Market Stability Workgroup 2.0

October 2018 - February 2019
Meeting materials

Market Stability Workgroup

Notice Posted: September 27, 2018
Date of Meeting: October 3, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Agenda

I. Call meeting to order

II. Meeting logistics

a. New member introductions

b. Review changes to Workgroup from Spring session

III. Review Workgroup's charge

IV. Review of Workgroup's previous recommendations

V. Relevant & timely updates since Workgroup last convened

a. Authorizing legislation for a RI Reinsurance Program passed
b. 2019 Health Insurance Rates filed and approved
c. Executive Order signed by Governor Raimondo in support of low premiums and the ACA

VI. Workgroup syllabus

VII. Reinsurance basics and financing

VIII. Preview of the Workgroup's next meeting to be held on October 16th at 8:30 am

IX. Public comment

X. Adjourn

United Way of Rhode Island is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Jonelie Cardoza at 401.462.6428 or email her at jonelie.cardoza@ohic.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP "2.0"

Wednesday, October 3, 2018
8:30 – 10:30 a.m.
The United Way of Rhode Island

Workgroup Membership

Cristina Amedeo, Managing Director of UW 2-1-1 & The POINT, United Way of Rhode Island
Stephen Boyle, Chair of RI's Health Insurance Advisory Council and President of the Greater Cranston Chamber of Commerce
David Burnett, Chief Growth Officer, NHPRI
Al Charbonneau, Executive Director, Rhode Island Business Group on Health
Ralph Coppola, Senior Advisor, Meridien Financial Group
Gayle Goldin, Senator, Vice Chair of the Senate Committee on Health and Human Services
Jane Hayward, President & Chief Executive Officer, Rhode Island Health Center Association
Peter Hollmann, MD, Chief Medical Officer, Brown Medicine
Joshua Miller, Senator, Chair of the Senate Committee on Health And Human Services
General Counsel & Privacy Officer, BCBSRI
Janet Raymond, SVP of Economic Development & Operations, Greater Providence Chamber of Commerce
Samuel Salganik, Attorney and Health Policy Analyst, Rhode Island Parent Information Network
John Simmons, Executive Director, Rhode Island Public Expenditure Counsel
Susan Storti, PhD, RN, President & Chief Executive Officer, Substance Use and Mental Health Leadership Council of RI
Larry Warner, MPH, Strategic Initiative Officer, Rhode Island Foundation
Teresa Paiva Weed, President, Hospital Association of RI
Bill Wray, Chair of HSRI Advisory Board and Chief Risk Officer at The Washington Trust

TODAY'S AGENDA

1. **Reconvening the RI Marketing Stability Workgroup**
    1. Meeting logistics
    2. Workgroup "Charge"
    3. Recap of work done to date
    4. Timely updates since the Workgroup last met
    5. "Syllabus" for Workgroup "2.0"

2. **Reinsurance Basics and Financing**

RECONVENING THE RI MARKET STABILITY WORKGROUP

Meeting Logistics

- OHIC will serve as the Workgroup's primary point of contact for meeting logistics

- Bi-weekly meetings from October through January (with a break for the holidays)
  - **United Way of RI** will host all meetings (50 Valley St., Providence)
  - Meetings will typically be held on **Tuesday mornings**, 8:30 – 10:30 am; *with the exception of today and* Wednesday, October 31st

- Agendas, minutes and materials will be posted to the Secretary of State's website

RECONVENING THE RI MARKET STABILITY WORKGROUP

The RI Market Stability Workgroup "Charge"

Goal: Identify and propose sensible, state-based policy options for Rhode Island that will be in service the following principles:

Guiding Principles:

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

RECONVENING THE RI MARKET STABILITY WORKGROUP

June 2018 Report: *Near-Term Recommendations*

- **1332 WAIVER**. The state should be authorized to submit a waiver request to implement a state reinsurance program.

- **SHORT-TERM LIMITED DURATION (STLD) PLAN REGULATION**. The Office of the Health Insurance Commissioner (OHIC) should be provided regulatory oversight authority of STLD plans to ensure they're subject to the same consumer protections that apply to all other private health insurance products.

- **STATE SHARED RESPONSIBILITY REQUIREMENT**. The state should implement a state-level requirement to enroll in health coverage to mitigate the impact of the repeal of the federal penalty.

RECONVENING THE RI MARKET STABILITY WORKGROUP

June 2018 Report: *Future Work*

- How should RI fund a state reinsurance program?
- Should RI pursue additional health coverage-related affordability initiatives– and if so– what programs?
- How should a state-level shared responsibility requirement be designed and implemented?
- Should RI pursue codifying additional ACA consumer/market-based protections in state law?

RECONVENING THE RI MARKET STABILITY WORKGROUP

Since we last met…

- **2019 rates filed and approved**

	NHPRI	BCBSRI	UHC	Tufts
Individual Market	8.7%	7.5%	n/a	n/a
Small Group	-0.2%	4.6%	-5.0%	10.2%
Large Group	n/a	8.0%	8.1%	10.3% (HMO)
				10.2% (PPO)
Rates expressed in terms of weighted average rate increase/decrease				

- **Authorizing legislation for a Reinsurance Program passed** (S 2934A + H 8351) – establishes the RI Reinsurance Program and authorizes HealthSource RI to apply for a 1332 waiver. Aims to mitigate the impact of high-risk individuals on health insurance rates.

THE 1332 WAIVER PROCESS

Step	Target Timeline
1. Authorizing Legislation	✓ ***Complete***
2. RFP for Actuarial Work	✓ ***Complete***
3. Actuarial Work Begins	November 2018
4. 1332 Waiver Application Drafting • Public notice/comment period	Winter, 2019 • 30 days at minimum
⏰ *2020 Rate development*	Late winter, 2019
5. Application Submission	Early Spring 2019
⏰ *2020 Rate filing*	May 2019
6. HHS and Treasury Prelim. Review	Late Spring 2019 (30-45 days after application submission)*
7. Funding appropriated	Early Summer 2019
8. Final Decision of HHS and Treasury	Summer 2019 (2-6 months after the application completeness determination)*

**CMS has indicated that reinsurance program waivers will be reviewed and approved quickly if they are similar to approved waivers from other states.*

RECONVENING THE RI MARKET STABILITY WORKGROUP

Executive Order Signed by Governor Raimondo – Maintaining Low Premiums and Protecting the Affordable Care Act in Rhode Island (September 26, 2018)

- **Reiterates commitment to the principles of the ACA** and directs EOHHS, OHIC and HSRI to take all necessary actions to protect access to affordable, quality healthcare;
- Directs the State to seek to **codify ACA consumer protections**;
- Directs the State to seek **federal approval for a reinsurance program** to maintain an attractive market and keep premiums low;
- Directs OHIC to **guard against discriminatory practices** in the health insurance arena;
- Directs HSRI to take all efforts to **ensure Rhode Islanders are aware of Open Enrollment** and educated about their plan options; and
- **Requires the State to establish an individual market reinsurance program** with the objectives of maintaining an attractive market for insurers and keeping premiums low.

