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OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP 2.0

Meeting #3

Wednesday, October 31, 2018
8:30 – 10:30 a.m.
The United Way of Rhode Island

UPDATES SINCE OUR LAST MEETING

- Meeting 2 Follow-ups:
  - Who are the remaining uninsured?
  - Assessment Follow-Ups
- Correction from Meeting 2:
  - See appendix, slide 32
- New Guidance:
  - 1332 & HRA

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

Topic(s) for Discussion	Meeting Date
Meeting 1 **Regrouping: Workgroup "2.0" + Reinsurance Recap**	Wednesday, October 3rd
Meeting 2 **Reinsurance Financing Options**	Tuesday, October 16th
Meeting 3 **Affordability Programs in Addition to Reinsurance**	***Wednesday***, October 31st
Meeting 4 **Shared Responsibility Requirement**	Tuesday, November 13th
Meeting 5 **Wrap-Up/Opportunity for Follow-Up**	Tuesday, November 27th
Meeting 6 **Reaching Recommendations**	Tuesday, December 11th
Meeting 7 **Recommendations (*reserved if needed*)**	Tuesday, December 18th

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

Topic(s) for Discussion	Meeting Date
Break for the holidays	Mid-December – early January
Meeting 8 **Possible Codification of ACA Consumer and Market Protections**	Tuesday, January 8th
Meeting 9 **Legislative Recommendations**	Tuesday, January 22nd
Meeting 10 **Legislative Recommendations (*reserved if needed*)**	Tuesday, February 1st

TODAY'S AGENDA

Affordability Programs

1. **Learnings from Other States**
   What are some state based approaches to enhance affordability?

2. **Supplemental Affordability Options for Rhode Island**
   Three Illustrative Options
   What might these programs cost?

3. **Next Steps**
   Shared Responsibility Payment Details

Affordability Program Options

October 31, 2018

FCG Faulkner Consulting Group

Reminder: Workgroup Recommendations

Excerpted from Final Report of the Workgroup

…near-term recommendations:

- A 1332 waiver under the ACA to implement a reinsurance program
- State authority to regulate Short-Term Limited Duration (STLD) health plans
- A state-based shared responsibility requirement

In addition… The Workgroup therefore also recommends the following:

- ***Future market stability actions required:*** *Rhode Island should focus next on how to fund a state reinsurance program and how to best design and implement a shared responsibility requirement.* ***Additionally, further efforts must be made to address the particulars of the aforementioned affordability initiatives, including whether any further affordability initiatives are necessary…***

The Workgroup noted that impacts on subsidized and unsubsidized individuals should be considered:

- *Throughout its deliberations, the Workgroup noted that the state should consider the impacts of any recommendations on* ***those who purchase on the individual market, including those who receive federal premium tax credits and those who do not****.*

Reminder: Workgroup Guiding Principles

Guiding Principles

1. Sustain a balanced risk pool;
2. Maintain a market that is attractive to carriers, consumers and providers; and
3. Protect coverage gains achieved under the ACA.

Goal

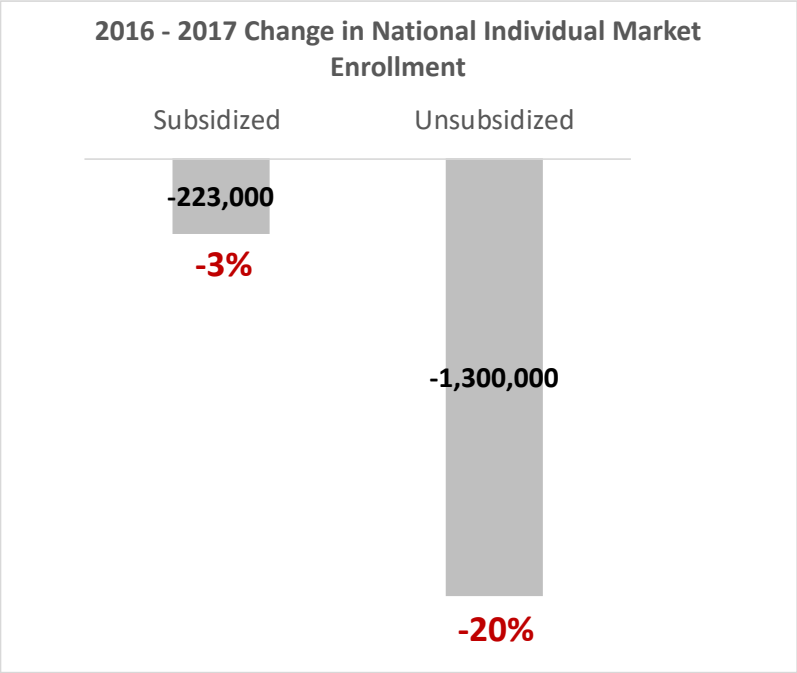
Identify and propose sensible, state-based policy options for RI that will be in service to those Principles

Reminder: What Are We Protecting Against?

Rate increases in the Individual Market can lead to **rapid declines in unsubsidized enrollment** and result in market instability.

2016 – 2017 National Example

+ Average premium increase: **21%**
- Decline in Individual Market enrollment: -**10%**
  - **Decline in unsubsidized enrollment: -20%**
  - Decline in subsidized enrollment: -**3%**

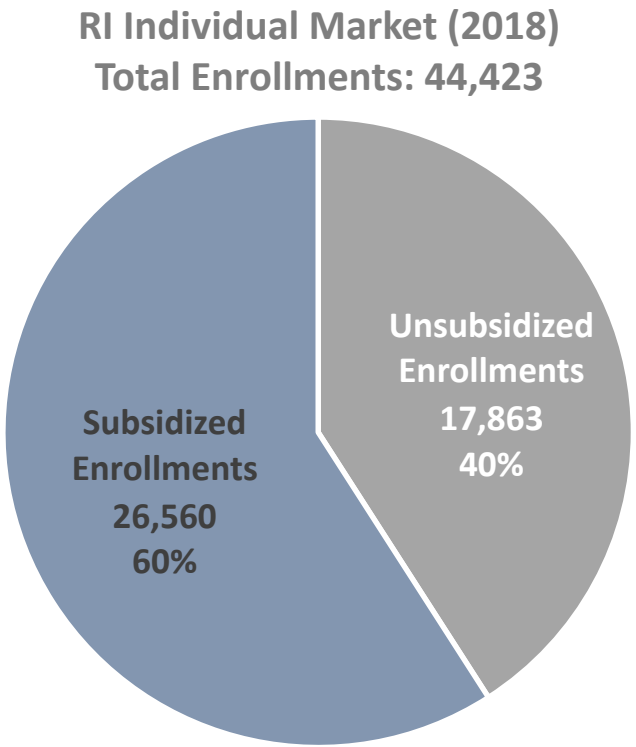


Sources: CMS Issue Brief, July 2018, *Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment*

