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ANNUAL MEETING AND PUBLIC POLICY FORUM

NOVEMBER 5-6 2020

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Regulating the Health Insurance Markets: What's New for 2021

Moderator: Barbara Klever, Chair, Academy Individual and Small Group Markets Committee

Panelists:

- **Christina Whitefield**, CCIIO
- **Lina Rashid**, CCIIO
- **Michelle Koltov**, CCIIO
- **Brent Plemons**, CCIIO
- **Jeff Wu**, CCIIO
- **Allison Yadsko,** CCIIO
- **Allison Orris**, Manatt Health, Manatt, Phelps & Phillips, LLP

CCIIO Presentation

Allison Orris Presentation

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Regulating the Health Insurance Markets: What's New for 2021

Allison Orris

American Academy of Actuaries
November 6, 2020

Support for some of the slides in this presentation was provided by the Robert Wood Johnson Foundation's State Health and Values Strategies (SHVS) program.

Agenda

- **Medicaid & COVID-19**
  - Medicaid Enrollment & State Budget Challenges
  - Key COVID-19 Legislation
  - Other Options to Support Medicaid Providers During the COVID-19 Crisis
- **Medicare & COVID-19**
- **Q&A**

Medicaid & COVID-19

Medicaid & COVID-19: Key Considerations as the Pandemic Continues

- Medicaid is a countercyclical program—demand for the program goes up during periods of economic downturn.
- Increased demand will strain state budgets, forcing states to make hard decisions about how to sustain access to care for Medicaid beneficiaries, and how to support the providers who serve them.
- We are just seeing the tip of the iceberg; policymakers are continuing to make decisions with imperfect information about what lies ahead.

Medicaid & COVID-19

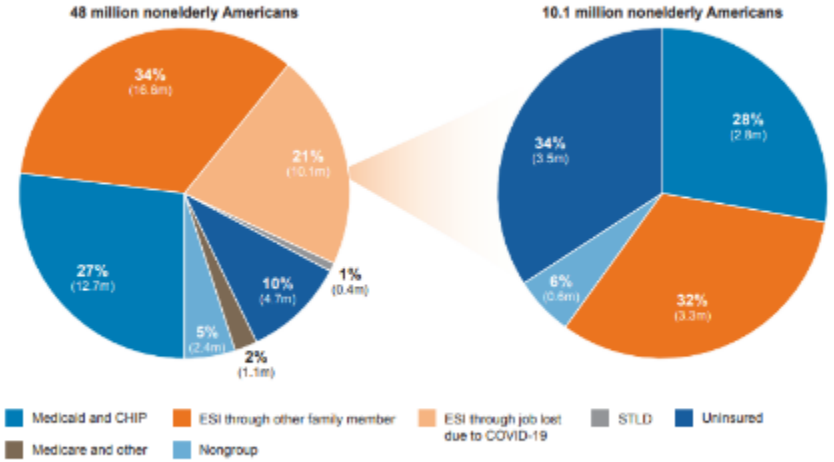
Medicaid Enrollment & State Budget Challenges

Expected Shifts in Coverage

The loss of employer-sponsored coverage will cause more individuals and families to shift to Medicaid and Marketplace coverage, or to become uninsured.

Figure 1. Health Insurance Coverage Prior to Pandemic Among Those with Subsequent Job Loss in Family, 2020

Figure 2. Post Job Loss Coverage Among Workers and Family Members Losing ESI Due to COVID-19 Recession, 2020



Due to COVID-19-related job loss, approximately:

- **7.3 million** fewer individuals will have employer-sponsored health insurance coverage.
- **4.3 million** more people will enroll in Medicaid or the Children's Health Insurance Program (CHIP).
- **2.9 million** individuals will become uninsured.

Coverage trends will vary by state, with non-expansion states more likely to see a rise in the uninsured.

Notes: Estimates can be interpreted as applying to the average month in the last three quarters of 2020. ESI is employer-sponsored insurance. STLD is short-term limited duration plans, CHIP is Children's Health Insurance Program.
Source: Urban Institute's Health Insurance Policy Simulation Model, Changes in Health Insurance Coverage Due to the COVID-19 Recession: Preliminary Estimates using Microsimulation, July 2020.

