from ESRD because of the cost associated with the condition. In total, WSHIP covers 771 Medicare enrollees under age 65 and 325 over age 65. Nearly half of the under age 65 enrollees and over a third of the over age 65 enrollees have ESRD. Medicare covers approximately 80% of enrollee costs and the supplemental plans cover the remaining 20%. The average cost per member per month for WSHIP's current Medicare Supplement enrollees with ESRD is \$876 for medical claims and \$38 for pharmacy claims. If these enrollees did not have supplemental coverage, they would most likely pay out-of-pocket for these expenses, on average approximately \$11,000 per year.

WSHIP's Medicare Supplement plan is also important for transplant patients because without full insurance coverage, patients are generally not eligible for a transplant.

Expanded Medicaid

Expanded Medicaid will be an option for some of the people who fall into the under 65 disabled population if they meet the requirements for the program. However, income information for those on WSHIP's non-Medicare and Medicare Supplement plans is unknown, so there is no way to know how many members would benefit from the expanded program. Another factor concerning the expansion of Medicaid is that while a new mandatory eligibility category was established under the law (i.e. citizens and legal residents with incomes up to 138% FPL), the Supreme Court of the United States ruled in June 2012 that states could not be penalized if they did not expand coverage to this new group, and it is therefore uncertain if all states will comply with this requirement.^{vi}

Undocumented Immigrants

Undocumented immigrants can currently purchase health insurance in the commercial market, are not limited in their plan choices, and are subject to the Standard Health Questionnaire. There is only limited information available about undocumented immigrants and health care coverage. One source is the PEW Hispanic Center, which performed a national study to find out how undocumented Hispanic immigrants accessed health care. They found that 60% of Hispanic adults living in the United States who are not citizens or legal permanent residents lack health insurance. The reason they lack health insurance is not necessarily tied to the cost or lack of access to coverage. The study points out that 43% of this group are younger than 30 and just over one-third (34%) report that they either missed work, or spent at least a half day in bed due to illness over the past year. This population as a whole is fairly young and healthy and seeks health care less as a result. When they do access care, 41% of non-citizen, non-legal permanent resident Hispanics state that their usual provider is a community clinic or



health center and only 15% report that they use private doctors, hospital outpatient facilities or health maintenance organizations.^{vii}

The biggest coverage concern surrounding the undocumented population arises when considering the HIV/AIDS population. CDC guidelines recommend treating all HIV-infected individuals with antiretroviral therapy.^{viii} This not only ensures the best health outcomes for the patients, but also greatly reduces the risk of HIV transmission to other individuals. The National Institutes of Health (NIH) released findings from a large-scale clinical study which concluded that men and women with HIV reduced their risk of transmitting the virus to their heterosexual partners by 96% when taking oral antiretroviral therapy.^{ix} For these reasons, it is important that they have access to affordable, comprehensive health care options. The individual mandate and guaranteed issue requirements of the ACA will create an environment in which individuals are not turned down for coverage in the commercial market, so there is little reason to believe that undocumented immigrants will have a problem enrolling in a commercial plan. Concerns arise when considering the affordability of these plans, since the undocumented population will not be eligible to participate in the Exchange and take advantage of federal low-income subsidies.

Immigrants Lawfully Present in the U.S.

The following rules apply to lawfully present immigrants under the ACA.

- Lawfully present adult immigrants residing in the U.S. over five years who meet the 138% FPL income eligibility criterion will gain additional access to Medicaid (if it is available in Washington State).
- Those residing in the U.S. for fewer than five years (i.e., within the five-year bar) with incomes between 138% and 400% FPL, who do not have access to affordable employer-sponsored coverage, will be eligible for subsidized coverage through state Health Benefit Exchanges.
- Those residing under five years with income below 138% will not be eligible for Medicaid but can purchase health coverage through an Exchange with the cost-sharing requirement that they pay 2% of their income.^x

As stated in the section above, immigrants that are not lawfully present are not eligible to purchase insurance coverage in the Exchange, but may purchase coverage through the commercial market.

High Cost Drugs

In the event that the plans offered in the Exchange or in expanded Medicaid do not cover certain drugs on their formularies, WSHIP could be an option for people who need these drugs. The HIV/AIDS population is one such population. The average pharmacy claims per member per month for WSHIP members with HIV/AIDS is \$1,911. This is nearly double the average pharmacy costs for the other conditions studied. It is important that the pharmacy plans offered in the Exchange and expanded Medicaid cover the drugs necessary to treat these individuals.