Starting Point: RI Individual Market

Are additional affordability initiatives needed to **support the workgroup Guiding Principles:**

1. Sustain a balanced risk pool,
2. Maintain an attractive market, or;
3. Protect coverage gains achieved under the ACA?

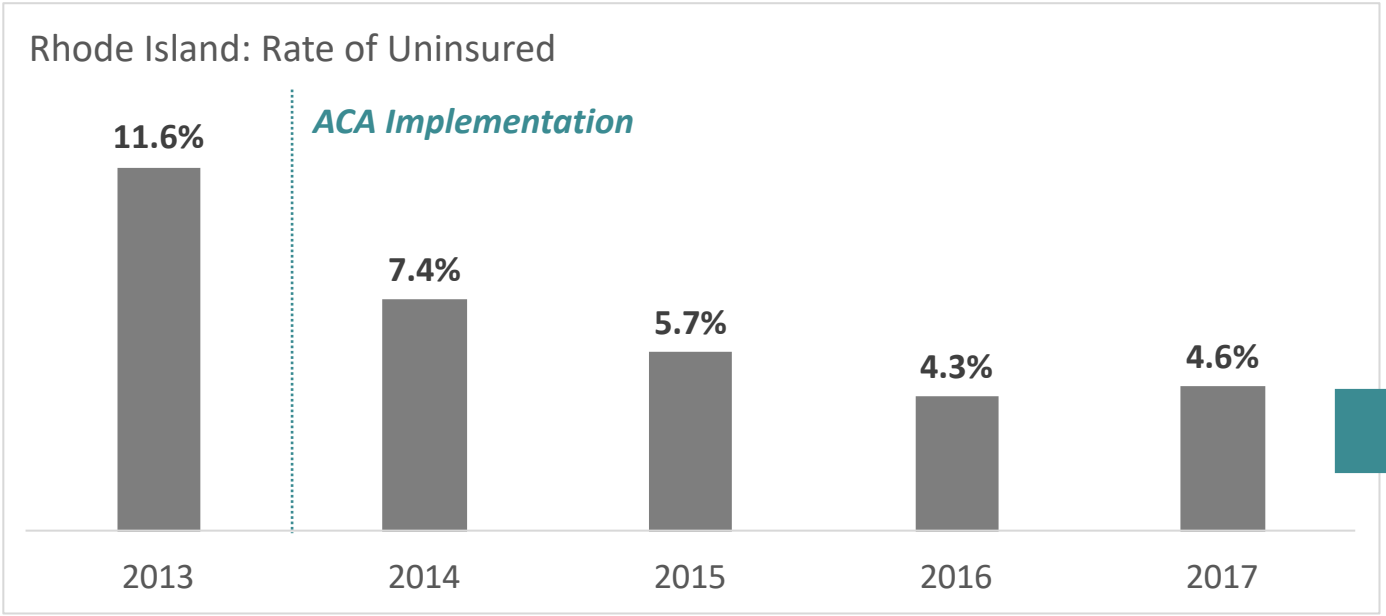


Reinsurance addresses stability of premium costs for unsubsidized enrollees

Source: Off Exchange: 2019 Rate Filing, March 2018; On Exchange: HSRI Legislature Report, Feb – Sept. 2018 Average

Starting Point: RI Uninsured

The RI rate of uninsured dropped by nearly two-thirds since 2013 but most recently has stabilized/ increased slightly



*As of 2017, Rhode Island had the **4th** **lowest rate of uninsured** in the nation.*

Source Data: American Community Survey (ACS), 2013-2017

Today's Agenda

1. **Learnings from Other States**
   What are some state based approaches to enhance affordability

2. **Supplemental Affordability Options for Rhode Island**
   Three Illustrative Options
   What might these programs cost?

3. **Next Steps**
   Shared Responsibility Payment Details

Backup: Response to questions from last meeting
Who are the remaining uninsured?

Learnings from Other States

- **Very few states have implemented supplemental affordability programs***
  - **MA:** Supplemental premium and cost-sharing subsidies
  - **MN:** One year 25% premium rebate program for unsubsidized enrollees
  - **MD:** Proposed “Health Insurance Down Payment” program (didn’t pass)
  - **VT:** Supplemental cost-sharing reductions for individuals up to 300% FPL

- There was a **federal proposal** under the Obama administration/Senator Tammy Baldwin for a supplemental affordability program targeting young adults

- **Unlikely to qualify for federal funding** *(state funded only)*
  - **MA:** Only one that was federally funded – but predated ACA

* See next slide for additional details

Details: Learnings from Other States

	Program Overview	Funding Source	Implementation
Massachusetts Supplementary premium and cost sharing subsidies	• Enrollees up to 300% FPL are eligible for "ConnectorCare," which wraps federal ATPC and CSRs to meet a state affordability schedule that exceeds the federal affordability schedule • Individuals are eligible for 1 of 5 ConnectorCare plan types, with low co-pays and no co-insurance or deductible	• State funded with federal financial participation (FFP) under the Medicaid 1115 waiver • State funds are held in a dedicated trust	• MA subsidy program pre-dated the ACA
Minnesota Rebates for Unsubsidized Customers	• Unsubsidized enrollees (+400% FPL) received a 25% health insurance premium rebate • Program administered by insurers, who received state funding to reduce consumers' premium bills	• State funded • $313 M budgeted, $137 M used	• Funded for 2017 only (response to dramatic 50-66% rate increase in 2017)
Maryland Health Insurance Down Payment Program	• In place of the federal individual mandate penalty, a state-based individual mandate penalty is assessed • Uninsured taxpayers elect to share their information with the Exchange when filing an income tax return • Assessed penalty becomes a down payment that can be used towards the cost of insurance • If a plan is available at 0 additional cost, the individual is enrolled immediately; if not, the penalty is saved in an escrow account and is available for use during the next open enrollment	• State-based individual mandate penalty funds • Assessed penalty follows the person and can be applied towards the cost of purchasing a plan • Penalties not used to purchase a plan go to the state	• State legislation: included in the "Protect Maryland Health Care Act" • Not implemented – legislation did not pass
Vermont Supplementary cost-sharing reductions	• Enrollees 200-250% FPL receive enhanced CSRs • Enrollees 250-300% FPL receive some CSRs (not available under federal standard)	• State funded	• Currently operating

Rhode Island Options

Are there specific supplemental affordability programs we should consider to support the Workgroup's Guiding Principles?

