THE STATE OF WYOMING

Matthew H. Mead
Governor

**Insurance Department**

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Tom Glause
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January 12, 2017

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education, Labor, and Pensions (HELP)
Washington, D.C. 20515

Dear Chairman Alexander and Members of the HELP Committee:

Thank you for the opportunity to provide input and ideas for your consideration regarding the repeal, replacement, or modification of the Affordable Care Act. As insurance and health policymakers, we are keenly aware of the potential under the new administration to reform health insurance and health care delivery. The questions you posed as well as the questions posed by Majority Leader McCarthy prompted the Wyoming Department of Insurance and the Wyoming Department of Health to evaluate the past, present, and future of health care in Wyoming and how changes or repeal of the Affordable Care Act (ACA) might impact our state. This letter reflects conclusions from those discussions from the respective agency's perspective.

**Background: Wyoming health care costs**

Wyoming faces some of the highest private health care costs in the nation. While data on the self-insured and group markets is sparse, individual market premiums in the State are among the highest in the country.[1] The exact drivers behind these costs are not known, but two underlying factors are at least partially responsible:

- Geography. Wyoming's rural and frontier nature exacerbates the cost of health care. Wyoming is the least populated state in the nation with approximately 585,000[2] people in a land area covering nearly 98,000 square miles[3], making Wyoming second only to Alaska in population density.[4] Nearly 2/3 of the state is mountain ranges and rangelands and the remaining third is high elevation prairie. Wyoming's geography creates physical access problems for patients, makes it hard to recruit providers, and complicates the development of networks by insurers.

- Demographics. Wyoming's population is aging rapidly. The State has one of the highest proportions of "baby boomers" and one of the lowest proportions of "Generation X" in the

[1] Where the 2017 national average for a second-lowest cost silver premium for a 27-year-old on the Federally-facilitated Marketplace averages $302, comparable coverage will cost $413 in Wyoming. "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace," ASPE Research Brief, October 24, 2016, located at: https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf.
[2] U.S. Census Bureau Population Estimates, July 2016, list Wyoming as having a population of 585,501, a decline of 0.2% from July 2015; http://www.census.gov/programs-surveys/popest.html.
[3] http://www.netstate.com/states/geography/wy_geography.html.
[4] "Population Density by State," http://www.statemaster.com/graph/peo_pop_den-people-population-density.

country.[5] Its residents age 65 and older have increased at a rate of 20.8 percent, compared to a national growth rate of 18.6 percent for the same population over the same period.[6] Over one-fifth of the state's total residents are projected to be over 65 by 2030 when all baby boomers will be in this age group.[7]

**Background: an economy susceptible to boom-and-bust**

Wyoming's economy depends heavily on mineral extraction and tourism. Low prices for oil and gas, along with decreasing demand for coal have depressed output, increased unemployment, and reduced State revenues by an estimated 23 percent for 2017-18. The reduction in mineral revenue has stressed Wyoming's social safety net. Any additional financial burden on the State will be very difficult to bear in the current economic situation.

**Background: Wyoming's health insurance market**

In addition to the smallest population, Wyoming also has one of the smallest (proportionally) pools of fully-insured lives in the United States. Of the estimated 326,000 residents with primary private insurance, for example, approximately 240,000 (73%) are in self-insured plans governed by federal (ERISA) statutes.[8]

It is commonly understood that health care costs drive insurance premium costs; insurance costs do not drive health care costs. The overall cost of health care in Wyoming is significantly higher than the national averages. Wyoming's combination of low population, large geographic area, age demographics, fewer health care providers than in urban areas, a higher percentage of smokers (16.4-20.1% compared to 15.1% nationally[9]), and population centers near state borders resulting in resident travel to out-of-state providers drives up costs. Any changes that Congress makes to the ACA must take into consideration potential impacts on small, rural states like Wyoming, whose challenges are different than those facing larger, more populated, urban states. Clearly, ACA Reform cannot be a "one size fits all" solution. Further, Wyoming's regulation of the insurance market is statutorily limited.