The Pandemic Is Altering the Medicaid Landscape

Medicaid enrollment is rising, and state spending is increasing, as a result of COVID-19.

- According to a KFF survey of Medicaid directors, states expect Medicaid enrollment and spending to increase by over 8% each in FY 2021.
  - KFF also reports that states are taking policy actions to respond to the pandemic but that most cite budget concerns as the biggest challenge looking ahead.
- Manatt Health's analysis shows that from February through August 2020, the median state among the 24 states with available data for that period saw total enrollment growth of 8.3%, with the average state seeing monthly growth well above previous levels.
  - Enrollment growth has been fastest among non-elderly, non-disabled adults in most states.
  - Enrollment growth has been substantially slower, though it is still rising, among child and aged, blind, and disabled eligibility categories.

Sources: Medicaid Enrollment & Spending Growth: FY 2020 & 2021, Kaiser Family Foundation, available here; Tracking Medicaid Enrollment Growth During COVID-19 Databook Overview, Manatt Health, available here.

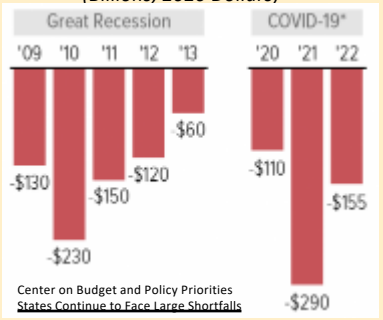
COVID-19 & State Budgets

The growth in Medicaid expenditures comes at the same time that states are experiencing simultaneous and severe drops in revenue alongside growing social services needs.

- Projections forecast state revenue declines exceeding 20% for 2021, compared to a 11.6% drop during the Great Recession (2008–2009).
- The federal Medicaid matching rate increase in the Families First Coronavirus Relief Act (FFCRA) is helpful, but states will still face pressure to reduce Medicaid spending while enrollment rates are rising.
- Rising unemployment rates are putting new demands on state spending.
- Many states have convened special legislative sessions to both address falling revenue and appropriate additional funding for health care programs.
- There will be pressure to cut vital programs to meet constitutional and statutory obligations and balanced budget requirements.

COVID-19 State Budget Shortfalls

(Billions, 2020 Dollars)



One study projects a total state budget shortfall of $555 billion from SFY 2020 to state fiscal year (SFY) 2022. Since states are required to balance their budgets, they will likely make cuts to critical program areas (e.g., education, health care).

Most states expect revenue reductions of 5%-15% in SFY 2020 and reductions of 10%-25% in SFY 2021.

Sources: State Health & Value Strategies, Understanding the Fiscal Impact of COVID-19, June 2020; Center on Budget and Policy Priorities, States Grappling With Hit to Tax Collections, June 2020.

The Current & Future Medicaid Landscape

The economic fallout from COVID-19 will alter the trajectory of Medicaid policy.

- **Medicaid accounts for a significant portion of state budgets,** and the program is vulnerable to cuts as budgets constrict—this could mean cuts to eligibility, benefits, or provider payments.*
- Prior to the COVID-19 pandemic, states showed interest in **value-based payment approaches**; the pandemic will likely impact how quality payments are distributed and designed going forward.
- Oklahoma and Missouri voters affirmed **Medicaid expansion** ballot initiatives during the pandemic. Will other states follow?
- **Work and community engagement requirements** are on hold in many states due to ongoing litigation and COVID-19-related restrictions;* the future of these requirements is unclear, but CMS just approved a partial Medicaid expansion with work requirements in Georgia and an enhanced benefit package tied to work requirements in Nebraska.
- **Congressional activity on state fiscal relief will influence state policy.**

*Under the Families First Coronavirus Response Act, states are prevented from making changes to eligibility and covered services while receiving the enhanced COVID-19 Federal Medical Assistance Percentages (FMAP).