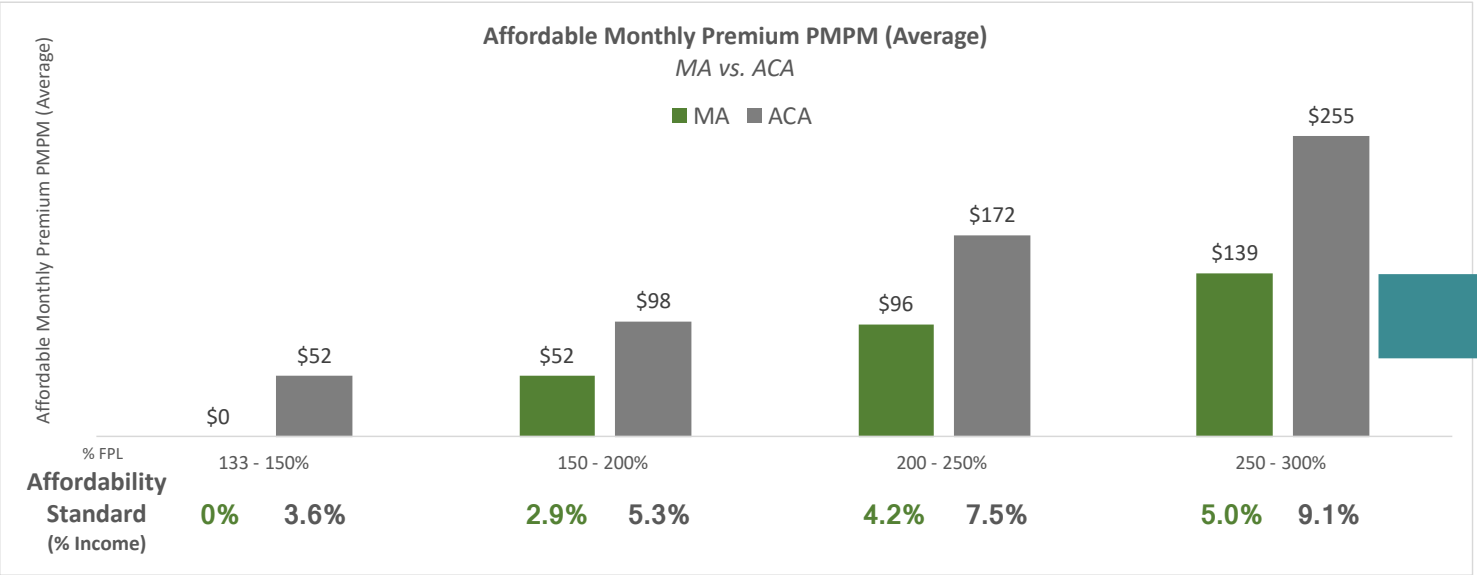
	Example 1	Example 2	Example 3
Target Population:	Low income populations APTC/CSR eligible	Unsubsidized Populations	Subsidy Eligible Young Adults APTC/CSR eligible
Description:	Supplemental premium subsidy or CSR	Premium rebate program or other premium subsidy	Supplemental premium subsidy
Benchmark States:	Massachusetts Vermont	Minnesota	Former Federal Proposal (Obama/Senator Baldwin)

Guiding Principles

1. Sustain a balanced risk pool,
2. Maintain an attractive market, or;
3. Protect coverage gains achieved under the ACA?

The Massachusetts ConnectorCare Program

- MA provides enhanced premium subsidies to Exchange enrollees up to 300% FPL via an enhanced state affordability schedule
- Pre-dates the ACA (and is uniquely federally matched)
- MA has an uninsured rate of 2.5%, compared to 4.6% in RI.



Matching MA's enhanced state affordability schedule in RI would cost at least an estimated **$17.5 Million**

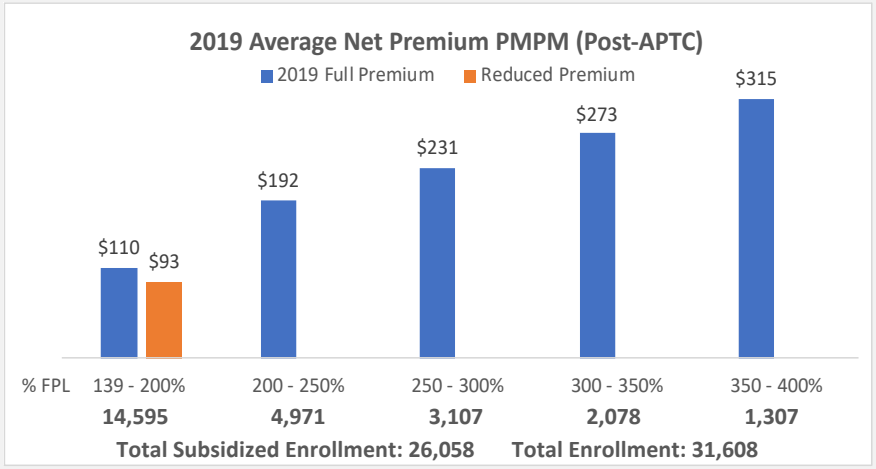
- Based on comparison of MA CY 2019 Individual Affordability Schedule and ACA CY 2019 Affordability Schedule – note that MA has three separate affordability schedules: Individuals, Couples, and Families - the schedule for individuals has been compared to the standard ACA schedule in the above
- Funding estimate is based on 2018 HSRI enrollment data and does not factor any increase in enrollment