RECONVENING THE RI MARKET STABILITY WORKGROUP

The objectives for our work ahead include forming recommendations for policymaker's consideration, including:

- A method (or methods) for funding the RI Reinsurance Program;
- Whether RI should pursue other initiatives to address health coverage affordability and, if so, what programs;
- Aspects of design and implementation for a state-level shared responsibility requirement; and
- A package of consumer and/or market-based protections for codification in RI law.

The final work product may take the form of draft budget article language and/or legislative language, accompanied by an executive summary.

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

FCG | Faulkner Consulting Group

Reinsurance Refresher

Market Stability Workgroup 2.0

Wednesday, October 3, 2018

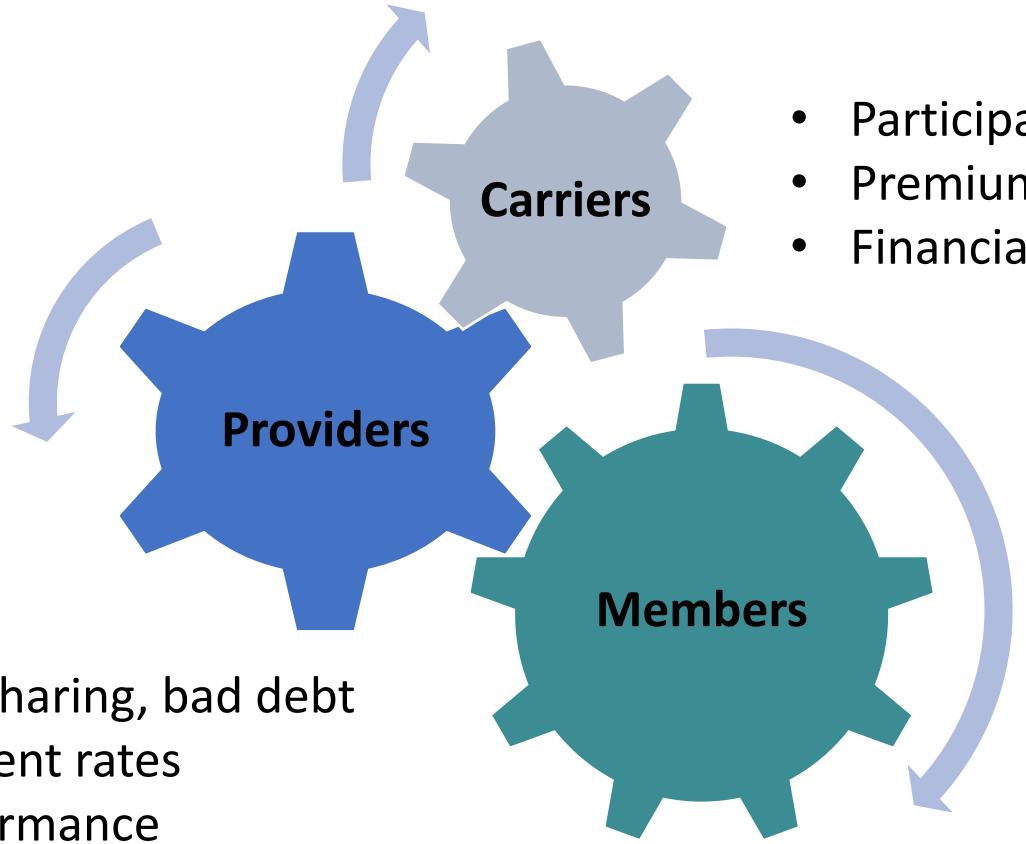
Reinsurance Refresher

- **Background on Reinsurance Program**
  What it is, how it works

- **Relevant Updates from Other States**
  Reinsurance Programs, Sources of Funds

- **Next Steps**
  Reinsurance Program Funding Deep Dive: Sources and Uses of Funds

Reminder: Individual Market Stability - "Precarious"



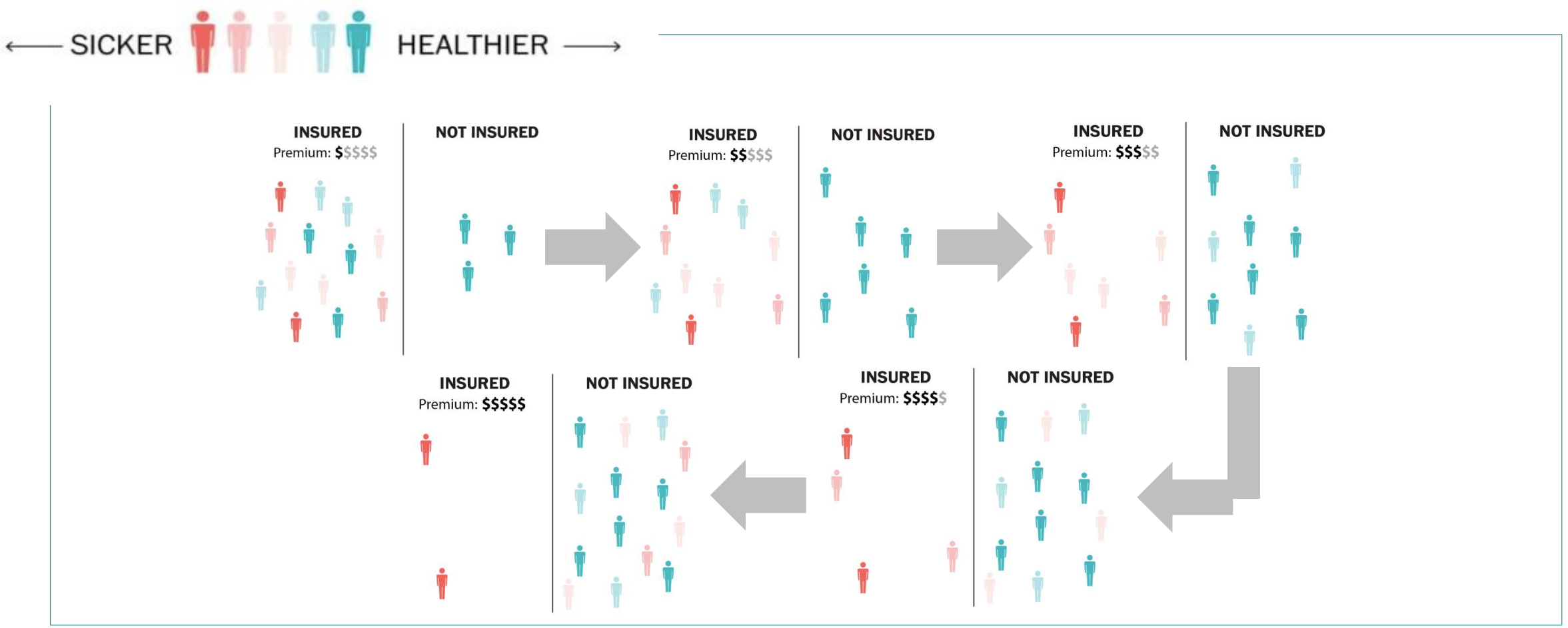
- Participation
- Premium increases
- Financial performance, MLR