- Wyoming is one of three "direct enforcement" states, where the Centers for Medicaid and Medicare Services (CMS) generally enforce federal standards related to health insurance due to the State's Department of Insurance lacking statutory authority to enforce one or more of these standards.

- Wyoming is one of four states that does not have a federally approved "effective state rate review program." In 2011, Health and Human Services (HHS) implemented a nationwide program for states to conduct reviews of proposed rates above the applicable threshold of 10%, but if a state lacked the resources or authority to conduct the required rate review, HHS would conduct these reviews. Wyoming has neither the statutory authority nor resources to conduct rate review so it opted for HHS's review process. Nonetheless, Wyoming strongly supports state regulated insurance.

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[5] State of Wyoming Economic Analysis Division, Press Release, June 23, 2016.
[6] Id.
[7] http://www.ncsl.org/research/health/health-insurance-premiums.aspx
[8] Estimates from 2014 5-year American Community Survey data and Medical Loss Ratio data reported to CMS.
[9] "Current Cigarette Smoking Among Adults in the United States," Centers for Disease Control and Prevention, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/.

**Principles: Insurance regulation should remain under State control**
The State believes that state government regulation of insurance is wholly appropriate, and that the key functions of insurance regulation continue under State control under any reform.

The fundamental purpose of state regulation of insurance is to protect consumers. States typically structure regulations around key functions, to include: company and producer licensing, product regulation, market conduct, financial regulation, and consumer services. These important functions should continue under state control even if the reform of the health care system takes on a more national approach.

State systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept.

Health insurance markets are locally-based and should remain so. Wyoming DOI urges Congress to approach any ACA reform or replacement as a federal-state partnership, recognizing the substantial experience and expertise of the states. The nation's health care crisis is beyond the capacity of the states to solve independent of federal reforms.

**Principles: Keys to successful health care transformation**
Prior to the enactment of the ACA, the National Association of Insurance Commissioners (NAIC) urged Congress to consider five keys for the successful transformation of the U.S. health care system. Those five keys are still relevant today, and Wyoming DOI supports these principles.

- **Protect the rights of consumers.** States already have patient protections, solvency standards, fraud prevention programs, marketing rules and other oversight mechanisms in place to protect consumers; these should not be preempted by the federal government.
  Federal policymakers should preserve state oversight of health insurance and avoid preempting or superseding state consumer protections.

- **Address health care spending**. Any effort to increase access to and affordability of insurance will not be successful over time unless the overriding issue of rapidly rising health care costs is addressed. Any changes should be done in a manner that is consistent with sound and sustainable cost control practices. Any changes in health insurance will not be effective over time without substantial changes in the health care delivery system, such as ensuring access to primary care, managing chronic diseases, and eliminating waste and inefficiency.

- **Promote state innovation.** Congress must carefully consider the impact of changes on the states' ability to be effective partners in solving our health care crisis. Broad standards are superior to prescriptive rules, in order to maximize state flexibility to implement reforms that are responsive to local and regional market conditions. Changes should allow states to be innovative and to create systems that address their particular needs and circumstances.

- **Stop cost-shifting.** Inadequate reimbursement payments in federal health programs may have led to significant shifting of costs to the private sector. This has resulted in higher overall costs and decreased access for many consumers, and hampers the ability of states to implement reforms. Any federally-offered options must provide full federal fiscal funding to cover increased

costs, especially for high needs beneficiaries. Additional costs cannot be absorbed by the already pressured state budgets.

- **Avoid adverse selection.** Any reforms must be carefully constructed to ensure the long-term health of the market. Any program that grants consumers the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. Likewise, setting different rules for different plans within the pool or allowing consumers to wait until they get sick to purchase insurance, without penalty, can have adverse consequences on the pool.

State regulators have been at the forefront of ACA implementation and understand the impact federal regulations and interpretations have had on state health insurance markets and consumers. Changes to the regulatory landscape can have a significant impact on the availability and affordability of health insurance, so we urge policymakers to work with regulators to ensure stability in our markets and access to care for our consumers.

