April 26, 2019

State Relief and Empowerment (Section 1332) Draft Waiver Application Public Comment Cover Letter

In her proposed 2020 budget, Governor Raimondo included a State reinsurance program in Article 14 designed to help maintain and protect gains of the Affordable Care Act in Rhode Island by mitigating premium increases. That proposal is currently under consideration by the Rhode Island General Assembly. If approved as proposed, the reinsurance program would first impact rates for 2020. To meet Federal requirements for that timeline, the State needs to release a draft waiver application for public comment in April 2019. If the General Assembly does not approve the proposed reinsurance program as part of the FY20 budget, this waiver application will not be submitted.

Specifically, the State of Rhode Island is seeking public comment on its draft Section 1332 State Relief and Empowerment Waiver Application and supporting appendices. The application seeks to waive certain requirements of the ACA with the goal of expanding state's flexibility. A public comment period is an important step in the waiver development process and is required to happen prior to the application's submission to the Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS), and the Department of the Treasury. The State is not obligated by this draft application or the public comment period to implement or fund a reinsurance program.

As a requirement of the 30-day public comment period, the State will conduct at least two public hearings which will be held at the following dates and times:

- May 10, 2019 from 1:00pm – 3:00pm at the Department of Administration, Conference Room B, 1 Capitol Hill, Providence, RI 02908, and
- May 20, 2019 from 9:00am – 11:00am at the Department of Labor and Training Conference Room, 1511 Pontiac Ave, Cranston, RI 02920.

To implement the proposed reinsurance program for plan year 2020, the application must be submitted to the federal government by mid-summer 2019. This deadline will allow for two months of review, including a federal 30-day comment period and final federal approval. If the reinsurance program is approved on this timeline, the favorable impact on rates will be seen in the 2020 plan offerings for the start of Open Enrollment in November 2019.

The goal of the proposed reinsurance program is to mitigate anticipated premium increases in the year 2020 and beyond for Rhode Islanders purchasing health insurance coverage in the individual market. This is particularly important for those who do not qualify for federal tax credits. The program would work by using reinsurance funds to partially reimburse carriers for certain claims for higher-cost members in the individual market. This would allow the insurers to set lower premiums than they otherwise would have without such reimbursement.

Your feedback is important to us and to the success of this program. You can submit your public comments by email to 1332waiverapplication@healthsourceri.com, or by postal mail to: State of Rhode Island 1332 Waiver Application, HealthSource RI, 501 Wampanoag Trail, Suite 400, Riverside, RI 02915 by May 25, 2019 and/or by attending the public meetings to provide feedback in person.

Rhode Island's 1332 Draft Waiver Application

April 26, 2019
DRAFT POSTED FOR PUBLIC COMMENT

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Attachment 2: Legislation

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The following attachments will be appended after the public comment period:

Attachment 4: List of interested parties and stakeholders

Attachment 5: Copies of public hearing notice and written testimony from Public Hearing #1

Attachment 6: Copies of public hearing notice and written testimony from Public Hearing #2

Attachment 7: Copy of public notice of comment period notice inviting public comments and copies of additional written public comments received

Attachment 8: Copies of email and tribal consultation letter to representative(s) of the Narragansett Indian Tribe

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Executive Overview

Request

The State of Rhode Island, through its state-based health insurance marketplace – HealthSource RI (HSRI), submits this 1332 State Innovation Waiver request to the Center for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS), and the Department of the Treasury. This request seeks waiver of Section 1312(c)(1) under Section 1332 of the Affordable Care Act (ACA) for a period of five years beginning in the 2020 plan year to develop a state-based reinsurance program. This waiver will not affect any other provision of the ACA but will result in a lower market-wide index rate, thereby lowering premiums and reducing the federal cost of the premium tax credit (PTC) and advance payments of the PTC (APTC). The waiver is intended to stabilize individual market enrollment, to mitigate rate increases, and to encourage insurance companies to continue to offer plans in the state's individual market.

Basis for Request and Goal of the Proposed Rhode Island Reinsurance Program

Early and Ongoing Impacts of the ACA

The results of the ACA across the country were mixed. In Rhode Island the effect of the ACA has been largely beneficial. The ACA has allowed HSRI to foster a competitive, stable individual marketplace and, in 2018, the state had the lowest benchmark plan cost in the country. Over 100,000 Rhode Islanders have become covered because of the ACA, cutting the rate of uninsured by nearly two-thirds as compared to 2012. Today, 96 percent of Rhode Islanders have coverage.[1] Furthermore, Rhode Island is ranked second-highest in the nation for percentage of children with health insurance coverage and is tied for sixth-highest overall.[2]

The ACA has been a success in Rhode Island because (a) key provisions such as guaranteed issue and community rating were already priced into the state's health insurance rates; (b) the Office of the Health Insurance Commissioner (OHIC) is well-established and has played a stabilizing role in the state's rate-setting process; and (c) the state's public and private sector stakeholders have effectively worked together.

However, premiums in Rhode Island's individual market have been rising over the last few years and are anticipated to continue to rise in the future. Between 2017 and 2019, the average monthly premium for HealthSource RI customers not eligible for tax credits increased by 26%.[3] Expert analysis of the individual market in RI projects a 9.6% increase in individual premiums from 2019-2020.[4]

As a result of rising premiums, healthier enrollees may choose not to sign up for health coverage or may not stay covered. This will negatively skew the risk pool toward the less healthy, causing

[1] RI Health Insurance Survey, 2018.
[2] Kaiser Family Foundation estimates based on Census Bureau American Community Survey, 2017. www.kff.org
[3] Internal HSRI analysis of unsubsidized customer premiums.
[4] Wakely Actuarial and Economic Analysis – see Attachment 1 Table 4.

greater increases in premiums for those remaining in the risk pool. As premiums continue to rise over multiple years, more and more healthy enrollees may drop coverage and the pool may get progressively smaller and sicker. This will disproportionately impact the unsubsidized population, who face the full brunt of premium increases. When too many unsubsidized customers are priced out of the market, there remains little to no incentive for carriers to control rising premiums or offer product choice. The end result is likely to be a market which is out of reach for many individuals and families, and decreasingly attractive to new and existing carriers.

The individual market writ large has been, and continues to be, volatile due to factors such as the phase out of the transitional reinsurance program and the recent repeal of the individual mandate penalty. In addition, populations newly insured under the ACA have been sicker and/or riskier than anticipated, which has led to higher premiums. The individual market also faces potential challenges of adverse selection due to the availability of alternative insurance products such as short-term limited duration (STLD) plans and Association Health Plans[5].

Ensuring Ongoing Success in Rhode Island

A group of Rhode Island stakeholders, called the Market Stability Workgroup (the Workgroup), was convened in April 2018 by the OHIC and HSRI to study and consider what state action could be taken to mitigate risks to health coverage costs, consumer choice and access. An ongoing and declining enrollment trend in the small group market as well as a more recent decline in the individual market that is expected to continue were additional motivators.

In June 2018, the Workgroup published its recommendation that Rhode Island pursue a 1332 waiver, provided for under the ACA, to implement a reinsurance program to mitigate anticipated premium increases in the year 2020 and beyond. The Workgroup further recommended that Rhode Island implement a state-level shared responsibility requirement, and leverage the funds raised to protect the affordability of health coverage in the individual market. For the complete report and makeup of the Workgroup, see Attachment 3.

The creation of the Rhode Island reinsurance program will help bring certainty and stability to future premium rates in Rhode Island's individual health insurance market. A reinsurance program as envisioned by the Workgroup has the potential to moderate anticipated premium increases across the individual market, thus tempering the direct impact that annual rate increases would have on enrollees who do not receive federal affordability assistance. The program is also expected to encourage insurer participation in the individual market, a critical factor to the state's ongoing success under the ACA.

Operation, Funding, and Impact of the Rhode Island Reinsurance Program

The Rhode Island General Assembly passed legislation in 2018 authorizing HSRI to pursue a 1332 waiver to establish a reinsurance program to stabilize the state's individual market. Additional legislation is currently under review that would establish a state revenue source for the reinsurance program through the implementation of an individual mandate penalty.

[5] Association health plans are already regulated under Rhode Island state law, mitigating the risks posed by their possible expansion.

- The Rhode Island Market Stability and Reinsurance Act, R.I. Gen. Laws § 42-157.1, passed and was signed into law on July 2, 2018. This law authorizes the director of the state's exchange, HSRI, to establish and implement a state-based reinsurance program, to provide reinsurance to carriers that offer health insurance coverage on the state's individual market that meets the requirements of a waiver approved under 42 U.S.C. § 18052.
- H 5151, Article 14, Relating to Market Stability, is a budget article that has been proposed and endorsed by Rhode Island Governor Gina Raimondo and is currently under review by the legislature. The proposed law would authorize the state to establish a health insurance mandate by Jan 1, 2020, and to impose financial penalties on certain Rhode Islanders not meeting the statute's requirements. The new statute also authorizes the state to utilize any penalties collected under this new statute as a state funding source for its individual market reinsurance program.

Total funding for RI's reinsurance program for 2020 has been estimated to be approximately $14.7 million. The 2018 statute authorizes the establishment of a fund to be administered by the director of HSRI to support the operation and administration of the program. Through this waiver request, Rhode Island seeks federal pass-through funds to partially offset state expenditures.

The reinsurance program will reimburse qualifying individual health insurers for a percentage of an enrollee's claims between an attachment point and a cap, the parameters of which will be set through regulations promulgated by HSRI. In 2020, the program is projected to reimburse fifty percent (50%) of claims between an attachment point of $40,000 and cap of $97,000. HSRI estimates that the reinsurance program, as part of the waiver proposal, will result in a net premium decrease of 5.9% in 2020 and 6.3% in 2021.[6] We define net premium decrease as the difference between expected premiums with and without the reinsurance program.

The reinsurance program will incentivize carriers to manage health care costs and utilization for individuals whose risk is covered by the reinsurance program. The initial coinsurance rate of 50% will hold the carriers responsible for the remaining 50% of the costs for those covered individuals. This will provide more than adequate incentive for RI's participating carriers to manage health care costs and utilization of members covered by the reinsurance program.

Compliance with Section 1332

Rhode Island's waiver, if approved, will produce a net premium decrease and increase affordability of health insurance in Rhode Island's non-group health insurance market. As a result, we estimate that enrollment in the individual market will increase by approximately 0.9% in 2020, 1.0% in 2021, and between 0.7% and 0.9% from 2022 through 2029 compared to baseline (see Table 1 below). The waiver will not impact the comprehensiveness of coverage in Rhode Island, except insofar as individuals with coverage have more comprehensive coverage

[6] Wakely Actuarial and Economic Analysis, Attachment 1, Table 8, Baseline Data and Detailed Results after Reinsurance, by Year. Combined reduction in premiums for reinsurance funding and improved morbidity.

than those without. The waiver will have no material impact on premiums, comprehensiveness, or enrollment in group coverage or public programs. The reduction in individual health insurance premiums, including premiums for the second-lowest-cost silver plan, will reduce net federal spending by between $6.4 million and $7.4 million per year during the five years the waiver is in place (see Table 1 below). The state requests federal pass-through funding for each year equal to the amount of the federal savings. Accordingly, the waiver will not increase the federal deficit in any year of the waiver.

The waiver will advance several of the principles described in the section 1332 guidance released in October 2018, including increasing access to affordable private market coverage and supporting competition in the individual market. This approach fosters state innovation by allowing Rhode Island to take control of meeting the needs of its own unique health care system.

Table 1 – Summary of Individual Market Projections – Baseline and After Reinsurance

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline											
Total Non-Group Enrollment	43,023	42,434	42,146	41,877	41,572	41,272	40,984	40,713	40,459	40,197	39,941
APTC Enrollment	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134
Total Non-Group Premium PMPM	$463.05	$507.45	$531.40	$555.22	$584.10	$614.43	$645.68	$677.13	$708.61	$743.08	$779.21
APTC PMPM	$335.00	$376.27	$397.37	$418.30	$444.16	$471.39	$499.47	$527.70	$555.91	$587.00	$619.66
Total Premiums (millions)	$239.06	$258.4	$268.8	$279.0	$291.4	$304.3	$317.6	$330.8	$344.0	$358.4	$373.5
Total APTCs (millions)	$105.06	$118.0	$124.6	$131.2	$139.3	$147.8	$156.6	$165.5	$174.3	$184.1	$194.3
After Reinsurance											
Total Non-Group Enrollment		42,834	42,563	42,271	41,943	41,622	41,315	41,026	40,756	40,479	40,207
APTC Enrollment		26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134
Total Non- Group Premium PMPM		$477.37	$498.10	$521.72	$550.16	$580.05	$610.86	$641.87	$672.94	$706.97	$742.67
APTC PMPM		$352.74	$371.33	$392.10	$417.61	$444.51	$472.25	$500.14	$528.02	$558.78	$591.10
Total Premiums (millions)		$245.4	$254.4	$264.6	$276.9	$289.7	$302.9	$316.0	$329.1	$343.4	$358.3
Total APTCs (millions)		$110.6	$116.5	$123.0	$131.0	$139.4	$148.1	$156.9	$165.6	$175.2	$185.4
Reduction in Premiums		-5.9%	-6.3%	-6.0%	-5.8%	-5.6%	-5.4%	-5.2%	-5.1%	-4.9%	-4.7%
Change in Total Non-Group Enrollment		0.9%	1.0%	0.9%	0.9%	0.8%	0.8%	0.8%	0.7%	0.7%	0.7%
Reinsurance Program Cost and Funding											
Reinsurance Funding (millions)		$14.7	$16.2	$16.2	$16.3	$16.4	$16.5	$16.6	$16.7	$16.8	$16.9
Difference in APTCs (millions)		$7.4	$8.2	$8.2	$8.3	$8.4	$8.5	$8.6	$8.7	$8.9	$9.0
PTC Adjustment (millions)		($0.7)	($0.8)	($0.8)	($0.8)	($0.8)	($0.8)	($0.8)	($0.8)	($0.8)	($0.8)
Difference in HIT (millions)		($0.3)	($0.3)	($0.3)	($0.3)	($0.3)	($0.3)	($0.3)	($0.3)	($0.3)	($0.3)
Estimated Net Federal Savings (millions)		$6.4	$7.1	$7.2	$7.3	$7.4	$7.5	$7.5	$7.6	$7.7	$7.8

Source: Attachment 1: Wakely Actuarial and Economic Analysis. Data from Table 8 Baseline Data and Detailed Results after Reinsurance by Year, Table 9 Detailed Results of Federal Savings by Year, and Table 4 2018 to 2020 Baseline Average Enrollment and Premium Data / Estimates

I. Rhode Island's 1332 Waiver Request

Like others across the country, Rhode Island's individual health insurance market has seen significant changes and challenges over the past several years. That said, it has remained relatively competitive and stable. This is largely due to the state's efforts to work collaboratively with Rhode Island's health insurance carriers to ensure a stable and adequately-priced market with multiple statewide plan options. Despite this relative success, insurance premiums in the individual market have increased significantly in the last three years and are expected to continue to increase into 2020.[7] Higher costs will result in increased numbers of uninsured Rhode Islanders, particularly impacting middle-income individuals and families who do not receive a premium tax credit and thus pay the full cost of their health insurance premiums in the individual market.

Rhode Island seeks a waiver of Section 1312(c)(1) under Section 1332 of the ACA for a five-year period, beginning in the 2020 plan year, to develop a state reinsurance program. The creation of such a program in the individual market by the 2020 plan year is necessary to preserve the relative affordability of Rhode Island's individual insurance market as well as the insured rates achieved in the state under the ACA. The waiver is intended to stabilize individual market enrollment, to mitigate rate increases, and to encourage insurance companies to continue to offer plans in the state's individual market.

Section 1312(c)(1) requires "all enrollees in all health plans . . . offered by [an] issuer in the individual market . . . to be members of a single risk pool." This application requests a waiver of the single risk pool requirement to the extent it would otherwise require excluding expected state reinsurance payments when establishing the market-wide index rate. A lower index rate will result in lower premiums for Rhode Island's second lowest-cost silver plan, resulting in a reduction in the overall PTC that the federal government is obligated to pay for subsidy-eligible consumers in Rhode Island. The waiver does not require changes to any other ACA provision.

Without a reinsurance program, individual health insurance premiums are expected to rise at an unsustainable rate. Consequently, more Rhode Island residents will be unable to afford - and be forced to go without - health insurance, further driving up rates due to adverse selection and provider cost shifting. By implementing a reinsurance program, Rhode Island will reduce the potential for further market disruption, lower the cost of individual premiums, and decrease federal subsidy obligations.

By mitigating high-cost individual health insurance claims, the reinsurance program will help to stabilize Rhode Island's individual market and make premiums more affordable. Table 1 above shows that with the waiver and reinsurance program in place, individual market premiums are expected to be 5.9 percent lower in 2020 than they would be absent the waiver.

This premium reduction will reduce federal APTC cost. Table 1 shows that absent the waiver, 2020 federal APTC spending in Rhode Island will be an estimated $118.0 million. After

[7] Wakely Actuarial Analysis, see Attachment 1.

factoring in the waiver, total 2020 federal APTC spending is estimated to be $110.6 million – a reduction of $7.4 million. Similar reductions are estimated for each year of the 10-year budget window.