At this point in time, there is nothing that would indicate that people enrolling in the Exchange or expanded Medicaid will not be given options that provide them with adequate coverage, but because there is so little known about the details of the plan designs that will be offered, this is still a valid concern. There may be gaps in coverage that won't be known until the plan designs have been released and those gaps may affect some of the high cost members identified in this study, especially those living with HIV/AIDS.



Comparison of Current WSHIP Benefits to Potential Exchange Benefits

The following table compares the essential benefit plan, defined in Washington as the Regence Innova Plan, to the current WSHIP benefit plans. The Comments column makes note of areas where the WSHIP plans do not comply with the defined essential benefits or ACA requirements.

Benefit	Essential Benefit Plan Regence Innova	WSHIP	Comments
Acupuncture	12 visits per calendar year	12 visits per calendar year	
Ambulance	Covered	Covered	
Dialysis	Covered	Covered	
Emergency Room Services	Covered	Covered	
Home Health	130 visits per calendar year	130 visits per calendar year	
Hospice	Respite care limited to 14 days per lifetime	Respite care limited to \$7,500 per calendar year	
Hospital and Ambulatory Surgical Center	Covered	Covered	
Massage Therapy	Not Mentioned	12 visits per calendar year	Unknown
Maternity	Covered	Covered	
Medical Supplies and Equipment	Covered	Covered	
Mental Health and Substance Use Disorder Services	Covered	Chemical Dependency: 30 inpatient days, 28 outpatient visits	Will not comply with Essential Benefits
Office Visits	Covered	Covered	
Prescription Drugs	Covered	Covered	
Preventive Care and Immunizations	Covered with no cost sharing	Limited to \$500 per calendar year all plans	Does not comply with ACA requirements
Radiology and Lab - Outpatient	Covered	Covered	
Rehabilitation Services	Inpatient: 30 days per calendar year; Outpatient: 25 visits per calendar year	Covered	
Skilled Nursing Facility	60 inpatient days per calendar year	100 days per calendar year	
Spinal Manipulations	10 spinal manipulations per calendar year	Covered	
Temporomandibular Joint Disorders	Covered	\$1,000 lifetime maximum	Unknown
Transplants	Covered	\$350,000 lifetime max	Does not comply with ACA requirements
Exclusions	<ul style="list-style-type: none"> • Cosmetic • Counseling • Custodial Care • Dental • Infertility • Investigational 	<ul style="list-style-type: none"> • Cosmetic • Counseling • Custodial • Dental • Education and Training 	



Populations Served by WSHIP

Benefit	Essential Benefit Plan Regence Innova	WSHIP	Comments
	<ul style="list-style-type: none"> • Medications without a Prescription • Military Service Related • Motor Vehicle Coverage • Obesity or Weight Reduction • Orthognathic Surgery • Personal Comfort Items • Physical Exercise Programs • Private Duty Nursing • Riot, Rebellion, Illegal • Routine Foot Care • Routine Hearing Care • Self-Help, Self-Care, Training • Services to Alter Refractive Character of the Eye • Sexual Reassignment • Sexual Dysfunction • Travel and Transportation • Work Related 	<ul style="list-style-type: none"> • Fertility • Foot Care • Government Medical Facilities • Military and War Related • Not Medically Necessary • Obesity and Weight Control • Sex or Gender Reassignment • Sexual Dysfunction • Transportation or Travel • Vision and Hearing • Work Related 	
Other Essential Benefits in Statute: <ul style="list-style-type: none"> • Habilitative¹ Services • Pediatric Oral and Vision Care 	Not mentioned in Innova plan description, but mentioned in the law	Not covered	Does not comply with Essential Benefits

WSHIP also has two Limited plans that have a combined total of 17 members. These plan designs do not comply with the Essential Benefits outlined in the ACA.