Medicaid Providers Have Been Impacted by COVID-19

COVID-19 is straining Medicaid providers, potentially threatening access for Medicaid beneficiaries now and in the future.

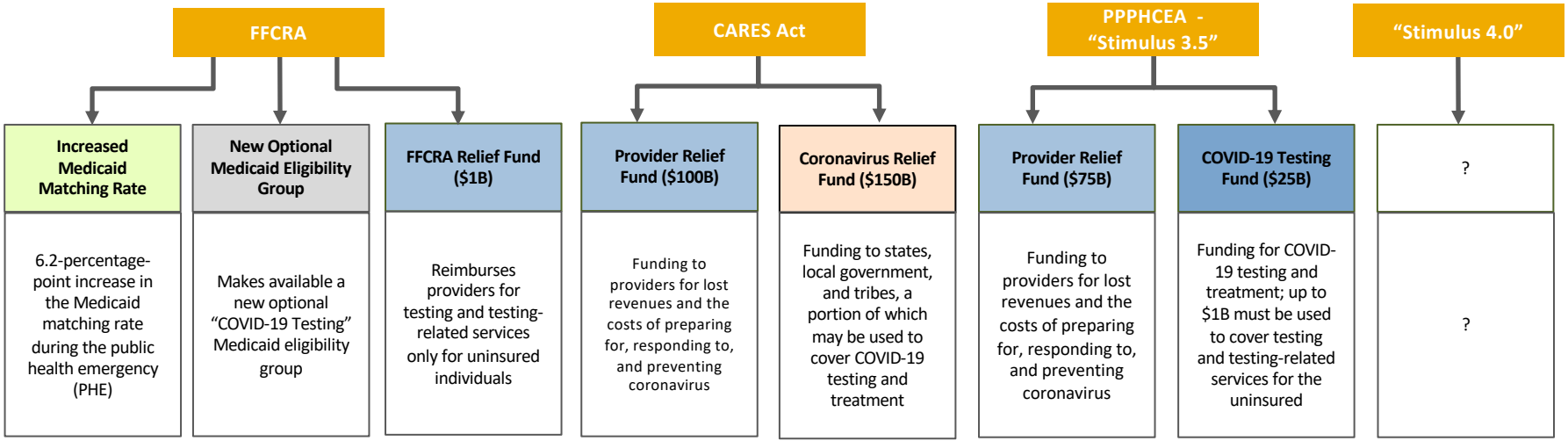
- Medicaid providers typically operate at lower margins than other providers.
  - Some small, community-based Medicaid providers have only weeks of cash reserves on hand.
- Decreased utilization and higher costs related to COVID-19 can threaten the financial stability of some providers, jeopardizing access for Medicaid beneficiaries now and into the future.
  - Even after accounting for federal support, hospital margins are estimated to be -7% in the second half of 2020, compared to 3.5% in 2019, according to one analysis.
  - Outpatient visits fell by 60% in mid-April and are still 10% lower compared to a pre-COVID-19 baseline, even after accounting for increased telemedicine visits.
- Congress and HHS have taken steps to direct payments to providers during the pandemic.
- Many states also have supported Medicaid providers by increasing payment rates, providing retainer payments, or adopting other payment strategies.

Sources: American Hospital Association, New Analysis Shows Dramatic Impact of COVID-19 on Hospital & Health System Financial Health, July 2020, available here; The Commonwealth Fund, The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots, August 2020, available here.

Key COVID-19 Legislation

Summary of Key Legislation & Funding Streams

Legislation in March and April 2020 authorized increased Medicaid matching funds, a new Medicaid eligibility group, and new funding streams for providers.



Families First Coronavirus Response Act (FFCRA): Key Medicaid Provisions

- **Optional COVID-19 Testing Medicaid Group**
  - Coverage is for *testing and testing-related services only*, not for treatment or vaccines.
  - Medical assistance and administrative costs are matched at 100% FMAP.
  - No income limit; regular Medicaid residency and immigration rules apply. Ends when the public health emergency (PHE) declared by the Secretary is over.
  - Eighteen states have adopted this optional group.
- **State Fiscal Relief**
  - Temporary 6.2-percentage-point increase in the Medicaid matching rate for states and territories.
  - Increased FMAP is available from January 1, 2020, through the last day of the calendar quarter in which the PHE ends (i.e., December 31, unless the PHE is extended again).
  - Applies to the regular Medicaid match rate so long as states meet conditions.