To establish the state's reinsurance program, Rhode Island seeks federal pass-through funds in the amount of the federal savings for PTC, subject to the cap imposed by the statutory deficit neutrality requirement of the 1332 Waiver Program. Table 1 shows that after taking into account the waiver's federal PTC savings and impact on federal revenues from the health insurance providers fee (HIT), Rhode Island requests pass-through funding of $6.4 million in 2020.[8]

II. Compliance with Section 1332 Guardrails

A. Scope of Coverage Requirement (1332(b)(1)(C)):

As previously noted, the waiver will reduce the cost of coverage in the individual market. The lower cost of coverage will allow more Rhode Island residents to purchase or maintain coverage in the individual market than without the waiver. As indicated in Table 1, enrollment in the individual market is expected to increase by approximately 0.9% in 2020 over what it would have been absent the waiver, with similar increases in later years. The waiver will have no material impact on the availability of other types of coverage, such as Medicaid, CHIP, and employer-based insurance, so no impact is expected on the number of individuals in those programs. The waiver will have a positive impact on vulnerable populations who buy coverage in the individual market since premiums will be lower.

B. Affordability Requirement (1332(b)(1)(B)):

As noted above, the reinsurance program will make the cost of individual coverage lower than it would be absent the waiver in each year it is in effect. The waiver will not affect the premiums or cost-sharing for coverage obtained through other means, such as Medicaid, CHIP, and employer-based coverage.

Employer contributions and employee wages are not expected to be affected by the waiver. The waiver will have a positive impact by improving access to coverage for vulnerable populations who buy coverage in the individual market because premiums will be lower.

C. Comprehensiveness Requirement (1332(b)(1)(A)):

The waiver will have no material effect on the comprehensiveness of coverage for Rhode Island residents. Regardless of whether the waiver is granted, all Rhode Island ACA-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits provided by other types of coverage such as Medicaid, CHIP, and grandfathered plans will not be impacted. The waiver is expected to increase access to comprehensive and affordable coverage, thereby increasing the number of individuals with effective health coverage and access to high quality health care. Individuals gaining health coverage under the waiver will have coverage for more comprehensive health benefits than they would absent the waiver.

[8] For a detailed explanation of how the PTC adjustment is calculated using the latest Office of Tax Analysis (OTA) methodology, please see Attachment 1 page 13.

D. Deficit Neutrality Requirement (1332(b)(1)(D)):

As stated above, Rhode Island anticipates that average individual premiums will be lower under the waiver by 5.9 percent in 2020, 6.3 percent in 2021, and similar amounts in 2022 through 2028. Because federal APTC costs are tied to the second-lowest-cost silver plan, lower premiums will result in lower federal spending net of revenues in each year that the waiver is in effect.

The waiver will produce net federal savings of about $6.4 million in 2020 and similar amounts in later years. Rhode Island requests pass-through funds in each year equal to the net expected federal savings under the waiver. As shown in Table 2 for selected time periods and in Attachment 1 for each year, granting pass-through funding in these amounts will not result in the waiver increasing the federal deficit in any year, over the 5 years of the waiver, or over a 10-year budget window.

Table 2 – Impact to Federal Deficit Savings/Costs, Selected Time Periods

Category of Impact	2020	2020-2024	2020-2029
Savings in APTC (millions)	$7.4	$40.5	$84.3
PTC Adjustment (millions)	($0.7)	($3.8)	($7.9)
Difference in HIT (millions)	($0.3)	($1.4)	($2.9)
Estimated Net Federal Savings (millions) *Requested pass through funds*	$6.4	$35.3	$73.4

III. Description of the Rhode Island 1332 Waiver Proposal

A. Authorizing Legislation

Rhode Island passed legislation in 2018 related to pursuing a 1332 waiver to establish a reinsurance program to stabilize the state's individual market. The text of this legislation can be found in Attachment 2.

The Rhode Island Market Stability and Reinsurance Act, R.I. Gen. Laws § 42-157.1, was signed into law by Rhode Island Governor Gina Raimondo on July 2, 2018. This statute establishes the reinsurance program and gives HSRI the authority to implement a 1332 waiver. Specifically, this law authorizes the director of the state's exchange, HSRI, to establish and implement a state-based reinsurance program and to provide reinsurance to carriers that offer health insurance coverage on the state's individual market that meets the requirements of a waiver approved under 42 U.S.C. § 18052.

Legislation to authorize state funding for the reinsurance program has been introduced by Governor Raimondo and is currently under review by the legislature. H 5151 Article 14, Relating to Market Stability, is a budget article that will authorize the state to establish a state requirement for Rhode Island residents to maintain minimum essential health coverage starting Jan 1, 2020. The proposed legislation also includes a shared responsibility payment penalty to be imposed for Rhode Islanders not complying with a requirement to obtain qualifying health

coverage. The proposal also authorizes the placement of any shared responsibility payment penalties collected into a Health Insurance Market Integrity Fund, to be used as a state funding source for the individual market reinsurance program. The text of this legislation can also be found in Attachment 2.

The reinsurance program will reimburse individual health insurers for a percentage of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (reinsurance cap). For 2020, Rhode Island is projected to set the attachment point at $40,000, the reinsurance cap at $97,000, and the coinsurance rate at 50 percent. Current actuarial estimates show that these parameters will result in total estimated reinsurance payments matching the funding available.

Given that the actual values of revenue, funding and claims may differ from projected values, the state has laid out the following rules for management of the reinsurance program so that program decisions will be predictable and transparent. The reinsurance program will be underfunded if mandate revenues or federal pass-through funds are lower than expected and/or reinsurance claims costs are higher than expected. In the event that the reinsurance program is underfunded, the State will decrease the reinsurance claims payments made to carriers by adjusting the coinsurance rate down. If the reinsurance program has higher than expected funding due to higher state revenues or federal pass-through funds and/or lower reinsurance claims costs than expected, the state will set a higher coinsurance rate for claims eligible for reinsurance. The maximum coinsurance rate under the program would be 100% of claims eligible for reinsurance.

The Health Insurance Market Integrity Fund, authorized by R.I. Gen. Laws 42-157.1, will support the operation and administration of the reinsurance program. The director of the state's health insurance exchange is authorized to administer the fund. The fund will consist of:

> (1) Any pass-through funds received from the federal government under a waiver approved under 42 U.S.C. § 18052;
> (2) Any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the state;
> (3) Any funds designated by the state to provide reinsurance to carriers that offer individual health benefit plans in the state, including penalty fees for non-compliance with the state's mandatory health insurance requirement; and
> (4) Any other money from any other source accepted for the benefit of the fund.

Beginning in 2021, the RI Division of Taxation will collect a penalty from all tax filers who did not maintain the minimum required health insurance coverage in the prior year, as specified by state law. The funds collected in the form of penalty payments will be deposited in the Health Insurance Market Integrity Fund as described above, a restricted receipt account established for the purpose of providing a state share for the individual market reinsurance program approved under a 1332 waiver. The implementation of the state's reinsurance program is contingent by law upon CMS approval of the 1332 waiver request. The funding source is not contingent on waiver approval.

B. Federal Pass-Through Funding

The waiver is designed to improve Rhode Island residents' access to affordable and comprehensive coverage. The goals of the reinsurance program are to spread the risk of high-cost claimants across the broader health insurance market, thereby lowering premiums for the individual market. In doing so, the reinsurance program will incentivize individual enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability.

Because the amount of PTC received by taxpayers is tied to the second-lowest-cost silver plan available through HSRI, the waiver will reduce net federal expenditures due in the form of PTCs. Through this waiver request, Rhode Island seeks the amount of these federal savings, net of other costs that result from the waiver. Rhode Island will use these funds to help pay for the reinsurance program.

The waiver will have no impact on Rhode Island's compliance with the ACA's restrictions and requirements regarding the usage of federal funds related to certain abortions services included in qualified health plans offered through the exchange.

IV. Draft Waiver Implementation Timeline

HSRI will be responsible for implementing the reinsurance program. HSRI will promulgate regulations for the program's operating processes, requirements, payment parameters, and procedures. HSRI will deploy both federal pass-through funds and funds collected by the RI Division of Taxation resulting from the imposition of a state penalty for individuals not enrolling in minimum essential coverage. HSRI will collect and analyze reinsurance claims and distribute reinsurance payments to eligible insurers.

Establishment and implementation of the reinsurance program are anticipated to follow the timeline below:

Apr - Jun 2018	8 public meetings of the Market Stability Workgroup are held
Jul 2, 2018	Rhode Island Market Stability and Reinsurance Act is signed into law
Oct 2018 – Feb 2019	10 additional public meetings of the Market Stability Workgroup are held
Feb 18, 2019	First Contact Narragansett Indian Tribe about waiver
Mar 20, 2019:	OHIC sends rate filing instructions to carriers for CY2020 rates, including parameters of proposed reinsurance program
Apr 15, 2019	Final Actuarial and Economic Analysis is delivered to the state
Apr 26,2019	CMS-required public comment period begins: Post draft waiver for 30-day public comment period, including location, date, and time of public hearings
May 10, 2019	Waiver Public Hearing #1
May 20, 2019	Waiver Public Hearing #2
May 25, 2019	Complete consultation meeting with representatives of the Narragansett Indian Tribe and document Tribal feedback.
May 25, 2019	CMS-required Waiver 30-day public comment period is over
May 31, 2019	Carriers file rates for 2020 plan year
TBD	State Legislature passes, and Governor enacts, funding source of state share of reinsurance program.
TBD	1332 application is submitted to CMS at StateInnovationWaivers@cms.hhs.gov

TBD	CMS deems waiver complete.
TBD	CMS posts waiver for 30-day public comment period
TBD	CMS public comment period complete. CMS begins review.
TBD	CMS issues decision on waiver, issues Special Terms and Conditions for RI
Sep 2019	2020 Rate filings approved by OHIC
Dec 31, 2019	CMS recommends federal pass-thru funding for 2020 by this date
Jan 1, 2020	2020 rates are in effect; reinsurance program begins
Jan 1, 2020	Individual market issuer claims collection begins
May 2020	Issuer rate filings due for 2021 plan year
May 2020	HSRI posts notice of Public Forum to solicit comments on the progress of a section 1332 waiver as required under 45 CFR 155.1320(c)
Jun 2020	HSRI holds a public forum to solicit comments on the progress of a section 1332 waiver
Jun 2020	HSRI publicly posts a summary of the forum and submits summary to CMS.
Jun 2020	HSRI sets attachment point/cap/ coinsurance rate targets for 2021
Sep 2020	2021 Rate filings approved by OHIC
Dec 31, 2020	CMS notifies state of 2021 pass-thru funding by this date
Jan 1, 2021	2021 rates in effect
Mar 2021	HSRI submits a quarterly report to the Secretary of HHS
Mar 2021	HSRI submits a 2020 Draft Annual Report to CMS
Apr 2021	HSRI posts the 2020 Draft Annual Report on its public web site
Apr 2021	HSRI receives comments from CMS on draft annual report
May 2021	HSRI posts notice of Public Forum to solicit comments on the progress of a section 1332 waiver as required under 45 CFR 155.1320(c)
May 2021	Issuer Rate filings due for 2022 plan year
Jun 2021	HSRI publicly posts the Final Annual Report for the waiver year 2020
Jun 2021	HSRI submits a quarterly report to the Secretary of HHS
Jun 2021	HSRI holds a public forum to solicit comments on the progress of a section 1332 waiver
Jun 2021	HSRI sets attachment point/cap/ coinsurance rate targets for 2022
Sep 2021	HSRI submits a quarterly report to the Secretary of HHS
Sep 2021	2022 Rate filings approved by OHIC
Sep 2021	Insurers submit claims for individual market for 2020
Nov 2021	CMS makes 2020 pass-thru payment to RI
Nov 2021	2020 state revenue collected for 2020 tax year is transferred to HSRI
Nov 2021	HSRI makes 2020 reinsurance payments to the Health Plans
Dec 2021	HSRI submits a quarterly report to the Secretary of HHS
Dec 31, 2021	CMS notifies state of 2022 pass-thru funding

V. Additional Information and Reporting

A. Administrative Burden

Waiver of Section 1312(c) will cause minimal administrative burden and expense for Rhode Island and for the federal government. The waiver will cause no additional administrative burden to employers and individual consumers because Section 1312(c) does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Individual health insurance carriers will experience some administrative burden and associated expense as a result of the reinsurance program; however, the monetary benefit to carriers from the program will far exceed any resulting administrative expense.

Rhode Island has the resources and staff necessary to absorb the following administrative tasks that will be required of the state under this waiver:

- Administer the reinsurance program
- Distribute federal pass-through funds
- Monitor compliance with federal law
- Collect and analyze data related to the waiver
- Perform reviews of the implementation of the waiver
- Hold annual public forums to solicit comments on the progress of the waiver
- Submit annual reports (and quarterly reports if ultimately required) to the federal government

It will be necessary for the federal government to perform the following administrative tasks under this waiver:

- Review documented complaints, if any, related to the waiver
- Review state reports
- Periodically evaluate the state's 1332 waiver program
- Calculate and facilitate the transfer of pass-through funds to the state

Rhode Island believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so that their impact will be minimal. Waiver of Section 1312(c)(1) does not necessitate any changes to the Federally-Facilitated Marketplace or to IRS operations and will not impact how APTC and PTC payments are calculated or paid.

B. Impact on Residents Who Need to Obtain Health Care Services Out-of-State

Because Rhode Island shares borders with both Massachusetts and Connecticut, carrier service areas and networks that cover border counties generally contain providers in those states, especially in areas where the closest large hospital system is located in the border state. Granting this waiver request will not impact insurer networks or service areas that provide coverage for services performed by out-of-state providers.

C. Ensuring Compliance: Preventing Waste, Fraud, and Abuse

The Office of the Health Insurance Commissioner (OHIC) is responsible for regulating and ensuring regulatory compliance and monitoring the solvency of all Rhode Island carriers; performing market conduct analysis, examinations, and investigations; and providing consumer outreach and protection. OHIC investigates all complaints that fall within the agency's regulatory authority.

Measures are already in effect to guarantee the integrity of all HSRI functions. These measures will be applied to the implementation and operation of the reinsurance program, which will minimize the risk of waste, fraud and abuse. The State of Rhode Island and HSRI prepare comprehensive financial accounting statements annually. Financial statements are audited annually, with the most recent audit completed for the fiscal year ending in 2018. HSRI will administer the reinsurance program in accordance with its existing accounting, auditing, and reporting procedures. Auditing and reporting obligations of participating insurers will be established by state regulation.

Along with being audited annually by two independent external auditors (BerryDunn and the EFPR Group), HSRI is also subject to audit by the Office of Internal Audit in the Office of Management and Budget for the State of Rhode Island and the Office of the Auditor General. The reinsurance program will also be subject to audit by the Office of Internal Audit.

The federal government is responsible for calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

At the end of the initial waiver period, HSRI will measure and report on how well the waiver achieves its stated goal of improving access to and enrollment in affordable, comprehensive health insurance coverage. Evaluation of the success of the waiver will be incorporated into existing report(s) required under the Special Terms and Conditions (STCs) issued by CMS.

D. State Reporting Requirements and Targets

HSRI will assume responsibility for the reporting requirements of 45 CFR 155.1324, including the following:

- Quarterly reports (45 CFR 155.1324(a)): To the extent required, HSRI will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.

- Annual reports (45 CFR 155.1324(b)): HSRI will submit annual reports documenting the following:

  (1) The progress of the waiver, including how well the waiver is progressing in achieving its stated goals.
  (2) Data, similar to that contained in Attachment 1, on compliance with Section 1332(b)(1)(B) through (D) of the ACA.
  (3) Modifications, if any, to the essential health benefits for compliance with Section 1332(b)(1)(A) of the ACA.
  (4) The premium for the second lowest-cost silver plan under the waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
  (5) A summary of the annual post-award public forum required by 45 CFR 155.1320(c) together with a summary of action taken in response to public input.
  (6) Any additional information required by the terms of the waiver.

To the extent that quarterly reporting is required under 45 CFR 155.1324(a), HSRI recommends that such reporting commence no sooner than April 30, 2021, in order to provide some experience with the program about which to report. HSRI will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the waiver.

VI. Supporting Information and Miscellaneous

A. 45 CFR 155.1308(f)(4)(i) – (iii)

The supporting information required by 45 CFR 155.1208(4)(i) – (iii), including the actuarial analyses and certifications, the economic analyses, the detailed deficit neutral 10-year budget plan, and the data and assumptions demonstrating that the proposed waiver is in compliance with 1332(b)(1)(A) – (B) are found in Attachment 1.

VII. Public Comment and Tribal Consultation

A. Public Comment

On April 26, 2019, HSRI opened public comment on this waiver request and posted notice of the opportunity to comment on the Marketplace's website: https://healthsourceri.com/1332waiver. On the same date, HSRI sent notice via email to its list of interested parties and stakeholders. The list is comprised of individuals and organizations with an expressed or demonstrated interest in insurance-related matters.

