HealthSourceRI
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OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP

Tuesday, May 22, 2018
8:00 – 10:00 a.m.
The Institute for the Study & Practice of Non-Violence

ADDRESSING FEEDBACK FROM PREVIOUS SESSIONS

- Commonwealth Fund survey was shared
- Recently passed Vermont legislation and article regarding the same was sent out
- Analysis concerning the impact of reinsurance on low-income, subsidized enrollees was shared
- Request made for talking points as we move closer to recommendations
- Update on reinsurance/1332 and STLD legislation

RI MARKET STABILITY WORKGROUP: EIGHT WEEK SYLLABUS

Topic(s) for Discussion	Meeting Date
Meeting 1 Introductions + Setting the Stage	Wednesday, April 18
Meeting 2 What has been accomplished + What is at risk in RI	Wednesday, April 25
Meeting 3 National Survey of State Actions + Considerations	Tuesday, May 1
Meeting 4 Policy Deep Dive: the "carrot" approach	Tuesday, May 8
Meeting 5 Policy Deep-Dive: the "stick" approach	Tuesday, May 15
Meeting 6 **Regroup on Package of Policy Options + Begin Discussion of Recommendations**	**Tuesday, May 22**
Meeting 7 Overview of Factors Influencing Premiums + Moving Towards Final Recommendations	Tuesday, May 29
Meeting 8 Reaching Final Recommendations	Tuesday, June 5

TODAY'S AGENDA

Purpose of Today's Meeting

- To begin outlining the core tenets of the Workgroup's final recommendations
- To leave with clear direction from the Workgroup regarding the process for developing and finalizing recommendations over the course of the next two weeks

Today, we ask that you

- Raise any outstanding questions, concerns or requests for further information that would be helpful to you as this Workgroup forms final recommendations
- Offer input on both the process and format for developing the Workgroup's final recommendations

TODAY'S AGENDA

(continued)

Today, we ask that you consider the following questions:

1. Do you think action is needed?
2. Should action come in the form of a package?
3. If so, should that package address all three legs of the stool?

Recall that recommendations may be couched in terms of "now" or "later" items or as items for which this Workgroup recommends further study.

TODAY'S AGENDA

1. Discussion to begin outlining the Workgroup's possible recommendations

2. Discussion of the Workgroup's process for reaching final recommendations and the format for conveying those recommendations

THE CHARGE TO THE WORKGROUP

Rhode Island has been here before. In response to the passage of the ACA, our state pulled together a coalition of experts.

Those efforts resulted in providing **access to high-quality, affordable health coverage** to more Rhode Islanders than ever before.

In 2018, continued efforts are needed to protect that success – **for Rhode Island's individuals, families and business community.**

Guiding Principles:

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

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

KEY CONCERNS

Unbalanced Risk Pool – without a penalty, younger/healthier populations are likely to drop coverage, leaving older/sicker enrollees in the market

Premium Increases – as riskier, costlier populations remain enrolled, non-group and small business coverage costs are likely to increase

Loss of Coverage – coverage gains will erode as young/healthy drop coverage and others begin to get priced out of the market; rates of uncompensated care will creep up as insured rates decline

Erosion of key consumer protections & essential benefits – new proposed rules will usher in new, non-ACA compliant plans that attract young/healthy enrollees and further compromise non-group/small business risk pools

RECAP OF ACTIVITY IN OTHER STATES

Massachusetts

- Individual responsibility provision enacted as part of 2007 health reform, remains in effect
- Revenue supports affordability measures (help w/premiums + OOP up to 300% FPL)

New Jersey

- Individual responsibility provision passed state legislature, awaiting governor's signature
- Revenue supports reinsurance program

District of Columbia

- Individual responsibility provision legislation introduced as part of Mayor's Budget, to be considered by City Council in late May
- Revenue supports affordability measures

Vermont

- Legislature passed bill mandating health insurance coverage
- Conference committee agreed to compromise; coverage required effective 2020, but working group to recommend approaches to penalty, qualifying coverage, exemptions

Maryland

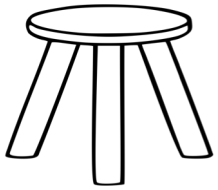
- Legislation enacted instructing advisory commission to consider individual responsibility provision

Source: State Health & Values Strategies, Jason Levitis, Market Stability Workgroup meeting 5 held on May 15, 2018