- Uninsured
- Member cost sharing, bad debt
- Provider payment rates
- Financial performance

- Market size
- Enrollment trends
- Enrollment churn

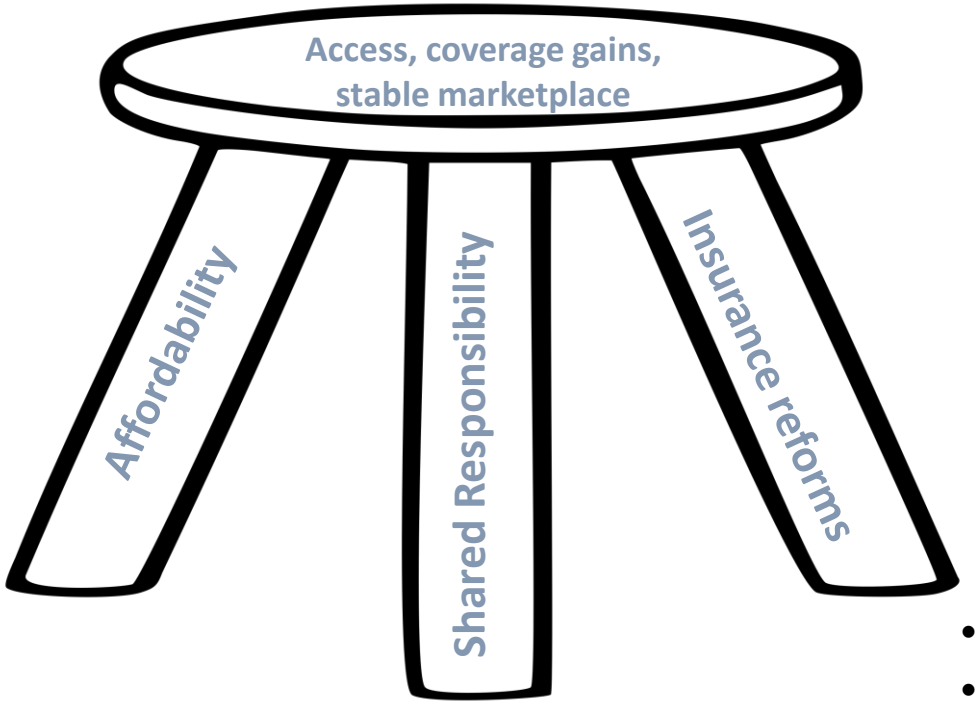
What Might Happen: If Healthy People Leave

As healthier people leave the market, premiums rise, causing more people to leave the market and triggering a feedback loop



Source: *Washington Post, Wonkblog Analysis, 6/23/17*

Sources of Market Stability

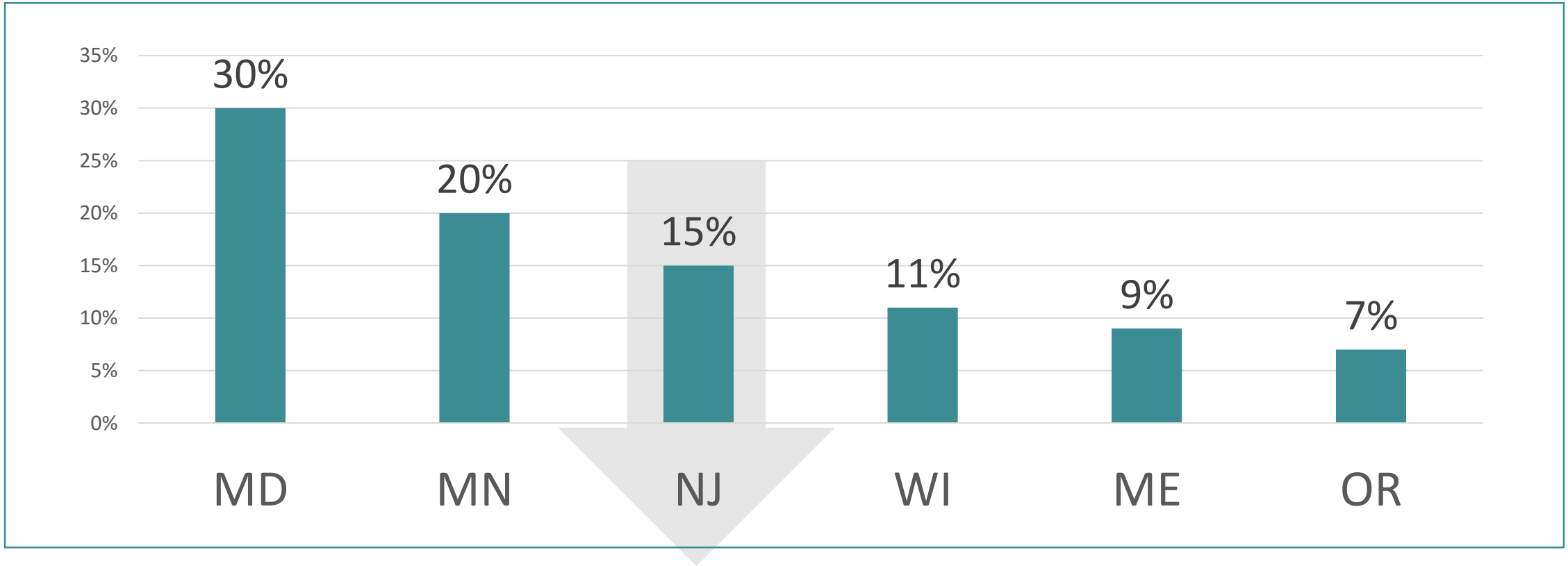


- **Reinsurance**
- State funded additional premium subsidies
- Coverage Incentive Program