**Wyoming Department of Insurance (DOI) Priorities**

Wyoming DOI generally supports regulatory reforms or changes to the ACA. For purposes of this letter, it is necessary to address changes and possible reforms, as well as possible strategies, processes, or ideas within a complete repeal and development of an entirely new system. It is very difficult to address timelines for implementation of changes without knowing what those changes might be. We agree there are longer term legislative reforms needed, including addressing the issue of health care costs. Wyoming stands ready to be a resource and is willing to work on regulatory reforms that could help improve the health insurance market. The following list articulates Wyoming DOI priorities at this time.

**1. Stabilize Markets**

**a.** Individual and small group market insurance choices are very limited in Wyoming. We must maintain our existing insurers, as well as attract new insurers to the Wyoming market.

- Blue Cross/Blue Shield of Wyoming (BCBS) remains the only insurer on the Federally Facilitated Marketplace (FFM) after WINhealth Partners went into liquidation in January 2016.
- As of January 1, 2017, Wyoming has just two carriers in the off-exchange individual market: Blue Cross/Blue Shield of Wyoming and Freedom Life. However, it is noteworthy that Freedom Life has not marketed nor sold any plans in the State for the coming year.
- On the small-group off-exchange market, Blue Cross/Blue Shield of Wyoming and United Healthcare are the only carriers.
- Wyoming's market has shrunk. Since January 2012, fourteen health insurance companies have exited the Wyoming market for a variety of reasons.
- The lack of competition has created a distrust among the Wyoming constituency that a health insurance monopoly exists in Wyoming. While we do not feel that an insurance monopoly is present, the lack of competition is concerning.
- Speculation about further disruption in the market as a result of court actions (e.g. *House of Representatives v. Burwell)*, and uncertainty over the future of the ACA or its replacement plan are destabilizing in this regard. If the existing plan is repealed without a replacement

plan or if a transition plan extends over too long a period of time, Wyoming's market will be negatively impacted.

- Repeal without an articulated replacement plan could have a destabilizing effect on our already uncertain market.

**b.** Wyoming DOI supports several specific changes to the existing ACA. There needs to be a more rigorous process to review the number of Special Enrollment Periods (SEPs), a system to verify SEP qualifications, and a procedure for review of individual exemptions.

**c.** Wyoming DOI supports reconsidering the ACA's 90-day grace periods. Wyoming has seen first-hand the difficulties created by conflicts between the ACA grace periods and our state statutory grace periods. This inconsistency has created ambiguity and confusion between carriers and insureds resulting in "gaming the system" by some individuals.

**d.** Changes need to be made to address third-parties who divert consumers from Medicare coverage to enroll in Marketplace plans, particularly in the case of individuals with End Stage Renal Disease. There needs to be consistency in determining consumers that are eligible for other government coverages, and modifications to the federal risk adjustment formula.

**e.** Continue individual and small group transitional or "grandmothered" plans until the revised or replaced ACA plan has been developed. These plans are scheduled to end in 2017. Continuation of transitional plans could provide a stabilizing factor in that individuals enrolled in these plans would not be disrupted while other changes are being developed and implemented.

2. **Provide more state flexibility.** As previously stated, Wyoming has rather unique demographics and challenges. Greater flexibility in determining what plans work for our market -- i.e., what health benefits are essential, age-rating curves, etc. -- would be a valuable change. Greater flexibility in developing waiver programs and allowing states to re-define Essential Health Benefits benchmarks could be beneficial. Under the current structure, Wyoming has been hesitant to explore benefits beyond the essential health benefits parameters, fearing that federal oversight would deem these benefits as state mandated benefits and required to be paid by the state. Greater flexibility may provide greater fairness among the states.

3. **Improve the regulatory environment.** Since Wyoming is a direct enforcement state, it has not experienced some of the regulatory issues experienced by other states. Nonetheless, Wyoming supports a number of regulatory changes.