OVERVIEW OF POLICY OPTIONS

ACA's 3-legged Stool

1. Affordability measures
2. Shared responsibility mandates
3. Insurance reform



	Policy Options	RI Legal Status	Other States Considering/ In place?
Affordability "carrot" considerations	Reinsurance program via 1332 waiver	• Proposed in S2785 (in part) • Draft authorization bill text delivered to House and Senate	AK, CA, CO, DC, HI, IA, LA, ME, MD, MN, MT, NE, NH, NJ, NM, OK, OR, PA, VT, WA, WI
	State-funded additional premium subsidies	• Exists only for low-income parents of kids enrolled in RIteCare (Medicaid)	MA, MN, VT
	Health Insurance Down Payment (aka Coverage Incentive Program)	• None	MD
Shared responsibility "stick" considerations	Individual shared responsibility requirement/mandate	• In federal law, penalty set to $0 as of January 1, 2019	CA, CT, DC, HI, MA, MN, NJ, VT, WA
	Continuous coverage requirement/coverage lockout periods	• Proposed in ACA repeal/replace legislation	Unknown
	Employer mandates	• Federal law for groups over 50, enforcement began in 2017	MA, HI
Insurance reform red = action taken blue = identified as an item for further discussion	Consumer protections (annual/lifetime limits ban, Essential Health Benefits, dependents up to 26, pre-existing conditions, rating rules, etc.)	• In federal law • Proposed in S2785 – Codifies into state law	Varies by state
	Statutorily ban/create stricter rules for STLD plans (ie. limit their availability or require them to satisfy comprehensive coverage requirements) or limit expansion of AHPs	• Proposed federal regs relax STLD requirements • Draft bill text on STLDs delivered to House and Senate • Some existing regulatory authority to limit in RI • RI statutory limits on AHPs	AR, CA, CO, IN, MA, MD, NY, NJ, OR

DISCUSSION QUESTIONS

1. Do you think action is needed?
2. Should action come in the form of a package?
3. If so, should that package address all three legs of the stool?

Recall that recommendations may be couched in terms of “now” or “later” items or as items for which this Workgroup recommends further study.

DISCUSSION

PROPOSED NEXT STEPS

Workgroup to prepare recommendations in the following format

1. A **cover letter** containing relevant background on the establishment, Charge and Guiding Principles of the Workgroup as well as a recap of the process followed and key considerations noted; and
2. A **White Paper** outlining the specific recommendations of the Workgroup.

PUBLIC COMMENT?

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APPENDIX

AFFORDABILITY ASSISTANCE & INCENTIVES

Reinsurance: How it Works

Reinsurance cap
Issuer is responsible for costs above the cap

Coinsurance rate
Issuer is paid a portion of claims costs, based on the coinsurance rate

Attachment point
Issuer is responsible for costs up to the attachment point

Considerations:

- Reduces insurer claims' costs
- Covers a portion of the most expensive claims
- Attachment point + coinsurance rate can be adjusted each year
- Reduces rate uncertainty, volatility

Health Insurance Down Payment

Maryland

- Replace federal mandate penalty with down payment on coverage
  - Where possible, seek coverage at or below penalty cost
  - Provide directed consumer assistance
  - Support continuous enrollment

Health Insurance Down Payment

Pros

- Less punitive if directed to personal coverage
- Maintains pre-repeal risk pool
- Builds pool of healthier risk
- Familiar to consumers

Cons

- Requires significant operational development
- Low benchmark (lower APTC) could result in lower availability of low dollar plans

Subsidy Wraps - ConnectorCare

Massachusetts

- Massachusetts uses state funds to support the costs (both premium and out of pocket) for enrollees up to 300% of poverty ($75,000 per year for a family of 4)
- Plans are highly standardized, differing on networks and regional offering
- Even with subsidies, monthly premium costs can be out-of-range for consumers
- Higher than anticipated out-of-pockets can drive current customers if costs are non-recurring

Rebates for Unsubsidized Consumers

Minnesota

- Enrollees in the individual market not eligible for APTC
- 25% rebate, applied directly to monthly premium bill
- Carriers and state managed program enrollment and administration
- 50-66% rate increase in 2017
- $313 million budgeted, $137 million used
- Carriers and state managed program enrollment and administration
- Program only funded for 2017
  - Reinsurance implemented
  - 2018 rate increase was 3-5%