HSRI is scheduled to hold two public hearings:

- May 10, 2019 from 1:00pm – 3:00pm at the Department of Administration, Conference Room B, 1 Capitol Hill, Providence, RI 02908, and
- May 20, 2019 from 9:00am – 11:00am at the Department of Labor and Training Conference Room, 1511 Pontiac Ave, Cranston, RI 02920.

At the public hearings, testimony will be collected from members of the public in attendance. Members of the public are also invited to submit written public comments on this waiver request.

After the public hearings, this waiver application will be updated with details on the attendance at public hearings, a summary of testimony offered, and a summary of written public comments. The public comment period is scheduled to close May 25, 2019.

B. Tribal Consultation

HSRI is engaging in tribal consultation with representatives of the Narragansett Indian Tribal Nation, which is the only federally-recognized Indian Tribe in Rhode Island. Rhode Island's draft application has been made available to the Tribe electronically and in hard copy.

HSRI will hold a meeting for the purpose of tribal consultation. After the consultation this waiver application will be updated with the details on attendance at the tribal consultation meeting and a summary of comments offered by the tribe.

VIII. Alignment with Section 1332 Principles

Rhode Island's waiver, if approved, will advance several of the principles described in CMS's 1332 guidance issued in October 2018:

- **Provide increased access to affordable private market coverage**. The reinsurance program will produce a net premium decrease exclusively for those purchasing private health insurance. Specifically, the net premium decrease for private health insurance in the individual market will be approximately 5.9 percent or more for each of the five years the waiver is in effect. The reinsurance program will also support competition in the health insurance market, helping to ensure access to private insurance coverage.
- **Support and empower those in need**. By producing a net premium decrease in the individual market, the waiver will target its impact at those who are not currently eligible for financial assistance and therefore generally face both the largest premiums for health insurance as well as the largest year-over-year increases in premiums. Unlike individuals eligible for APTC, who are generally insulated from the impact of premium changes, individuals ineligible for APTC are responsible for the full premium. They are also currently unprotected from annual increases in premiums. The reinsurance program will mitigate premium increases, providing support to those who currently receive no assistance.
- **Foster state innovation**. The waiver is a state-run approach to making coverage more affordable that is suited to the specific needs of Rhode Island. States across the country have pursued innovative approaches to strengthening their health care systems. A reinsurance waiver has been identified by Rhode Island as the approach that meets its needs while allowing it to take control of its own health care system.

Attachment 1

www.wakely.com

State of Rhode Island

Section 1332 State Innovation Waiver
Actuarial and Economic Analysis

April 22, 2019

Prepared by:

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Appendices

Introduction

The individual health insurance market in the state of Rhode Island ("Rhode Island") has been relatively stable. However, the state wishes to further strengthen its individual market and provide greater access through lower premiums to its citizens. In order to increase access through lower premiums, Rhode Island is submitting a Section 1332 State Innovation Waiver ("1332 waiver" or "waiver"). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for Rhode Island's 1332 waiver to be approved, the state must demonstrate that the waiver does not interfere with the four "guardrails". The four guardrails are: coverage, affordability, comprehensiveness, and deficit neutrality.

The waiver, as proposed, would reduce premiums through the introduction of a state-based reinsurance program starting in 2020. The reinsurance program would operate similarly to the Federal Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2020, Rhode Island will set the attachment point at $40,000, the reinsurance cap at $97,000, and the coinsurance at 50%.

The reinsurance program will be funded, contingent on approval of the 1332 waiver, through a state appropriation for the 2020 plan year. Based on the best estimate, the total program funding would be $14.7 million, with the state funding representing an estimated $8.3 million. The state funding portion is projected to be $8.3 million in 2020 regardless of the Federal funding amount. If the reinsurance program, in operation, has higher than expected funding due to higher mandate revenues or federal pass-through funds and/or lower reinsurance claims costs than expected, the state will pay out these funds to carriers in the form of a higher coinsurance rate for claims eligible for reinsurance

The goals of the reinsurance program are to remove the volatility of high cost claimants from being solely the risk of any one insurer as well as to lower premiums for the individual market in total (as the reinsurance funding will come from sources outside the individual market). In doing so, the reinsurance program would incentivize enrollees to join or remain in the market while simultaneously maintaining incentives for carriers to control cost. In addition to providing lower premiums to residents of Rhode Island, the reinsurance program would also reduce federal outlays through lower premium tax credits.

The reinsurance program is not the only program Rhode Island is proposing to increase stability in the individual market. Rhode Island has also proposed a state individual responsibility mandate. This program is designed to incentivize individuals to purchase coverage. This proposed program is not dependent on 1332 waiver approval and consequently its effects are included in the baseline of all estimates included in this report.

As part of its 1332 waiver, Rhode Island is requesting federal funds as a way of offsetting some of the costs incurred by the reinsurance program. Rhode Island's reinsurance program will reduce premiums for those purchasing insurance coverage in the individual market. It will also reduce the amount of Premium Tax Credits (PTCs) Rhode Islanders receive over the next ten years. PTCs are subsidies for eligible enrollees that can be used to reduce the cost of premiums for plans purchased through the Exchange. The amount of PTCs available for eligible consumers are benchmarked to the second lowest cost silver plan (SLCSP) available on the Exchange. If premiums are reduced (including the SLCSP), then the amount the Federal Government will be required to pay in PTCs will also be reduced.

This report demonstrates that the savings on aggregate PTC amounts exceed lost federal revenue that may result from the reinsurance program. Furthermore, the reinsurance program will not reduce but rather would improve Rhode Islanders' access to affordable and comprehensive coverage. The waiver requests that Rhode Island receive the amount of federal savings from PTCs, net of other costs, as a result of the reinsurance program.

The state of Rhode Island, HealthSource Rhode Island (HSRI), retained Wakely Consulting Group, LLC ("Wakely") to analyze the potential effects of a state-based reinsurance program on the 2020 individual ACA market. This document has been prepared for the sole use of Rhode Island. Wakely understands that the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

This actuarial report is a supplement to Rhode Island's 1332 waiver report. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Other sections of the waiver contain the non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by qualified individuals.

Analysis Results

As described previously, the four guardrails of an approved 1332 waiver application are: 1) Coverage Requirement; 2) Affordability Requirement; 3) Comprehensiveness Requirement; and 4) Deficit Neutrality.

Wakely's analysis estimated that the waiver meets each of the four guardrails not only in 2020 but in each subsequent year over the 10-year window. The high-level 2020 guardrail results are shown in Table 1.

Table 1: 2020 High-Level Guardrail Results

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2020)	Relative premium decrease of 5.6% to 6.0%
Comprehensiveness	No change to EHBs
Deficit Neutrality (2020)	Federal savings of $4.5 million to $7.8 million
Deficit Neutrality (10-year)	Federal savings each year of 10-year window

Coverage, Affordability, and Comprehensiveness

The reinsurance program is expected to decrease premiums in the non-group market. The reduction in premiums should increase overall coverage. Existing research from the Congressional Budget Office (CBO)[1] and the Council of Economic Advisors (CEA)[2] has noted that premium decreases should result in enrollment increases. As the reinsurance program has no impact on other cost-sharing, the decreased premiums also improves affordability for consumers. Similarly, the reinsurance program would have no effect on the comprehensiveness of coverage. EHB requirements will not be affected by the reinsurance program. Individuals purchasing coverage in the non-group market would have the same benefits with the reinsurance program as they would without it.

Deficit Impact

The following tables display the impact of the reinsurance program on Rhode Island's individual market both for 2020 and for the 10-year deficit window. Based on the best estimate assumptions,

[1] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf
[2] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

in 2020, the waiver reduces premiums[3], increases non-group enrollment, and creates millions in federal savings (which incorporates PTC savings net of other federal revenue). These results are shown in Table 2. The results are similar for years 2020 to 2029, although impacts on premium and enrollment decrease over time, as is shown in Appendix C.

Table 2: 2020 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Premiums	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-5.9%	+0.9%	$6.4 million

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to PTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in Table 3.[4]

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit ($ millions)[5]
Difference in PTCs[6]	$76.3
Difference in Mandate Penalty	$0.0
Difference in User Fees	$0.0
Difference in HIT	($2.9)
Estimated Net Federal Savings	$73.4

Data and Methodology

The following steps were taken to estimate the impact of a state-based reinsurance program on Rhode Island's individual market both for 2020 and for the 10-year deficit window.

1. Wakely's model incorporates 2017, 2018 and emerging 2019 experience as base data, which was provided by Rhode Island insurers.

[3] The premium impacts shown throughout the report represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been in 2020. They do not show 2020 premium changes relative to 2019.
[4] Insurers that utilize the Healthcare.gov platform are assessed a fee by the Federal government. This fee is calculated as percent of Exchange premium. Since Rhode Island is a state-based Exchange, no Exchange fee offset was assumed. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. Individual mandate penalties were set to $0 effective for the 2019 benefit year.
[5] Numbers may not add up due to rounding.
[6] Note PTC savings is the APTC amounts times the PTC ratio of 90.6%.

Wakely sent a data call to all Rhode Island insurers that offered individual market ACA-compliant plans in 2017, 2018 or 2019. The data call requested full year 2017 and 2018 and emerging 2019 enrollment, premium, and Advanced Premium Tax Credit (APTC) information, which was used to inform the baseline estimates. The 2018 premiums and enrollment were summarized to create a baseline picture of Rhode Island's market. The 2019 enrollment, APTC, and premium data were adjusted to account for expected attrition to estimate average enrollment. The summarized amounts are shown in Table 4.

Table 4: 2018 to 2020 Baseline Average Enrollment and Premium Data / Estimates[7]

Baseline	2018	2019	2020
Average Annual Enrollment			
Total Non-Group Enrollment	43,640	43,023	42,434
Exchange Enrollment	31,535	31,613	31,422
APTC Enrollment	26,013	26,134	26,134
Non-APTC Exchange Enrollment	5,523	5,479	5,287
Off-Exchange Enrollment	12,105	11,411	11,012
Total Non-APTC Enrollment	17,627	16,889	16,300
Per Member Per Month (PMPM) Amounts			
Total Non-Group Premium PMPM	$435.76	$463.05	$507.45
Exchange Premium PMPM	$413.09	$439.60	$481.76
Gross Premiums PMPM for APTC Members	$426.90	$455.59	$499.28
Net Premiums PMPM for APTC Members	$121.02	$120.59	$123.00
APTC PMPM	$305.89	$335.00	$376.27
Total Annual Dollars			
Total Non-Group Premiums	$228,200,000	$239,060,000	$258,400,000
Total APTCs	$95,480,000	$105,060,000	$118,000,000

2. The 2020 enrollment, premium, and APTC amounts were estimated using 2018 and 2019 insurer information submitted to Wakely, as well as 2018 data from the Center for Medicaid and Medicare Services (CMS) and other publicly available information.

[7] Note total premiums and APTCs were rounded.

a. The state average premium was based on the 2018 and February 2019 insurer information. The 2019 average premiums were increased by the average estimated 2020 rate increase, which would include increases to account for trend, market morbidity changes, higher premiums due to the reinstatement of the health insurance tax (also known as the health providers fee or the HIT), and an adjustment for historical financial performance. Further details are included in Appendix A.

b. To estimate the average 2020 APTC amounts, Wakely used the 2018 and emerging 2019 APTC information from Rhode Island insurers including APTC amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We also used the CMS reports from 2018 and adjusted the insurer data as necessary. We then inflated net premiums for APTC enrollees by the estimated 2020 premium increase of 2% for indexing. The 2020 average gross premium is then reduced by the 2020 average net premium (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2020 APTC PMPM amounts

c. The 2020 individual market enrollment was calculated using 2018 and emerging 2019 data from CMS and Rhode Island insurers. It was then adjusted to account for changes in enrollment due to net attrition throughout 2019, as discussed in Appendix A. Our best estimate, based on conversations with Rhode Island, assumed that because of the proposed implementation of state specific mandate and other regulatory changes, 2020 enrollment would only modestly vary from 2019. This is in part because of the introduction of a Rhode Island specific individual mandate and regulations and statutes that will limit enrollment in non-ACA individual market products such as short-term limited duration plans or association health plans. To the extent that experience deviates from this assumption, the results of this analysis will be impacted.

The estimated 2020 baseline information is shown in Table 4.

3. To estimate the effects of the reinsurance program, Wakely assumed that $14.7 million dollars would be the total funding available to reduce premiums in 2020. None of the funds were assumed to cover administrative costs for Rhode Island to operate the program. Enrollment was re-estimated with the lower post-reinsurance premium, using an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a final individual market average enrollment per scenario. The results for the best estimate scenario are shown in Table 5.

4. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.

a. A health reform study from Massachusetts[8] indicated that enrollees who leave the market have costs that are approximately 73% compared to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program. Wakely further assumed that only enrollees without subsidizes would enroll in the individual market as a result of lower premiums due the reinsurance program. Unsubsidized enrollees would have their premiums decreased due to reinsurance but subsidized enrollees would not. For more details, please see the Appendix.

b. The result is an additional 0.2% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program.

c. Applying the additional reduction due to morbidity improvement to the reduction in plan liability results in an overall premium reduction estimate of 5.9% under the best estimate scenario.

d. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of further iterations.

5. The best estimate assumptions resulted in a reduction in premiums of 5.9% due to the reinsurance program and resulting improvement in morbidity.

Table 5: Estimated 2020 Average Enrollment and Premium Amounts After Reinsurance

After Reinsurance	
Reinsurance Funding	$14,720,000
Reduction in Premiums (Reinsurance Funding)	-5.7%
Reduction in Premiums (Improved Morbidity)	-0.2%
Reduction in Premiums (Combined Reinsurance and Improved Morbidity)	-5.9%
Total Non-Group Premium PMPM	$477.37
Exchange Premium PMPM	$453.20
APTC PMPM	$352.74
Change in Total Non-Group Enrollment	0.9%
Total Non-Group Enrollment	42,834
Exchange Enrollment	31,552

[8] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

After Reinsurance	
APTC Enrollment	26,134
Total Premiums	$245,380,000
Total APTCs	$110,620,000

6. To calculate the pass-through amounts Wakely calculated the difference in APTC in the baseline scenario and waiver scenario. Wakely then multiplied the APTC savings amount by the ratio of total PTC subsidy after reconciliation to APTC based on tax data for benefit year 2016 (or 90.6%) to arrive at the PTC savings amount.[9] This amount was then reduced by the potential HIT fee differences between baseline and waiver scenarios.

7. The following are the assumptions incorporated for the 10-year estimates:

    a. Premiums were trended using National Health Expenditure Data from CMS.[10] In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 2.0% based on 2018 rate filing information and discussions with the carriers.

    b. The individual market enrollment was assumed to have small decreases as a function of premium increase using the Council of Economic Advisor's (CEA) take-up function for each year.[11]

    c. In 2020 total reinsurance funding was set equal to $14.7 million based on targeting state funding at $8.3 million.

    d. In 2021, and all future years, total reinsurance funding was solved by targeting total state funding of $9.05 million.

The results of these assumptions, such as enrollment (both in total and various distributions), changes to the SLCSP, and impact on the federal deficit are discussed in Appendix A and Appendix C.

[9] This aligns with the methodology for calculating the PTC as noted in the "Method for Calculation of Section 1332 Waiver 2019 Premium Tax Credit Pass-through Hey Amounts" document located at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Treasury-Method-Calculation-1332-Pass-through-Amounts.pdf

[10] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html- Table 17. Premiums were trended by private health insurance excluding medigap and property and casualty.

[11] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

Scenario Testing

Wakely performed scenario testing, which primarily involved changing the enrollment, premium, PTC ratio assumptions, and Federal modeling for 2020. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis. We tested for a scenario (Scenario 2) where the impact of reinsurance on the second lowest cost silver is less than Scenario 1. Scenario 3 and Scenario 4 tested for scenarios in which enrollment and premium growth differed from the best estimate. Finally, Scenario 5 tested for a scenario in which pass-through amounts are lower than carriers expect. This can happen, as Federal modeling assumptions for the pass-through amount could be announced following rate setting. In these additional scenarios, amounts for reinsurance payments may not equal the reinsurance amounts announced for rating setting purposes since the state funding is assumed to be constant at $8.3 million but the Federal pass-through changes.

Further details regarding the scenario testing can be found in Appendix A and Appendix C. The high-level results of the scenario testing are shown in Table 6. Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios.

Table 6: High-Level Results of Scenario Testing

Scenario	1	2	3	4	5
Description	Best Estimate	Low Reinsurance Impact	Moderate Enrollment Increase	Moderate Enrollment Decrease and Pass-through Calculations More Favorable to State	Best estimate Enrollment and Pass-through Calculation Less Favorable to State
Total Funding (available for reinsurance operations)	$14.72	$13.31	$13.39	$16.08	$12.81
Total Reduction in Premiums	-5.9%	-5.9%	-5.6%	-6.0%	-5.9%
Estimated Net Federal Savings (millions)	$6.42	$5.01	$5.09	$7.78	$4.51
Estimated State Funding (millions)	$8.30	$8.30	$8.30	$8.30	$8.30

Appendix A
Data and Methodology

2020 Baseline Enrollment and Premium Estimates

To create the baseline estimates, Wakely completed the following steps:

1. Wakely sent a data call to all Rhode Island carriers that offered individual market ACA-compliant plans in 2018 or 2019. The data call requested full year 2018 and emerging 2019 enrollment, premium, and APTC information, which was used to inform the baseline estimates.

