**Protecting Health Coverage in Louisiana Task Force Meeting**

Thursday, September 12

9:30 AM

House Committee Room 4

Louisiana State Capitol Baton Rouge

CALL TO ORDER

Chair Matthew Block, Governor’s executive counsel, called the meeting of the Protecting Health Coverage in Louisiana Task Force to order at 9:30 AM on September 12, 2019, in House Committee Room 4 at the Louisiana State Capitol.

ROLL CALL

The roll was called by Ms. Valencia Burton. A quorum was established.

**Members Present**

Lance Barbour*, Louisiana Government Relations Director for the American Cancer Society Action Network (At-large appointee representing a consumer health group)*

Stephen Barnes, PhD*, Director, Kathleen Babineaux Blanco Public Policy Center, University of Louisiana at Lafayette (At-large appointee with expertise in economics)*

Matthew Block, *Governor’s Executive Counsel (Governor’s designee)*

Jeanie Donovan, *Policy Director at Louisiana Department of Health (Secretary of Health’s designee)*

Jeff Drozda, *CEO at the Louisiana Association of Health Plans (At-large appointee representing the insurance industry)*

Korey Harvey, *Vice President and Deputy General Counsel at Blue Cross and Blue Shield of Louisiana (At-large appointee representing the insurance industry)*

Beverly Haydel, *President/CEO, Sequitur Consulting (Attorney General’s designee)*

Christina Lord, MD, *Physician (At-large appointee representing health care providers)*

Tiffany Netters, *Executive Director 504HealthNet* (*At-large appointee representing a consumer health group)*

Frank Opelka, *Deputy Commissioner of Health, Life, & Annuity at Louisiana Department of Insurance (Commissioner of Insurance’s designee)*

Rep. Joe Stagni, *(House Health & Welfare designee)*

**Members Absent**

Sen. Regina Barrow*, (Senate Health & Welfare Committee designee)*

REVIEW AND APPROVAL OF MINUTES

Chair Block introduced the minutes from the previous meeting. Mr. Drozda moved to accept the minutes. Mr. Opelka seconded. With no objection, the minutes were approved.

STATE OF COMMITTEE

Chair Block reminded the committee of the projected timeline for the task force, including the February 1, 2020 deadline for a finalized report. Mr. Drozda has put forth items for discussion during the October meeting. Chair Block encouraged other members to let the committee know if they have any other items for discussion or presentations they would like the committee to see.

UPDATE ON ACT 412

Chair Block called Frank Opelka, Deputy Commissioner of Health, Life, and Annuity for the Louisiana Department of Insurance to discuss updates on Act 412.

Mr. Opelka reminded the members of the email sent out with further updates. LDI sent out an RFI seeking feedback from stakeholders on LDI’s work in establishing programs to reduce the price of high cost plans in the individual market. It included five questions serving more as a guide. Asked for brief description of any program LDI might consider as it conducts its analysis under Act 412 and for details on where those programs have been tried and how things went. Asked for feedback on the Maine model, formalizing previous discussion. Asked what particular populations or costs LDI should consider during the analysis. Asked if stakeholders had small initiatives they would like LDI to consider, short of a full program.

Chair Block asked who LDI anticipates responding and what kind of proposals or initiatives they anticipate seeing.

Mr. Opelka explained that due to the short timeline they have for the analysis, LDI does not expect to see responses including items not already discussed. If anybody has ready to go programs, LDI will welcome the input.

Chair Block asked Mr. Opelka to go through the timeline of incorporating the responses into LDI’s analysis.

Mr. Opelka explained that LDI already began their research for what they believe should go into the analysis and are hoping to get responses by the end of October, which will be around the time LDI finishes developing the analysis to be completed. At that point, LDI will try to incorporate everything they received into a final request of the actuary. Expected to be sometime around the end of the year, partly because the ruling of the Texas v. US lawsuit will likely require further time to adjust the analysis. LDI then hopes to give the actuary three months to conduct their analysis and have it completed by March 1, 2020 and have a report ready.

Chair Block asked if there has been any outreach by the department to other states such as Maine, as many of the insurers in Louisiana have presence in other states and there could be some advice given or lessons learned given by other states’ departments.