SHARED RESPONSIBILITY PAYMENT

Review of Reasons to Consider a State Individual Responsibility Provision

- Replaces federal policy: keeps premiums down and enrollment up (next slide)
- Creates outreach opportunities
- Tool for limiting substandard plans
- Favorable fiscal calculus
- Expands 1332 options by improving baseline
- Manageable implementation

Review of Reasons for Federal Individual Responsibility Provision

Status Quo Pre-ACA

- Individual insurance market characterized by practices that disadvantaged people with pre-existing conditions or who incurred large expenses while enrolled
- High rates of uninsured, “free riders”
- Uncompensated care increased prices broadly

Experience with Applying Consumer Protections without Ensuring Broad Coverage

- Adverse selection death spiral: higher premiums, diminished risk pool, fewer choices

Approach in ACA (and Mass. Health Reform)

- Consumer protections paired with coverage incentives (premium subsidy, individual responsibility provision)
- CBO: penalty repeal will reduce coverage by 13M, increase premiums 10%

Potential Approach: Mirror Federal Rules

How It Works:

- Use federal law as baseline and default
- Enact state penalty through "conformity" with federal penalty as of a fixed date (pre-repeal)
- Incorporate federal regulations and guidance as starting point
- Make technical adjustments for state legal and administrative context
- Make policy adjustments as desired to reflect state preferences
- Penalty is administered through state tax system

Potential Approach: Mirror Federal Rules

Why:

- Maximizes continuity and eases compliance amid short implementation timeline
- Simplifies legislative drafting
- Eases implementation (regs, forms, taxpayer education)
- Reduces re-litigation and "winners and losers"
- Readily accommodates specific policy changes

Model legislation reflecting this approach is available at
http://shvs.org/resource/model-legislation-for-state-individual-mandate/

Potential Policy Adjustments

Interaction with Federal Penalty

- Reduce state penalty by any Federal penalty to avert double-payment if reinstated (like Mass.)

Address Substandard Plans

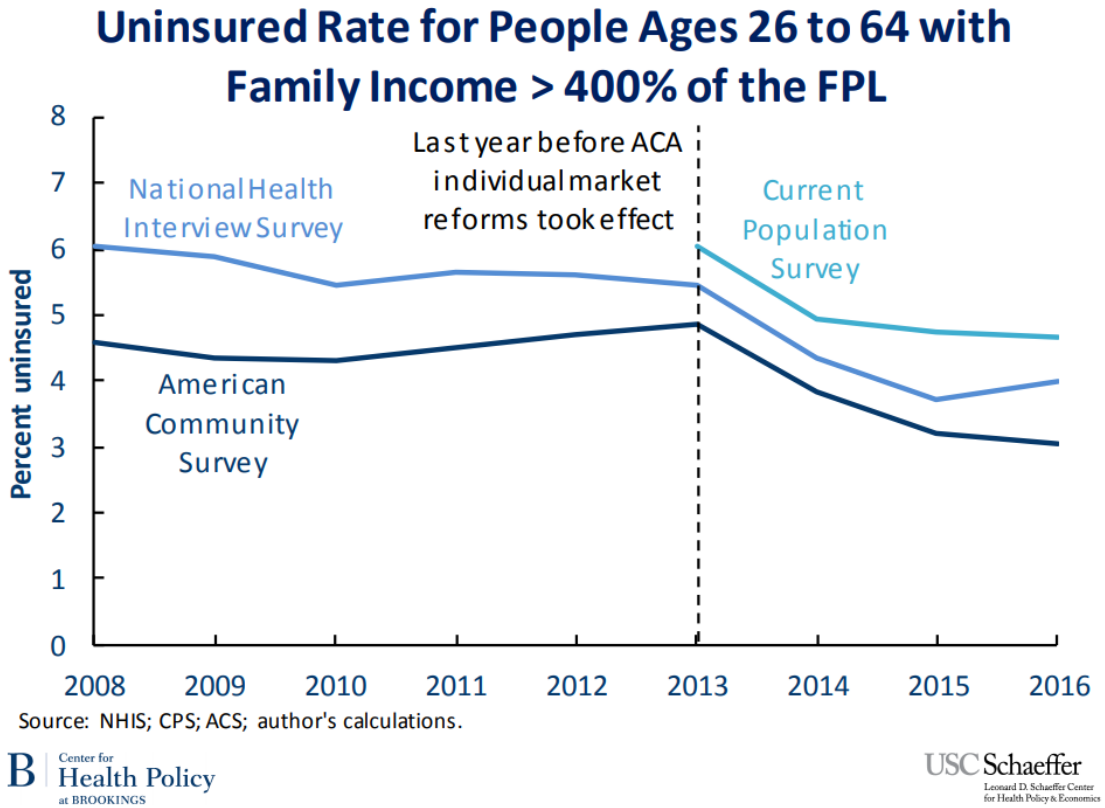
- Options include AHPs, health sharing ministries, grandfathered plans, certain employer coverage