FMAP Conditions

To qualify for the 6.2-percentage-point increase, states must:

- Maintain program-wide Medicaid eligibility standards, methodologies, or procedures that are no more restrictive than what the states had in place as of January 1, 2020.
- Not charge premiums for any Medicaid beneficiaries that exceed those that were in place as of January 1, 2020.

The "continuous coverage requirement" means that beneficiaries cannot lose coverage until the end of the month in which the PHE ends.

- Not terminate any individuals from Medicaid if they were enrolled in the program as of March 18, 2020, or if they are enrolled during the PHE, unless the individual voluntarily terminates eligibility or is no longer a resident of the state.
- Cover—without any cost-sharing—testing, services, and treatments related to COVID-19, including vaccines, specialized equipment, and therapies.
- Assure that non-federal share contributions by localities decline in recognition of the increased federal contribution.

Key Provisions in FFCRA

	Effective Date	Expiration Timeline	Current End Date	Citations
Enhanced FMAP	January 1, 2020	End of the quarter in which the PHE ends	March 31, 2021	FFCRA § 6008(a)
• **Maintenance of Effort (MOE) Requirement**	January 1, 2020	End of the quarter in which the PHE ends	March 31, 2021	FFCRA § 6008(b)(1) & (2)
• **Continuous Coverage Requirement**	March 18, 2020	End of the month in which the PHE ends	January 31, 2020	FFCRA § 6008(b)(3)
• **Required Coverage (With No Cost-Sharing) of COVID-19 Tests, Treatments, and Vaccines**	January 1, 2020	End of the quarter in which the PHE ends	March 31, 2021	FFCRA § 6008(b)(4)
Coverage for the Optional COVID-19 Testing Eligibility Group	March 18, 2020 (or a later date chosen by the state)	End of the PHE	January 20, 2021	SSA §§1902(a)(10)(A)(ii)(XXIII) & (ss) [42 USC §§ 1396a(a)(10) & (ss)], as added/amended by FFCRA § 6004(a)(3) and CARES § 3716

Key CARES Act & PPPHCEA Provisions

- **Coronavirus Relief Fund—$150B fund** to states, tribal governments, and local governments with populations of 500,000 or more.
  Key features include:
  - Funding is distributed by the Treasury in proportion to state population, with a floor of $1.25B per state; local governments may receive up to 45% of state allocation.
  - Few restrictions on use of funds, but statute directs funds may only be used for necessary expenditures: incurred due to COVID-19, not accounted for in state budget, and incurred between March through December 2020.
- **Provider Relief Fund (PRF)—$175B** fund to reimburse eligible healthcare providers for expenses or lost revenues attributable to COVID-19 and not reimbursable by other sources.
  - Potential Recipients: Medicare- or Medicaid-enrolled suppliers and providers, and for-profit and not-for-profit entities within the United States, that provide diagnosis, treatment, and care for possible or expected cases of COVID-19.
  - Potential Uses: Building or construction of temporary structures, leasing of properties, medical supplies and equipment, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.
  - Prohibition on Balance Billing
  - Auditing/Reporting Requirements