Example 1: Target Low Income Populations

(A) Target the lowest income bracket only

*Reduce net premiums by **15%** for **139 – 200% FPL** segment*

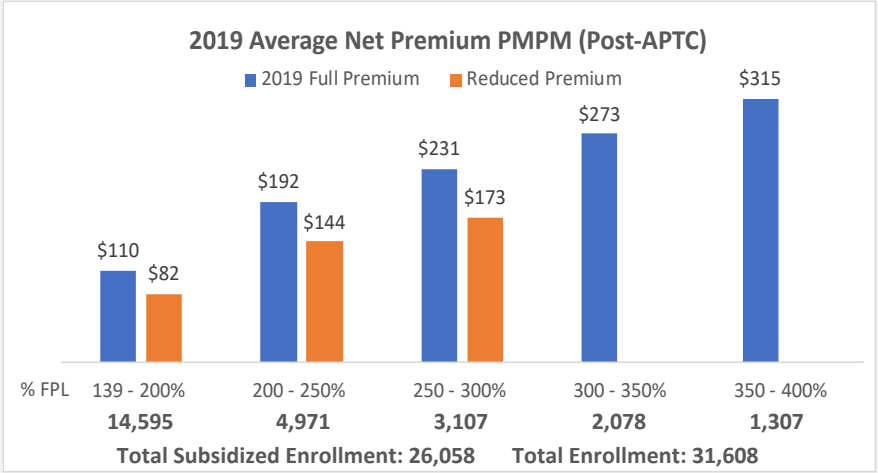
Est. Cost: **$2.9 Million**



(B) Target the population up to 300% FPL

*Reduce net premiums by **25%** for **139 – 300% FPL** segment*

Est. Cost: **$9.8 Million**



Funding estimates are based on 2018 HSRI enrollments, and do not consider take-up of uninsured in the target segment – added cost for increased take-up:

- **$455,000** with 50% uninsured take-up (2,300 members; $198 PMPY)
- **$3.4 M** with 50% uninsured take-up (6,400 members; $530 PMPY)

Note: 2019 Average Net Premiums shown are based on 2018 actual data, assuming no change in FPL or affordability standard for 2019 (consistent post-APTC premium for 2019)

Do these options support the Workgroup's Guiding Principles:

***(1)** Sustain balanced risk pool; (2) Maintain attractive market, or; (3) Protect coverage gains achieved under the ACA?*

Example 2: Target Unsubsidized Population

Minnesota Example

- Provide a **25%** premium rebate to **unsubsidized enrollees (400% FPL +)**

Estimated Cost: $22.3 Million

Considerations

- MN's program was a one-year stop gap measure funded for 2017 only
- Program was a response to dramatic 50 – 66% rate increases for 2017
- In 2018, MN implemented a reinsurance program

- Note: Funding estimates are based on 2018 HSRI enrollments, and do not consider take-up of uninsured in the target segment. Added cost for increased take-up: **$4.2 M** with 50% uninsured take-up (3,300 members; $1,250 PMPY)
- Note: the cost of this initiative is sensitive to annual rate increases - estimate shown is for 2019 based on a 9% average rate increase for 2019

Do these options support the Workgroup's Guiding Principles:
(1) *Sustain balanced risk pool; (2) Maintain attractive market, or; (3) Protect coverage gains achieved under the ACA?*

Example 3: Target Subsidy Eligible Young Adults

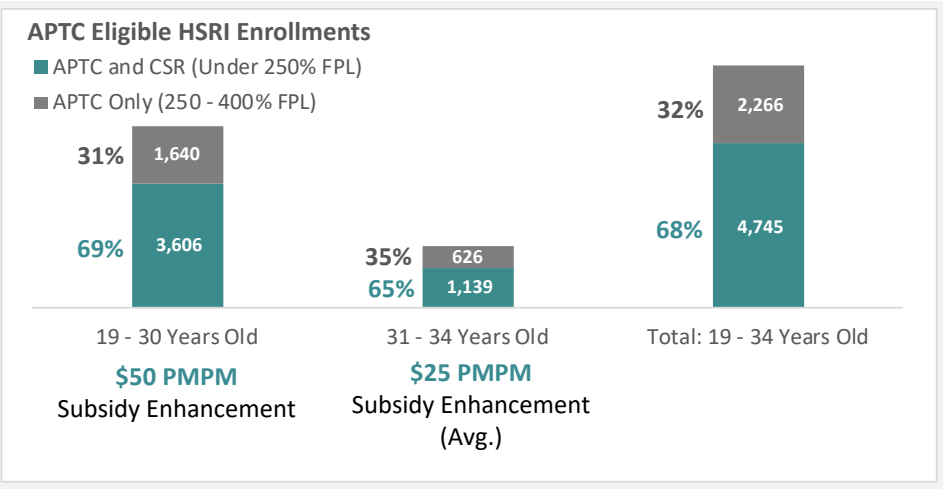
Obama Administration/ Senator Tammy Baldwin Proposal

- For APTC eligible **enrollees ages 19 - 30**, increase subsidy by **$50 PMPM**
- For APTC eligible **enrollees ages 31 – 34,** increase subsidy **with sliding scale**, declining to $0 at 35

Estimated Cost: $3.7 Million*

Considerations

- Encourages young people to enroll
- Targeted: 26-35 year olds have high uninsured rate (11.4%)
- Younger people likely to be lower risk



* Preliminary estimate shown is based on total proposed premium enhancement; the total tax credit (APTC + enhancement) cannot exceed the cost of the SLCSP; does not consider the intersection of the SLCSP cost and the total enhanced tax credit at the member level (cost estimate is overstated)

* Funding estimates are based on 2018 HSRI enrollments, and do not consider take-up of uninsured in the target segment – added cost for increased take-up: **$2.3 M** with 50% uninsured take-up (4,300 members; $527 PMPY)

Do these options support the Workgroup's Guiding Principles:
(1) *Sustain balanced risk pool; (2) Maintain attractive market, or; (3) Protect coverage gains achieved under the ACA?*

Discussion

- Are there specific supplemental affordability programs we should consider to support the Workgroup's Guiding Principles?
- Do you have any questions about these options?
- Are there any options you would eliminate from consideration?

	Example 1	Example 2	Example 3
Target Population:	Low income populations APTC/CSR eligible	Unsubsidized Populations	Subsidy Eligible Young Adults APTC/CSR eligible
Description:	Supplemental premium subsidy or CSR	Premium rebate program /other premium subsidy	Supplemental premium subsidy
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Guiding Principles

1. Sustain a balanced risk pool,
2. Maintain an attractive market, or;
3. Protect coverage gains achieved under the ACA?

Next Steps

Meeting 4: Shared Responsibility Payment

- Federal model and revenue it raised in RI
- Deviations from the federal model and revenue impact of those differences
- Regroup on how deviations would impact the workgroup's goals of: attractiveness, coverage gains and stability

PUBLIC COMMENT?