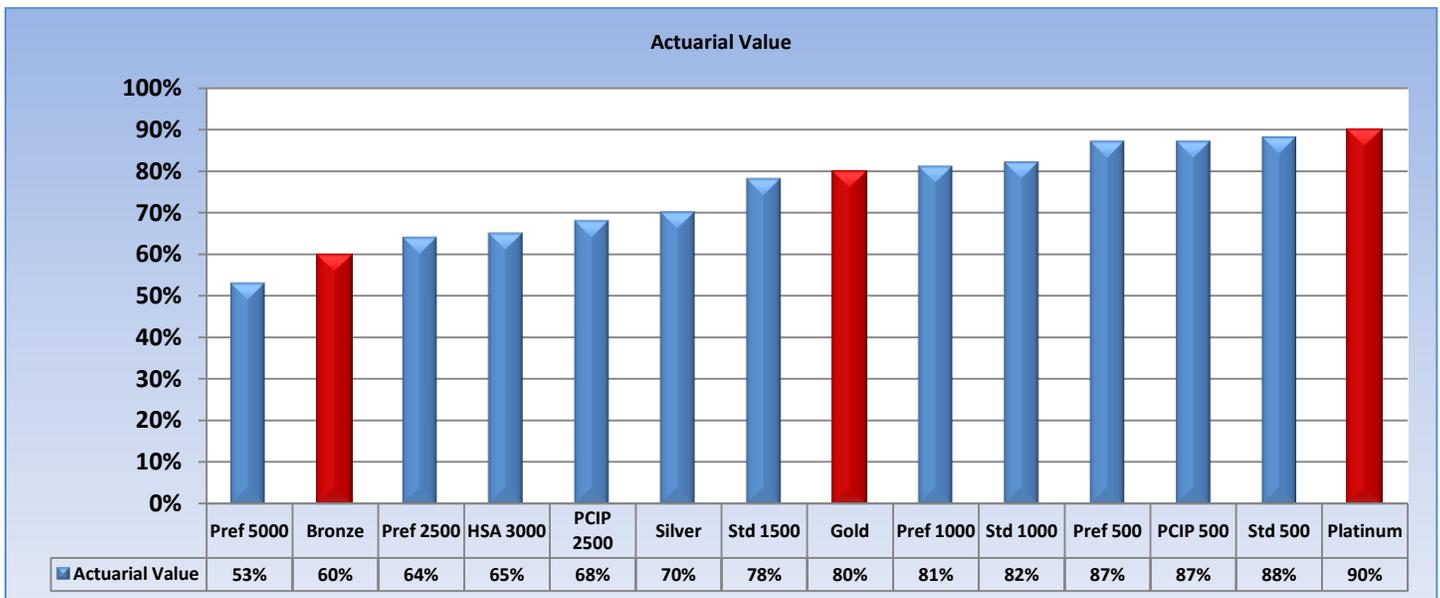
¹ According to Section 1915(c)(5)(A) of the Social Security Act, **Habilitative Services** means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and (B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but (C) does not include— (i) special education and related services (as such terms are defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401)) which otherwise are available to the individual through a local educational agency; and (ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730)



Actuarial Values of WSHIP Benefits and Potential Exchange Benefits

The Affordable Care Act requires issuers offering non-grandfathered health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan must meet distinct levels of coverage, called “metal tiers” – bronze, silver, gold, or platinum. Under the statute, each metal tier corresponds to an Actuarial Value (AV), calculated based on the cost-sharing features of the plan. The expression of AV as a metal tier will allow consumers to easily compare plans based on cost-sharing features.

Actuarial value is calculated based on the cost-sharing provisions for a set of benefits. A bronze plan is required to have an AV of 60%; a silver plan, 70%; a gold plan, 80%; and a platinum plan 90%. Plans will have the flexibility to independently develop cost-sharing structures as long as each plan’s AV is equal to 60%, 70%, 80%, or 90%. It is anticipated that a ± 2% variance will be allowed. HHS intends to propose using a standard data set for all AV calculations, for which HHS would develop a national standard population. They intend to develop a publicly available AV calculator that plans would use to determine AV, but it has not yet been released. In the absence of the standardized AV calculator, we have used our own standardized database and calculated AV values for the metal plans and WSHIP’s current plans, as shown in the chart below.



This chart shows that the WSHIP plans generally fall in line with the metal plans, so members moving from WSHIP plans to one of the metal plans will have plan choices that are not significantly different in cost sharing than the plans they are currently enrolled in.

The cost sharing in the metal plans will be defined by the issuers, but in order to get an idea of the general cost sharing levels that might be available we have prepared the following table showing the current WSHIP cost sharing parameters and the corresponding actuarial values.