Provider Relief Fund

GENERAL DISTRIBUTION Providers receive a minimum 2% of patient revenue.	**$50B**	**Phase I: Medicare providers** *(providers that bill FFS Medicare)*
	$18B	**Phase II: Medicaid, CHIP, dental, and other providers that did not receive *any* Phase I payment *plus* providers that did not receive their full 2% of patient revenue payment in Phase I**
	$20B	**Phase III: Previously eligible Phase I and Phase II providers *plus* newly eligible providers including certain behavioral health providers (e.g., addiction counseling centers) and providers that began practicing between January 1 and March 31, 2020**
TARGETED DISTRIBUTIONS These are additive to General Distribution payments.	**$22B**	**High-Impact Distribution** *(hospitals in "hot spots," determined based on number of COVID-19 inpatient admissions in January-June)*
	$14.7B	**Safety Net Hospitals Distribution** *(hospitals that meet certain patient percentage, uncompensated care, and profitability measures; acute care facilities; and freestanding children's hospitals)*
	$11.3B	**Rural Distribution** *(hospitals in rural/small metropolitan areas or with rural Medicare designations, health centers located in rural areas)*
	~$9.9B	**Skilled Nursing and Long-Term Care Facilities Distributions** *(CMS-certified facilities with 6+ beds)*
	$0.5B	**Tribal Hospitals, Clinics, Urban Health Centers Distribution**
COVID-19 UNINSURED PROGRAM Only distribution that pays for services provided.	**TBD ($1B as of 10/22)**	**Claims for Treating and Administering Vaccines to Uninsured COVID-19 Patients** *(this HRSA program also covers testing, but those claims are not funded by the Provider Relief Fund)*

What Are the Challenges for Medicaid Community-Based Providers?

1. The **General Distribution methodology** (2% of net patient revenue) **disadvantages Medicaid providers**, which often have much lower revenues and thinner margins than other providers.

2. **Medicaid community-based providers are left out of Targeted Distributions** (except rural health centers).

3. The **PRF is administratively complex**, the rules are ever-evolving, and there is a lack of provider-level payment transparency.

These issues most significantly disadvantage small, community-based providers serving urban, low-income communities.

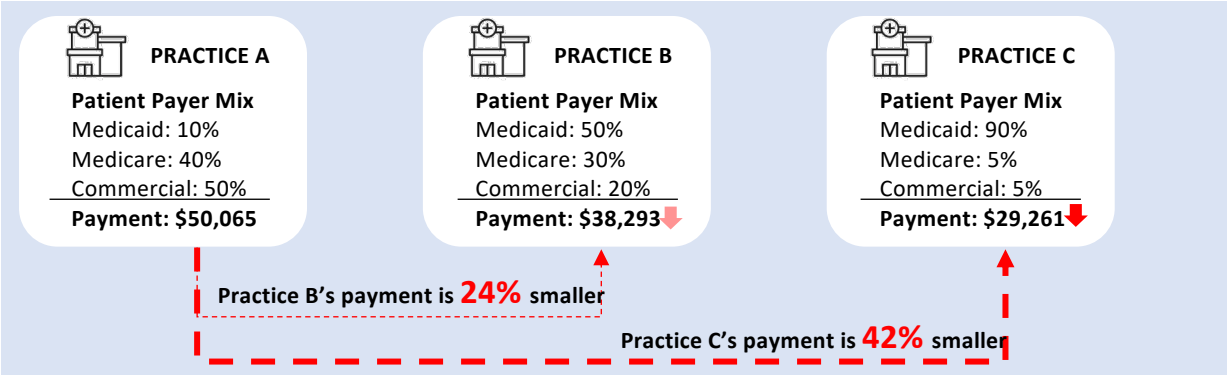
Source: COVID-19 Relief Needed to Keep Medicaid Community-Based Providers Afloat, The Commonwealth Fund, available here.

What Are the Challenges for Medicaid Community-Based Providers?

- Basing payments on a percentage of patient revenues gives the highest per-patient payments to high-commercial-volume providers and the lowest per-patient payments to high-Medicaid-volume providers.
- **This leaves the least well-resourced providers who operate on the thinnest margins with the least relief funding.**

"It's like hitting us [small Medicaid providers] twice … we're taking the first hit by getting paid so little, and now [HHS is] basing [our PRF payment] on something that's already too low."—OB provider in Indiana

Illustrative Example:
Practices A, B, and C each serve 2,500 patients—the only difference between them is their patients' source of coverage.