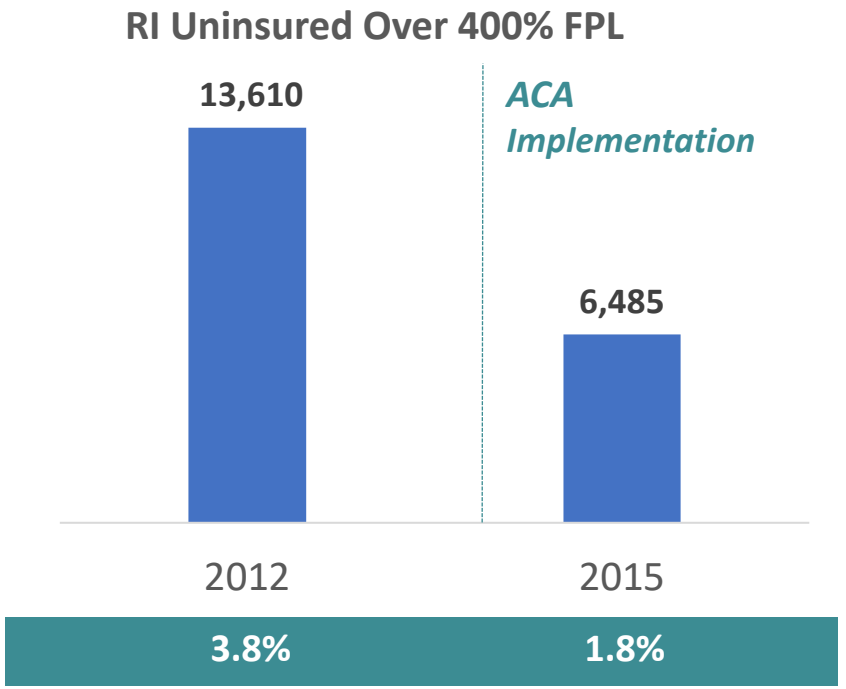
Use Penalty Revenue to Improve Affordability

- Options include state subsidies (like Mass., DC), reinsurance (NJ, DC), individual accounts (Maryland, Conn.)

Change Penalty Amounts and Exemption Rules

1. EFFECTIVENESS OF THE MANDATE, >400% FPL





Source: RI Health Insurance Survey (RI HIS)

- Unsubsidized population
- Notable drop post-mandate implementation
- Mandate not the only 2014 ACA change

Source: https://www.brookings.edu/wp-content/uploads/2018/02/fiedlerslidesfor030618-for-posting.pdf

2. FEDERAL PENALTY STRUCTURE IN RHODE ISLAND: REVENUE

- IRS likely to release final 2016 tax year data in Aug 2018
- IRS preliminary 2016 data* released for national level
  - Data as of Sept 2017, but projected for full year
  - National count of returns with a payment for tax year 2016 was 28% lower than 2015.
  - RI uninsured dropped by only 12.5% (4.8%--> 4.2%) over same time
  - Total national amount of payments was up 12%. RI may be up by more.
- Applying a 12% growth to RI 2015 data:

