Official Minutes

Market Stability Workgroup

Notice Posted: April 26, 2018
Date of Meeting: May 1, 2018
Meeting Time: 8:00 am
Meeting Location: Institute for the Study and Practice of Nonviolence
265 Oxford St
Providence, RI 02905

Workgroup Members Present: Steve Boyle (co-chair), David Burnett (on behalf of Peter Marino), Al Charbonneau, Ralph Coppola, Rosemarie Day, Gayle Goldin, Peter Hollmann, Samuel Salganik, Susan Storti, Rebecca Webber (on behalf of Kim Keck), Teresa Paiva-Weed, Bill Wray (co-chair)

Workgroup Members Absent: Joshua Miller, Janet Raymond, Jane Hayward, Sue Pearlmutter, Larry Warner, Cristina Amedeo, Mia Ackerman

Minutes

I. **Meeting was called to order** at 8:07 am by Co-Chair Bill Wray.

II. **Minutes** from the April 18, 2018 and April 25, 2018 meetings were approved unanimously.

III. **Opening Remarks/Feedback**
   a. Co-Chair Boyle opened the meeting by reviewing the day's agenda and noting that the meeting will focus on action across the nation, both state and federal, and on the Massachusetts experience. He asked if there were any questions about the agenda before starting the presentations. There were no questions.

IV. **New Member Introductions**
   a. Al Charbonneau, the Executive Director for the RI Business Group on Health, was introduced as a new addition to the Workgroup.

V. **Introduction of Meeting Presenter**
   a. Co-Chair Wray introduced the first presenter for the morning, Dan Muese, the Deputy Director at State Health and Value Strategies. Mr. Muese explained that State Health Value Strategies assists states in their efforts to transform health and

health care by providing targeted technical assistance to state officials and agencies.

VI. **Federal and State Landscape** (speaker: Dan Meuse, Deputy Director, State Health and Value Strategies)

a. Mr. Muese explained that he will build off Deb Faulkner's presentation from last week regarding what Congress has and has not done with respect to repeal and replace strategies concerning the Affordable Care Act (ACA). He mentioned that there is no single accepted definition of market stability, but that it is something you know when you see it. Generally, he noted, if rate increases are 20% or greate, your market is unstable.

The biggest concern in RI is that carriers threaten to leave the state, explained Mr. Muese. He said that payment discrepancies between carriers cause rate differentials; similar plans with similar cost sharing have different premiums. This confuses customers because the plans look so similar. Churn can also impact market stability, said Mr. Muese. When individuals shift between carriers it creates a challenge for carriers to develop rates.

Mr. Muese added that defunding CSRs, eliminating the mandate, loosening regulation on underwritten plans at the federal level can all also lead to instability in the market.

b. Mr. Muese discussed the Alexander/Murray bill. He explained that the bill proposed a replacement for CSR appropriations in legislation and proposed to reinstate the federal reinsurance program. The bill did not, however, pass, which shifted the onus onto the states.

c. Mr. Muese said the states are left with a few options: reinsurance, state level mandate penalty, short term plan regulation, policy abandonment. Mr. Muese explained the actions some of the states have made to date.

d. Reinsurance is a basic risk protection for health insurance carriers, said Mr. Muese. It effectively spreads risks across carriers. Reinsurance represents an opportunity to cut costs significantly. Mr. Muese said that we are considering this option for the first time now because up until 2017 there was reinsurance, risk corridor and risk adjustment at the federal level. When reinsurance went away, some carriers in other states threatened to leave the market. In Alaska, one carrier left and another threatened to leave. Alaska implemented a reinsurance program that is approximately 90% funded by the federal government.

e. Mr. Muese discussed the benefits of reinsurance. Reinsurance has a proven track record of reducing premiums guaranteeing carriers don't face large losses.

Mr. Muese reviewed the Reinsurance Premium Impact Model from the presentation deck. He explained that the Model shows that states may see a 10% rate spike between the base year and the first year without a reinsurance program.

Co-Chair Wray asked if states receive all the funds recognized by the federal government as savings, and Mr. Muese replied that they do.

Co-Chair Wray asked if the states were required to contribute to funding the reinsurance program. Mr. Muese said that there is usually a state share. In Alaska, the federal government pays about 90% and the State pays about 10%. In Minnesota, the federal government pays about 60% and the State 40%, and in Oregon the split is about 50%.

Teresa Paiva-Weed asked how state laws impact federal reserves. Mr. Muese explained that the federal government has been ambivalent about this.

Co-Chair Stephen Boyle asked where states have derived revenue from. Mr. Muese said that Alaska had a fund for reinsurance plus they added general revenue. Minnesota has a longstanding provider tax they tapped into. Wisconsin does not yet have a funding source.

Co-Chair Wray asked why Alaska's reinsurance program was covered 90% by federal dollars. Mr. Meuse explained that Alaska receives an extremely high amount of APTCs as compared to the other states.