- **State shared responsibility requirement**
- Employer mandates, Free rider penalty
- Continuous coverage requirements, lockouts

- **Consumer protections**
- Statutorily ban/create stricter rules for STLD plans
- Limit expansion of AHPs

Reinsurance Programs: Targeted Premium Impact by State



New Jersey Rate Filings Confirmed this Target

"If New Jersey had taken no action to stabilize its market, carriers indicated…that residents would have seen premium rates in the individual market ***rise by 12.6 percent*** *over last year. Instead, as a result of the continuation of an individual mandate in New Jersey, carriers requested a* ***5.8 percent average increase in premium rates****. Federal approval of the 1332 State Innovation Waiver in August, designed to lower anticipated premium rate increases, ultimately resulted in a combined or total average* ***decrease of 9.3 percent in the 2019 rates*** *compared to 2018."*

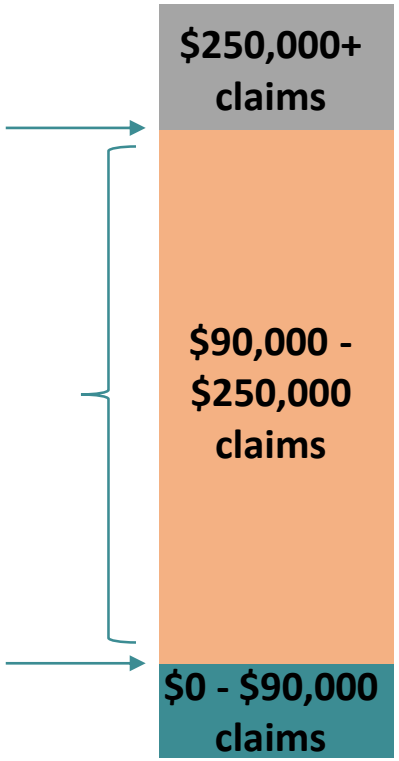
Reinsurance Fundamentals

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
- Targeted: Covers a portion of the most expensive claims
- Reduces rate uncertainty, volatility
- "Scalable": Attachment point + coinsurance rate can be adjusted each year

Reinsurance Funding Mechanisms from Other States

State	Source of State Funding for Reinsurance
Alaska	• Premium tax applied to all lines of insurance
Maine	• One-time nominal $500 insurer license fee • Insurer/TPA fee of up to $4 PMPM based on insured lives (excludes state/fed employees) • Ceding premium (90% of premium received) paid by insurers ceding covered persons to Maine reinsurance program • Optional assessments to cover Net losses – up to $2 PMPM
Maryland	• Assessment on insurers and MCOs that are regulated by the state (2.75%)
Minnesota	• State general funds • Portion of the 2% state provider tax (applies to hospitals and other providers)
New Jersey	• State individual mandate • Annual general fund appropriation
Oregon	• Premium assessment on fully insured commercial major medical (1.5%), includes premiums for self insured public plans • 2018 also funded by balance of 2 existing funds - Oregon Health Insurance Marketplace (OHIM) operating budget and Oregon Medical Insurance Pool (OMIP)
Wisconsin	• State general purpose funds

Next Steps: Reinsurance Program Funding – Sources and Uses

- Review approximate revenue required to fund a reinsurance program
- Estimate revenue raised from Shared Responsibility Payment (SRP)
- Identify/estimate revenue raised from Alternative Funding Mechanisms

PUBLIC COMMENT?

THANK YOU

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Backup

Individual Market Stability: "Precarious"

Premiums	• Average annual premium increase 2015-2018: 4% • Study of 21 states: RI saw the lowest average annual % change in the cost of its benchmark silver plan 2014- 2018
Enrollment	• Enrollment grew substantially in 2014, then stable • High annual turnover (~30%) • Federal actions more directly threaten the Individual Market
Member Choice	• Two carriers offering plans on the Exchange
Provider Stability	• Decline in uninsured => reduction in uncompensated care • Rising member cost sharing, bad debt • Provider payment rates under pressure: Medicaid Expansion, commercial rate regulation
Carrier Stability	• Average Individual Market MLR for NHP and BCBS combined was 77% in 2014, 85% in2015 and 2016 • Compares favorably to national Individual Market MLR averages (86% in 2014, 92% in 2015, and 93% in 2016) • Varies considerably by carrier

Sources: Premium increase average based on OHIC annual rate summary; carrier averages are enrollment weighted by year based on enrollment distribution by carrier from 2018 rate filing submissions, and evenly averaged for the multi-year period
KFF Study: *An early look at 2018 premium changes and insurer participation on ACA Exchanges*, August 10, 2017
Turnover: In 2017, roughly 30% of Exchange users churned on or off of coverage over the course of the year
Average Individual Market MLR, (NHP and BCBSRI average, evenly weighted); Individual Market Rate Filings 2017, OHIC website
National Individual Market MLR: CMS, *Summary of 2016 Medical Loss Ratio Results*

Recent State Activity: Reinsurance

Authorizing Legislation Enacted

- Rhode Island
- Texas
- Virginia
- Kentucky

Public Draft of Application

- Idaho
- Louisiana
- New Hampshire

Waiver Approved

- Alaska
- Oregon
- Minnesota
- Maryland
- New Jersey
- Wisconsin
- Maine

Notes:

- Montana and Nevada have authorizing legislation that was vetoed
- Six state applications were either withdrawn or incomplete: CA, IA, MA, OH, OK, VT

Reinsurance Funding Mechanisms: Lessons from Other States

Funding Mechanism	ME	AK	MD	OR	MN	NJ	WI
Premium based Assessment		X	X	X			
Covered lives based assessment (Policy or Provider based)	X*				X		
Shared Responsibility Payment (SRP)						X	
State General Revenue					X	X	X
Other	X			X			