Mr. Opelka explained that LDI has a weekly call with the National Association of Insurance Commissioners (NAIC) members, specific to health regulators, and the plan is to pose to them a set of similar questions as those within the next two weeks. There have been a few calls to other states, but LDI has not received much response, potentially due to timing issues.

Chair Block asked for clarification that all communication with other states has been through NAIC. Mr. Opelka confirmed.

PRESENTATION OF BLUE CROSS BLUE SHIELD OF LOUISIANA INDIVIDUAL MARKET WHITE PAPER

Chair Block called Korey Harvey, Vice President and Deputy General Counsel at Blue Cross and Blue Shield of Louisiana, to give a presentation on individual market data.

Mr. Harvey explained he was asked to give an overview of how the finances in individual markets work. The Affordable Care Act (ACA) has a number of larger reforms such as guaranteed issue, ban on pre-existing conditions exclusions, dependent coverage to age 26, and a host of others. In terms of actuarial estimates, some of them are not expensive. For example, keeping dependents on a policy until age 26 is not an expensive reform. Some of them we have had in state law for a while. However, the really expensive reforms include the guaranteed issue, limits on how insurers can craft rates or premiums. Before ACA, those restrictions did not exist. For example, the extent to which one had guaranteed issue was limited, there were a host of things you had to do before able to purchase a policy. The idea that you could walk in from the street without being insured and buy a policy was new with ACA in that insurers do not ask questions about health or make you pay more if you are sick and less if you are healthy. What happens is, all of those people are put into one risk pool and it averages out. Meaning the only way your premium would stray from the average is based on your age, a set amount each year from age 21 to 64, your geographic area, tobacco use, and family size. Before that, insurers could charge more if you were unhealthy, rating based on gender, etc. With ACA, a lot more coverages and services had to be included in plans. Since everyone was averaged out with costs, theoretically some costs would go up and some would go down.

The framers of ACA came up with two primary ways to subsidize the cost of insurance. One is premium tax credit based on income, up to 400% of federal poverty level with a sliding scale from there. Basically, the more you make, the less of a credit you receive. Tax credit paid to insurance companies to reduce the cost of your premium. Second finance mechanism, cost sharing reductions (CSRs), reduces your out of pocket costs. Whether you qualify is different than the tax credit, because it is less generous in terms of income. Today in Louisiana about 91% of enrollees in individual market get some form of subsidy, average level of subsidy is 80% of premium. The problem is this system frequently leaves those 9-10% of people who make too much money to qualify for the subsidies without help. For example, those people will feel every penny of the 15% rate increase next year. The problem seen within individual markets is that those unsubsidized people tend to leave the market when premiums go up. Late last year actuaries looked at what it would cost to maintain the reforms, if ACA were overturned and tax credits and subsidies were discontinued. Without subsidies, what kind of premiums would people be looking at. Estimated for a middle of the road policy, it would be $25,000 a year per person. If you want to maintain those reforms, need some mechanism that helps break down the cost of the individual market.

Chair Block asked how subsidies are calculated, whether they are capped, the formula or how the process of obtaining a subsidy works.

Mr. Harvey explained that the subsidies are not capped, they are based on the premium costs and the plan that is chosen. In order to get them, you must choose a certain kind of middle plan which covers 70% actuarial value of your costs. Subsidies are linked to the cost of the plan and how much you get depends on where you fall on the federal poverty level scale.

Chair Block asked if subsidies are netted out against the tax credit.

Mr. Harvey explained that they are separate in that the tax credit brings down your monthly premium while subsidies break down your out of pocket costs.

Mr. Opelka clarified that the subsidy works by taking your actuarial value that you purchase and brings that value up based on your income level.

Ms. Haydel asked for clarification on the level the subsidies go to.

Mr. Harvey clarified that the tax credits go up to 400% the federal poverty level and the subsidies go up much less.

Ms. Haydel asked if there is any subset of the population that does not quite qualify for Medicaid expansion that is also ineligible for a tax credit or subsidy and what happens to the people that fall into that middle category.

