



# **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.



## ***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<sup>2</sup> 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

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<sup>2</sup> 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.

	2018					2019												2020		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Further Recommendations	◊																			
General Assembly Session						◊														
Carriers Prepare Rates						◊														
Rate Review Period						◊														
Open Enrollment						◊													◊	

**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.<sup>3</sup>

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

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<sup>3</sup> 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.