Considerations

- ✓ Contribution to Market Stability
- ✓ Who Pays/How much they Pay
- ✓ Administrative Feasibility
- ✓ State Financial Burden
- ✓ Sustainability

Market Stability Workgroup

Date of Meeting: October 3, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Workgroup Members Present: Cristina Amadeo, Stephen Boyle, Al Charbonneau, Ralph Coppola, Marie Ganim (co-chair), Jane Hayward, Peter Hollmann, Liz McClaine (for David Burnett), Hon. Joshua Miller, Monica Neronha, Janet Raymond, Samuel Salganik, Zachary Sherman (co-chair), John Simmons, Susan Storti, Lisa Tomasso (for Teresa Paiva Weed), Larry Warner

Workgroup Members Absent: Hon. Gayle Goldin, Bill Wray

Minutes

I. Meeting was called to order at approximately 8:40am.

II. Meeting logistics

a. New member introductions – all members introduced themselves and Zach Sherman announced that while he was not currently in the room, John Simmons will also be joining as a member of the Workgroup.

b. Review changes to Workgroup from Spring session – Marie Ganim announced that the prior chairs would be given a reprieve this time, and that herself and Zach Sherman would be chairing the group.

c. Marie Ganim asked the group to share any thoughts they have on things we can improve from the last workgroup, convened in the spring, to improve the member's participation and experience. The only comment, from Steve Boyle, was that greater time could be dedicated to soliciting member feedback during the meeting to ensure that anyone who has thoughts to share has an opportunity to weigh in.

III. Review Workgroup's charge – Zach Sherman reviewed the goal of identifying and proposing sensible, state-based policy options for RI that will be in service of the Workgroup's guiding principles (from the first convening of the group).

IV. Review of Workgroup's previous recommendations – Zach Sherman reviewed the near and longer-term recommendations made by this Workgroup in the spring. He pointed out that among them was for the state to submit a waiver request to implement a state reinsurance program, though he noted a funding mechanism remained unidentified and work was left to be done. He also noted the "future work" or longer-term recommendations, which included how RI should fund a reinsurance program, whether there should be other health coverage related affordability initiatives (and if so, what should they be?), how the specifics of state-based shared responsibility requirement should be designed and implemented and, finally, whether RI should pursue codifying additional ACA consumer or market-based protections in state law.

V. Relevant & timely updates since Workgroup last convened

a. 2019 Health Insurance Rates filed and approved – Marie Ganim reviewed the individual, small and large group rates as approved for 2019.
b. Authorizing legislation for a RI Reinsurance Program passed – Marie Ganim recognized the General Assembly for their work to introduce and pass the reinsurance legislation. This authorized the state to move forward to seek a 1332 waiver through the federal government to run a reinsurance program.
    i. Zach Sherman updated the Workgroup on the ongoing work, led by HSRI, to apply for a 1332 waiver. HSRI has issued an RFP for actuarial work in support of the application, and is currently negotiating a contract with the successful bidder. The application is intended to be submitted in the early spring in order to give the carriers a sense of what the state program may look like.
    ii. A question was asked about how long the actuarial work would take and Zach answered that it was anticipated to take 2-3 months.
    iii. Zach Sherman explained that CMS had advised states to keep in line with other state applications in order to streamline approval.
    iv. Monica Neronha noted that multiple filings are very complicated and time consuming for the carriers (as was experienced during the CRS defunding) and said that if the date for filing rates on the individual side could be moved, that would alleviate some of that concern.

c. Executive Order signed by Governor Raimondo in support of low premiums and the ACA – Marie Ganim reviewed the Executive Order recently signed by the Governor which addresses actions to protect access to health insurance, work on reinsurance and protect principles of the ACA.
    i. Marie noted the legislation around the Short Term Limited Duration plan regulation had not been passed last session and that she is hopeful this work will continue and be completed in the upcoming session.

ii. Janet Raymond asked about feedback given on the legislation. Marie answered that it had been introduced fairly late in the session and it got lost in the shuffle of the end of the session.
iii. Steve Boyle asked for confirmation as to whether these plans need to comply with state requirements. Marie answered that they're using their authority to achieve that, but that there is not a state statute clearly imposing that requirement on carriers of these plans.
iv. Larry Warner asked if a potential sponsor on the House side had been identified; Marie answered that, yes, someone had been in touch about that, yes.
v. Steve Boyle shared that calls had come through soliciting enrollment in these plans. Marie also shared that she'd received calls and that she's concerned about the fraud.
vi. Susan Storti asked whether a consumer alert could be done which the leadership council could share with their membership and constituency.
vii. Marie agreed.
viii. Christina Amedeo added that a partnership with DLT would be helpful – there is a partnership for rapid response with United Way and DLT – because these companies are getting the names of workers about to be laid off and targeting them.
ix. Liz McClaine shared that when consumers drop these plans (having realized that they're not good coverage), they don't qualify for a special enrollment because they've not lost health coverage under the ACA.
x. Senator Miller advised that when this proposed bill arises again in the General Assembly, we need to make sure that the message is clear that existing RI carriers do not want to sell these products. There seems to have been confusion about this last spring in the General Assembly.

VI. Workgroup syllabus – Marie Ganim reviewed the objectives for this Workgroup, which are; 1) forming a recommendation regarding reinsurance funding, 2) a recommendation regarding pursuit of other affordability initiatives and if so, what programs, 3) detailed recommendations regarding design and implementation for a state-level shared responsibility requirement, and 3) a possible package of consumer and market-based protections in RI law.

a. Marie then reviewed the intended syllabus for the Workgroup over the next several weeks.
b. John Simmons asked whether there would be an analysis of the fiscal impact of the ACA and Marie answered that would be best addressed as a part of meeting of 8.
c. John Simmons added that short-term, transitional coverage should be considered as a part of this conversation as well. Marie clarified that the proposed legislation was intended to bring them under the regulatory structure. John expressed that he felt we should have a good idea of what the short-term plans are – and what we'd be regulating. Zach added that the administration had allowed these plans to be long-term options (not short, transitional), and that making them truly short-term

could be an option for the state. Senator Miller added that the concern seemed to be focused on the quality of the plans and less about their availability.

d. John said quality was subjective to the person buying it so it's important to continue the discussion.