Populations Served by WSHIP

WSHIP Plan	Actuarial Value	Deductible	Coinsurance	Max Out of Pocket (Includes Deductible and Rx)
Pref 5000	53%	\$5,000	20%	\$15,000
Bronze	60%			\$6,050
Pref 2500	64%	\$2,500	20%	\$10,000
HSA 3000	65%	\$3,000	20%	\$5,250
PCIP 2500	68%	\$2,500	20%	\$5,950
Silver	70%			\$6,050
Std 1500	78%	\$1,500	20%	\$3,000
Gold	80%			\$6,050
Pref 1000	81%	\$1,000	20%	\$2,500
Std 1000	82%	\$1,000	20%	\$2,500
Pref 500	87%	\$500	20%	\$1,500
PCIP 500	87%	\$500	20%	\$1,500
Std 500	88%	\$500	20%	\$1,500
Platinum	90%			\$6,050

Cost of Coverage

Health Insurance Subsidies Under ACA

Citizens and legal residents in families with incomes between 100% and 400% of poverty who purchase coverage through a health insurance Exchange are eligible for a tax credit to reduce the cost of coverage. The amount of tax credit that a person can receive is based on the premium for the second lowest cost Silver plan in the Exchange where the person is eligible to purchase coverage. The amount of the tax credit varies with income such that the premium a person would have to pay would not exceed a specified percentage of their income, as follows:^{xi}

Income Level	Premium as a % of Income	Single Annual Premium	Family of Four Annual Premium
Up to 133% FPL	2% of income	\$0 - \$295	\$0 - \$613
133-150% FPL	3-4% of income	\$446 - \$670	\$920 - \$1,383
150-200% FPL	4-6.3% of income	\$670 - \$1,407	\$1,383 - \$2,904
200-250% FPL	6.3-8.05% of income	\$1,407 - \$2,248	\$2,904 - \$4,639
250%-300% FPL	8.05-9.5% of income	\$2,248 - \$3,183	\$4,639 - \$6,569
300-400% FPL	9.5% of income	\$3,183 - \$4,245	\$6,569 - \$8,759

The 2012 Federal Poverty Level (FPL) is \$11,170 for an individual and \$23,050 for a family of four.^{xii}

In addition, ACA provides for reduced cost sharing for families with incomes at or below 250% of poverty by making them eligible to enroll in health plans with higher actuarial values. The amount of additional protection varies with incomes, as follows:



Populations Served by WSHIP

Income Level	Actuarial Value
100-150% FPL	94%
150-200% FPL	87%
200-250% FPL	73%

ACA limits the total amount that people must pay out-of-pocket for cost sharing for essential benefits. Generally, the limits are based on the maximum out-of-pocket limits for Health Savings Account-qualified health plans (\$6,050 for single coverage and \$12,100 for family coverage in 2012), which will be indexed to the change in the CPI until 2014. After 2014, the limits will be indexed to the change in the cost of health insurance. People with incomes at or below 400% of poverty will have their out-of-pocket liability capped at lower levels, as follows:

Income Level	Reduction in Out-of-Pocket Liability	2012 Maximum Out-of-Pocket Value
100-200% FPL	2/3 of the maximum	\$2,017
200-300% FPL	1/2 of the maximum	\$3,025
300-400% FPL	1/3 of the maximum	\$4,033

It is important to note that once someone with an Exchange plan becomes eligible for Medicare, their access to a subsidy disappears.^{xiii} These people will be allowed to continue their Exchange plan, but will have to pay for the entire premium out-of-pocket.^{xiv}

Comparison of Cost Between WSHIP and Potential Exchange Plans

Under the ACA, the cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c) (2) (A) (ii) of the Internal Revenue Code of 1986 for self-only and family coverage, for taxable years beginning in 2014. For 2012, the dollar amounts outlined in the IRC are \$6,050 for self-only coverage or \$12,100 for family coverage.

The following table presents specific examples of five actual high-cost WSHIP enrollees with serious health conditions, showing their current benefit plans, medical and pharmacy claims, premium, and out-of-pocket expenses. For each of the five enrollees, we estimated the amount of premium under the Silver Plan and the out-of-pocket expense that would be necessary at various income levels.