   Wakely used the 2019 insurer data to calculate average enrollment and average premiums. Wakely used the 2019 insurer data to identify the February experience, including enrollment, state average premium, average Exchange premium, average APTC amount, gross premiums for individuals with APTC, and net premium for individuals with APTC. The data was compared to CMS reports to confirm consistency.

   The data call also requested full year 2017 and 2018 enrollment and claims information in continuance tables. The use of this data is discussed in Appendix B.

2. The relationship between February 2018 and average 2018 experience was studied to approximate average 2019 experience from February 2019 insurer data. The adjustment varied by subsidized, non-subsidized on-Exchange, and non-subsidized off-Exchange.

3. Metal level distribution was estimated using 2019 insurer submitted data while FPL distribution was estimated using 2019 data supplied by HSRI.

4. For the best estimate, overall enrollment in 2020 was estimated using a non-linear enrollment response function estimated by the CEA take-up function.[12] The function computes expected enrollment change based on premium rate increases and the portion of the market that is not receiving subsidies. This resulted in an enrollment decrease of 1.4% compared to 2019. 2020 APTC enrollment was assumed to be consistent with 2019 enrollment, as these enrollees are partly shielded from premium increases. Wakely assumed that Rhode Island's individual mandate, effective in 2020, as well as policies limiting enrollment in short-term limited duration plans would reduce the potential number of people exiting the individual market, which resulted in the low change in enrollment. The result of these three assumptions is that enrollment changes would occur among the unsubsidized portion of the non-group market. The changes in enrollment were distributed pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented.

[12] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

5. For 2020, premiums were estimated using the 2019 insurer submitted data and data sources described previously. The average 2020 premium was increased by approximately 9.6% to account for all rating factors such as trend, financial adjustment, change in morbidity due to enrollment changes, and to account for the health insurance tax returning for the 2020 benefit year.

6. To estimate 2020 APTC PMPMs, we used emerging 2019 Rhode Island insurer data to calculate the average net premium among APTC enrollees (that is the actual amount APTC enrollees pay). We increased the 2019 required contribution (i.e., net premium) to conform with the indexing of the contribution rate. We increased it 2% from 2019. We then inflated gross premiums for APTC enrollees (the 2020 APTC amounts plus net premiums) by the 2020 estimated premium increase (9.6%). This new gross premium amount is reduced by the net premium amount (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2020 APTC PMPM amounts. These assumptions, in totality, were used to generate the baseline estimates shown in Table 4.

2020 Waiver Effects

The impact of the $14.7 million in reinsurance funding (as discussed previously) as a reduction to premiums was estimated by dividing the total reinsurance funding amount of $14.7 million by the total estimated 2020 baseline individual market premium.

Based on a review of the continuance tables of the various carriers, we expect that the impact of reinsurance will be less for the issuer that had the SLCSP in 2019 but the extent to which it will be lower, or if it will be at all, will be determined based on the actual issuer rate filings. As a result, the premium reduction to the second lowest cost silver plan as a result of the reinsurance program is expected to be smaller than the market average in all of our scenarios (albeit that difference between the market average impact and impact on the SLCSP differs by scenario). Gross APTC premiums in the best estimate were decreased by 4.5% (to calculate APTC) which is over 1% less than the impact to the market.

The decrease in premiums is expected to produce an increase in enrollment relative to what Rhode Island would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function (as discussed previously). APTC enrollment is assumed to stay the same as the baseline since these members are generally unaffected by rate changes.[13] If, contrary to our assumption, APTC enrollment were to drop, the deficit savings would

[13] This assumption does not preclude normal churn that occurs within the individual market. Normal churn, enrollees leaving for employer-sponsored insurance or enrollees joining the individual market who previously had coverage in Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2020 as had coverage in 2019.

be considered more conservative as the true savings to the Federal government may be higher. New enrollees are expected to be above 400% FPL or otherwise ineligible for APTC. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that enrollees who stay in the market due to the implementation of reinsurance will be healthier and/or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.[14] These results were discussed previously and are shown in Table 5.

Federal pass-through amounts were calculated in the following manner, consistent with the methodology outlined by the Office of Tax Analysis (OTA).[15] First, the aggregate amount of advanced-premium tax credits in the baseline scenario were compared to the aggregate amount of advanced premium tax credits in the waiver scenario. The difference in advanced premium tax credits is then adjusted to calculate the total premium tax credit subsidy. To do that Wakely relied on discussions with OTA and CMS to estimate the PTC ratio as well as using publicly available IRS tax statistics from the 2016 benefit year.[16] The actual data used by OTA for the 2020 calculations will be from 2017 as well as from 1095-A data, which are currently not public at the time of Wakely completing this report. The ratio of total PTC subsidy after reconciliation to APTC based on tax data for benefit year 2016 (or 90.6%) was multiplied by the APTC savings. This total PTC savings are then reduced by potential differences in the HIT fee. This new aggregate amount is the total net Federal savings.

Additionally, we note that a different methodological approach to the application of the premium tax credit adjustment could result in a different pass-through. According to the OTA methodology,[17] the adjustment to advanced premium tax credits to calculate premium tax credits is handled at the last step via a ratio multiplied by APTC savings. However, if a different methodology were applied, such as PTC ratio applied directly to APTC amounts at the baseline, the result would increase the pass-through of the best estimate (thus reducing the needed state funds by the same amount) by $700,000, or a 4.7% higher pass-through rate.

[14] https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/
[15] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Treasury-Method-Calculation-1332-Pass-through-Amounts.pdf
[16] https://www.irs.gov/statistics/soi-tax-stats-historic-table-2
[17] ibid

Alternative Scenarios

Wakely estimated four additional 2020 scenarios to analyze the robustness of the initial 2020 or Scenario 1 findings. The following were the scenarios that were modeled:

- Scenario 1 (Best Estimate): 2020 enrollment was lower than 2019 estimated enrollment, using the elasticity function to model enrollment drops due solely to premium increases. Those leaving the market were estimated to have a morbidity 27% lower than the market.[18] Average baseline premium rates were estimated to be 9.6% higher than in 2019. The reinsurance program is estimated to lower market average premiums by 5.9% after morbidity impacts with the SLCSP decreasing by 4.7% (4.5% before morbidity).

- Scenario 2: In this scenario, the impact of reinsurance on the second-lowest cost silver plan premium was 1% smaller than Scenario 1, or 3.5% before the impact of morbidity. A lower impact to the SLCSP reduces ATPC savings which lowers pass-through amounts compared to Scenario 1. Assuming the state funding cannot exceed $8.3 million, the lower pass-through results in funding for reinsurance payments of $13.3 million.

- Scenario 3: This scenario assumes that 2020 enrollment (both subsidized and unsubsidized) is 5% higher than the best estimate and gross premiums are 3% lower than the best estimate. This would mean that APTC amounts are less than Scenario 1. Finally, the impact to the SLCSP is 1% less than the best estimate. These numbers selected are reasonable discrepancies to highlight the sensitivity of the results. As a result, total funding available for reinsurance payments would be $13.4 million.

- Scenario 4: This scenario models a larger enrollment decrease (roughly 3.5% overall including a 2.6% reduction in subsidized enrollment) compared to Scenario 1. Premiums increase more than Scenario 1 due to healthier members leaving the market. Given uncertainty in pass through calculation, Scenario 4 includes a variation in which the calculated pass-through amounts do not include offsets for lower HIT fee. Finally, the impact on the SLCSP plan is 0.5% lower than market average impact. The available funds for reinsurance payments would be $16.1 million.

- Scenario 5 models a scenario that has different issuer assumptions and pass-through methodology assumptions. In this scenario carriers perceive the level of enrollment in Scenario 1. However, the SLCSP premium is reduced 1% less than the reduction estimated in Scenario 1. Furthermore, the premium tax ratio used to adjust APTC amounts is lower than projected (82.6% rather than 90.6%). This can happen if there were dramatic changes in tax filing behavior in 2017 relative to 2016. As a result, total premium

[18] This was calculated using morbidity factors measured by CEA and referenced elsewhere in the paper. https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

reduction is 5.9% and total funding available for reinsurance payments would be $12.8 million.

For each of the scenarios, the same reinsurance methodology was applied as was used in the baseline scenario: $8.3 million in state funding was applied to the individual market and total funding was then solved for based on the pass-through amount. Each scenario produced a decrease in the state average premiums PMPM in 2020 between 5.6% to 6.0%. In each scenario, the lower premiums resulted in more enrollees in the individual market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in fewer Federal dollars being spent in 2020 as a result of the reinsurance program relative to the baseline. The detailed results of the scenario testing are shown in Table 7.

Scenario 1 is the best estimate scenario. This scenario was used for the 10-year economic analysis.

Table 7: Summary of Alternative Scenario Results for 2020

Scenario	1	2	3	4	5
Description	Best Estimate	Low Reinsurance Impact	Moderate Enrollment Increase	Moderate Enrollment Decrease and Pass-through Calculations More Favorable to State	Best estimate Enrollment and Pass-through Calculation Less Favorable to State
Baseline					
Total Non-Group Enrollment	42,434	42,434	44,556	40,951	42,434
Exchange Enrollment	31,422	31,422	32,993	30,474	31,422
APTC Enrollment	26,134	26,134	27,441	25,443	26,134
Total Non-Group Premium PMPM	$507.45	$507.45	$507.45	$515.00	$507.45
Exchange Premium PMPM	$481.76	$481.76	$481.76	$488.93	$481.76
APTC PMPM	$376.27	$376.27	$361.30	$383.70	$376.27
Total Non-Group Premiums	$258,400,000	$258,400,000	$271,320,000	$253,080,000	$258,400,000
Total APTCs	$118,000,000	$118,000,000	$118,970,000	$117,150,000	$118,000,000
After Reinsurance					
Target Reinsurance Funding	$14,720,000	$14,720,000	$14,720,000	$14,720,000	$14,720,000
Reduction in Premiums (Reinsurance Funding)	-5.7%	-5.7%	-5.4%	-5.8%	-5.7%
Reduction in SLCSP Premiums (Reinsurance Funding)	-4.5%	-3.5%	-3.5%	-5.3%	-3.5%
Reduction in Premiums (Improved Morbidity)	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%

Scenario	1	2	3	4	5
Description	Best Estimate	Low Reinsurance Impact	Moderate Enrollment Increase	Moderate Enrollment Decrease and Pass-through Calculations More Favorable to State	Best estimate Enrollment and Pass-through Calculation Less Favorable to State
Total Premium Impact	-5.9%	-5.9%	-5.6%	-6.0%	-5.9%
Total SLCSP Premium Impact	-4.7%	-3.7%	-3.7%	-5.5%	-3.7%
Total Non-Group Premium PMPM	$477.37	$477.37	$478.80	$485.04	$477.37
Exchange Premium PMPM	$453.20	$453.20	$454.56	$460.48	$453.20
APTC PMPM	$352.74	$357.73	$343.36	$356.76	$357.63
Percent Change in Total Enrollment	0.9%	0.9%	0.9%	0.9%	0.9%
Total Non-Group Enrollment	42,834	42,834	44,955	41,324	42,834
Exchange Enrollment	31,552	31,552	33,122	30,595	31,552
APTC Enrollment	26,134	26,134	27,441	25,443	26,134
Total Premiums	$245,380,000	$245,380,000	$258,300,000	$240,520,000	$245,380,000
Total APTCs	$110,620,000	$112,190,000	$113,070,000	$108,920,000	$112,160,000
Savings					
Estimated APTC Savings	$7,380,000	$5,820,000	$5,910,000	$8,590,000	$5,850,000
Estimated PTC Adjustment	($690,000)	($550,000)	($560,000)	($810,000)	($1,020,000)
Difference in Insurer Fees	($260,000)	($260,000)	($260,000)	$0	($260,000)
Estimated Federal Savings	$6,420,000	$5,010,000	$5,090,000	$7,780,000	$4,510,000
Estimated State Funds Available	$8,300,000	$8,300,000	$8,300,000	$8,300,000	$8,300,000

Scenario	1	2	3	4	5
Description	Best Estimate	Low Reinsurance Impact	Moderate Enrollment Increase	Moderate Enrollment Decrease and Pass-through Calculations More Favorable to State	Best estimate Enrollment and Pass-through Calculation Less Favorable to State
Total Funding Available for Reinsurance Payments	$14,720,000	$13,310,000	$13,390,000	$16,080,000	$12,810,000
Estimated Pass-Through (Based on Total Funding Available for Rein Payments)	43.6%	37.6%	38.0%	48.4%	35.2%

Beyond 2020

For years beyond 2020, Wakely made the following assumptions:

- Baseline premiums (both total non-group and on-Exchange) as well as Gross Premium Amounts for individuals with APTC were trended by the Office of the Actuaries National Health Expenditure spending for each year of the 10-year window.[19]
- APTC Net Premiums were increased 2% annually to account for indexing.
- Enrollment was reduced by the projected increase in premium using the CEA take-up function.
- The total funding was determined based on a Rhode Island funding amount of $9.05 million and the estimated pass-through for the year.
- For each year, the same methodology of applying reinsurance, calculating the change in premiums and APTC amounts as a result of reinsurance, and calculating the change in enrollment as a result of lower premium was used consistently to that described for 2020. The detailed results are shown in Table 8.

[19] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 8: Baseline Data and Detailed Results after Reinsurance, by Year[20]

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Total Non-Group Enrollment	42,434	42,146	41,877	41,572	41,272	40,984	40,713	40,459	40,197	39,941
APTC Enrollment	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134
Total Non-Group Premium PMPM	$507.45	$531.40	$555.22	$584.10	$614.43	$645.68	$677.13	$708.61	$743.08	$779.21
Gross Premium PMPM for APTC Mbrs	$499.28	$522.84	$546.28	$574.69	$604.54	$635.28	$666.22	$697.20	$731.11	$766.66
Net Premium PMPM for APTC Mbrs	$123.00	$125.46	$127.97	$130.53	$133.14	$135.81	$138.52	$141.29	$144.12	$147.00
APTC PMPM	$376.27	$397.37	$418.30	$444.16	$471.39	$499.47	$527.70	$555.91	$587.00	$619.66
Total Premiums	$258,400,000	$268,760,000	$279,010,000	$291,380,000	$304,310,000	$317,550,000	$330,810,000	$344,030,000	$358,440,000	$373,470,000
Total APTCs	$118,000,000	$124,620,000	$131,180,000	$139,290,000	$147,830,000	$156,640,000	$165,490,000	$174,340,000	$184,090,000	$194,330,000
After Reinsurance										
Reinsurance Funding	$14,720,000	$16,200,000	$16,200,000	$16,300,000	$16,400,000	$16,500,000	$16,600,000	$16,700,000	$16,800,000	$16,900,000
Reduction in Premiums (Reinsurance Funding)	-5.7%	-6.0%	-5.8%	-5.6%	-5.4%	-5.2%	-5.0%	-4.9%	-4.7%	-4.5%
Reinsurance Assessment	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in Premiums (Improved Morbidity)	-0.2%	-0.3%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%
Total Non- Group Premium PMPM	$477.37	$498.10	$521.72	$550.16	$580.05	$610.86	$641.87	$672.94	$706.97	$742.67
APTC PMPM	$352.74	$371.33	$392.10	$417.61	$444.51	$472.25	$500.14	$528.02	$558.78	$591.10
Change in Total Non-Group Enrollment	0.9%	1.0%	0.9%	0.9%	0.8%	0.8%	0.8%	0.7%	0.7%	0.7%

[20] Please Appendix C for total federal savings net of federal losses under the reinsurance program.

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Total Non-Group Enrollment	42,834	42,563	42,271	41,943	41,622	41,315	41,026	40,756	40,479	40,207
APTC Enrollment	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134
Total Premiums	$245,380,000	$254,410,000	$264,640,000	$276,900,000	$289,720,000	$302,850,000	$316,000,000	$329,110,000	$343,410,000	$358,330,000
Total APTCs	$110,620,000	$116,450,000	$122,970,000	$130,970,000	$139,400,000	$148,100,000	$156,850,000	$165,590,000	$175,240,000	$185,380,000

Appendix B
Reinsurance Parameters

Reinsurance Parameters

As noted previously, the reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2020, Rhode Island has estimated that parameters will be the following: the attachment point at $40,000, the reinsurance cap at $97,000, and a 50% coinsurance rate.

Wakely used the continuance tables provided from all insurers for 2018 calendar years to estimate the reinsurance parameters for the program. The 2018 data was used in the modeling with the 2017 continuance table serving as a cross-check for reasonability and consistency. To obtain 2020 claims data consistent with the best estimate scenario, various adjustments to the data were performed including enrollment, morbidity, and annual claim increases.