VII. Reinsurance basics and financing –

a. Deb Faulkner offered some review in terms of what has already been presented to and discussed by the Workgroup on the topic of reinsurance. She recalled that the Workgroup had heard about the "precarious" status of the individual market in RI in terms of how it was performing for individuals, providers and carriers.
    i. Al Charbonneau pointed out that we've seen growth in the individual market, noting that its largely reliant on the subsidy and doesn't that make the individual market precarious in and of itself? Deb agreed this was the case.
    ii. Steve Boyle asked if we've seen churn on the unsubsidized market. Deb said she hasn't seen it split by subsidized/unsubsidized, but generally, churn in and out of the exchange's individual market was about 30%.
    iii. Deb recalled the "three-legged stool" of market stability, which sets forth that you need affordability, a shared responsibility requirement and insurance reforms working in concert. She noted that the group had been looking to shore up the shared responsibility and consumer protections aspect of this stool, as are many states.
    iv. Deb then reviewed the point of seeking a 1332 waiver – it allows the state to waive the requirement that everyone be in the same pool and allows that federal funds be leveraged to pay for the reinsurance program. She shared several examples from state reinsurance programs, offering a range of premium impact percentages. There are six states with approved programs and another six that are in process of seeking approval for the same. There is a lot of national activity around reinsurance. She highlighted NJ as having both a reinsurance program and a shared responsibility requirement – the result of the combined impact of these policies was a 15% decrease from reinsurance and a 7.3% decrease from the individual responsibility requirement in rates.
    v. Steve Boyle asked if these states were taking any other measure to control cost increases that could be contributing to these premium impact numbers. Deb said MD had been pursuing a broad package but was unsure if other state action on cost-containment were underway, though noted the numbers she was sharing were specifically attributable to reinsurance programs.
    vi. Al Charbonneau added that if you can't get at long-term costs, you'd risk the reinsurance program becoming unaffordable. Deb agreed – the underlying costs must be addressed.
    vii. Larry Warner asked how this would coincide with cost trend efforts being led by OHIC and whether we'd be able to track the impact of each policy separately? Marie explained that we wouldn't anticipate necessarily that claims will change, just who pays for them.

viii. Monica Neronha said that we can understand what happens with reinsurance by looking at the early years of the ACA. You saw rates go up after the initial 30% impact – it's a one-time reduction in rates. The program mitigates increase but you don't get it year over year. That is why the overall cost-trend work is important. Marie added that you can look at the impact of the investment back then – the first three years of the ACA – and the investment of $23 million had an impact of about 11%.

ix. Deb continued, pointing out that policy goal is to keep volatility down.

x. Monica Neronha added an example: 6 people who were very ill had a 2% impact on rates – they were very expensive and BCBSRI saw those claims after the claim period – and reinsurance would potentially be in place to protect against that kind of thing.

xi. Deb briefly reviewed some of the fundamentals regarding how reinsurance works and some of the key considerations.

xii. Sam Salganik asked what the ACA had used for an attachment and coinsurance rate, but the question couldn't be answered.

xiii. Senator Miller asked what part was budget driven and what part was design driven as Deb reviewed the state examples. She said it was hard to know – it is best to look to the starting premium as the key driver, but without looking at the discussion by the policymakers at the time it's hard to know. Marie Ganim added to that, agreeing that states were driven by the need to stabilize their market and the annual increases to premium they were anticipating.

xiv. Deb then reviewed the funding mechanisms – noting that some states felt they had no other choice due to premium increases other than using General Revenue. But, you do see use of assessments (provider or covered lives) and a shared responsibility requirement (enforced through a penalty) to fund reinsurance.

xv. Janet Raymod asked what a small general fund allocation was. Marie explained that the federal funds would be used first, then the shared responsibility payment and then the General funds would plug whatever was left.

xvi. Peter Hollman asked how the individual requirement helped fund anything. Deb answered that its enforced through a penalty. Zach Sherman added that a percentage and a flat rate can be used to assess taxpayers.

xvii. Sam Salganik noted that 2/3 of the federal penalty raised from RI came from households at $50k or below and 85% came from $75k or below, so the fast majority came from lower-income households.

xviii. Zach Sherman added that that's who the remaining uninsured are. He added that the team at HSRI is working on a model to help us look at various iterations of the shared responsibility payment mechanism to understand how such changes would impact various demographics.

xix. Zach added that the goal was to raise zero revenue because the policy goal is to have everyone uninsured. He then noted that in MD, they supplanted

the moratorium on the Health Insurance Tax, and used that to fund their program.

xx. Deb asked the group to weigh in on potential ideas in addition to those used in states with existing programs.

xxi. Peter Hollman noted that doing so would make the application process harder. Zach Sherman added that it was a good time to discuss now and review later.

xxii. John Simmons stated that one option needs to be self-paid by those receiving the benefit. So, an individual market premium assessment.

xxiii. Deb said that when you look at a PMPM, the more you can design the "who pays" however you want, though there will be an impact to the federal government and they'll consider that in the state's application.

xxiv. Sam Salganik asked if the MD assessment applied to the Medicaid MCOs? Deb said she was not sure if they apply it to their Medicaid MCO's, but it is something to consider.

xxv. Ralph Coppola suggested that the self-insured might be an area to explore – to level the field. Deb added there's a premium tax and a broad-based assessment to pay for vaccinations for children and you could even those out somewhat.

xxvi. Marie Ganim invited anyone from the public in attendance to ask a question or make a comment.

xxvii. Lauren Conway from United Healthcare asked what we get from the federal government through this application. Deb explained that you propose a federal share, which is similar to the share of the subsidized population (about 60% in RI) and that's what you hope to get. They then have to pay less to subsidize that population and then they're willing to fund the equivalent towards reinsurance. Lauren Conway, CFO of United Healthcare, added that if the group were considering an assessment beyond the individual market it would prompt United to ask for a seat at the table.

xxviii. Peter Hollman asked if the staff had considered anything new as far as a funding mechanism. Deb said that many of the ideas are recycled. Peter proposed pharmaceutical company profits could be an idea. Deb said she hadn't seen that nationally yet, but the one most connected to the program goals is the shared responsibility payment requirement. It's a policy and funding lever.

xxix. John Simmons asked whether we will we talk about the self-funded market and whether we'll consider the component parts of reinsurance? Deb answered that a lot of the details will be considered by the actuaries. We can look at the impact of those components, but the question of the best combination would be work done by actuaries.

xxx. Monica Neronha added that looking at the self-funded businesses is a very different population; so, look at them but also consider the impact from the federal reinsurance program.