Sam Salganik asked if RI's share of federal funds would be closer to 50%. Mr. Muese responded that we don't yet know, but that RI could expect a reinsurance program to be funded about 40% by the federal government.

f. Mr. Muese reviewed the Reinsurance Activity Map from the presentation deck. He indicated that Alaska, Minnesota and Oregon have active reinsurance programs.

g. Mr. Muese went on to explain the 1332 Waiver process. He said that 1332 Waivers are tools to achieve a policy goal. They enable states to obtain federal dollars. He said that coverage structure and subsidy structure can be waived through a 1332 Waiver, but that affordability, comprehensiveness and coverage

scope cannot be waived. There is also a budget neutrality requirement. He said that part of applying for a 1332 Waiver requires states to pass legislation authorizing them to apply for the waiver and making the program contingent on federal approval of the 1332 Waiver. However, even if legislation does not commit state funding, it can still satisfy the legislative requirements necessary to apply for a 1332 Waiver.

h. Ms. Paiva-Weed asked if there were any other ways to obtain federal funds besides a 1332 Waiver, and Mr. Muese said that Iowa and Idaho thought about using a Medicaid Waiver. Ms. Paiva-Weed asked about Massachusetts' efforts and Mr. Muese responded that Massachusetts is not doing active reinsurance work.

i. Mr. Muese discussed the repeal of the federal individual mandate. Explained that the federal mandate will be repealed in 2019 and that the CBO estimates a 10% rate increase without the mandate. Massachusetts already has a state individual mandate in place.

j. For timing purposes, Mr. Muese skipped the part of the presentation deck on short-term limited duration health plans.

k. Mr. Muese discussed the employer mandate. Explained that employers with at least 50 full-time equivalent employees face an annualized penalty per full-time employee if any employee receives APTC. He said the employer mandate wasn't enforced until 2017 but is now being fully enforced by the IRS.

VII. **The Massachusetts experience** (speaker: Audrey Gasteier, Chief of Policy and Strategy, Massachusetts Health Connector)

a. Audrey Gasteier introduced herself as the Chief of Policy and Strategy at the Massachusetts Health Connector. She said that she has been with the Health Connector since 2007.

b. Ms. Gasteier explained that Massachusetts has been administering its own individual mandate since July 1, 2007. It was included as a part of Massachusetts' health reform law, passed in 2006. She stated that the mandate in Massachusetts is a policy tool that was designed with 3 components: 1) minimum creditable coverage standards; 2) affordability; 3) penalties.

c. Ms. Gasteier said that individuals who do not have minimum creditable coverage in Massachusetts may be subject to a penalty. The Penalty has a step-wise,

progressive function. For instance, the penalty threshold for Massachusetts residents between 0-150% of the is $0.

d. Co-Chair Wray asked if Massachusetts residents are subject to both the State and federal mandate. Ms. Gasteier responded Massachusetts nets out any federal penalty that residents may owe from any state penalty they may owe. She said that Massachusetts's Department of Revenue manages the penalty because it is administered through the State's tax code.

e. Ms. Gasteier said that penalties had been pulling in about $18M/year in revenue to MA, but that it had dropped to about $12M/year because people could net out what they paid to the feds. Ms. Gasteier said that Massachusetts had a designated trusted into which penalty payments are deposited. The trust is used to lower the cost of insurance for those meeting certain income requirements.

f. Ms. Gasteier discussed the outreach purposes to which the mandate has leant itself in Massachusetts. She said that the data has afforded Massachusetts the opportunity to analyze and use detailed administrative data on health insurance coverage of its residents. A lot of tax lawyers have very strong opinions about the purposes to which tax data may be used to reach penalty payers. Massachusetts reached an agreement a few years ago and now it sends a letter to individuals regarding the penalty and their options.

g. Ms. Gasteier said that there was not forceful public pushback when Massachusetts implemented its mandate in 2007. It is very strongly supported by stakeholders, and has survived three different governors from different political parties. Rosemarie Day affirmed that the Massachusetts mandate is generally strongly supported by the religious community, insurers, and other stakeholders.

h. Ms. Gasteier discussed other developments in MA Health Care. She said that under the Baker administration, there was concern about swelling Medicaid enrollments, and that low-wage workers who at another time in history were in employer coverage were now in Medicaid. In response, Massachusetts implemented an Employer Medical Assistance Contribution that required employers in the State with five or more employees to pay a tax regardless of whether the employer offers health coverage to its employees. Massachusetts is also in the process of implementing a new low-wage payroll tax on employers whose employees are on Medicaid. She said this new tax is in the process of being rolled out and that employers have expressed concern.