1. The best estimate scenario enrollment decrease of 1.8% from 2018 to 2020 was applied to the data.
2. The morbidity changes from 2018 to 2020 was modeled under the assumption that members leaving the market had a health relativity of 73% as those staying in the market. This resulted in a morbidity increase of 0.4%.
3. Claims were trended to 2020 by estimating annual medical cost trend and morbidity increases as described above. These trends were determined based on a combination of actuarial judgement, review of ACA rate filing documents, expectation of the return of the HIT fee in 2020, and consideration that the MLR is expected to be lower after the impact of the reinsurance program.
4. The annual claim increase was then solved for using the preceding three adjustments, resulting in an annual claim increase of 7.3% annually from 2018 to 2020. This annual claim increase includes adjustments outside of trend such as metal mix changes.

The resulting 2020 data was used to determine the reinsurance parameters. Wakely estimated the $14.7 million in funding would be spent with an attachment point of $40,000, 50% coinsurance, and a cap of $97,000. If the reinsurance program, in operation, has higher than expected funding due to higher mandate revenues or federal pass-through funds and/or lower reinsurance claims costs than expected, the state will pay out these funds to carriers in the form of a higher coinsurance rate for claims eligible for reinsurance. The maximum coinsurance to be paid out is 100% of claims eligible for reinsurance. In the unlikely event that allocated program funding is higher than what would be required for paying out 100% of claims eligible for reinsurance, the State would then make a determination about how to best use those funds.

It is important to note that the assumptions in this estimate are inherently uncertain. The resulting parameters will vary from these estimates to the degree the actual enrollment, morbidity, trend,

and other assumptions vary from those used in this analysis. In addition, if there are significantly more or fewer high cost claimants in 2020 compared to 2017 and 2018, the results from this analysis may also vary. Finally, insurers are expected to have differing impacts from one another due to the reinsurance program based on how they vary from the market average in the assumptions discussed previously in this section.

Appendix C
Guardrail Requirements

Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least a comparable number of enrollees (and most likely a greater number of individuals covered).

Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable as would be provided absent the waiver coverage to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be lower in 2020 and lower than they otherwise would have been each year of the waiver as a direct result of the reinsurance program. Cost sharing for plans will remain within the federal requirements and should therefore not impact affordability. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least as affordable coverage for residents (and most likely greater affordability for residents).

Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensive coverage for residents.

Deficit Neutrality

PTCs

Since PTCs are benchmarked to the SLCSP, the decrease in premiums (specifically the SLCSP) will result in lower per person PTC amounts in 2020. Since enrollees who have PTCs are generally unaffected by changes in gross premiums, due to the subsidies shielding them from premium increases, the introduction of reinsurance is not expected to decrease the number of enrollees with PTCs. Due to the combination of a non-decreasing number of enrollees with APTCs and a decrease in premiums, which is connected to PTC amounts, Wakely's analysis estimates that the overall aggregate amount of PTCs will be lower each year over the 10-year window. These results are shown in Table 9.

Table 9: Detailed Results of Federal Savings, by Year

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline										
Total Non-Group Enrollment	42,434	42,146	41,877	41,572	41,272	40,984	40,713	40,459	40,197	39,941
Exchange Enrollment	31,422	31,328	31,241	31,142	31,045	30,951	30,863	30,781	30,696	30,613
APTC Enrollment	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134
Total Non-Group Premium PMPM	$507.45	$531.40	$555.22	$584.10	$614.43	$645.68	$677.13	$708.61	$743.08	$779.21
Exchange Premium PMPM	$481.76	$504.49	$527.11	$554.52	$583.32	$612.99	$642.84	$672.73	$705.46	$739.76
APTC PMPM	$376.27	$397.37	$418.30	$444.16	$471.39	$499.47	$527.70	$555.91	$587.00	$619.66
After Reinsurance										
Total Non-Group Enrollment	42,834	42,563	42,271	41,943	41,622	41,315	41,026	40,756	40,479	40,207
Exchange Enrollment	31,552	31,464	31,369	31,262	31,158	31,059	30,965	30,877	30,787	30,699
APTC Enrollment	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134	26,134
Total Non-Group Premium PMPM	$477.37	$498.10	$521.72	$550.16	$580.05	$610.86	$641.87	$672.94	$706.97	$742.67
Exchange Premium PMPM	$453.20	$472.88	$495.30	$522.30	$550.68	$579.93	$609.37	$638.86	$671.18	$705.06
APTC PMPM	$352.74	$371.33	$392.10	$417.61	$444.51	$472.25	$500.14	$528.02	$558.78	$591.10
Federal Savings Calculations										
Exchange User Fees	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HIT	0.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Difference in APTCs	$7,380,000	$8,170,000	$8,220,000	$8,320,000	$8,430,000	$8,540,000	$8,640,000	$8,740,000	$8,850,000	$8,960,000
PTC Adjustment	($690,000)	($770,000)	($770,000)	($780,000)	($790,000)	($800,000)	($810,000)	($820,000)	($830,000)	($840,000)
Difference in User Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference in HIT	($260,000)	($290,000)	($290,000)	($290,000)	($290,000)	($290,000)	($300,000)	($300,000)	($300,000)	($300,000)
Estimated Net Federal Savings	$6,430,000	$7,110,000	$7,160,000	$7,250,000	$7,350,000	$7,450,000	$7,530,000	$7,620,000	$7,720,000	$7,820,000
Pass-Through as a Percent of Total Funding	43.6%	43.9%	44.2%	44.5%	44.8%	45.1%	45.4%	45.7%	45.9%	46.2%

Offsets to PTC Savings

INDIVIDUAL RESPONSIBILITY REQUIREMENT

As part of the ACA, individuals that can afford insurance but forgo insurance are generally required to pay a fee. However, as part of the Tax Cuts and Jobs Act of 2017, the individual responsibility requirement was set to $0 for 2019 and future years. Therefore, it will not directly affect federal savings.

EXCHANGE USER FEE

Rhode Island operates its own state-based Exchange and therefore changes in premiums due to a 1332 waiver would not impact Federally-facilitated Exchange fees.

HEALTH INSURANCE PROVIDERS FEE

The reinsurance program could also impact the health insurance providers' fee, or HIT. Section 9010 of the ACA requires that a tax on health insurance providers be set at an amount totaling $14.3 billion in 2018 and increasing thereafter generally at the rate of premium increase. We estimate that Rhode Island's reinsurance program will have minimal impact on national premium growth rate and therefore does not materially impact employer-sponsored insurance premiums and therefore would not have any impact on HIT amounts. However, given uncertainty in the methodological calculations of the final pass-through, Wakely included the estimated impact. To estimate the decrease in collected fees, Wakely first estimated the baseline collection for 2020 using rate filing information and discussions with carriers. This yielded a weighted average estimate of 2.0% for the HIT fee. This amount was held constant over the 10-year window to align the fee with overall premium growth. To calculate the impact of the waiver, Wakely estimated the total HIT for the baseline and the waiver scenario to arrive at the federal costs due to the health insurance providers' fee for the implementation of the waiver. These estimates are conservative as the losses on Rhode Island's insurers may be partially or even fully captured by taxes on non-Rhode Island health insurance providers given that statutory construction of the fee.

OTHER FEDERAL IMPACTS

Wakely did not directly estimate the impact of the proposed waiver on the collections related to the Cadillac or Excise tax, small business tax credit or income taxes. It is unlikely that any of these would have a significant impact on the overall savings.[21]

[21] http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf

EMPLOYER MARKETS

A detailed analysis of the group markets was not completed. It is not expected that the reinsurance program will have an impact on the small group, large group, federal employee health benefits program, and other health programs in the state. In particular, we do not expect enrollment migration from the group market to the non-group market as a result of the reinsurance program.

DEFICIT NEUTRALITY IN ALTERNATIVE SCENARIOS

In addition, Wakely calculated the impact of the federal savings under the alternative 2020 scenarios discussed previously. As can be seen in Table 10, there is no 2020 scenario in which net federal savings, because of the reinsurance program, would contribute to the Federal deficit.

Table 10: Estimated 2020 Federal Savings in Alternative Scenarios

Scenario	1	2	3	4	5
Description	Best Estimate	Low Reinsurance Impact	Moderate Enrollment Increase	Moderate Enrollment Decrease and Pass-through Calculations More Favorable to State	Best estimate Enrollment and Pass-through Calculation Less Favorable to State
Difference in APTCs	$7,380,000	$5,820,000	$5,910,000	$8,590,000	$5,850,000
PTC Adjustment	($690,000)	($550,000)	($560,000)	($810,000)	($1,020,000)
Difference in Mandate Penalty	$0	$0	$0	$0	$0
Difference in User Fees	$0	$0	$0	$0	$0
Difference in Insurer Fees	($260,000)	($260,000)	($260,000)	$0	($260,000)
Estimated Net Federal Savings	$6,430,000	$5,010,000	$5,090,000	$7,780,000	$4,570,000

Appendix D
5 and 10 year Projections

Tables 11, 12, and 13 show various information as required under the CMS checklist.

In Table 11, the second lowest cost silver for each rating area (Rhode Island only has one rating area) is based on the 21-year old non-tobacco premium.

Table 11: Second Lowest Cost Silver Plan Premium PMPM, with and without Reinsurance, by Rating Area and Year

Rating Area	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline											
1	$263	$288	$303	$317	$333	$351	$368	$386	$404	$424	$445
After Reinsurance											
1		$275	$289	$302	$319	$336	$353	$371	$389	$408	$429

Table 12: Projected Enrollment by FPL, with and without Reinsurance, by Year

	2019	2020	2021	2022	2023	2024
Baseline						
Total Non-Group Enrollment	43,023	42,434	42,146	41,877	41,572	41,272
Total Non-Group APTC Eligible	26,134	26,134	26,134	26,134	26,134	26,134
<100% of FPL	1,061	1,047	1,040	1,040	1,040	1,040
≥100% to ≤150% of FPL	4,327	4,327	4,327	4,327	4,327	4,327
>150% to ≤200% of FPL	9,146	9,146	9,146	9,146	9,146	9,146
>200% to ≤250% of FPL	5,317	5,317	5,317	5,317	5,317	5,317
>250% to ≤300% of FPL	3,517	3,517	3,517	3,517	3,517	3,517
>300% to ≤400% of FPL	3,827	3,827	3,827	3,827	3,827	3,827
>400% of FPL	15,828	15,253	14,972	14,703	14,398	14,098
After Reinsurance						
Total Non-Group Enrollment		42,834	42,563	42,271	41,943	41,622
Total Non-Group APTC Eligible		26,134	26,134	26,134	26,134	26,134
<100% of FPL		1,047	1,040	1,040	1,040	1,040
≥100% to ≤150% of FPL		4,327	4,327	4,327	4,327	4,327
>150% to ≤200% of FPL		9,146	9,146	9,146	9,146	9,146
>200% to ≤250% of FPL		5,317	5,317	5,317	5,317	5,317
>250% to ≤300% of FPL		3,517	3,517	3,517	3,517	3,517
>300% to ≤400% of FPL		3,827	3,827	3,827	3,827	3,827
>400% of FPL		15,653	15,389	15,097	14,769	14,448

Table 13: Projected Enrollment by Metal Level with and without Reinsurance, by Year

	2019	2020	2021	2022	2023	2024
Baseline						
Total Non-Group Enrollment	43,640	42,434	42,146	41,877	41,572	41,272
Catastrophic	-	-	-	-	-	-
Bronze	10,848	10,548	10,476	10,409	10,333	10,259
Silver	18,940	18,416	18,291	18,175	18,042	17,912
Gold	13,853	13,470	13,379	13,293	13,196	13,101
Platinum	-	-	-	-	-	-
After Reinsurance						
Total Non-Group Enrollment		42,834	42,563	42,271	41,943	41,622
Catastrophic		-	-	-	-	-
Bronze		10,647	10,580	10,507	10,426	10,346
Silver		18,590	18,472	18,346	18,203	18,064
Gold		13,597	13,511	13,418	13,314	13,212
Platinum		-	-	-	-	-

Appendix E
Reliances

The following is a list of the data Wakely relied on for the analysis:

- Issuer submitted premium and enrollment information for 2017, 2018, and for January/February 2019
- Insurers submitted APTC information, including enrollment and premiums, for 2018 and January/February 2019
- Insurer submitted paid claim continuance tables for 2017 and 2018
- The 2016, 2017, and 2018 Open Enrollment Report PUF produced by HHS[22] [23] [24]
- Effectuated Enrollment Reports released by CMS[25]
- CBO Analysis on Impact of Repeal of the Mandate[26]
- Information from the State of Rhode Island for on-Exchange demographic and FPL data

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Rhode Island for reasonability.

Any impact due to private commercial reinsurance was not reflected in the analyses but the parameters were set to minimize overlap with private reinsurance.

The following are additional reliances and caveats that could have an impact on results:

- Data Limitations. Wakely received data submissions for full year 2017 and 2018 and emerging 2019 experience from insurers offering individual market ACA-compliant plans. The majority of the insurers submitted all the requested information. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.
- Political Uncertainty. There is significant policy uncertainty. Future federal actions in regards to reinsurance funds, direct enrollment, silver-loading, prescription drugs, and/or CSR payments could significantly change premiums and enrollment in 2020 or future

[22] https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report
[23] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html
[24] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html
[25] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf
[26] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

years. In particular, CSR funding or a requirement to spread the cost of CSRs across all metal levels could significantly decrease the pass-through percentage relative to what was estimated in this report. State political reactions to changes in the individual market could alter the results. Finally, at the time of writing the report the 2020 Notice of Benefit and Payment Parameters or the HRA regulation had not been finalized. Changes to policy encapsulated in those proposed regulations (such as to the premium adjustment percentage) may impact the results of this report.

- Enrollment Uncertainty. Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also have uncertainty (for example, state mandate). All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.

- Premium Uncertainty. Given that several recent changes to statutory and regulatory rules of the individual market (e.g., mandate) have not reached steady state in their effects on the individual market, there is uncertainty in how insurers may respond in their 2020 premiums. These uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.

- Pass-Through Uncertainty. Ultimately, the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely's models, differences in the pass-through amounts are possible.

- Reinsurance Operations. If actual operations of the reinsurance program differ from the data configurations used in this analysis, Wakely's analysis would need to be adjusted to match actual reinsurance data requirements. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results.

Appendix F
Disclosures and Limitations

Responsible Actuary. Julie Peper and Matt Sauter are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries. Julie is a Fellow of the Society of Actuaries and Matt is an Associate of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen contributed significantly to the analysis and contents of this report.

Intended Users. This information has been prepared for the sole use of the management of Rhode Island. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. The extent to which the enrollment experience for 2020 is different than expected results could be affected. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Rhode Island will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Rhode Island.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2019 experiences. Change in emerging 2019 enrollment and experience could impact the results. Additional changes in regulations (e.g., premium adjustment percentage) could impact findings. For example, at the time of writing the report the 2020 Notice of Benefit and Payment Parameters or the HRA regulation had not been finalized and were not included in the analysis.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

Attachment 2 Legislation

2018 -- S 2934 SUBSTITUTE A

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LC005817/SUB A
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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- HEALTH CARE--HEALTH INSURANCE

Introduced By: Senator Joshua Miller

Date Introduced: May 29, 2018

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 42 of the General Laws entitled "STATE AFFAIRS AND GOVERNMENT" is hereby amended by adding thereto the following chapter:

CHAPTER 157.1

RHODE ISLAND MARKET STABILITY AND REINSURANCE ACT

42-157.1-1. Short title and purpose.

(a) This chapter shall be known and may be cited as the "Rhode Island Market Stability and Reinsurance Act."

(b) The purpose of this chapter is to authorize the director to create the Rhode Island reinsurance program to stabilize health insurance rates and premiums in the individual market and provide greater financial certainty to consumers of health insurance in this state.

(c) Nothing in this chapter shall be construed as obligating the state to appropriate funds or make payments to carriers.

42-157.1-2. Definitions.

As used in this chapter:

(1) "Director" means the director of the Rhode Island health benefits exchange.

(2) "Exchange" means the Rhode Island health benefits exchange established within the department of administration by § 42-157-1.

(3) "Health insurance carrier" or "carrier" has the same meaning as it does in § 27-18.5-2.

(4) "Health insurance coverage" has the same meaning as it does in § 27-18.5-2.

(5) "Individual market" has the same meaning as it does in §27-18.5-2.

(6) "Office of the health insurance commissioner" means the entity established by § 42-14.5-1 within the department of business regulation.

(7) "Program" means the Rhode Island reinsurance program established by § 42-157.1-3.

(8) "Program fund" or "fund" means the fund established by § 42-157.1-5.

(9) "State" means the state of Rhode Island.

42-157.1-3. Establishment of the Rhode Island reinsurance program.

(a) The director is authorized to establish and implement a state-based reinsurance program, to be known as the Rhode Island reinsurance program:

(1) To provide reinsurance to carriers that offer health insurance coverage on the individual market in the state;

(2) That meets the requirements of a waiver approved under 42 U.S.C. § 18052; and

(3) That is consistent with state and federal law.