Mr. Harvey explained that if you fall below 138%, you are not eligible for the tax credits. Medicaid was a choice for individual states and Congress could not force individual states to expand Medicaid. The law originally assumed Medicaid expansion. So when Congress expanded Medicaid to 138%, thinking it would happen in every state, they saw no reason to have tax credits available to those eligible for Medicaid. Some of the problems seen in markets in states where Medicaid was not expanded, was that those people below 138% could not afford to buy insurance. Meaning those states either needed to expand Medicaid or make tax credits available to them so they could afford it. It created a hole where some of the poorest people in the state were left without coverage. between Medicaid expansion and the ACA subsidies. Is there not a middle class group that the individual market is not able to provide relief for. Mr. Landry asked Mr. Harvey to answer whether there is or is not a population of people trapped

In response to a question from Attorney General Landry, Mr. Harvey explained that there are some people in the individual market who don’t receive tax credits or subsidies and pay relatively high premiums. Right now, with Medicaid expansion in Louisiana, that trap we originally had is no longer there.

Mr. Landry wanted to clarify that the discussion was about people in individual market and asked what is that percentage of people.

Mr. Harvey replied that, as of last month, that was just under 100,000 people in Louisiana are in the individual market.

Mr. Landry replied that he believes it is around 90,000 people. He asked whether the ACA falling in Louisiana affects primarily 90,000 people.

Mr. Harvey clarified that was true if they were only talking about tax credits.

Mr. Landry asked how much competition exists in Louisiana in the health insurance market.

Mr. Harvey replied that right now there are only two companies with common ownership. Next year a third company will enter the market in three geographic areas.

Mr. Landry asked what positions he takes as far as tearing down barriers of creating policies across state lines. Would that not help increase competition and bring prices down.

Mr. Harvey explained that the problem with policies across state lines is that a lot of health care is driven by local costs. Even if Blue Cross Blue Shield in Illinois sold policies in Louisiana, most of the costs of an insurance policy is the goods and services it covers. The costs in Louisiana will not change if another insurer comes in.

In response to a question from Mr. Landry, Mr. Harvey agreed in general that deregulation would be a good thing for the market.

Chair Block commented that a few clarifying points were necessary before moving forward. Medicaid expansion is tethered to the Affordable Care Act. ACA is what authorized Medicaid expansion; if it goes away, so does Medicaid expansion. At the previous task force meeting, there was discussion about the cost, divided into two elements. To replace the protections afforded within individual markets is what Mr. Harvey is discussing here. There is a separate analysis to find the cost of replacing Medicaid expansion, estimated around $3 billion, which the state currently does not have. Meaning the state cannot afford coverage for the 450,000 individuals currently on Medicaid expansion. Anyone who knows how Congress plans to replace Medicaid expansion and replace the $3 billion that the state needs to cover the cost of providing the same coverage it does today, the task force should hear it because that is the exact purpose of the task force. All of this was discussed in the August meeting of the task force. Act 412 is limited to a study of just the individual market, which Mr. Opelka confirmed at the August meeting and could do so, again, today. Act 412 looks at how we effect a replacement model for those 90,000-100,000 people.

In response to a question from the Chair, Mr. Harvey replied legislation was attempted similar to the Maine model that the DOI looked at and part of the argument is that one reason you do want to maintain a viable individual market is that you never know when you are going to need it. People go in and out of it, you might be unemployed for a number of reasons for 6-9 months and COBRA continuation can be expensive. One reason being that group policies are so generous that you try to pay more yourself with an upcharge for admin costs that can get expensive. We hate to view the individual market as residual, in that you go when you have no other option, but it kind of is. We used to have the high risk pool for the really unhealthy, they were not in the individual market so the individual market used to be easier to afford. You never know when you will need it, which is why Blue Cross Blue Shield argues to try to get the costs down.

Chair Block asked for confirmation that the individual market is not a fixed population of 100,000 people that is unchanged. Rather, it is people going in and out of employment where they may have group coverage just as people who are in and out of Medicaid coverage.

Mr. Harvey confirmed. It depends on eligibility.

Chair Block referenced the Kaiser Family Foundation study where they estimated the number of non-elderly adults in Louisiana that would have a declinable pre-existing condition that is now protected by ACA is about 849,000 Louisianans, 30 percent. Asked if Mr. Harvey had any reason to dispute that number.