   **a.** Allow greater flexibility and transparency for states to post their rates in a timeframe and manner relevant to each state. Under the current structure, insurers must submit anticipated rates in April of 2017 for 2018 rates. The uncertainty of the ACA's future, including the outcome of litigation over cost sharing reductions (CSRs) and other market stabilization programs could negatively impact insurance costs in the near future.

   **b.** Revise network adequacy. Some states want to stop the ACA's federal network adequacy reviews, claiming the states already conduct the reviews and the duplicated effort is unnecessary. Wyoming does not have the financial or personnel resources to conduct network adequacy reviews and relies upon federal review. If the new health plan removes the federal

role in network adequacy reviews, Wyoming will need additional financial resources to conduct state network adequacy reviews.

c. Wyoming DOI supports clarification of the scope and application of nondiscrimination regulation (Sec. 1557). Wyoming agrees that the nondiscrimination regulation should not apply to non-comprehensive coverage and should not pre-empt state actions.

d. Revise the Summary of Benefits and Coverage requirements to give carriers and employers more flexibility.

e. Wyoming DOI supports changing the definition of Essential Community Providers to allow for multi-provider practices to be counted as multiple providers. The rural nature and low population of our state necessitates multi-provider practices. Wyoming seeks to enhance access to healthcare service, supports the development of an adequate healthcare workforce, and promotes collaboration in expanding comprehensive, community-based health care. The expanded definition of essential community provider will make that objective more readily achievable.

f. While we have reservations about the marketing practices and exclusions of some of the short-term, limited benefit insurance plans, we have recently observed the value of having such products available to the consumer for longer durations than three months, provided that the product expressly details the scope and duration of the plan.

In April, 2016, when a large number of coal miners in Wyoming were laid-off from their jobs, their severance packages put the miners in a financial bind. Employers offered COBRA coverage, but the coverage was too costly for many of the workers. Many of the workers wanted to purchase a short-term plan to cover them until the next Open Enrollment period began. With the 3 month duration, this would not have been possible. Wyoming is opposed to the recent regulation that re-defines short-term, limited duration plans as no more than 3 months. Further, Wyoming is opposed to the prohibition on the sale of limited benefit plans unless the consumer has ACA-defined comprehensive coverage.

g. A number of reform/replace measures are being discussed in popular media, among them the sale of insurance across state lines. In 2013, the Wyoming Legislature passed Wyo. Stat. §§26-18-301 *et seq.*, Sale of Out-of-State Health Insurance Policies. Wyoming DOI does not see that sales across state lines would be a solution or that it would help drive down costs. To date, no insurers have approached the Wyoming DOI to offer such a plan and no policies are in place. It is likely that, for out-of-State insurers to secure favorable pricing and thereby offer competitive premiums, they would need to invest time and effort in developing provider networks around the State. As previously noted, Wyoming's small insurance market and rural nature make this difficult. New companies can enter states today with ease and many companies sell in multiple states but contracting with providers to create an adequate network has been problematic. Insurers have not found the notion popular since they must still comply with applicable state mandates, and build a network of providers for competitive pricing.
Based upon Wyoming's experience, unless additional considerations are made, this proposed reform will have little or no effect. Because the cost of health care varies significantly among the states, insurers must price policies differently in different states. The reasons for the cost difference are many. For example, in states with provider shortages, networks cannot be

effectively used to hold prices down by getting providers to bid against each other. The original purpose behind the sale across state lines was to avoid expensive state mandates which were adding to the costs of insurance. It appears that if insurers cannot price their products based on the real costs where their insureds live and receive care, they will be unwilling to sell.

**Wyoming Department of Insurance Suggestions**

1. **Revitalize high-risk pools.** Create a mechanism for covering catastrophic claims separate from individual insurance pools since chronic and catastrophic conditions are the drivers for a significant percent of insurance rate increases. Although most states disbanded their high-risk pools since the ACA, Wyoming has continued its high-risk plan. Consider revitalizing the state high-risk pools or create large federal high-risk pools, supported by federal funding.

   Keeping the most expensive claims out of the individual pool, while still providing coverage for families, may help in predictability in pricing. If the coverage were provided so the costs are spread to society in general and not to the small pool of individuals, costs for individual health insurance could be kept more manageable and predictable.