(b) The program is intended to mitigate the impact of high-risk individuals on health insurance rates offered in the individual insurance market on and off of the exchange.

(c) The director is authorized to establish reinsurance payment parameters for calendar year 2020 and each subsequent calendar year that include:

(1) An attachment point;

(2) A coinsurance rate; and

(3) A coinsurance cap.

(d) Carriers must provide the exchange and the office of the health insurance commissioner with data the director prescribes by rules and regulations as necessary to determine reinsurance payments in a time and manner determined by the director.

(e) The director may alter the parameters established in accordance with §§ 42-157.1-3(c) and 42-157.1-3 (d) as necessary to secure federal approval for a waiver submitted in accordance with § 42-157.1-6.

42-157.1-4. Powers of the director.

(a) The director may:

(1) Contract with the federal government or another unit of government to ensure coordination of the program;

(2) Apply for any available federal funding for the program;

(3) Undertake, directly or through contracts with other persons or entities, studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) Formulate general policy and adopt rules and regulations that are reasonably necessary to administer this chapter, including regulations establishing a reinsurance program to mitigate the impact of high-risk individuals on health insurance rates.

42-157.1-5. Establishment of program fund.

(a) A fund shall be established to provide funding for the operation and administration of the program in carrying out the purposes of the program under this chapter.

(b) The director is authorized to administer the fund.

(c) The fund shall consist of:

(1) Any pass-through funds received from the federal government under a waiver approved under 42 U.S.C. § 18052;

(2) Any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the state;

(3) Any funds designated by the state to provide reinsurance to carriers that offer individual health benefit plans in the state; and

(4) Any other money from any other source accepted for the benefit of the fund.

(d) Nothing in this chapter shall be construed as obligating the state to appropriate funds or make payments to carriers.

42-157.1-6. State innovation waiver.

In accordance with § 42-157-5, the director may apply to the United States Secretary of Health and Human Services under 42 U.S.C. § 18052, for a state innovation waiver to implement the program and seek federal pass-through funding for calendar years beginning January 1, 2020, and future years, to maximize federal funding.

42-157.1-7. Program contingent on federal waiver and appropriation of state funding.

If the state innovation waiver request in § 42-157.1-6 is not approved, the director shall not implement the program or provide reinsurance payments to eligible carriers.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- HEALTH CARE--HEALTH INSURANCE

***

This act would establish the Rhode Island reinsurance program that will provide reinsurance to insurance carriers that offer health insurance coverage on the individual market, to mitigate the impact of high-risk individuals on health insurance rates. The director of the Rhode Island health benefits exchange would be authorized to establish payment parameters for this program.

This act would take effect upon passage.

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LC005817/SUB A
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ARTICLE 14

RELATING TO HEALTHCARE MARKET STABILITY

SECTION 1. Section 27-18.5-2 of the General Laws in Chapter 27-18.5 entitled "Individual Health Insurance Coverage" is hereby amended to read as follows:

27-18.5-2. Definitions.

The following words and phrases as used in this chapter have the following meanings unless a different meaning is required by the context:

(1) "Bona fide association" means, with respect to health insurance coverage offered in this state, an association which:

(i) Has been actively in existence for at least five (5) years;

(ii) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(iii) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(iv) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member);

(v) Does not make health insurance coverage offered through the association available other than in connection with a member of the association;

(vi) Is composed of persons having a common interest or calling;

(vii) Has a constitution and bylaws; and

(viii) Meets any additional requirements that the director may prescribe by regulation;

(2) "COBRA continuation provision" means any of the following:

(i) Section 4980(B) of the Internal Revenue Code of 1986, 26 U.S.C. § 4980B, other than subsection (f)(1) of that section insofar as it relates to pediatric vaccines;

(ii) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1161 et seq., other than Section 609 of that act, 29 U.S.C. § 1169; or

(iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. § 300bb-1 et seq.;

(3) "Creditable coverage" has the same meaning as defined in the United States Public Health Service Act, Section 2701(c), 42 U.S.C. § 300gg(c), as added by P.L. 104-191;

(4) "Director" means the director of the department of business regulation;

(5) "Eligible individual" means an individual:

(i) For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, a governmental plan established or maintained for its employees by the government of the United States or by any of its agencies or instrumentalities, or church plan (as defined by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.);

(ii) Who is not eligible for coverage under a group health plan, part A or part B of title XVIII of the Social Security Act, 42 U.S.C. § 1395c et seq. or 42 U.S.C. § 1395j et seq., or any state plan under title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (or any successor program), and does not have other health insurance coverage;

(iii) With respect to whom the most recent coverage within the coverage period was not terminated based on a factor described in § 27-18.5-4(b)(relating to nonpayment of premiums or fraud);

(iv) If the individual had been offered the option of continuation coverage under a COBRA continuation provision, or under chapter 19.1 of this title or under a similar state program of this state or any other state, who elected the coverage; and

(v) Who, if the individual elected COBRA continuation coverage, has exhausted the continuation coverage under the provision or program;

(6) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

(7) "Health insurance carrier" or "carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a nonprofit hospital, medical or dental service corporation, or any other entity providing a plan of health insurance or health benefits by which health care services are paid or financed for an eligible individual or his or her dependents by such entity on the basis of a periodic premium, paid directly or through an association, trust, or other intermediary, and issued, renewed, or delivered within or without Rhode Island to cover a natural

person who is a resident of this state, including a certificate issued to a natural person which evidences coverage under a policy or contract issued to a trust or association;

(8)(i) "Health insurance coverage" means a policy, contract, certificate, or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health insurance coverage include short-term limited duration policies and any policy that pays on a cost-incurred basis, except as otherwise specifically exempted by subsections (ii), (iii), (iv), or (v) of this section.

(ii) "Health insurance coverage" does not include one or more, or any combination of, the following:

(A) Coverage only for accident, or disability income insurance, or any combination of those;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics; AND

(H) Other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits~~; and~~

~~(I) Short term limited duration insurance;~~

(iii) "Health insurance coverage" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are not an integral part of the coverage:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(C) Any other similar, limited benefits that are specified in federal regulation issued pursuant to P.L. 104-191;

(iv) "Health insurance coverage" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without

regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor:

(A) Coverage only for a specified disease or illness; or

(B) Hospital indemnity or other fixed indemnity insurance; and

(v) "Health insurance coverage" does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. § 1395ss(g)(1);

(B) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq.; and

(C) Similar supplemental coverage provided to coverage under a group health plan;

(9) "Health status-related factor" means any of the following factors:

(i) Health status;

(ii) Medical condition, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(viii) Disability;

(10) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(11) "Network plan" means health insurance coverage offered by a health insurance carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier;

(12) "Preexisting condition" means, with respect to health insurance coverage, a condition (whether physical or mental), regardless of the cause of the condition, that was present before the date of enrollment for the coverage, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information; and

(13) "High-risk individuals" means those individuals who do not pass medical underwriting standards, due to high health care needs or risks;

(14) "Wellness health benefit plan" means that health benefit plan offered in the individual market pursuant to § 27-18.5-8; and

(15) "Commissioner" means the health insurance commissioner.

SECTION 2. Section 35-4-27 of the General Laws in Chapter 35-4 entitled "State Funds" is hereby amended to read as follows:

35-4-27. Indirect cost recoveries on restricted receipt accounts.

Indirect cost recoveries of ten percent (10%) of cash receipts shall be transferred from all restricted-receipt accounts, to be recorded as general revenues in the general fund. However, there shall be no transfer from cash receipts with restrictions received exclusively: (1) From contributions from non-profit charitable organizations; (2) From the assessment of indirect cost-recovery rates on federal grant funds; or (3) Through transfers from state agencies to the department of administration for the payment of debt service. These indirect cost recoveries shall be applied to all accounts, unless prohibited by federal law or regulation, court order, or court settlement. The following restricted receipt accounts shall not be subject to the provisions of this section:

Executive Office of Health and Human Services

Organ Transplant Fund

HIV Care Grant Drug Rebates

Department of Human Services

Veterans' home -- Restricted account

Veterans' home -- Resident benefits

Pharmaceutical Rebates Account

Demand Side Management Grants

Veteran's Cemetery Memorial Fund

Donations -- New Veterans' Home Construction

Department of Health

Pandemic medications and equipment account

Miscellaneous Donations/Grants from Non-Profits

State Loan Repayment Match

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Eleanor Slater non-Medicaid third-party payor account

Hospital Medicare Part D Receipts

RICLAS Group Home Operations

Commission on the Deaf and Hard of Hearing

Emergency and public communication access account

Department of Environmental Management

National heritage revolving fund

Environmental response fund II

Underground storage tanks registration fees

Rhode Island Historical Preservation and Heritage Commission

Historic preservation revolving loan fund

Historic Preservation loan fund -- Interest revenue

Department of Public Safety

Forfeited property -- Retained

Forfeitures -- Federal

Forfeited property -- Gambling

Donation -- Polygraph and Law Enforcement Training

Rhode Island State Firefighter's League Training Account

Fire Academy Training Fees Account

Attorney General

Forfeiture of property

Federal forfeitures

Attorney General multi-state account

Forfeited property -- Gambling

Department of Administration

OER Reconciliation Funding

Health Insurance Market Integrity Fund

RI Health Benefits Exchange

Information Technology Investment Fund

Restore and replacement -- Insurance coverage

Convention Center Authority rental payments

Investment Receipts -- TANS

OPEB System Restricted Receipt Account

Car Rental Tax/Surcharge-Warwick Share

Executive Office of Commerce

Housing Resources Commission Restricted Account

Department of Revenue

DMV Modernization Project

Jobs Tax Credit Redemption Fund

Legislature

Audit of federal assisted programs

Department of Children, Youth and Families

Children's Trust Accounts -- SSI

Military Staff

RI Military Family Relief Fund

RI National Guard Counterdrug Program

Treasury

Admin. Expenses -- State Retirement System

Retirement -- Treasury Investment Options

Defined Contribution -- Administration - RR

Violent Crimes Compensation -- Refunds

Treasury Research Fellowship

Business Regulation

Banking Division Reimbursement Account

Office of the Health Insurance Commissioner Reimbursement Account

Securities Division Reimbursement Account

Commercial Licensing and Racing and Athletics Division Reimbursement Account

Insurance Division Reimbursement Account

Historic Preservation Tax Credit Account

Judiciary

Arbitration Fund Restricted Receipt Account

Third-Party Grants

RI Judiciary Technology Surcharge Account

Department of Elementary and Secondary Education

Statewide Student Transportation Services Account

School for the Deaf Fee-for-Service Account

School for the Deaf -- School Breakfast and Lunch Program

Davies Career and Technical School Local Education Aid Account

Davies -- National School Breakfast & Lunch Program

School Construction Services

Office of the Postsecondary Commissioner

Higher Education and Industry Center

Department of Labor and Training

Job Development Fund

SECTION 3. Chapter 44-30 of the General Laws entitled "Personal Income Tax" is hereby amended by adding thereto the following sections:

44-30-101. Requirements concerning qualifying health insurance coverage.

(a) Definitions. For purposes of this section:

(1) "Applicable individual" has the same meaning as set forth in 26 U.S.C. § 5000A(d).

(2) "Minimum essential coverage" has the same meaning as set forth in 26 U.S. C. § 5000A(f).

(3) "Shared Responsibility Payment Penalty" means the penalty imposed pursuant to subsection (c) of this section.

(4) "Taxpayer" means any resident individual, as defined in section 44-30-5 of the general laws.

(b) Requirement to maintain minimum essential coverage. Every applicable individual must maintain minimum essential coverage for each month beginning after December 31, 2019.

(c) Shared Responsibility Payment Penalty imposed for failing to maintain minimum essential coverage. As of January 1, 2020, every applicable individual required to file a personal income tax return pursuant to section 44-30-51 of the general laws, shall indicate on the return, in a manner to be prescribed by the tax administrator, whether and for what period of time during the relevant tax year the individual and his or her spouse and dependents who are applicable individuals were covered by minimum essential coverage. If a return submitted pursuant to this subsection fails to indicate that such coverage was in force or indicates that any applicable individuals did not have such coverage in force, a Shared Responsibility Payment Penalty shall hereby be assessed as a tax on the return.

(d) Shared Responsibility Payment Penalty calculation. Except as provided in subsection (e), the Shared Responsibility Payment Penalty imposed shall be equal to a taxpayer's federal shared responsibility payment for the taxable year under section 5000A of the Internal Revenue Code of 1986, as amended, and as in effect on the 15th day of December 2017.

(e) Exceptions.

(1) Penalty cap. The amount of the Shared Responsibility Payment Penalty imposed under this section shall be determined, if applicable, using the statewide average premium for bronze-level plans offered through the Rhode Island health benefits exchange rather than the national average premium for bronze-level plans.

(2) Hardship exemption determinations. Determinations as to hardship exemptions shall be made by the exchange under section 42-157-11 of the general laws.

(3) Religious conscience exemption determinations. Determinations as to religious conscience exemptions shall be made by the exchange under section 42-157-11 of the general laws.

(4) Taxpayers with gross income below state filing threshold. No penalty shall be imposed under this section with respect to any applicable individual for any month during a calendar year if the taxpayer's household income for the taxable year as described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income requiring the taxpayer to file a return as set forth in section 44-30-51 of the general laws.

(5) Out of State Residents. No penalty shall be imposed by this section with respect to any applicable individual for any month during which the individual is a bona fide resident of another state.

(f) Health Insurance Market Integrity Fund. The tax administrator is authorized to withhold from any state tax refund due to the taxpayer an amount equal to the calculated Shared Responsibility Payment Penalty and shall place such amounts in the Health Insurance Market Integrity Fund created pursuant to section 42-157.1-5 of the general laws.

(g) Deficiency. If, upon examination of a taxpayer's return, the tax administrator determines there is a deficiency because any refund due to the taxpayer is insufficient to satisfy the Shared Responsibility Penalty or because there was no refund due, the tax administrator may notify the taxpayer of such deficiency in accordance with section 44-30-81 and interest shall accrue on such deficiency as set forth in section 44-30-84. All monies collected on said deficiency shall be placed in the Health Insurance Market Integrity Fund created pursuant to section 42-157.1-5 of the general laws.

(h) Data Sharing.

(1) The tax administrator, upon written request from the exchange pursuant to section 42-157-13 of the general laws, shall disclose to officers, employees, and contractors of the exchange, the name, age, mailing address, income and penalty amount of any such applicable individual who, for the applicable year, did not have the minimum essential coverage required by subsection 44-30-101(b).

(2) Definition of applicable year. For purposes of this subsection, the term "applicable year" means the most recent taxable year for which information is available in the Rhode Island Department of Revenue's taxpayer data information systems, or, if there is no return filed for such taxpayer for such year, the prior taxable year.

(3) Restriction on use of disclosed information. Taxpayer information disclosed under this subsection may be used only for the purposes authorized by section 42-157-13 of the general laws.

(4) Privacy and Security. The exchange and the tax administrator shall develop a detailed

set of data privacy and data security safeguards to govern the conveyance of data between their agencies under this section. With respect to information disclosed by the tax administrator to the exchange pursuant to this subsection, the exchange its officers, employees and contractors shall be subject to R.I. Gen. Laws subsection 44-30-95(c).

(i) Application of Federal law. The Shared Responsibility Payment Penalty shall be assessed and collected as set forth in this chapter and, where applicable, consistent with regulations promulgated by the federal government, the exchange and/or the tax administrator. Any federal regulation implementing section 5000A of the Internal Revenue Code of 1986, as amended, and in effect on the 15th day of December 2017, shall apply as though incorporated into the Rhode Island Code of Regulations. Federal guidance interpreting these federal regulations shall similarly apply. Except as provided in subsections (j) and (k), all references to federal law shall be construed as references to federal law as in effect on December 15, 2017, including applicable regulations and administrative guidance that were in effect as of that date.

(j) Unavailability of Federal premium tax credits. For any taxable year in which federal premium tax credits available pursuant to 26 U.S.C. section 36B become unavailable due to the federal government repealing that section or failing to fund the premium tax credits, the Shared Responsibility Payment Penalty under this section shall not be enforced.

(k) Imposition of Federal shared responsibility payment. For any taxable year in which a federal penalty under section 5000A of the Internal Revenue Code of 1986 is imposed on a taxpayer in an amount comparable to the Shared Responsibility Payment Penalty assessed under this section, the state penalty shall not be enforced.

(m) Agency Coordination. Where applicable, the tax administrator shall implement this section in consultation with the office of the health insurance commissioner, the office of management and budget, the executive office of health and human services, and the Rhode Island health benefits exchange.

44-30-102. Reporting Requirement for Applicable Entities providing Minimum Essential Coverage.

(a) Findings.

(1) Ensuring the health of insurance markets is a responsibility reserved for states under the McCarran-Ferguson Act and other federal law.

(2) There is substantial evidence that being uninsured causes health problems and unnecessary deaths.

(3) The Shared Responsibility Payment Penalty imposed by subsection 44-30-101(c) of the general laws is necessary to protect the health and welfare of the state's residents.