Mr. Harvey did not dispute, agreeing it sounded correct when considering hypertension and conditions such as that.

Mr. Landry stated that the more we build the middle class, the more people get to make, the more businesses come in, the more they can afford to have group policies, the individual market shrinks. He asked Mr. Opelka what the average has been over the past 3 years.

Mr. Opelka replied that it has fallen significantly in the last few years partially as a result of expansion. Every state that has done expansion has seen a siphoning of their populations from individual markets to expansion population. Partially because of rate increases. As Mr. Harvey was noting, if you do not have a subsidy, you are fully at risk of increases and it is a very expensive product. One thing you see in their numbers is that the $25,000 estimate as the cost in the absence of a subsidy, is not just the cost of covering someone unsubsidized, but further adverse selection in that market. They are modeling that you probably will not have 90,000 people in that market, you would probably have half of that or some lesser number.

Chair Block and Mr. Landry discussed the cost of Medicaid expansion and Chair Block reiterated that there is no state general fund money that goes toward expansion.

Chair Block recognized Dr. Barnes. Dr. Barnes recognized that a lot of important issues were touched on today and he has a question about some of the numbers Mr. Harvey shared. Thinking about 437 million dollars in premium tax credits in 2018. In 2018, roughly100,000 people would have been in that market, not necessarily every one of them getting the tax credit. But if you have around 100,000 people, that would suggest that the average premium tax credit was about $4,370 dollars or less than $5,000 dollars. Is that correct?

Mr. Harvey replied that estimate is complicated by the number of people that come in and out of the individual market during a year. Meaning someone might be covered for five months, someone eleven months, so yes, as on average that would be correct. Mr. Harvey commented that he could find something more specific and get it to the task force.

Dr. Barnes replied that he wants to ensure the task force has a good general understanding of costs.

Mr. Harvey commented that by month, in 2018, when they averaged the premiums in the individual market, the average monthly premium was $648. The average premium after the tax credit was $201. Basically the average premium cost per year per person of $7,776 was reduced to an average of $1,620.

Dr. Barnes asked for clarity on how BCBSLA arrived at the $25,000 per year average premium in its white paper.

Mr. Harvey explained that is an actuarial estimate of what happens if the only people who still buy are people who absolutely need the coverage because they know because of any number of conditions who can afford the coverage because the only option besides that is bankruptcy and that is what the numbers look like for them because people who are really healthy have left the market. So you have a death spiral where only the sick remain, so the average gets worse because it is only an average of people with high claims costs.

Dr. Barnes asked in thinking about a future world, without ACA and premium subsidies, would those kinds of premiums apply to a much smaller group of people.

Mr. Harvey confirmed that it would be a much smaller group.

Dr. Barnes asked, in thinking about the premium tax credits, if there was anything in the analysis in terms of people’s choices to participate or not purchase a policy, anything that would inform the task force about the potential costs that is different from recent premium subsidies as a cost to maintain the kind of activity we have seen.

Mr. Harvey replied not really. There are different ways to try and lower costs and the tough part is how to finance it. He would always argue the broader your base, the better. The federal government had three programs from 2014-2016 to help keep the costs from getting worse. One of them was a reinsurance program where every single person in the market paid a tax, it did not matter if you were on a private plan, Medicare, Medicaid, a fee was paid. It went into a pool to help reduce costs of the individual market. Another complicated program was risk adjustment, where sometimes some insurers were good at avoiding bad risks and the ACA does not want to reward that, so there were complicated ways to determine what your risk profile is and what insurers should have looked like. If they did better than they should have, they would pay money to their competitors. Risk corridor was the last program, operating like Medicare where if insurers made too much profit, something around more than 3.5 percent, and that half of that money had to go back to the government. BCBS has lost huge sums of money in the individual market which is why, the General was asking about competition, in 2013 there were 15 companies and now we have two, possibly about to have three. The number of companies competing for business has declined so that does not help.