This comparison shows that in all five cases, the combined premium and claims under the Silver Plan will be less than under WSHIP for persons under 400% FPL. For persons above 400% FPL, the premium cost is unknown. For this analysis, we assumed the premium would be similar to the current WSHIP premium.



Populations Served by WSHIP

WSHIP Plan	Person 1	Person 2	Person 3	Person 4	Person 5
Condition	HIV	HIV	Cancer	ESRD	Other
Plan Deductible	\$500	\$500	\$2,500	\$1,500	\$2,500
Smoker?	N	Y	N	N	N
Allowed Claims Medical	\$67,872	\$131,794	\$499,411	\$827,345	\$1,245,128
Allowed Claims Rx	\$50,480	\$27,757	\$1,469	\$21,835	\$203
Total Allowed Claims	\$118,352	\$159,551	\$500,880	\$849,180	\$1,245,331
Current Monthly Premium	\$1,249	\$674	\$593	\$1,523	\$293
Current Annual Premium	\$14,988	\$8,088	\$7,116	\$18,276	\$3,516
Actual Medical OOP	\$1,364	\$1,000	\$5,311	\$2,000	\$5,000
Actual Rx OOP	\$500	\$500	\$746	\$1,000	\$203
Total Actual OOP (Including Premium)	\$16,852	\$9,588	\$13,173	\$21,276	\$8,718
Silver Plan Annual Max OOP (Premium and Claims)					
Above 400% FPL	\$21,038	\$14,138	\$13,166	\$24,326	\$9,566
400% FPL	\$8,278	\$8,278	\$8,278	\$8,278	\$8,278
250% FPL	\$5,273	\$5,273	\$5,273	\$5,273	\$5,273
150% FPL	\$2,687	\$2,687	\$2,687	\$2,687	\$2,687

For this analysis, we used the following set of assumptions:

- Claims were based on claims incurred 1/1/2011 through 12/31/2011
- All five members were on non-Medicare plans
- Premium for “Above 400% FPL” is the same as 2011 WSHIP premium
- The combined medical and pharmacy out-of-pocket maximum for “Above 400% FPL” is \$6,050. This does not include the amount paid in monthly premium.
- All five members choose the Silver plan
- No consideration was made for smoking status in the 150% - 400% FPL out-of-pocket maximum numbers



Current Eligibility Rules

Prior to 2014

Non-Medicare Plans General Eligibility Requirements

- You must be a resident of Washington state;
- You must have been rejected for coverage by an insurance carrier based upon the results of the Standard Health Questionnaire, or live in a Washington state county where individual health benefit plans are not offered; and
- You must not be eligible for Medicare or Medicaid coverage.

Dependent Eligibility

- Coverage for your dependent children is available provided that you are eligible for and are enrolled in WSHIP. Dependent children must be unmarried and under the age of 26. Coverage can be extended for dependent children over age 26 who are disabled.
- Children Under 19 Years of Age: Any person under the age of nineteen who does not have access to individual plan open enrollment or special enrollment, as defined in RCW 48.43.005, or the federal preexisting condition insurance pool, at the time of application to the pool is eligible for the pool coverage.

Medicare Plans General Eligibility Requirements

- You must be a resident of Washington state;
- You must be enrolled in Medicare Part A and Part B;
- You must provide evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a pre-existing conditions limitation on a Medicare supplemental insurance policy, or not have comprehensive Medicare Supplement coverage available to you; and
- You must not have access to a reasonable choice of Medicare Advantage Plans (Part C).

According to the Washington Department of Licensing, in order to establish WA residency you must do any of the following:^{xv}

- Arrive in WA and begin establishing a home in the state
- Register to vote
- Receive state benefits
- Get any WA State license at resident rates
- Receive in-state tuition fees

Enrollees as of 12/31/2013

RCW 48.41.160 and Section II.E. of WSHIP policies, "Continuity of Coverage: Replacement or Discontinuation" permit WSHIP to replace and also to discontinue a plan. Discontinuation of a plan requires at least 90 days notice of discontinuation, and that the pool offer the enrollee the option to enroll in any other plan offered by WSHIP for which the enrollee is otherwise eligible. The statute also requires the Board to perform an evaluation on the cost and quality care to pool enrollees and other factors prior to making the decision to terminate. This provision does not require the pool to offer an alternative plan other than any other plans that might be available.