(4) The reporting requirement provided for in this section is necessary for the successful implementation of the Shared Responsibility Payment Penalty imposed by subsection 44-30-101(c) of the general laws. This requirement provides the only widespread source of third-party reporting to help taxpayers and the tax administrator verify whether an applicable individual maintains minimum essential coverage. There is compelling evidence that third-party reporting is crucial for ensuring compliance with tax provisions.

(5) The Shared Responsibility Payment Penalty imposed by subsection 44-30-101(c) of the general laws, and therefore the reporting requirement in this section, is necessary to ensure a stable and well-functioning health insurance market. There is compelling evidence that, without an effective Shared Responsibility Payment Penalty in place for those who go without coverage, there would be substantial instability in health insurance markets, including higher prices and the possibility of areas without any insurance available.

(6) The Shared Responsibility Payment Penalty imposed by subsection 44-30-101(c) of the general laws, and therefore the reporting requirement in this section, is also necessary to foster economic stability and growth in the state.

(7) The reporting requirement in this section has been narrowly tailored to support compliance with the Shared Responsibility Payment Penalty imposed by subsection 44-30-101(c) of the general laws, while imposing only an incidental burden on reporting entities. In particular, the information that must be reported is limited to the information that must already be reported under a similar federal reporting requirement under section 6055 of the Internal Revenue Code of 1986. In addition, this section provides that its reporting requirement may be satisfied by providing the same information that is currently reported under such federal requirement.

(b) Definitions. For purposes of this section:

(1) "Applicable entity" means:

(i) An employer or other sponsor of an employment-based health plan that offers employment-based minimum essential coverage to any resident of Rhode Island.

(ii) The Rhode Island Medicaid single state agency providing Medicaid or Children's Health Insurance Program (CHIP) coverage.

(iii) Carriers licensed or otherwise authorized by the Rhode Island office of the health insurance commissioner to offer health coverage providing coverage that is not described in subparagraphs (i) or (ii).

(2) "Minimum essential coverage" has the meaning given such term by section 44-30-101(a)(2) of the general laws.

(c) For purposes of administering the Shared Responsibility Payment Penalty to individuals

who do not maintain minimum essential coverage under subsection 44-30-101(b) of the general laws, every applicable entity that provides minimum essential coverage to an individual during a calendar year shall, at such time as the tax administrator may prescribe, file a form in a manner prescribed by the tax administrator.

(d) Form and manner of return.

(1) A return, in such form as the tax administrator may prescribe, contains the following information:

(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy;

(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year, and

(iii) such other information as the tax administrator may require.

(2) Sufficiency of information submitted for federal reporting. Notwithstanding the requirements of paragraph (1), a return shall not fail to be a return described in this section if it includes the information contained in a return described in section 6055 of the Internal Revenue Code of 1986, as that section is in effect and interpreted on the 15th day of December 2017.

(e) Statements to be furnished to individuals with respect to whom information is reported.

(1) Any applicable entity providing a return under the requirements of this section shall also provide to each individual whose name is included in such return a written statement containing the name, address and contact information of the person required to provide the return to the tax administrator and the information included in the return with respect to the individuals listed thereupon. Such written statement must be provided on or before January 31 of the year following the calendar year for which the return was required to be made or by such date as may be determined by the tax administrator.

(2) Sufficiency of federal statement. Notwithstanding the requirements of paragraph (1), the requirements of this subsection (e) may be satisfied by a written statement provided to an individual under section 6055 of the Internal Revenue Code of 1986, as that section is in effect and interpreted on the 15th day of December 2017.

(f) Reporting responsibility.

(1) Coverage provided by governmental units. In the case of coverage provided by an applicable entity that is any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall be responsible for the returns and statements required by this section.

(2) Delegation. An applicable entity may contract with third-party service providers, including insurance carriers, to provide the returns and statements required by this section.

SECTION 4. Chapter 42-157 of the General Laws entitled "Rhode Island Health Benefit Exchange" is hereby amended by adding thereto the following section:

42-157-11. Exemptions from the shared responsibility payment penalty.

(a) Establishment of program. The exchange shall establish a program for determining whether to grant a certification that an individual is entitled to an exemption from the Shared Responsibility Payment Penalty set forth in section 44-30-101(c) of the general laws by reason of religious conscience or hardship.

(b) Eligibility determinations. The exchange shall make determinations as to whether to grant a certification described in subsection (a). The exchange shall notify the individual and the tax administrator for the Rhode Island Department of Revenue of any such determination in such a time and manner as the exchange, in consultation with the tax administrator, shall prescribe. In notifying the tax administrator, the exchange shall adhere to the data privacy and data security standards adopted in accordance with section 44-30-101(i)(4) of the general laws and 45 C.F.R. 155.260. The exchange shall only be required to notify the tax administrator to the extent that the exchange determines such disclosure is permitted under 45 C.F.R. 155.260.

(c) Appeals. Any person aggrieved by the exchange's determination of eligibility for an exemption under this section has the right to an appeal in accordance with the procedures contained within chapter 35 of title 42.

42-157-12. Special enrollment period for qualified individuals assessed a shared responsibility payment penalty.

(a) Definitions. The following definition shall apply for purposes of this section:

(1) "Special enrollment period" means a period during which a qualified individual who is assessed a penalty in accordance with section 44-30-101 may enroll in a qualified health plan through the exchange outside of the annual open enrollment period.

(b) In the case of a qualified individual who is assessed a shared responsibility payment in accordance with section 44-30-101 of the general laws and who is not enrolled in a qualified health plan, the exchange must provide a special enrollment period consistent with this section and the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Care and Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(c) Effective Date. The exchange must ensure that coverage is effective for a qualified individual who is eligible for a special enrollment period under this section on the first day of the

month after the qualified individual completes enrollment in a qualified health plan through the exchange.

(d) Availability and length of special enrollment period. A qualified individual has sixty (60) days from the date he or she is assessed a penalty in accordance with section 44-30-101 of the general laws to complete enrollment in a qualified health plan through the exchange. The date of assessment shall be determined in accordance with section 44-30-82 of the general laws.

42-157-13. Outreach to Rhode Island residents and individuals assessed a shared responsibility payment penalty.

Outreach. The exchange, in consultation with the Office of the Health Insurance Commissioner and the Division of Taxation, is authorized to engage in coordinated outreach efforts to educate Rhode Island residents about the importance of health insurance coverage, their responsibilities to maintain minimum essential coverage as defined in section 44-30-101 of the general laws, the penalties for failure to maintain such coverage, and information on the services available through the exchange.

42-157-14. Regulatory authority.

(a) Regulatory Authority. The exchange may promulgate regulations as necessary to carry out the purposes of this chapter.

SECTION 5. Sections 42-157.1-1 and 42-157.1-5 of the General Laws in Chapter 42-157.1 entitled "Rhode Island Market Stability and Reinsurance Act" are hereby amended to read as follows:

42-157.1-1. Short title and purpose.

(a) This chapter shall be known and may be cited as the "Rhode Island Market Stability and Reinsurance Act."

(b) The purpose of this chapter is to authorize the director to create the Rhode Island reinsurance program to stabilize health insurance rates and premiums in the individual market and provide greater financial certainty to consumers of health insurance in this state.

~~(c) Nothing in this chapter shall be construed as obligating the state to appropriate funds or make payments to carriers.~~

42-157.1-5. Establishment of program fund.

(a) ~~A fund shall be~~ The Health Insurance Market Integrity Fund is hereby established to provide funding for the operation and administration of the program in carrying out the purposes of the program under this chapter.

(b) The director is authorized to administer the fund.

(c) The fund shall consist of:

(1) Any pass-through funds received from the federal government under a waiver approved under 42 U.S.C. § 18052;

(2) Any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the state;

(3) Any funds designated by the state to provide reinsurance to carriers that offer individual health benefit plans in the state; and

(4) Any other money from any other source accepted for the benefit of the fund.

~~(d) Nothing in this chapter shall be construed as obligating the state to appropriate funds or make payments to carriers.~~

(d) A restricted receipt account shall be established for the fund which may be used for the purposes set forth in this section and shall be exempt from the indirect cost recovery provisions of section 35-4-27 of the general laws.

(e) Monies in the fund shall be used to provide reinsurance to health insurance carriers as set forth in this chapter and its implementing regulations, and to support the personnel costs, operating costs and capital expenditures of the exchange and the division of taxation that are necessary to carry out the provisions of this chapter, sections 44-30-101 through 44-30-102 and sections 42-157-11 through 42-157-14 of the general laws.

(f) Any excess monies remaining in the fund, not including any monies received from the federal government pursuant to paragraphs (1) or (2) and after making the payments required by subsection (f), may be used for preventative health care programs for vulnerable populations in consultation with the executive office of health and human services.

42-157.1-7. Program contingent on federal waiver ~~and appropriation of state funding~~.

If the state innovation waiver request in § 42-157.1-6 is not approved, the director shall not implement the program or provide reinsurance payments to eligible carriers.

SECTION 6. This article shall take effect upon passage.

Attachment 3: Recommendation of the Market Stability Workgroup

MAINTAINING THE STABILITY OF RHODE ISLAND'S HEALTH INSURANCE MARKETS

Key findings and recommendations of the Market Stability Workgroup

June 2018

EXECUTIVE SUMMARY & RECOMMENDATIONS

The Market Stability Workgroup was convened by the Office of the Health Insurance Commissioner (OHIC) and HealthSource RI (HSRI). The Workgroup was charged with considering what, if any, measures ought to be taken by the state to mitigate the potential impact of federal changes on health coverage costs, consumer choice, and access. Three Guiding Principles were determined for the group:

- Sustain a balanced risk pool;
- Maintain a market that is attractive to carriers, consumers and providers; and
- Protect coverage gains achieved under the Affordable Care Act (ACA).

Due to changing federal policy relative to the ACA, the Workgroup concluded that there is a significant cost associated with inaction at the state level. Reliable estimates-- both in terms of higher costs of insurance premiums, and the costs associated with increased numbers of uninsured Rhode Islanders-- consistently reveal an oncoming crisis that will particularly impact those who do not receive a premium tax credit to make their health coverage more affordable. These middle-income individuals and families pay the full cost of their insurance in the individual market.

The Workgroup, made up of a diverse group of stakeholders, met weekly for eight sessions between April 18 and June 5, 2018. The conveners provided background materials and invited outside national and local experts to provide an informed perspective on the topics that were being considered, with an emphasis on what other states have done or were in the process of considering. A syllabus for the eight-week term was developed at the outset of the Workgroup and adjusted as needed to respond to the pace and interests of the group. Meetings were open to the public and minutes were taken and posted for each two-hour session.

The Workgroup reviewed the progress Rhode Island has made since the ACA's implementation in 2014, including cutting the uninsured rate by almost two-thirds and keeping individual market rates among the lowest in the country. The Workgroup considered indicators of market stability, noting that Rhode Island's markets have been relatively stable while the future is more precarious, particularly and most immediately for the individual and small group markets. Recent federal actions that may undermine that stability include the repeal of the shared responsibility requirement (also known as the "individual mandate") penalty and the proposal to expand consumer access to non-ACA compliant plans. The Workgroup considered policy options aimed at protecting market stability. These options were categorized in terms of three key legs of the ACA: affordability, shared responsibility, and insurance reforms. 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.

Having reviewed all background materials and presentations, listened to each external expert, and engaged in hours of lively discussion, the Market Stability Workgroup reached a consensus that initial action should be taken, without delay, to begin to protect Rhode Islanders from unaffordable rate increases, including the following near-term recommendations:

- **A 1332 waiver under the ACA to implement a reinsurance program**: The state should be authorized to submit a 1332 waiver request as provided for under the ACA to implement a state reinsurance program. The state reinsurance program should be designed to mitigate premium increases in the year 2020 and beyond. The Workgroup recognized that 1332 waiver

applications require a stakeholder review process. It also noted that in addition to leveraging federal pass-through savings, matching funding from other sources would be identified and proposed separately through future legislation.

- **State authority to regulate Short-Term Limited Duration (STLD) health plans**: OHIC should be provided with regulatory oversight authority of STLD plans to ensure such plans are subject to the same consumer protections that apply to all other private health insurance coverage offered for sale in the state. OHIC and the Rhode Island Department of Business Regulation should continue to work together to ensure that other types of plans being offered in Rhode Island are adequately regulated to avoid harmful individual market segmentation.
- **A state-based shared responsibility requirement:** Rhode Island should implement a state-level shared responsibility requirement to mitigate the impact of the federal health insurance mandate penalty repeal. For the sake of continuity and simplicity, a requirement should be implemented as soon as practicable, with broad-based support, and should use the current federal structure as a basis. Any funds raised through the implementation of a shared responsibility requirement should be primarily designated for initiatives aimed at protecting the affordability of health coverage for the individual market.

In addition to the above policy recommendations, which should be addressed immediately, the Workgroup acknowledges that further work remains. 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 state should also carefully consider codifying into law critical consumer protections provided through the ACA which are currently at risk and vulnerable to future federal changes. Examples of critical consumer protections include, but are not limited to, coverage of the ten Essential Health Benefits categories, no-cost preventive services and bans on annual and life-time limits. The Workgroup also notes that these recommendations are necessary, but may not fully address all potential causes of market instability, and more actions may be needed in the future.
- **Context of health care costs**: The state should address the underlying drivers of health care costs. The Workgroup noted that its specific consideration of market stability does not encompass the complex and pervasive issue of addressing the underlying costs of providing healthcare in Rhode Island. The time limitations and core charge of this group precluded a complete deliberation on this topic. Without addressing this concern, high underlying costs will remain a risk to the health and stability of the market.

The Workgroup acknowledged that because time is of the essence, this future work should begin promptly and be undertaken through a formal structure and with participation from the legislative and executive branches. Carriers setting rates for the 2020 coverage year will consider actions taken during the 2019 legislative session.

By signing below, we each express our support for the Guiding Principles of the Workgroup, and for the recommendations as outlined in this Executive Summary:

Print Full Name	*Organization*	*Signature*
William K. Wray	Chair, HSRI Advisory	William K. Wray
Stephen C. Boyle	Cranston Chamber of Commerce	Stephen C. Boyle
RALPH Coppola	N. E. BUSINESS ASSOCIATION	
PETER HOLLMANN MD	RHODE ISLAND MEDICAL SOCIETY	
Al Cherbonneau	RI Business Group on Health	
Susan A. Stark, PhD, RN	The Substance Use and Mental Health Leadership Council of RI	Susan A. Stark, PhD, RN
M. Teresa Paiva Weed	President, Hospital Association of RI	M. Teresa Paiva Weed
Larry O. Warner, MPH	Rhode Island Foundation	
Samuel Salganik	Rhode Island Parent Information Network	
Jane Hayward	RI Health Center Association	Jane A. Hayward
Peter Marino	Neighborhood Health	
Kristina Amedeo	United Way 2-1-1 of Rhode Island	
Kim A. Keck	Blue Cross Blue Shield RI	Kim A Keck
Joshua Miller	RI State Senate	
Gayle Goldin	RI State Senate	
Janet Raymond	Greater Providence Chamber of Commerce	Janet Raymond

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[1] Representative Joseph McNamara and Representative Mia Ackerman are also members of the Market Stability Workgroup, however, for reasons due to scheduling challenges, were unable to participate.

SUMMARY OF WORKGROUP DISCUSSIONS AND FINDINGS

Background and Key Concerns

The ACA was passed in 2010 and took effect for coverage beginning on January 1, 2014. The law was designed to use a combination of incentives and penalties in order to reduce the rate of uninsured citizens and to make coverage more affordable. The ACA can be likened to a stable, three-legged stool, balanced and interdependent on three core principles: affordability, insurance reforms and shared responsibility.

The outcome of the implementation of the ACA was mixed on a national basis, with significant turmoil and volatility in some states. In Rhode Island, however, the effect of the ACA has been largely beneficial. Over 100,000 Rhode Islanders have coverage because of the ACA. Since 2012, the state cut its uninsured rate by nearly two-thirds and today, 96 percent of Rhode Islanders have coverage. Rhode Island is ranked third-highest in the nation for percentage of children with health insurance coverage and sixth-highest overall. The ACA has also allowed HealthSource RI to foster a competitive, stable individual marketplace resulting in rate decreases in two of the last four plan years from 2015-2018, and the lowest benchmark plan cost in the country in 2018.

The ACA has been a success in Rhode Island because (a) key provisions such as guaranteed issue and community rating were already priced into rates; (b) OHIC's stabilizing role in the rate-setting process was already operable; and (c) the public and private sector players in the state have cooperated effectively, despite some operational challenges in the early years. Recent federal actions threaten the state's ability to maintain this stability, with the individual and small group markets most immediately at risk. The individual market is most affected by federal actions, and has high annual turnover and relatively few competing carriers. The small group market has more competition, but has seen a steady trend of decline in enrollment predating the ACA by many years. State action is necessary to preserve the relative affordability of Rhode Island's insurance markets as well as the coverage levels achieved through the ACA.