THANK YOU

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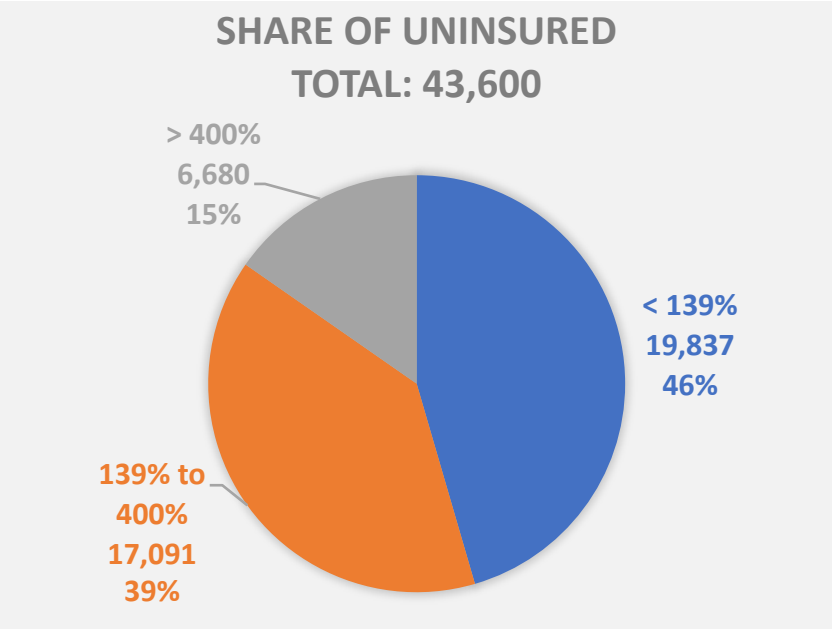
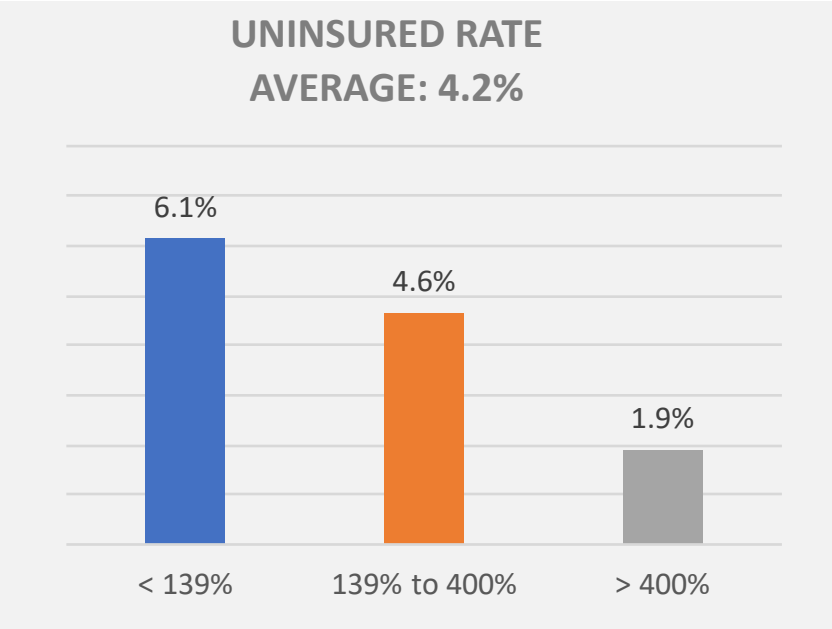
Back Up

October 31, 2018

Who Are the Remaining Uninsured? (by Income)

The remaining uninsured are disproportionately low income

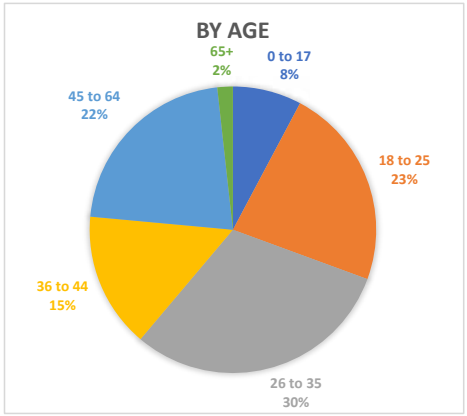


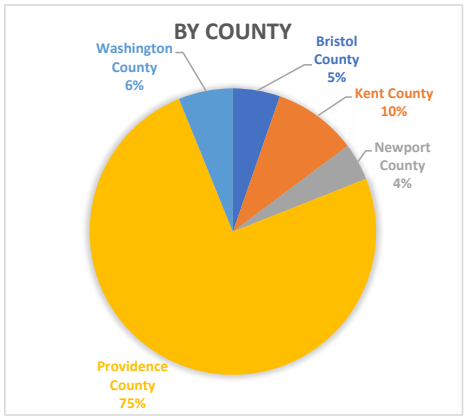


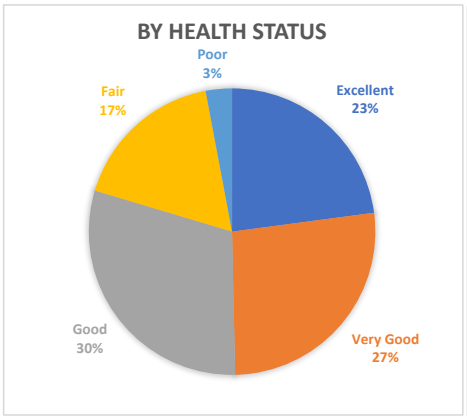
Note: Uninsured counts include undocumented individuals ineligible for Medicaid or subsidized coverage
See appendix for additional details on the remaining uninsured
Source Data: RI Health Insurance Survey, 2016

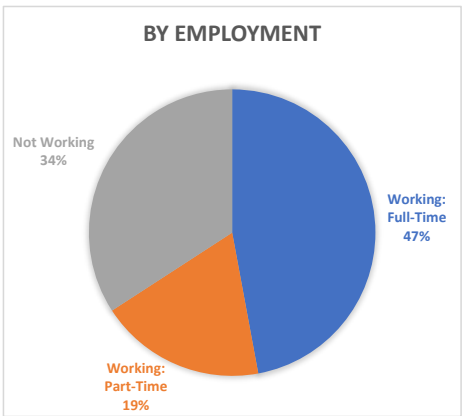
Who Are the Remaining Uninsured?