However, Section 48.41.110 affirmatively requires the pool to offer policies including a comprehensive policy. By combining these provisions it is clear that the Act (Chapter 48.41 RCW) requires WSHIP to offer policies as provided in Section 48.41.110. Although it can replace policies, it would not be able to terminate all non-Medicare policies under the current Act. Since the ACA will not permit the use of the SHQ after 2013 by carriers, new enrollees in the pool arising from administration of the SHQ will cease.



The Standard Health Questionnaire

Thus, without an amendment to the Act, the pool will continue and will be required to continue to offer policies although there will not be new enrollees for non-Medicare policies through use of the SHQ.

The Board is in favor of allowing current enrollees three years to evaluate their coverage options outside of WSHIP and also to mitigate their cost impact on the exchange if they were all to move on day one, but is uncomfortable recommending that the pool remain open indefinitely. The Board hopes that three years is enough time for Congress or the Legislature to make provisions to assure that all populations that may need WSHIP for adequate coverage in 2014 will have other options by 1/1/2017.

Possible Changes for 2014 and After

Non-Medicare

The Board recommends that the general eligibility requirements for WSHIP's non-Medicare plans be revised to read as follows until 12/31/2016:

- You must be a resident of Washington state;
- You must not be eligible for Medicare coverage, Medicaid coverage or health benefit plans offered through the Exchange or private market; and
- You live in a Washington state county where individual health benefit plans are not offered.

The Board recommends that WSHIP continue coverage for current non-Medicare enrollees until 12/31/2016.

The general eligibility requirements for WSHIP's non-Medicare plans currently require that an individual be rejected for coverage by an insurance carrier based upon the results of the Standard Health Questionnaire. This requirement will not be relevant in 2014, because insurance carriers will not be allowed to reject applicants for health reasons.

Non-Medicare Under age 19

The Board recommends removing the eligibility requirement concerning children under age 19 from WSHIP's eligibility rules as access to WSHIP outside of open enrollment periods will not be needed in 2014.

The current eligibility requirement for children under age 19 says that any person under the age of nineteen who does not have access to individual plan open enrollment or special enrollment, as defined in RCW 48.43.005, or the federal preexisting condition insurance pool, at the time of application to the pool is eligible for the pool coverage. After 2014, the under 19 population will have the same open enrollment periods as the rest of the population.

Medicare

The Board recommends maintaining the current general eligibility requirements for WSHIP's Medicare plans until such time as comprehensive coverage is available to persons covered by Medicare.

The Board recommends that WSHIP continue coverage for current Medicare enrollees until such time as comprehensive coverage is available to persons covered by Medicare.

The Board did not reach a unanimous decision on these recommendations. Four Board members believe that WSHIP's Medicare plans should not continue past 12/31/2016. Their opinion is that maintaining a state-based solution to provide ongoing eligibility for Medicare supplemental coverage continues a program designed for a different era and masks a larger issue that should be dealt with using a uniform and explicit approach at the federal level.



The Standard Health Questionnaire (SHQ)

How It Works Today

The SHQ is used by insurance carriers to determine eligibility of people who apply for private, individual medical coverage. Carriers are required by law to use this questionnaire and its scoring system if they sell plans for which you can be rejected based on your health. Applicants may only be rejected for coverage if they score 325 or more points. If an applicant is rejected, he or she is automatically eligible for coverage from WSHIP. WSHIP was created by the Washington legislature to offer health insurance to residents who are rejected for individual coverage. WSHIP is also responsible for the form and content of the questionnaire and for recertifying it every 36 months to ensure that it meets the requirements of state law. WSHIP does not administer or score the questionnaire; the carrier provides and scores the applicant's questionnaire.

Some individuals are exempt from taking the questionnaire and cannot be rejected by carriers if they meet other requirements of the plan. These exemptions are determined by the legislature and not by WSHIP. They are listed at the beginning of the questionnaire. WSHIP does not advise on whether or not an applicant qualifies for an exemption.

The questionnaire contains a list of medical conditions and each condition is assigned a point value. The Applicant is asked to mark any condition they have been diagnosed, treated, medicated, and/or monitored for within the timeframe specified. Their total score will be used by the carrier to determine eligibility for coverage.

What The ACA Says

Section 1201(2)(A)(a) of ACA states that "IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."