2. **Develop a consumer insurance education component**. A number of studies conducted by academics and commercial entities have addressed the issue of insurance knowledge and comprehension. An industry-sponsored study that asked individuals with health insurance to define insurance terms and calculate their bill found that consumers averaged less than 50% accuracy rates. Another insurance company survey found that only 23% of respondents understood the terminology used in their health policy, only half knew their monthly health insurance premium, and a small percentage understood common healthcare acronyms such as HMO, PPO and HSA.[10] A series of studies conducted by Consumer's Union using a variety of statistical methodologies concluded that consumers dread shopping for insurance, don't have a good understanding of cost-sharing concepts (specifically, deductibles, co-insurance levels and benefit maximums), and require a high level of numeracy to make informed judgments about and choices between medical plans."[11]

3. **Balance the risk pool.** A basic concept of health insurance is the creation of a balanced risk pool; medical costs incurred by the sick must be offset by collection of premiums from the healthy. One of the biggest failures of the ACA was the low percentage of the healthy population to enroll in an adequate and appropriate health plan. The younger, healthier population simply chose to pay the tax penalty, leaving the risk pool woefully unbalanced. Getting younger people into the pool will reduce adverse selection and stabilize or lower rates for everyone. The ACA's penalty approach of taxing individuals for failure to have adequate health insurance coverage did not work. Consider incentivizing for coverage rather than penalizing for failure to have insurance. Address a plan for coverage of individuals with pre-existing conditions while providing meaningful incentive for the healthy population to participate. **However, if the incentives are granted in the form of tax credits, equitable consideration must be given to rural states like Wyoming where health care costs are significantly higher than larger, urban states.** States like Wyoming with higher health care costs and higher insurance costs will need to receive higher tax credits.

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[10] George Loewenstein, Joell Y. Friedmand, Barbara McGill, Sarah Ahmad, *et al* "Consumers' Misunderstanding of Health Insurance," Journal of Health Economics, April 19, 2013.
[11] Ibid, cited in Health Policy Brief, 2012.

4. **Restructure age bands.** Wyoming DOI supports reinstituting the 5:1 age band, as opposed to the 3:1 band mandated by the ACA. This will lower prices for younger (and healthier) individuals and encourage them to buy insurance.

5. **Expand enrollment timeframes.** Allow people to enroll in health insurance every two or three years if they can prove continuous coverage in the interim. Require applicants to provide documented proof of a special enrollment event rather than an automatic special enrollment.

6. **Review the ten essential health benefits.** Allow carriers to have two or three standard plans, with optional add-ons, and give carriers greater flexibility to offer non-standard plans. As long as consumer protections for catastrophic benefits are in place, lower priced, less-generous plans may give consumers more options. In answer to your question about redefining the "Essential Health Benefits," we believe it will be necessary to seek input from Wyoming stakeholders, including consumers, insurers, and providers.

7. **Encourage innovation in the market.** Encourage innovation in product design with limited underwriting and allow consumers to be rewarded for healthier behavior through meaningful programs.

8. **Expand the scope, definitions, and use of health savings accounts (HSAs).** Revise the IRS code to increase qualified plans and annual contribution limits. However, the expansion of HSAs needs to be done in conjunction with expanded consumer education in health insurance knowledge, transparency in medical service prices and quality, and informed consumer choice. Explore ways in which small group employers could fund health savings accounts in lieu of employer-provided health insurance.

9. **Encourage transparency in health insurance and in health care services.** Consumers often complain about the unknown cost of medical services they receive. Research shows 69% of people say insurers should make prices public for medical services.[12] Additional research indicates consumers pay less attention to cost when they are insured. Wyoming supports greater transparency in health insurance cost, health care prices, and quality benchmarks and metrics for consumers to review. This will help inform consumers on price and quality. In the current market, individuals have no way of knowing what health care related procedures and items will cost.