VIII. **Wrap Up Discussion**

a. Rosemarie Day asked if there were any questions for Ms. Gasteier.

b. Ms. Paiva-Weed asked whether an employee in Massachusetts is permitted to enroll in Medicaid even if their employer offers health coverage. Ms. Gasteier responded that having access to employer health coverage does not preclude an employee from enrolling in Medicaid. She explained that employers are taking the position that it is unfair to tax them if their employees are on Medicaid when they are already offering health coverage.

c. Ms. Day offered for the group's input, an visual which identified policy options under consideration in the left column and the groups goals associated with the group's charge across the upper row. Ms. Day recapped the four policy options: 1) reinsurance; 2) individual mandate; 3) employer mandate; and 4) short-term limited duration plans. She asked the workgroup to analyze what the group learned from the presentations today that addresses the goals in the workgroup's charge of achieving a balanced risk pool, an attractive market and protecting coverage going forward.

d. Zachary Sherman added that we should also discuss whether there were any other policy options that the work group will consider.

e. There was consensus from the workgroup that reinsurance achieves a balanced risk pool, attractive market and protects coverage rights.

f. Mr. Salganik added that where reinsurance drives down rates it makes the market more attractive and protects coverage going forward, so he recommended that we add two check marks in the attractive market category. Co-Chair Wray added that we should add a check mark and half to the column under protect coverage gains for reinsurance.

g. There was a consensus that the individual mandate achieves a balanced risk pool, attractive market (partially) and protects coverage rights.

h. Mr. Salganik said that that the individual mandate creates an attractive market for carriers.

i. Co-Chair Wray asked if the individual mandate creates an attractive market for providers. Dr. Hollman said he thinks it does create an attractive market for providers. Co-Chair Wray mentioned consumers and said that we shouldn't

overstate that the mandate creates an attractive market for them. Even though it was supported in Massachusetts, RI is not Massachusetts.

j. Ms. Day recommended that we include a "yes/no" on the easel pad for whether the individual mandate is attractive to consumers and Co-Chair Wray agreed with this approach.

k. Ms. Paiva-Weed mentioned that in the presentation last week, we learned that the individual market rates were destabilizing prior to the federal individual mandate and that the federal individual mandate stabilized rates, which would make an individual mandate attractive to consumers.

l. Co-Chair Wray said that what may make the mandate unattractive to consumers is that they are being told they have to purchase health insurance. Rosemarie Day commented that if a person is only looking at the math then the mandate does make the market more attractive because it drives rates down. Ms. Day said that she also recognizes that there is the other part of the messaging around the requirement to purchase health coverage.

m. Ms. Day asked about whether the employer mandate achieves a balanced risk pool. Mr. Salganik asked what the state options are because there is already an employer mandate at the federal level. Mr. Wray mentioned that it hasn't been enforced at the federal level until recently.

n. Ms. Paiva-Weed said she would support state-based employer mandate and mentioned that Massachusetts has an employer mandate in addition to the federal mandate. Ms. Paiva-Weed would like to know how many employers in RI have employees who participate in Medicaid. She reiterated that employers need to be part of the conversation. Rosemarie Day pointed out that there is an equity issue around who is responsible for paying for paying and this it does not precisely fit into the workgroup's three goals. Co-Chair Wray recommended that we table further employer mandate discussions due to saliency and the fact that there were only a few minutes remaining in the meeting.

o. Ms. Day said that next week the group will discuss short-term limited duration plans.

p. Ms. Day asked if there were any other items that came out of the today's meeting that should be added to the list in green and blue.

q. Ms. Day asked if the workgroup members would like to add any items to the list for next week.

r. Co-Chair Boyle asked whether any states are using a carrot instead of stick, or some combination thereof. Mr. Salganik said that there are. He suggested you could provide additional affordability subsidies that can be targeted towards young, people, old people, young income people. He said this could be separate and apart from reinsurance or instead of reinsurance, instead of a mandate or in addition to a mandate. Director Sherman pointed out that Massachusetts is the only state that has additional subsidies.

s. Dan Muese added that Minnesota recognized that individuals 400-500% of the FPL are the most challenging to get into the market because they are not subsidy eligible but health coverage is still expensive. In response, Minnesota created a state-level tax rebate available to those who purchase coverage.

t. Mr. Meuse also said that a Medicaid buy-in is another option. He explained that this option could be made available where premiums were unaffordable and it would allow individuals meeting the income requirements to purchase Medicaid.

u. Mr. Salganik said that the consumer protections part of the three-legged stool are important and said that we need to shore up state law to ensure that rules around EHBs, zero cost sharing for preventive care, and the ability to stay on your parents' plan until the age of 26 are all important protections that need to exist in state law. When combined into a package these consumer protections make the idea of an individual mandate more palatable.

IX. **Public Comment**

a. Co-Chair Boyle asked if there were any public comments. Karen Malcolm, a member of the public stated that from her experience there is a clear understanding by the public that the mandate is a key leg in a three-legged stool. She said that RI's population is well educated on this topic and would accept a mandate as long as the affordability and consumer protection legs are there. Another member of the public, Linda Katz, recommended that we look to the Medicaid program as well.

X. **The meeting was adjourned** at 10:03.