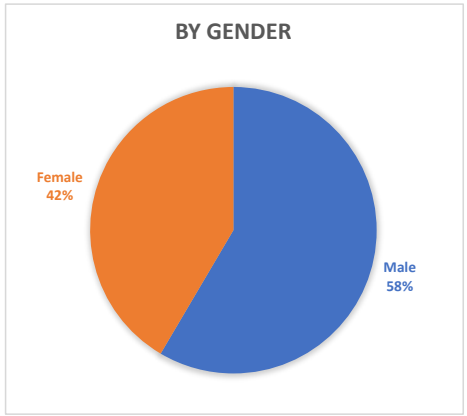
Total RI Uninsured: 43,609

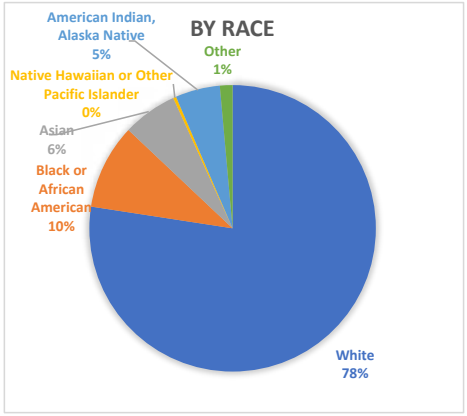


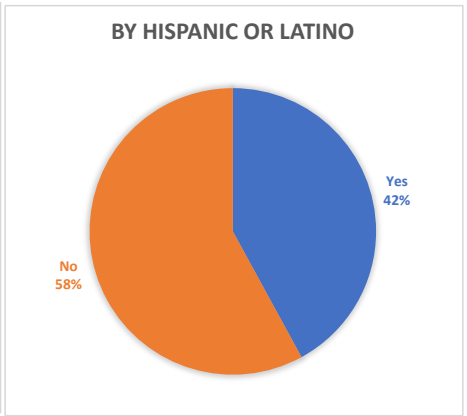


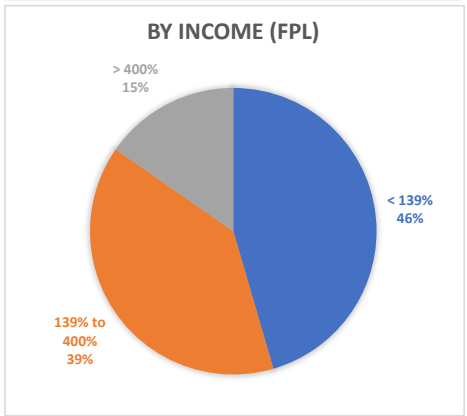








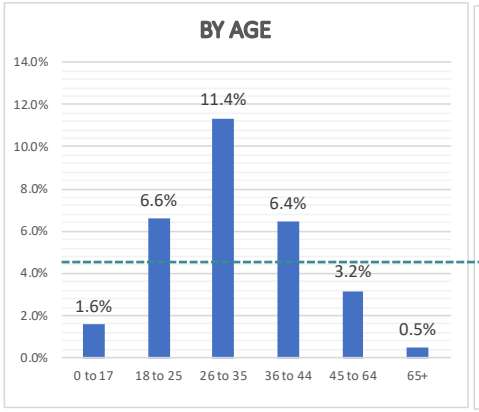


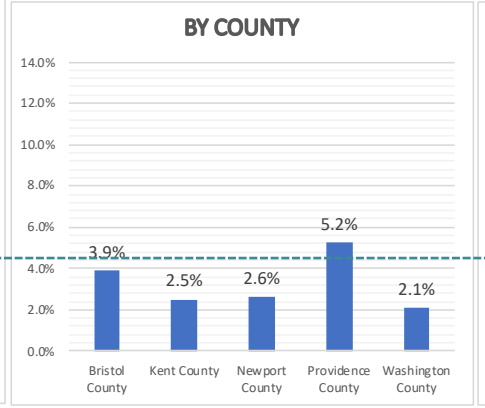


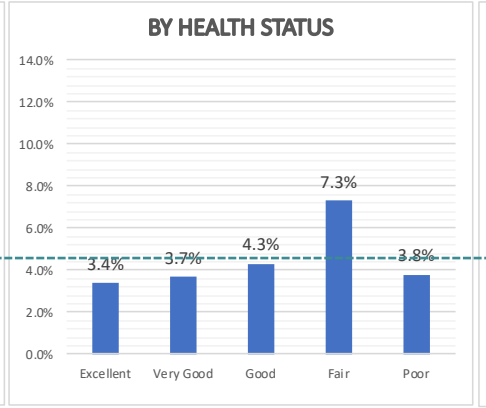
Source Data: RI Health Insurance Survey, 2016