1. She then added comments about families deciding to insure the sickest or third-party payers (advocacy groups, for example) and

that has an impact on the health of the risk pool. Reinsurance might have an impact on these types of behaviors.

xxxi. Christina Amedeo asked if BCBSRI is seeking co-occurring diagnoses with substance use and other conditions such as HIV or Hep-C.

xxxii. Susan Storti said that these individuals are ending up on intensive care units, so looking at that type of care would help elucidate on that type of care.

xxxiii. Senator Miller said it was important to keep in mind who saves in a reinsurance program, noting it's the state and self-insured, too – because their contracts are less expensive with the carrier. It's a direct impact.

xxxiv. John Simmons said you have to show that direct relationship. He wasn't sure what the impact would be. Senator Miller responded that the most expensive patients are Medicaid or uninsured. This gives an example of how just a few people can have an impact on the entire marketplace, including self-insured and the state. The expense is passed on to the other sectors of the market when there are a few very expensive patients.

VIII. Preview of the Workgroup's next meeting to be held on October 16th at 8:30 am

IX. Public comment – Marie Ganim invited public comment.

a. Lisa Tomasso added a comment about whether the low percentage of uninsured in RI – is this a benefit or challenge to yield premium impact from a reinsurance program? Deb answered that the contribution is driven by the share of subsidized consumers. To the extent the uninsured are high or low income, you might get a different share from the federal government.
b. Lauren Conway expressed concern that the penalty would not raise sufficient funding.
c. Zach Sherman pointed out that in 2017, it raised $11m.
d. Ralph Coppolla added that you need an incentive to get/keep people insured. If you're not going to penalize, what is the incentive?
e. Deb agreed a combination of carrots and sticks is important.

X. Adjourn

a. The meeting was adjourned at approximately 10:15 AM.

Market Stability Workgroup

Notice Posted: October 11, 2018
Date of Meeting: October 16, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Agenda

I. Call meeting to order
   a. Motion to approve October 3, 2018 meeting minutes
   b. New member introductions
   c. Meeting One follow-ups

II. Objectives for today's meeting
   a. Review agenda
   b. Focus of today's meeting: How to finance reinsurance program

III. Reinsurance
   a. Cost analysis, potential funding sources
   b. Other assessments and considerations

IV. Discussion/Consensus Building

V. Public comment

VI. Adjourn

United Way of Rhode Island is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Jonelie Cardoza at 401.462.6428 or email her at jonelie.cardoza@ohic.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP "2.0"

Tuesday, October 16, 2018
8:30 – 10:30 a.m.
The United Way of Rhode Island

NEW WORKGROUP MEMBERSHIP

Marc Backon, President of Commercial Products, Tufts Health Plan

Lauren Conway, Chief Financial Officer, UnitedHealthcare

WE HEARD YOU…

- Built-in time for Workgroup discussion and ample opportunity for all to participate
- Parameters of the ACA's reinsurance program (sent via email on 10/12/2018)
- Common terms defined in the appendix to ensure consistent use of terminology

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TODAY'S AGENDA

Reinsurance Program Financing Options

- Order of magnitude: establishing a shared understanding of the approximate impact and cost of a RI Reinsurance Program;

- Potential funding sources: understanding funding mechanisms deployed in other comparable states + reviewing key data points for RI; and

- Building consensus: assessing key considerations inherent in each possible funding approach and discussing the best path for RI.

Reinsurance Financing Options

October 16, 2018

FCG | Faulkner Consulting Group

RI Market Stability Workgroup 2.0

The objectives for our work ahead include forming recommendations for policymaker's consideration, including:

- **A method (or methods) for funding the RI Reinsurance Program;**
- Whether RI should pursue other initiatives to address health coverage affordability and, if so, what programs;
- Aspects of design and implementation for a state-level shared responsibility requirement; and
- A package of consumer and/or market-based protections for codification in RI law.

The final work product may take the form of draft budget article language and/or legislative language, accompanied by an executive summary.

Today’s Agenda: Reinsurance Programs

- **How Much Does it Cost:** Reinsurance Program Cost
  - How much might a Reinsurance Program Cost in RI
  - State share
- **How might we fund it:** Potential Sources of Funds
  - Lessons from other states
  - Factors to consider
  - Potential revenue
- **Discussion**

Reminder: Workgroup Recommendations

- **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.

  […]

- **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.