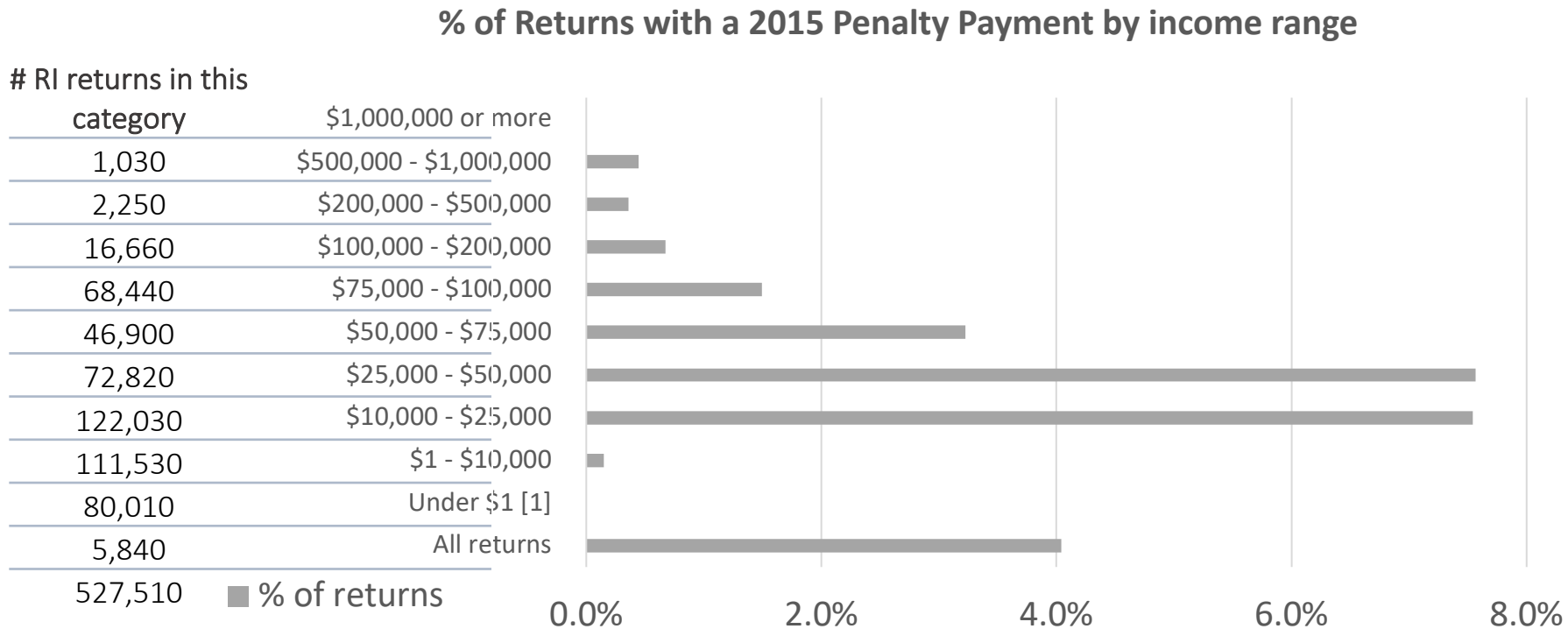
	2014	2015	2016	2017
Penalty Amount	Larger of $95 per person or 1% of income	Larger of $325 per person or 2% of income	Larger of $695 per person or 2.5% of income	Indexed for inflation
Total Payment	**$4.3M**	**$8.6M**	**$9.7M**	**tbd**

- 2017 onward—amount of penalty relatively steady per person, uninsured rate expected to be relatively steady as well, form revised for simpler exemptions
- Federal tax reform: increased filing threshold in 2018 may result in more exemptions and more disregarded income, and therefore less revenue

Source: *https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns#prelim

3. WHO PAID THE PENALTY?

- Lowest income bracket generally exempt
- Next lowest brackets pay most frequently—highest uninsured rates
- IRS instructions were confusing in 2015



Source: 2015 RI data from https://www.irs.gov/statistics/soi-tax-stats-historic-table-2

KEY EXEMPTIONS

- Tax filing threshold—no payment if income below $10,400, approx. 90% FPL for individual

- Affordability Exemption—no payment if cheapest employer or QHP w/ APTC coverage costs more than 8.13% of income
  - Medicaid coverage not considered, so vast majority of those below 138% FPL would be exempt

- Variety of additional hardship exemptions (e.g. bankruptcy, flood/fire, death in family)

INSURANCE REFORMS: REGULATION OF STLD PLANS

STLD PLANS: POTENTIAL IMPACTS

- Impact compounded by zeroing out mandate penalty
- Smaller, sicker individual market enrollment
  - HHS estimates 100-200k enrollment loss; Urban Institute estimates 2.1 million
  - Higher premiums for ACA-compliant plans
  - Higher federal outlays for APTCs ($96-$168M estimate)
  - Fewer plan choices
- Consumer-level impacts
  - Young, healthy get cheaper options (if unsubsidized)
  - Old, sick, or seeking comprehensive coverage pay more
  - Increased financial liability if get sick, injured
  - History of deceptive marketing tactics

ESTIMATED IMPACT IN RI

- Short term plans along with Mandate penalty repeal
  - Premiums in individual market +20.7%
  - Persons without Minimum Essential Coverage +12,000
  - Persons in individual market -17,000

*Source: 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