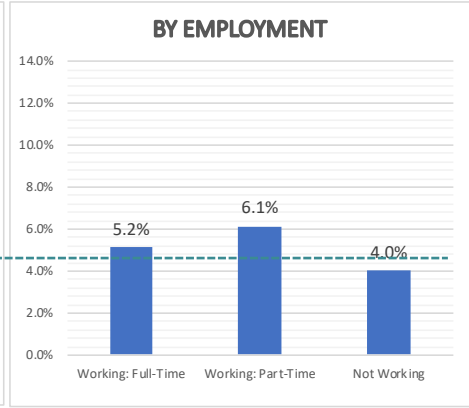
Uninsured Rates by Demographic

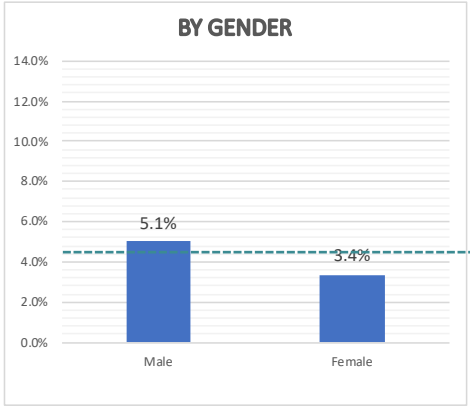
RI Uninsured Rate: 4.2%

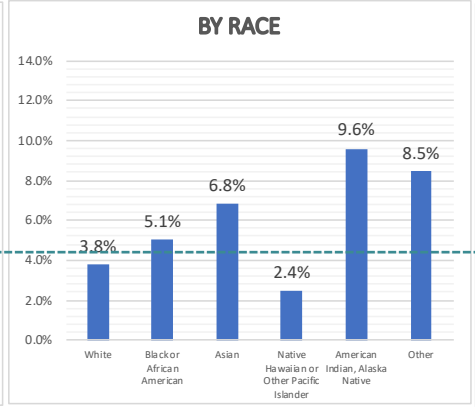


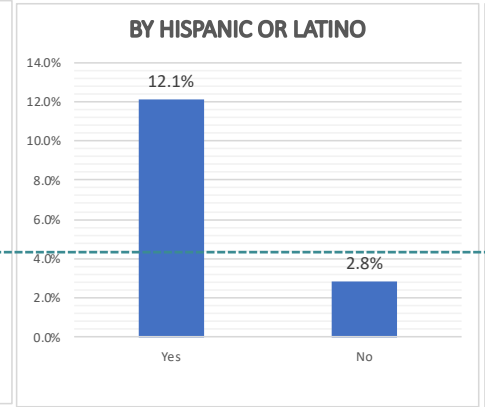


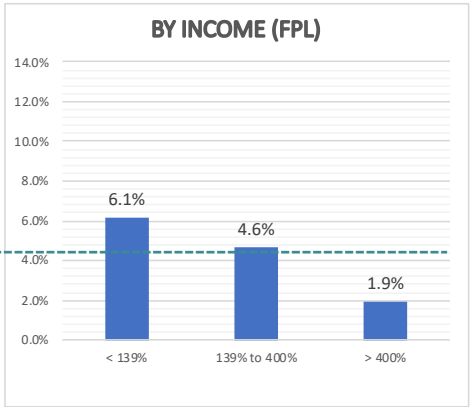












Source Data: RI Health Insurance Survey, 2016

Affordability: Subsidized Enrollees

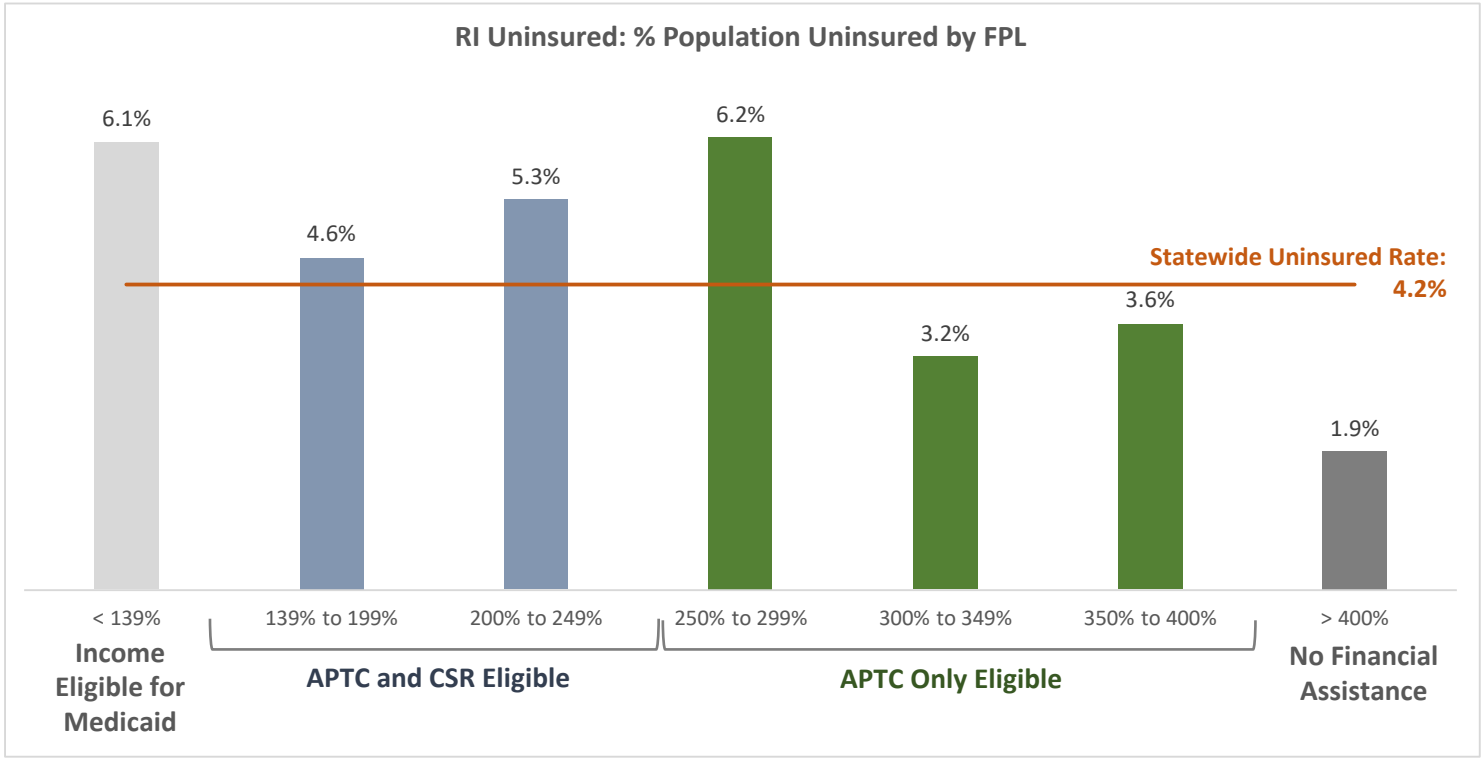
139-250% FPL => eligible for premium subsidies (APTCs) and cost sharing reductions (CSRs)
250-400% FPL => eligible for premium subsidies (APTCs) only

	FPL %	Eligibility	Average Income	Monthly Premium: Max. Affordable Average PMPM	Cost Sharing: Individual Deductible (SLCSP)
APTC + CSR	139% to 149%	APTC + CSR (CSR 94)	$17,482	$52	$0
	150% to 199%	APTC + CSR (CSR 87)	$21,184	$98	$800
	200% to 249%	APTC + CSR (CSR 73)	$27,254	$172	$3,425
APTC ONLY	250% to 299%	APTC Only	$33,324	$255	$3,500
	300% to 349%	APTC Only	$39,394	$324	$3,500
	350% to 400%	APTC Only	$45,525	$374	$3,500

Note: Income, premium, and deductibles shown above are for a single individual (one person household); deductible amount shown is for the 2018 SLCSP (second lowest cost silver plan); income and premiums shown are an average for the FPL bracket