The SHQ will no longer be a necessary tool because, as stated in the law, an insurer cannot deny an applicant because of a preexisting condition, so any person applying for coverage should be able to purchase it.

Conclusions

Under the ACA, health insurance issuers are prohibited from rejecting applicants based on health status, so the SHQ will no longer be a relevant tool. The Board recommends that it be eliminated for purposes of determining future WSHIP eligibility and that WSHIP no longer have the responsibility to maintain it. The Board recognizes that other ACA-compliant tools might continue to be used by insurance carriers to identify and monitor the health status of insureds in support of care management and wellness programs.



Assessment Issues

Assessment Projections

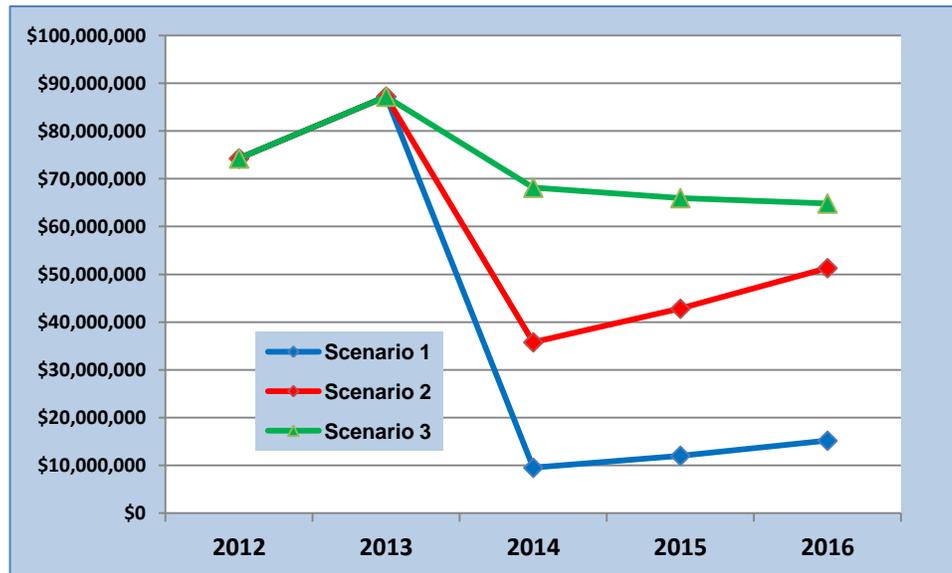
We prepared the following projections to illustrate the potential assessments necessary to support the financial needs of WSHIP through 2016 under three different enrollment scenarios.

Scenario 1: Beginning in 2014, the only participants in WSHIP will be those who are covered by Medicare Parts A and B. All others will have access to coverage elsewhere and will no longer be eligible for WSHIP.

Scenario 2: In 2014 and later, in addition to the Medicare enrollees, approximately 20% of the non-Medicare enrollees will continue in the Pool because they will not be eligible for adequate coverage through the Exchange or in the individual market.

Scenario 3: In 2014, half of the non-Medicare enrollees will leave the Pool immediately, with the rest of the non-Medicare enrollees leaving gradually at the rate of 2% per month. Coverage will continue in the Pool for Medicare enrollees.

Assessment Projections			
Year	Scenario 1	Scenario 2	Scenario 3
2012	\$74.3 million	\$74.3 million	\$74.3 million
2013	\$87.2 million	\$87.2 million	\$87.2 million
2014	\$9.5 million	\$35.8 million	\$68.1 million
2015	\$12.0 million	\$42.8 million	\$66.0 million
2016	\$15.1 million	\$51.8 million	\$64.8 million





Assessment Language

The following statutes describe WSHIP's assessment authority:

48.41.090 (2) (c) Except as provided in RCW 48.41.037, any deficit incurred by the pool shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members.

48.41.030 (14) "Member" means any commercial insurer which provides disability insurance or stop loss insurance, any health care service contractor, any health maintenance organization licensed under Title 48 RCW, and any self-funded multiple employer welfare arrangement as defined in RCW 48.125.010. "Member" also means the Washington state health care authority as issuer of the state uniform medical plan. "Member" shall also mean, as soon as authorized by federal law, employers and other entities, including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after May 18, 1987. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products or those products excluded from the definition of "health coverage" set forth in subsection (10) of this section.