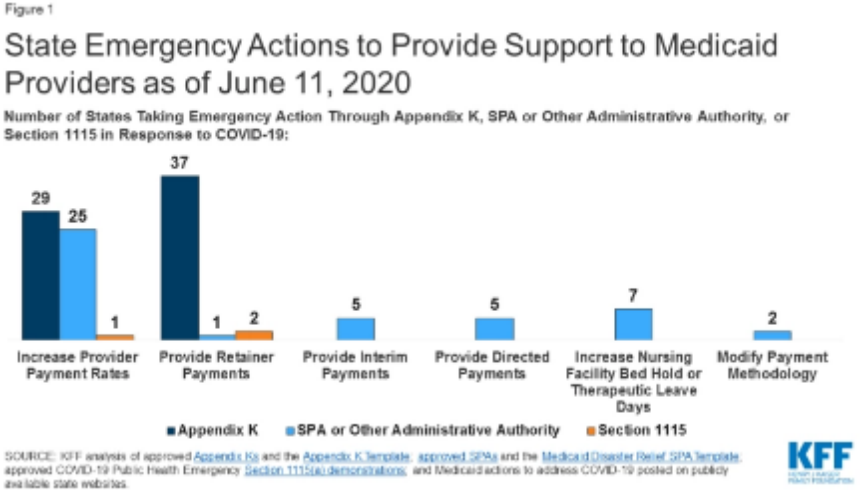
Manatt analysis based on the following assumptions: Medicare per-patient revenue is $850; Medicaid reimbursement is 63% of Medicare for the same services (based on Urban Institute's March 2017 analysis); commercial reimbursement is 143% of Medicare for the same services (based on Kaiser Family Foundation's April 2020 analysis). This analysis does not account for any variation in utilization between patient groups.

Medicaid & COVID-19

Other Options to Support Medicaid Providers During the COVID-19 Crisis

The Public Health Emergency Declaration Unlocked Various Flexibilities

- States implemented emergency federal authorities (e.g., Section 1135 waivers, 1915(c) Waiver Appendix K) and state-level regulatory flexibilities to respond to the pandemic.
- CMS has provided guidance and tools to help states adjust payment rates to providers in response to COVID-19.
  - Dozens of states have implemented Medicaid payment increases through disaster relief state plan amendments and managed care strategies.
- States have embraced telehealth and telemedicine.
- States will need to determine which flexibilities to scale back or sustain, taking into account fiscal implications.



Key Medicaid Payment Strategies

- **Modify existing payment methodologies.**
- **Increase state plan payment rates to providers with declining utilization.** For example, set fee-for-service rates at a level that allows providers to be paid equal to the prior year's Medicaid costs or Medicaid payments despite new, lower utilization levels.
- **Make advanced, interim payments to providers, with a reconciliation at a later date.** States may make interim payments based on a provider's historical claims volume before the COVID-19 pandemic. At a later date, the state would perform a reconciliation based on the provider's billable claims during the relevant period.
- **Make directed payments to providers.** Request authority to make directed payments through managed care plans to providers. Methodology could be based on prior year's costs or payments.
- **Permit increased number of nursing facility bed hold or therapeutic leave days.**
- **Request authority under Appendix K to modify provider payment rates/methodologies to respond to the emergency, including increased provider payment rates and retainer payments.**

CMS' May Guidance Provides New Managed Care Payment Flexibilities During the Public Health Emergency

Directed Payments

Guidance gives states new flexibility to implement managed care directed payments, including:

- **Higher limits on per-service payment levels**. CMS has previously used the average commercial rate (ACR) as a ceiling on directed payment arrangements. During the pandemic, CMS will evaluate directed payments to ensure providers will *not receive total payments that exceed what was assumed in capitation rates* absent the public health emergency. Capitation rates assumed normal utilization levels, so spreading the same dollars across sharply lower utilization may mean that, on a per-service basis, payments are considerably higher than the ACR.
- **Retroactive implementation of directed payments**. Directed payments must be tied to utilization, but CMS' guidance confirmed that directed payments can be made retroactively based on services delivered by a group of providers back to the beginning of the rate year. *As a result, states can implement directed payments mid-rate year as a tool to address provider shortfalls, depending on how COVID-19 continues to impact provider utilization and payment levels.*

States are required to establish a two-sided risk corridor on their Medicaid managed care rates as a condition for CMS approval of the directed payment, and must also submit a preprint and contract amendment. CMS will not require a rate amendment if payment amounts are de minimus (less than 1.5 % per rate cell).