Rate of Uninsured by Segment

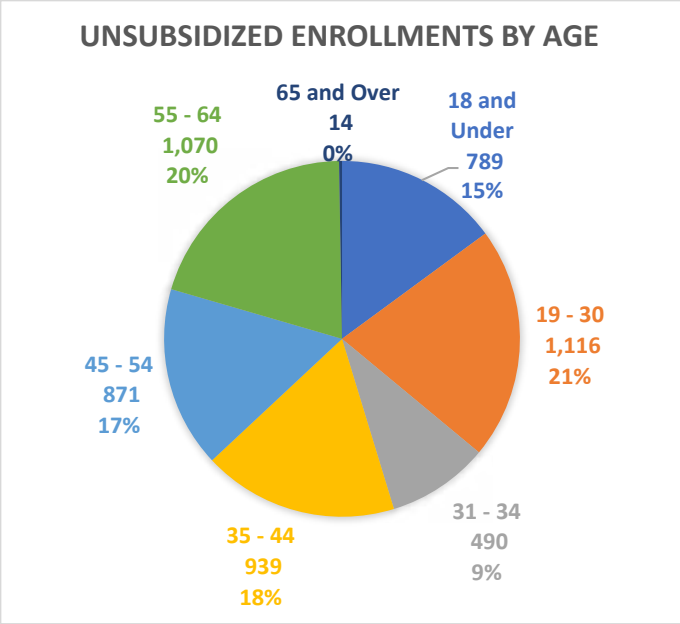
The rate of uninsured by segment is one indicator of affordability.

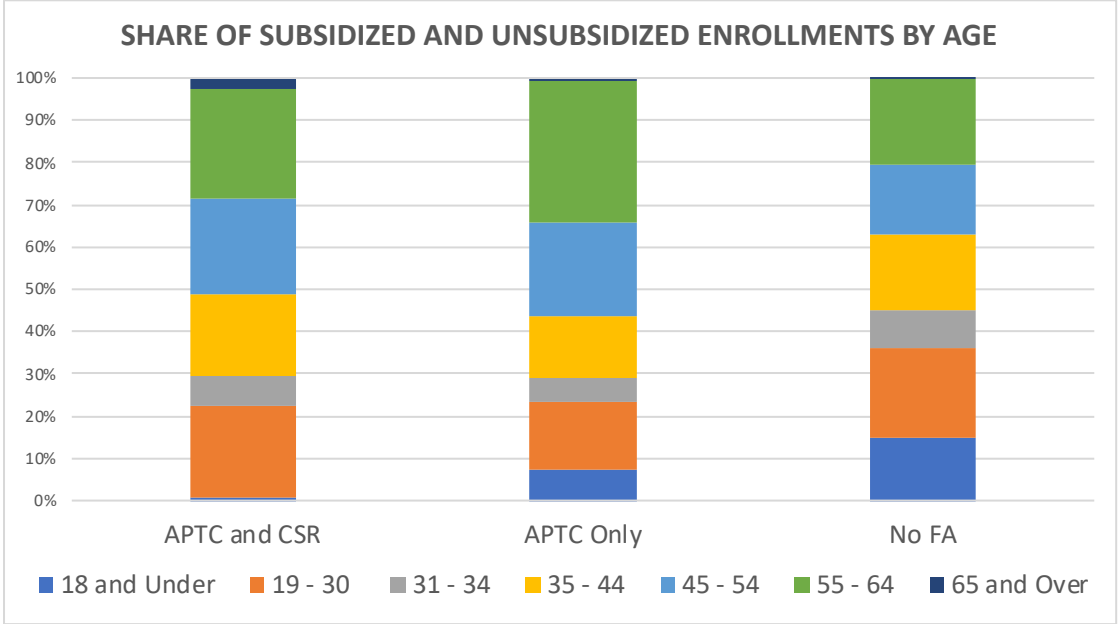


The subsidy eligible population ***139 – 300% FPL*** *has a higher than average uninsured rate.*

Source Data: RI Health Insurance Survey, 2016

Unsubsidized Enrollments by Age





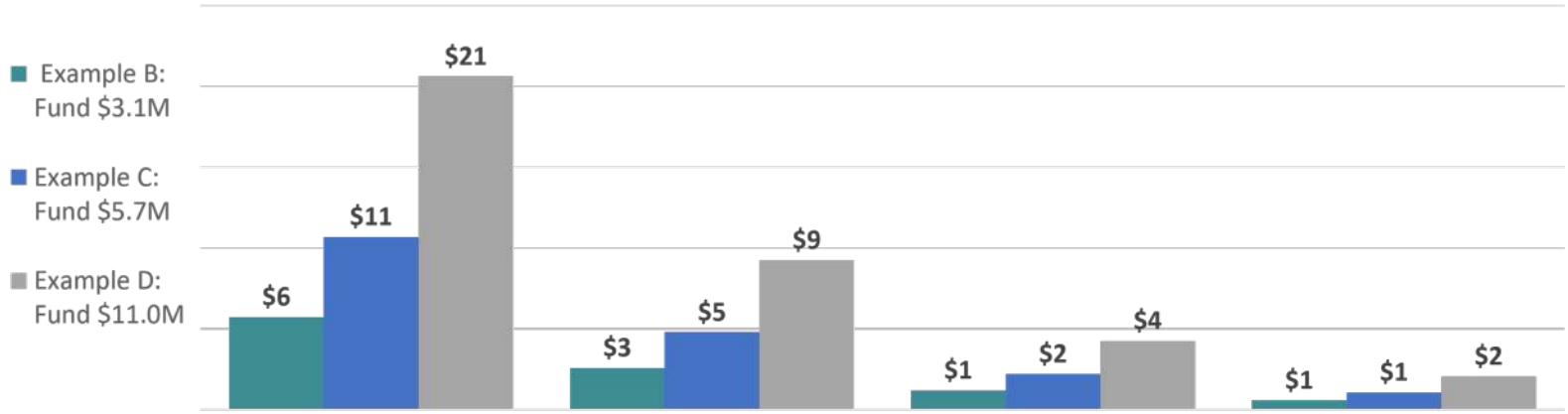
Source Data: HSRI Enrollment Data, April 2018

APPENDIX

Other Assessments: Who Pays?

The size of an assessment to raise funds in addition to SRP depends upon who pays.

Estimated Range of PMPM Assessment to Fund Remaining State Share



% Premium	1.6%	3.0%	5.8%	0.6%	1.1%	2.1%	0.3%	0.5%	1.0%	0.1%*	0.2%*	0.4%*

*% Premium shown for all covered lives is illustrative and assumes similar premium rates to the fully insured market.
Source: PMPMs based on April 2018 OHIC enrolled lives report. % Premium based on 2017 Earned premiums from April 2018 carrier rate review filings.

These are illustrative estimates for policy discussion only – actuarial projections of these numbers to be completed in early 2019.