Chair Block recognized Ms. Netters. Ms. Netters introduced herself as a representative of the community, the Executive Director of 504 Healthnet, a community-based nonprofit in New Orleans. Stated there is a big industry not being talked about, workers that are being left behind, which is the tourism and hospitality industry. Within the New Orleans area, they are currently organizing, there is a cry for help where they are not as health literate, they do not know about Medicaid and expansion. That is one of 504 Healthnet’s roles, to get the information out there. Wanted to raise attention that there are hospitality workers who work multiple jobs that may not qualify for approved benefits through their company because it might be a small business or they work less than 30 hours.

Mr. Landry directed a question to Mr. Harvey, mentioned how competition in the market place has decreased, so is it fair to say that ACA has done more to damage competition in the healthcare and insurance market than to increase competition in the healthcare market.

Mr. Harvey replied that it certainly has not helped the individual market. The twelve companies no longer in the market, early on quite a few of them realized it might be really hard to make money. Part of it is that it is incredibly hard to predict what a market is going to look like. Insurers have been around for centuries and what they try to specialize in is avoiding risk. Starting in 2012/2014, what Congress told insurers was that they cannot do that anymore. So the entire proposition of insurance, at least in the health arena, was turned upside down. Obviously, a lot of insurers exited. Would those companies probably still be in the market if the law had passed in March of 2010, the answer is probably yes. Then, there is trade off to that. That is what this comes down to, balancing the interests and realizing that there are consequences to some of the market reforms that we want.

Chair Block recognized Mr. Opelka. Mr. Opelka asked to return to the risk adjustment and reinsurance conversation. When talking about reducing prices, we are not talking about reducing the all-in price, we are talking about reducing the felt price from the perspective of insurer to insurer. It really just reduces that price by spreading those costs to a broader base. If you want to talk about reducing the all-in price, you really need to talk about reducing the price of care. In that arena, it has not come down to how much competition there is in the insurer market, it comes down to how much competition there is in the provider market. What has really changed in the last decade or so is that we have gotten very consolidated in the provider market to the point where we can now walk from New York City to LA, without trying very hard, and not walk through a market that is not consolidated. When you are in that situation, it is impossible for an insurer to drive down prices by itself, especially when it is selling a product to an insurer who is saying, “Don’t you dare restrict me from going see the one doctor I’ve got left.”

Mr. Harvey commented that this week, Rice released a study that showed, for the same services, the cost increase year over year was 6 percent by a physician group doing those services with a physician group purchased by a hospital. Mr. Opelka is right in that consolidation in that market does lead to higher costs. In cities where there is a big hospital system that just holds out for higher rates, insurers can say “Well you’re not interested in buying my product, I can go somewhere else.” Whereas in smaller cities, you might only have one option because of consolidation, making it difficult to negotiate. The more the consolidation of healthcare providers, the more it becomes harder for costs to go down or even be constrained.

Mr. Opelka commented, the other point brought up about shrinking the individual market in the absence of ACA, if it went away. Important to note is how that presumes that the subsidy goes away but the restrictions on requirements do not. If those requirements go away, it becomes more an open question of whether that market actually shrinks or even becomes more expensive, it is just that coverage becomes skimpier. Some people that may want or need that coverage or the access to care the coverage provides, may not have it.

Mr. Harvey replied that it would definitely be a race to the insurance department to get products filed as quickly as possible that covers a lot less stuff. Theoretically, a consumer could buy a really rich product or one that is not. Right now, that is not really an option.

Chair Block recognized Representative Stagni. Rep. Stagni commented that along the lines of consolidation among providers probably increases costs. If the ACA is overturned, the largest provider of salaries in the state is the health care industry.

Mr. Harvey replied he does not know, but believes it is something around 17 percent of the nation’s GDP.

Rep. Stagni commented his fear in terms of the ACA being overturned, is not only because it would have a domino effect into our economy, but it would open the door again to discriminatory policies.

Mr. Harvey commented that there are so many facets of that issue. We have a shortage of providers and a shortage of a particular type of provider. There are artificial limits on how many of them there can be, so to an extent the profession needs to control how many anesthesiologists or radiologists there are going to be and there is clear incentive to do that. A lot of different things play into that. If we had more providers that were not co-owned and controlled, then there would be some constraint on the increase. Then there are things like prescription drugs and costs. Just this month there was one person BCBS covers who has a generational disease that is a total atrophy of muscles. A brand new gene therapy can be given to the child that stops the disease in its tracks and it never develops, but the treatment is $1.7 million. On top of that, it is $750,000 a year in maintenance. Until we figure out a way to control the costs, or lower the costs of drugs, that is also a problem. The task force mentioned talking about that in the future, it used to be, around 10 years ago, around 12 percent of the cost of your insurances is for prescription drugs.