Guidance also clarifies that states may direct MCOs to make "retainer payments" to providers for home and community-based services covered under the managed care contract.

For more information, please see "Revisiting Medicaid Provider Payment Strategies During the COVID-19 Crisis," Manatt Health Webinar, September 17, 2020, available at https://www.shvs.org/wp-content/uploads/2020/09/Revisiting-Medicaid-Provider-Payment-Strategies-During-COVID.pdf.

Medicare & COVID-19

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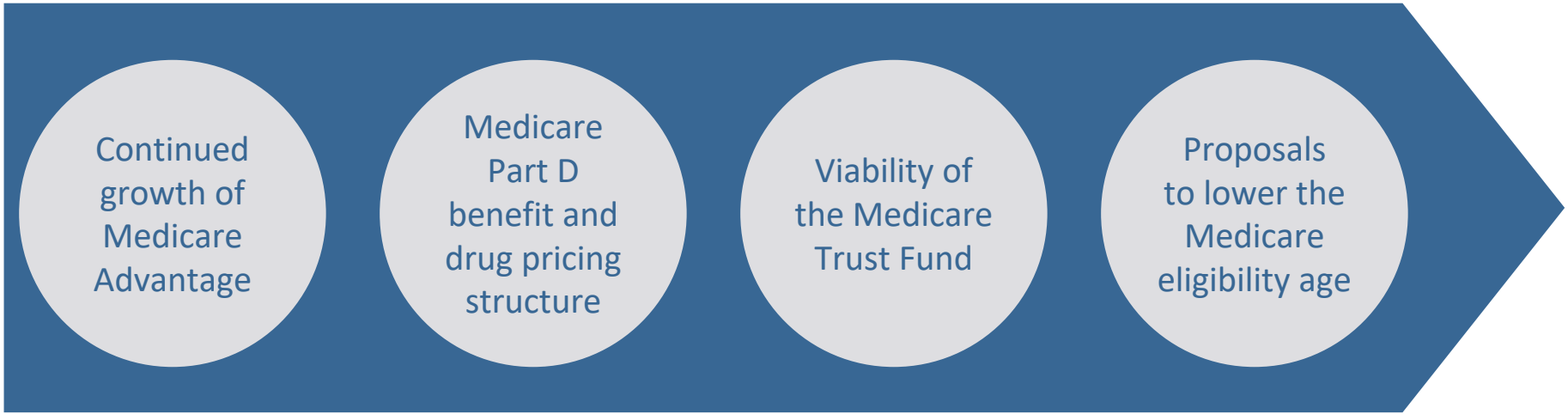
Medicare & COVID-19

Both Congress and HHS have taken steps to ensure access to care for Medicare beneficiaries, and support for Medicare providers.

- Provider Relief Fund
- Medicare Accelerated and Advance Payments
- Coverage guarantees for COVID-19 testing, treatment, and vaccines
- 20% payment bump to hospitals for inpatients with a COVID-19 diagnosis
- Section 1135 waivers and enforcement discretion (HIPAA/fraud and abuse, etc.)
- Rapid expansion of telehealth

Covered Services	Eligible Practitioners	Permissible Locations	Tech Platforms
• Practitioner services • ED visits, critical care • Hospital observation • Mental health counseling	Any practitioner eligible to bill Medicare for professional services *(now including OTs, PTs, and speech language pathologists)*	Both patient and practitioner may be anywhere *(including at home)* No restrictions on urban vs. rural	Common video technologies like FaceTime, Skype, or Zoom Audio-only for certain services, as listed in the Physician Fee Schedule

Medicare Trends as We Head into 2021



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Q&A

Questions?

Allison Orris

Counsel

aorris@manatt.com

202.585.6561

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Q&A