The federally-imposed penalty for not having coverage has been set to zero dollars starting in 2019, rendering the shared responsibility requirement, or "mandate," a non-factor in the upcoming HealthSource RI Open Enrollment period and beyond. As a result, healthier enrollees may choose not to sign up or stay covered, which could lead to higher premiums for those remaining in the risk pool. As premiums continue to rise over multiple years, more and more healthy enrollees may drop coverage and the pool may get progressively smaller and sicker. These negative consequences disproportionately impact the unsubsidized population, who face the full brunt of premium increases. National estimates vary in extent, but do agree that the uninsured rate and the cost of health insurance will both increase.

In addition, proposed federal changes could make it easier for individuals to join association health plans[2] and to purchase STLD plans, neither of which are required to include some ACA defined consumer protections, such as EHBs. As with the elimination of the mandate penalty, both changes

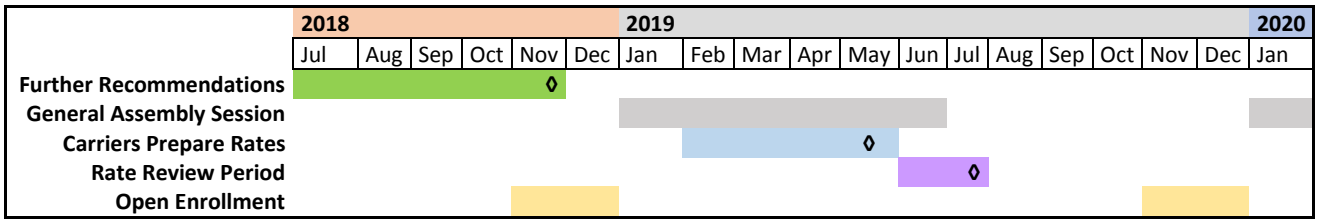
[2] Association health plans are already regulated under Rhode Island state law, mitigating the risks posed by their possible expansion.

may negatively skew the risk pool toward the less healthy, with concomitant greater increases in premiums.

Timeline for Action

The Workgroup recognized that while, most, if not all, of the options may not be timely in affecting 2019 rates, they would have an impact on the rate-setting process for 2020 premiums.

The proposed timeline below shows further recommendations being made prior to the 2019 legislative session. With prompt legislative action, these changes could be taken into account in advance of rates being filed and/or approved for 2020. Initial rate filings are typically due in mid-May and rates are typically approved in late July/early August.



Affordability

The issue of the affordability of health coverage was discussed throughout the deliberations of the Workgroup. The two most commonly discussed affordability themes were 1) mechanisms for driving down premiums costs, such as reinsurance, and 2) coverage take-up incentives for lower- and moderate-income populations. Other mechanisms for driving down premium costs such as reduction or elimination of fee for service payment, reduction or elimination of low value care, increasing capitation, and global budgeting were not discussed by the Workgroup.

The concept behind a reinsurance program is to mitigate significant premium increases by offsetting certain carrier costs. Specifically, within certain preset boundaries, reinsurance helps to cover claims costs for the highest cost enrollees with the most unpredictable claims. In so doing, reinsurance reduces some of the element of risk that carriers otherwise factor into their yearly premium rates.

In light of certain federal actions likely to give rise to greater market instability and thus rate volatility, much of the national conversation has focused on how states may take action to protect the affordability of health insurance premiums within their borders. Without an effective individual insurance coverage mandate in 2019, many consumers representing the healthiest risk for carriers may exit the marketplace and exacerbate yearly premium increases. While a majority of HealthSource RI enrollees receive federal premium tax credits to help offset their health coverage costs, those who do not qualify for this assistance, primarily moderate-income individuals and families, feel the brunt of annual rate increases. Consequently, should the risk mix in the individual market become increasingly older or sicker, the pressure for premium relief will grow. A reinsurance program, however, has the potential to moderate such premium increases across the individual market thus tempering the direct impact of annual rate increases upon enrollees who do not receive federal affordability assistance in the form of premium tax credits.

Reinsurance presents states with a tool to moderate year-over-year rate increases by providing carriers with greater predictability. It also offers an opportunity for states to draw upon federal savings to help pay for a reinsurance program if done through federal approval of a 1332 waiver under the ACA. By reducing premium costs and therefore federal premium tax credits, a reinsurance program creates federal savings, which can be leveraged by the state to create a larger reinsurance program. Many states have implemented reinsurance programs, and to date, three states (Alaska, Minnesota, and Oregon) have successfully obtained a 1332 waiver to implement a state reinsurance program paid for in part with federal pass-through savings.

Such waivers provide states with flexibility to modify major ACA coverage, tax credit or mandate provisions in pursuit of solutions or approaches that best suit the state's needs. They also offer states the opportunity to repurpose existing federal funds the state already receives as long as it does not have a negative effect on the federal deficit. By federal requirement, states must have explicit state statutory authority to apply for a 1332 waiver. However, application for a waiver does not commit a state to any funding.

The Workgroup reviewed material offering an estimate of what it would cost to fund a reinsurance program through a 1332 waiver that would achieve a 10 percent reduction in individual market premiums as compared to the otherwise projected increase. For Rhode Island, this cost was estimated (based upon other states' experiences) at $26 million, with $15 million of that amount funded through federal pass-through savings and approximately $11 million needed from other sources identified by the state prior to moving forward. Actuarial analysis is required as part of the 1332 waiver application, and would be needed to both refine this initial cost estimate and inform the state's reinsurance proposal.

In addition to a reinsurance program, the Workgroup considered other state programs aimed at addressing coverage affordability and incentives for coverage. The Maryland health insurance "down payment program" presented an example of how a state might seek to tie the imposition of a state mandate and penalty with an initial payment towards health coverage. Additional consumer outreach and assistance to facilitate enrollment in coverage would also be provided for under this proposal. Ultimately, the Workgroup heard that legislation to enact this proposal was not successful in Maryland and that there were pervasive concerns about operational and logistical challenges of implementing it.

Two additional state programs, Massachusetts' and Minnesota's, were reviewed with the Workgroup. Massachusetts' program uses state funds to offset premium and out-of-pocket costs for enrollees at 300 percent of the federal poverty level and below. Minnesota's program, which was in effect for 2017 only, was tailored to those not eligible for federal premium tax credits and applied a 25 percent rebate directly to consumer's monthly bill.

Although the Workgroup did not directly endorse any one approach amongst the state examples provided above, members articulated a strong interest in seeing similar affordability measures pursued in Rhode Island. In particular, the group expressed the need to focus on affordability both for those who receive federal premium tax credits and those who do not.

Insurance Reforms

Until recently, STLD plans were restricted to being sold for three months or less. STLD plans are not compliant with the ACA's consumer protections such as annual or lifetime dollar limits, guaranteed

issue or EHB requirements such as preventative, maternity and prescription drug coverage. While some states have prohibited the sale of STLD plans outright, others have taken steps to regulate them.

Under a new proposed federal rule, STLD plans will be permitted to be sold for up to 12 months and may be renewed year-over-year. Such an option may attract younger, healthier consumers away from the ACA-compliant insurance markets. The combination of a federal penalty repeal and the introduction of STLD plans is estimated by the Urban Institute to result in up to 17,000 fewer Rhode Island individual market enrollees.[3]

In addition to concerns about the impact to market stability, the Workgroup also raised concerns that the STLD marketplace is often fraught with misunderstanding, and frequent reports of blatant misrepresentation by the carriers of these products. In light of these concerns, the Workgroup reached the unanimous opinion that the state should take steps to ensure these plans are regulated in accordance with all other individual market products.

Amongst the menu of policy options reviewed by the Workgroup over the course of its deliberations were additional steps the state could take to ensure the continuity of key consumer and marketplace protections implemented at the federal level by the ACA. Among others, Connecticut has recently taken action to address some of these protections in state law. While currently the law of the land, such provisions as the ban on annual and lifetime limits, the ten EHB categories, the ability for dependents up to age 26 to enroll in their parent's plan, rating rules and the prohibition on exclusions for pre-existing conditions are all considered critical health insurance components in need of continuation should future federal changes occur.

Shared Responsibility

Under the ACA, shared responsibility refers to federal requirements that individuals buy health insurance, and that large employers offer health insurance to their employees. The individual requirement, in particular, goes hand-in-hand with ACA insurance reform rules by encouraging healthy people to join the risk pool and keep premiums low. Congress, effective in 2019, repealed the shared responsibility enforcement mechanism, or individual mandate penalty, while the employer mandate remains and federal enforcement activity has recently increased.

One obvious policy counter to the federal repeal is to re-impose a shared responsibility requirement at the state level. Massachusetts has had a state-level mandate for over a decade, and it is believed to have been an important factor in achieving the state's high level of insurance coverage prior to the ACA's passage (in fact, the ACA was designed to model Massachusetts in many ways).

The Workgroup reviewed efforts of multiple other states who have wrestled with this issue in 2018. For example, Vermont recently decided to impose a mandate, effective as of 2020. The interim time will be used by a state working group that has been tasked to develop recommendations to the legislature for implementation and enforcement of the mandate. Maryland chose to create an advisory group for a similar purpose, among others, though without any commitment as to whether a mandate

[3] Blumberg, Buettgens, Wang. "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending." The Urban Institute: March 14, 2018. https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending

will be imposed. New Jersey has enacted shared responsibility requirement legislation and the District of Columbia is currently deliberating on a similar package as part of their legislative process.

From an administrative standpoint, the simplest way to adopt a state-based shared responsibility requirement would be to follow the federal model, with minor adjustments for state-specific circumstances. This is because many of the administrative aspects of the ACA mandate still exist in federal law, and could therefore become the basis for a similar process at state level. The federal structure is also familiar to taxpayers and tax preparers in Rhode Island and maintaining the status quo is an attractive approach to protect coverage gains achieved under the ACA.

The Workgroup strongly agreed that a state-level shared responsibility requirement would satisfy the Guiding Principles of the group. The measure would unequivocally support market attractiveness for carriers and providers, and for most consumers as well, with the caveat that many who forgo coverage would pay penalties.

The Workgroup reviewed the revenue raised in Rhode Island by the federal mandate in 2015, which was $8.6 million, and the estimated 2016 revenue of $9.7 million. The majority of this revenue was raised from penalties paid by households with incomes below $75,000. The Workgroup agreed that revenue raised by a state-level shared responsibility requirement should be designated for affordability programs. This could include reinsurance as well as other affordability programs. There was also agreement that the enforcement structure of the requirement, as well as the affordability initiatives, should take into account the impact on lower-income Rhode Islanders.

Because the employer mandate is still in effect at the federal level, and enforcement has recently increased, there is not much room for additional state action. The Workgroup also considered various continuous coverage requirements, which had been proposed in Congress as alternatives to a mandate to buy coverage. However, these requirements may dis-incentivize the uninsured from enrolling, and may be more feasible through federal rather than state legislation. For these reasons, the Workgroup agreed that continuous coverage requirements did not merit inclusion in the recommendations.

Other considerations

Among the range of peripheral options that could be considered complementary to the Guiding Principles of the Workgroup, one in particular resonated most strongly with the members. This concern was how, and through what venue, the state could enact meaningful reforms aimed at addressing the underlying costs of providing healthcare in the state of Rhode Island. The Workgroup believed this concern merited further work and potential action, however, the time limitations and core charge of this group precluded a complete deliberation on the topic. Nevertheless, it is important to note that the Workgroup expressed a strong and consistent interest in seeing the state address the underlying drivers of healthcare costs in the state, noting that without doing so, high underlying costs will remain a risk to market stability. The Workgroup notes that there are other venues, such as OHIC's work to revisit its Affordability Standards, where work to add effective cost control measures to existing value-based strategies is underway.

MAINTAINING THE STABILITY OF RHODE ISLAND'S HEALTH INSURANCE MARKETS

Further action recommendations of the Market Stability Workgroup

January 2019

BACKGROUND

The Market Stability Workgroup was originally convened by the Office of the Health Insurance Commissioner (OHIC) and HealthSource RI (HSRI) in the spring of 2018. The Workgroup was charged with considering what, if any, measures ought to be taken by the State to mitigate the potential impact of federal policy changes on health coverage costs, consumer choice, and access. Three Guiding Principles were developed in support of the Workgroup's charge:

- To sustain a balanced risk pool;
- To maintain a market that is attractive to carriers, consumers and providers; and
- To protect coverage gains achieved under the Affordable Care Act (ACA).

Over the course of eight weekly sessions the Workgroup deliberated on state-based solutions for achieving the Guiding Principles and recommended the following:

- The State should be authorized to submit a 1332 waiver request as provided for under the ACA to implement a state reinsurance program to mitigate premium increases in the year 2020 and beyond.
- OHIC should be provided with regulatory oversight authority of Short Term Limited Duration (STLD) plans to ensure such plans are subject to the same consumer protections that apply to all other private health insurance coverage offered for sale in the state.
- The State should implement a state-level shared responsibility requirement to mitigate the impact of the federal health insurance mandate penalty repeal. The requirement should use the current federal structure as a basis and any funds raised should be primarily designated to pay for health coverage affordability initiatives.

The Workgroup also recommended further action on: 1) how to fund a reinsurance program, 2) the best way to implement a shared responsibility requirement, 3) if an additional affordability program is necessary and 4) if critical ACA consumer protections should be codified into state law. A full accounting of the Workgroup's key findings and recommendations can be found here.

Pursuant to the above original set of recommendations, the General Assembly passed, and the Governor signed, a bill to authorize a Rhode Island 1332 waiver application for a reinsurance program. The Workgroup appreciates this important step and thanks the General Assembly and the Governor for their action.

FURTHER ACTION RECOMMENDATIONS

In the fall of 2018, the Workgroup reconvened to study and make recommendations on the further actions related to shared responsibility and affordability. Additional meetings to study consumer protections are scheduled for early 2019. Over the course of eight biweekly meetings, the Workgroup reviewed and discussed information on different ways to fund a reinsurance program; who has historically paid the federal shared responsibility requirement payment; and examples of other affordability programs from other states. In addition, actuaries from Wakely Consulting Group presented on the impact of a Rhode Island reinsurance program through a 1332 waiver application.

After careful consideration and determined debate, the Workgroup made the following statements in support of their original recommendations and the three Guiding Principles:

- The Workgroup agrees that the State of Rhode Island should implement and fund an actuarially sound reinsurance program to mitigate premium increases in 2020 and beyond. The reinsurance program should have a meaningful and stabilizing impact on the cost of health insurance for Rhode Islanders purchasing in the individual market.
- The Workgroup agrees there should be a state-level shared responsibility requirement to encourage and promote enrollment in health insurance, to maintain the stability of the individual market's risk pool and to mitigate increases in uncompensated care.
- The Workgroup agrees revenue raised from the shared responsibility requirement should be dedicated to the reinsurance program and serve as a primary funding source thereof.
- The Workgroup agrees the shared responsibility requirement should be based on the federal model including all federal exemptions. In addition, deviations from the federal model should be considered to reduce the impact on low income populations. Potential deviations for consideration could be the decrease or elimination of the flat dollar penalty and/or an exemption for individuals or households with income at or below Medicaid expansion eligibility (138% Federal Poverty Level).
- The Workgroup agrees the State should conduct outreach and enrollment support to Rhode Islanders who are subject to the shared responsibility requirement penalty. The State should make every effort possible to enroll eligible penalty payers into coverage.

These are our final recommendations on these topics. The Workgroup will further explore if critical protections of the ACA should be codified in State law. An omission of that subject from these recommendations should not be understood as expressing any position on that topic from the Workgroup.

The Workgroup respectfully recommends the Governor and the General Assembly act on these recommendations in the 2019 legislative session in the interest of protecting the stability of Rhode Island's health insurance markets and the coverage gains achieved under the ACA over the last five years. All the agendas, materials, and meeting minutes from the Workgroup meetings can be found here.

By signing below, we each express our support for the Guiding Principles of the Workgroup, and for the recommendations as outlined above:

Print Full Name	Organization	Signature
Monica A. Neerenberg	Blue Cross & Blue Shield of RI	Monica A. Neerenberg
Elizabeth McClaine	Neighborhood Health Plan of Rhode Island	Elizabeth McClaine
Susan A. Starti, PhD, RN	The Substance Use and Mental Health Leadership Council of RI	Susan A. Starti, PhD, RN
Raisting Amedeo	United Way 2-1-1 RI	Raisting Amedeo
Ralph Coppola	IRV Wealth, RI Business SBA Summit, Coalition	
Marc Backon	Tufts Health Plan	
Peter Tellmann MD	RI Medical Society	
Sam Salgado	RI Parent Information Network	
Stephen C. Boyle	Cranston Chamber of Commerce	Stephen C. Boyle
Joshua Miller	RI Senate	
Teresa Paiva Weed	HARI	M. Teresa Paiva Weed
Larry Warner	Rhode Island Foundation	
Al Charbonneau*	RI Business Group on Health	Al Charbonneau
Jane A. Hayward	Rhode Island Health Center Association	Jane A. Hayward
Janet Raymond	Greater Providence Chamber of Commerce	Janet Raymond
W.H. Lang	Washington Trust	W.H. Lang

* with letter