10. **Reform market stabilization measures.** Whatever stabilization programs are developed or revised, they must include sound actuarial analysis that encourages solid business practices by insurance carriers. Insurance pricing must reflect actual market costs.

    The revised ACA or its replacement plan must still consider the need for stability in the market, regardless of whether Congress revises or replaces "risk adjustment" "risk corridors", and "reinsurance", collectively known as the "3 Rs" programs.

    The risk adjustment program has little relevance in Wyoming, since the State has just one carrier. However, the original concept of risk adjustment was to transfer funds between carriers based on the relative health of their insured population, where relative health was based on a complicated

[12] Jacqueline DiChiara, "Healthcare Consumers Lack Transparency, Price Info Awareness," RevCycleIntellligence, August 17, 2015, revcycleintelligence.com/news/healthcare-consumers-lack-transparency-price-info-awareness.

HHS/CMS model. Carriers with populations that were healthier than the market average pay into the program, and carriers that have less healthy populations receive those payments. The design intended to always net to zero. If the risk adjustment plan continues, some thought should be given to an alternative stabilizing program for states like Wyoming.

The 2014 risk corridor payment at just 12.6% of the anticipated value arguably contributed to the liquidation of Wyoming's WINhealth Partners in January of 2016. The new or revised ACA plan should address the damage caused by the failure of the risk corridors component. Any new or revised plan must restore confidence with insurance carriers that they can rely upon the federal government's authority.

Consider revitalizing and continuing reinsurance as a public reinsurance option. For example, the Wyoming Health Insurance Pool (WHIP)[13] was created as an insurer of last resort for individuals in Wyoming who, prior to the ACA, were unable to acquire coverage in the individual market because of pre-existing conditions.

With guaranteed issue, the feasibility of this program diminished yet a small population remained in the WHIP pool. Wyoming is interested in exploring how high risk pools might be expanded as a type of funded reinsurance to include high-risk individuals, alleviating financial pressures of keeping that population in the general coverage pool. Additionally, Wyoming is interested in revitalizing programs like our Wyoming Small Employer Health Reinsurance Program (WySEHRP)[14] which allowed for the reinsurance of small groups or individuals within a small group plan in accordance with established assessments, standards, rates, and premiums. However, with only one participating carrier in the WySEHRP plan, it became necessary to sunset the plan.[15]

**Wyoming Department of Health (WDH)**

Wyoming Department of Health (WDH) programming provides not only access to health insurance for low-income residents though Medicaid, but also access to health care services via community-based behavioral health providers, programs to serve the elderly, and public health programs which provide both direct services and population-based initiatives to enhance the health of communities in Wyoming. The WDH also operates five health care facilities for vulnerable, high-need individuals. The WDH is therefore considered a "super agency," in that it contains the following divisions under the leadership of a single state agency:

- Aging Division (including three state-run aging facilities);
- Public Health Division;
- Behavioral Health Division (including two state-run behavioral health facilities); and,
- Wyoming Medicaid.

[13] Wyo. Stat. §26-43-101 *et seq.*
[14] Wyo. Stat. §26-19-307 *et seq.*
[15] With ACA transitional plans ending in 2017, the WySEHRP program will end in 2019, following a 2 year runout period.

Depending on decisions and guidance from the federal government in the coming months, reforms to the ACA will likely impact all WDH divisions. In addition, recent media attention has been given to possible changes to federal reimbursement policy for Medicaid and other state-administered health care programs, including the possibility of block grants or per capita allotments.

Wyoming is a rural and frontier state. We have a large geographical area, and the smallest population in the country. Wyoming's economy is also heavily dependent on mineral extraction and tourism – and operates in 'boom and bust' cycles. Health care reforms from Washington must consider impacts to small, rural states – like Wyoming – that struggle with access issues, provider recruitment and retention, economic fluctuation, and lack of competition among providers and insurers.

**Pending federal decision points**

There are a significant number of pending decisions on the exact design of any alternative funding model for Medicaid and other public health care and insurance programs.