Potential Changes to Assessment Process

The WSHIP Board of Directors has long believed that the most appropriate means of funding WSHIP would be a broad assessment mechanism that includes both fully insured and self-insured health insurance programs. Currently, only fully insured comprehensive, multiple employers welfare associations (MEWAs), and stop loss insurance carriers are assessed, although state law allows for assessment of self-funded plans as soon as authorized by federal law.

While the ACA requires assessment of Third-Party Administrators (TPAs) on behalf of self-funded plans for reinsurance contributions, those collections will be made by the federal government, not the states. Current legal review, however, indicates that an amendment of the WSHIP act to extend WSHIP member assessments to TPAs (as distinguished from self-funded plans) should not result in pre-emption under the federal ERISA statute. In 2011, the cost of WSHIP assessments was \$1.75 pmpm for every person covered in the insured market. Adding TPAs as members of WSHIP would reduce that amount to a payment of \$1.16 pmpm, thus making WSHIP assessments more fair and equitable among all payers.

The Board recommends adjusting the category of members paying WSHIP assessments to include TPAs for self-funded plans if a cost-effective mechanism can be developed by the state to determine and regulate TPA assessments and the Pool is anticipated to remain open.

The Board did not reach a unanimous decision with regard to TPA assessments. Two Board members believe that the idea of assessing self-funded plans is not practical because during the three year transition period, the non-Medicare Pool membership will phase out. Current assessments are relatively low and will decrease further during the transition period and the cost of having the state develop a cost-effective mechanism to determine and regulate TPA assessments is likely to outweigh the benefit.



Resources

- ⁱ “October 2012 Approved Medicare Supplement (Medigap) Plans.” Washington State Office of the Insurance Commissioner – Statewide Health Insurance Benefits Advisors (SHIBA)
- ⁱⁱ “Understanding Medicare Enrollment Periods.” Department of Health and Human Services, Revised November 2011. <<http://www.medicare.gov/publications/pubs/pdf/11219.pdf>>.
- ⁱⁱⁱ “Medicare Open Enrollment Starts Oct. 15 – Local Help Available.” Washington State Office of the Insurance Commissioner, October 10, 2012. <<http://www.insurance.wa.gov/news/2012/10-10-12.shtml>>
- ^{iv} Cubanski, Juliette and Neuman, Patricia. “Medicare Doesn’t Work as Well for Younger, Disabled Beneficiaries as it Does for Older Enrollees.” *Health Affairs*, 2010; 29:9:1725-1733.
- ^v “Medigap Policies For People Under Age 65 With A Disability or End-Stage Renal Disease (ESRD).” Medicare.gov, May 7, 2012. <<http://www.medicare.gov/medigap/under65.asp>>.
- ^{vi} Kates, Jen. “How the ACA Changes Pathways to Insurance Coverage for People with HIV.” *Policy Insights*, The Henry J. Kaiser Family Foundation, September 18, 2012. <<http://policyinsights.kff.org/2012/september/how-the-aca-changes-pathways-to-insurance-coverage-for-people-with-hiv.aspx>>
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- ^{ix} Panel on Antiretroviral Guidelines for Adults and Adolescents. “Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents.” Department of Health and Human Services. Accessed October 4, 2012. <<http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf>>.
- ^x Lichello, Patricia. “Health Care Access for Adult Immigrants in Washington State: The Implications and Potential of Health System Reform.” *Safe Table Forums*, University of Washington Health Policy Initiative, 2012, Number 16.
- ^{xi} “Explaining Health Care Reform: Questions About Health Insurance Subsidies.” The Henry J. Kaiser Family Foundation, July 2012.
- ^{xii} “2012 HHS Poverty Guidelines.” U.S. Department of Health and Human Services, *Federal Register*, Volume 77, Number 17, January 26, 2012.
- ^{xiii} “Explaining Health Care Reform: Questions About Health Insurance Subsidies.” The Henry J. Kaiser Family Foundation, July 2012.
- ^{xiv} “Rules and Regulations.” U.S. Department of Health and Human Services, *Federal Register*, Volume 77, Number 59, March 27, 2012.
- ^{xv} “Moving? Get a WA State License.” Washington State Department of Licensing. <<http://www.dol.wa.gov/driverslicense/moving.html>>.