Chair Block asked Mr. Harvey that underlying his previous comment of more insurers participating in the individual market pre-ACA is the fact that these plans did not protect people with preexisting conditions.

Mr. Harvey confirmed.

Chair Block also asked about the implications for the individual market if the preexisting condition protections were in place without the federal subsidies.

Mr. Harvey referred back to the study that pegged the average annual premium cost at $25,000.

Chair Block reiterated that this would lead to a death spiral. Chair Block then discussed with Mr. Harvey the mechanics and real world implications of the preexisting condition protections, including community rating.

Chair Block then asked Mr. Harvey to describe the insurance landscape without the ACA protections in place.

Mr. Harvey responded that pre-ACA Blue Cross had stopped preexisting condition exclusions but would charge more due to preexisting conditions. Mr. Harvey confirmed that the costs for someone with a preexisting condition like cystic fibrosis would be astronomical compared to what a person is paying now under the ACA.

Mr. Landry asked Mr. Harvey what would happen if Congress repealed the HMO tax or other revenue generators for the ACA. Mr. Landry then asked whether Congress could repeal the federal subsidies.

Mr. Harvey confirmed they could and Chair Block reminded the task force that Congress has chosen not to do so.

Dr. Barnes asked Mr. Harvey to comment on health care utilization.

Mr. Harvey noted that utilization has increased significantly since the enactment of the ACA.

Dr. Barnes asked whether the experience of those with grandfathered plans is significantly different than those with ACA compliant plans.

Mr. Harvey noted that Blue Cross Blue Shield’s pre-ACA policies were relatively generous, but Mr. Harvey would follow-up to see what the difference in coverage and premium look like today.

UPDATE ON TEXAS V. US LAWSUIT

Attorney General Landry outlined the plaintiff states’ arguments for invalidating the ACA. He anticipated a ruling from the 5th Circuit Court of Appeals within sixty days.

Chair Block asked what currently about the ACA the Attorney General objects to within the ACA.

Mr. Landry responded that Congress is usurping the policing power of the states.

Chair Block asked what specific power of the states is being infringed upon.

Mr. Landry urged Chair Block to read the plaintiff states’ briefs.

Chair Block again asked what the ACA is preventing the states from doing. This is an important consideration as we consider how states should respond to the ACA being invalidated.

Mr. Landry responded that the ACA is a one size fits all plan that is a path to socialized medicine.

Chair Block asked Mr. Landry what funding mechanism would be utilized to replace the lost federal subsidies. He also asked Mr. Landry about progress with discussions with Rep. Scalise about funding and also about funding for Medicaid expansion.

Mr. Landry claimed that what is owed by Louisiana for Medicaid expansion is unattainable. Mr. Landry touted the potential impact of a Guaranteed Benefits Pool for protecting people with preexisting conditions.

Mr. Landry claimed that Medicaid expansion would cost the state $6 billion at some point in the future.

Chair Block invited the Attorney General to a future Appropriations Committee meeting to learn how financing for Medicaid expansion works and how it has saved state general fund dollars for purposes such as vehicles in the Attorney General’s Office.

Chair Block explained how an uninsured individual costs the state more money via uncompensated care out of the state general fund with a lower state match rate.

PUBLIC COMMENTS

An employee from Louisiana Health Care Connections commented that maintaining patient engagement is one way of controlling health costs in Louisiana. The employee was worried that LHCC’s business is at risk and encouraged the task force to maintain patient engagement.

OTHER BUSINESS

Mr. Drozda brought up his desire to discuss access to health care and health coverage, specifically the issues of high costs of prescription drugs and surprise billing.

ADJOURNMENT

Motion to adjourn by Mr. Opelka

Second by Mr. Drozda.

Without objection the meeting adjourned.