In considering these decisions, the Department recommends keeping several principles in mind:

- Federal funding levels should be determined fairly.
    - Base year funding should adjust for differences in FMAP between states.
    - States that did not implement optional Medicaid expansion should not be penalized under any new health care law. Funding for optional expansion and wavier populations must be fairly accounted for and all states given the opportunity to benefit from these additional funds, if included in base funding amounts.
    - Changes in federal funding to states must be indexed to changes in inflation, regional variations in health care costs, and economic fluctuation.
    - Any requirement for matching state funds must make allowances for downturns in state economic activity and appropriate reductions to allow states to maintain balanced budgets. This is especially true for state economies dependent on the energy industry.
- States should have maximum flexibility.
    - States must be given flexibility in determining eligible populations and services in order to balance access with value, and to avoid the consumption of limited state and federal funding by only required populations over time;
    - If specific populations or benefits are required, these should be limited to a set proportion of funds, with states allowed to implement enrollment caps and waiting lists as necessary.
    - Reporting requirements should be significantly scaled back to reduce spending on administrative functions.

**Wyoming Department of Health: priorities in health care reform**

In addition to these principles in implementation, the Department has two major objectives as to the substance of health care reform.

1. **Maintain or increase access to care for all Wyoming residents.**

- Wyoming Medicaid has one of the highest provider participation rates in the country, with 99% of practicing physicians, 100% of nursing homes and hospitals, 85% of pharmacies and 78% of practicing dentists.

- This is largely due to the (relatively) high rates paid to providers by Wyoming Medicaid.[16] Protecting these rates is therefore one of the best ways the Department of Health can encourage providers to stay with the program and thereby maintain access for Medicaid members in a frontier state.

- In order to protect provider rates in a time when both State and federal funding may be limited, the State will need to compromise in other areas, to include benefit design, enrollment and eligibility, and member cost-sharing. These compromises will impact access to health insurance and health care services, and potentially funding for population-based health initiatives and other social services.

- Potential changes in funding, coverage, or patient cost-sharing in both the private and public health care systems may impact demand for other state-administered health care programs.

  For example, Wyoming's Public Health Division provides services to low-income adults who either do not qualify for Medicaid or face high out-of-pocket costs for their health care. Consideration should be given to potential cost-shifting to, or increased demand in such programs.

  Additionally, coverage changes in the ACA Marketplace/Exchange and in Medicaid may increase uncompensated care provided by Wyoming hospitals, many of which serve rural and frontier communities already struggling with health care access issues.

- Congress should also consider funding sources for public health programs that were, or have become, part of the ACA – but are not directly tied to Medicaid or the individual health insurance exchanges. For example, Wyoming's Public Health Division receives funding for the Vaccines for Children Program which provides free vaccinations to eligible children. The funding was originally allotted through the Centers for Disease Control's budget, but now comes from the Prevention and Public Health Funds (PPHF). If the ACA is repealed, PPHF funds will no longer exist, jeopardizing ongoing funding for this program.

**2. Use additional flexibility to increase value.**

- Generally speaking, value is a factor of price and quality. Wyoming Medicaid is interested in experimenting with various payment arrangements that create incentives for value over volume (e.g., to behavioral health providers based on high-need client outcomes in employment and housing; to long-term care providers for providing home and community based services that prevent institutionalization in nursing homes; etc.).

- States, especially those rural and frontier in nature, should leverage existing infrastructure and resources when available and appropriate. Consolidating administrative functions among

[16] http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

State-administered health plans, for example, could create efficiencies and better options for health care coverage for Wyoming residents.

- When possible, the federal government should relax restrictions on the use of federal funds and encourage states to innovate in delivering the highest quality coverage and care, and the best outcomes for the neediest populations. The extent to which states are granted flexibility in Medicaid and other state-administered programs depends heavily on pending federal decisions, some of which are listed above.

Thank you for the opportunity to provide background information and to respond to your questions. We look forward to being an active participant as Congress moves forward in revising or replacing the Affordable Care Act.

Sincerely,

Tom Glause
Wyoming Insurance Commissioner

Thomas O. Forslund
Director, Wyoming Department of Health