Cost for RI Reinsurance Program: Three Factors

(1) Targeted Impact

State sets key parameters to accomplish desired impact

- Scalable, budget dependent
- Typical: 7-20%

(2) Total Program Cost

To be developed by actuaries, estimates based on key market characteristics

- Individual Market Size
- Premium Levels
- Market Volatility

(3) State Share

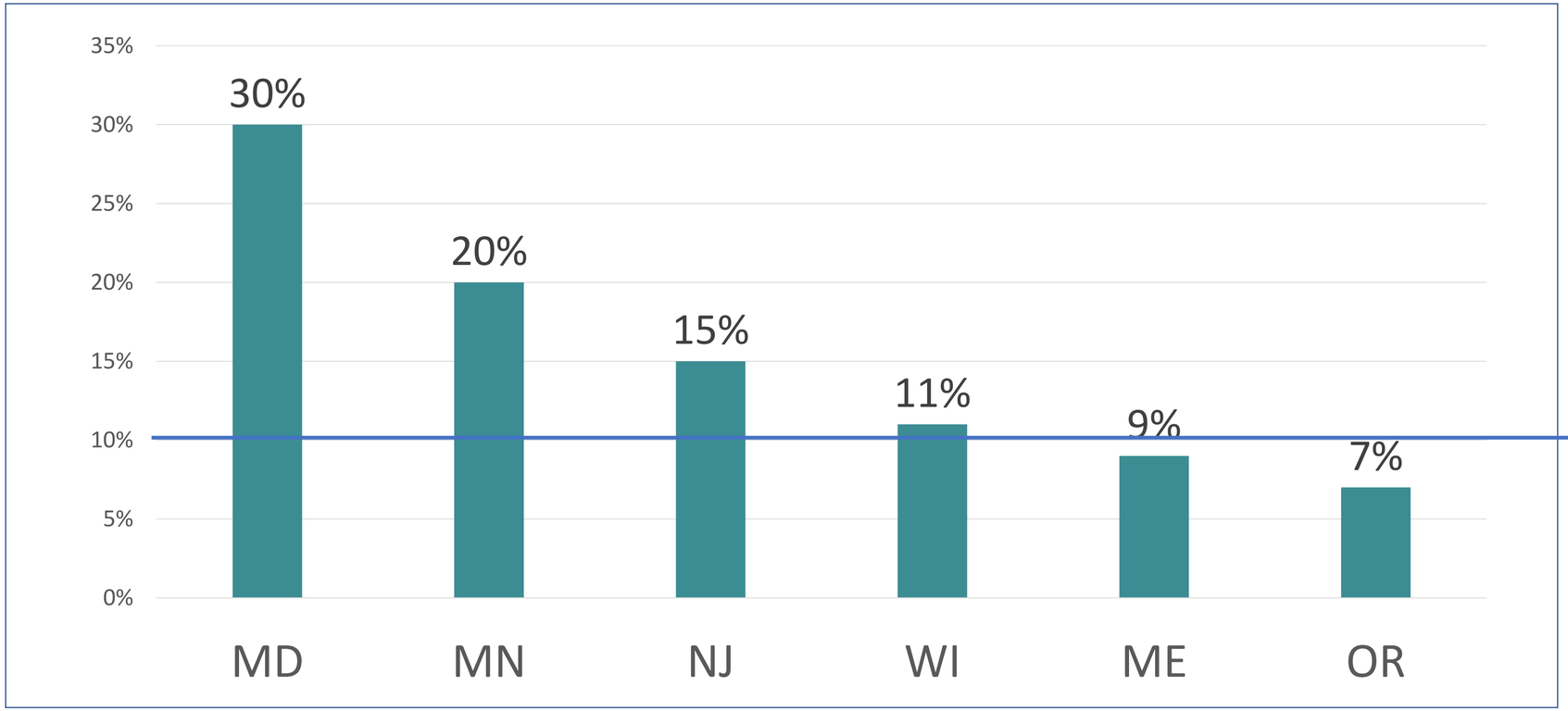
The 1332 Waiver allows RI to use APTC savings from reduced on-exchange premiums to fund the program

- Subsidized market as % of total market

Note: RI is in the process of contracting with an actuarial firm to provide detailed projections of total reinsurance program cost and anticipated federal pass-through funding from a 1332 Waiver.

(1) Reinsurance Programs: Targeted Premium Impact by State

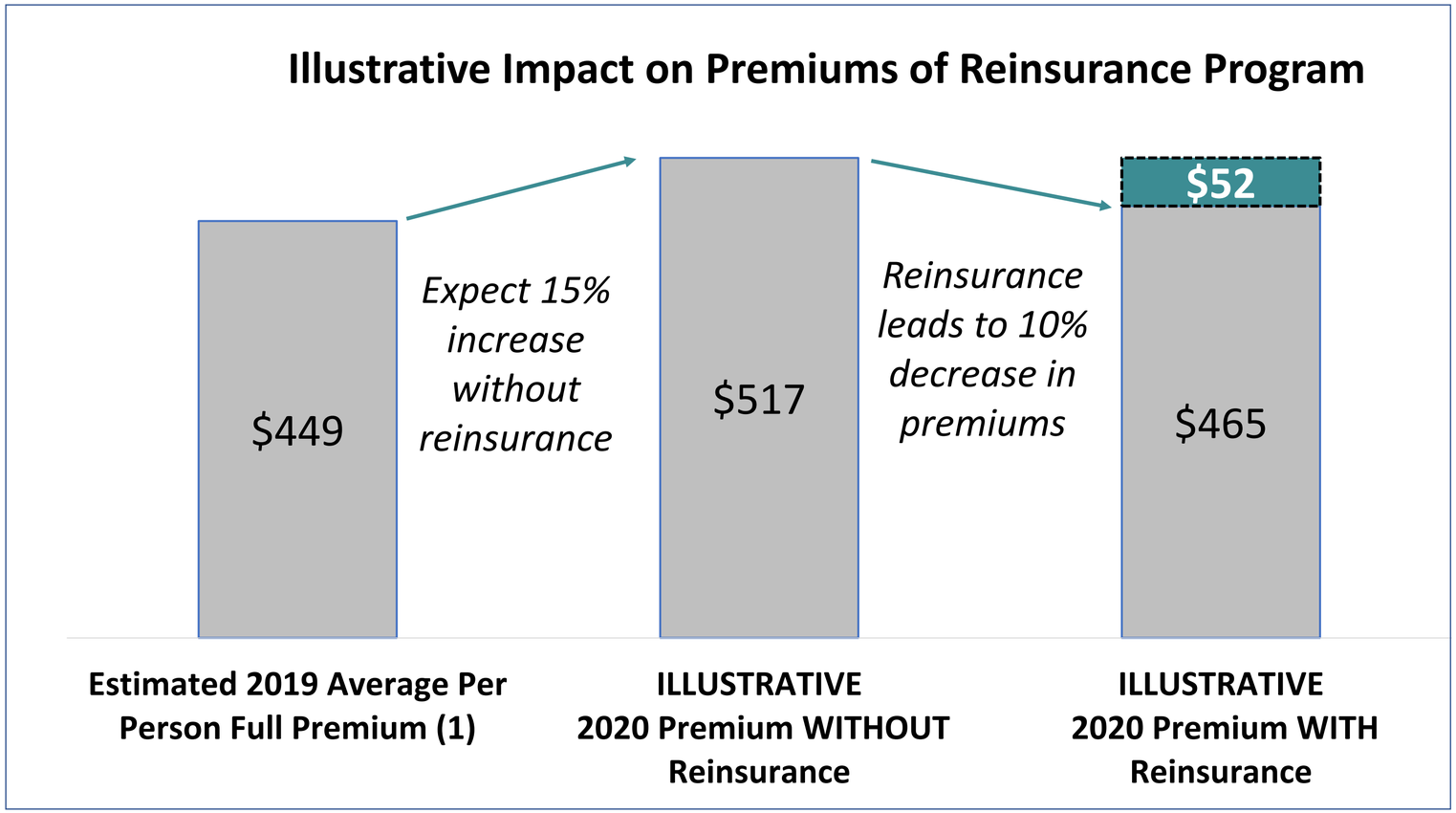
States with approved 1332 waivers have targeted between 7% and 30% premium impact from their reinsurance programs.



Illustrative Target for RI: 10% of projected 2020 Individual Market Premium

(2) Total Program Cost: Estimated $27 Million

We estimate that in order to achieve a 10% premium impact in 2020 we would need to develop a reinsurance program that would cost an estimated $27 M.



Total Cost: $27 M

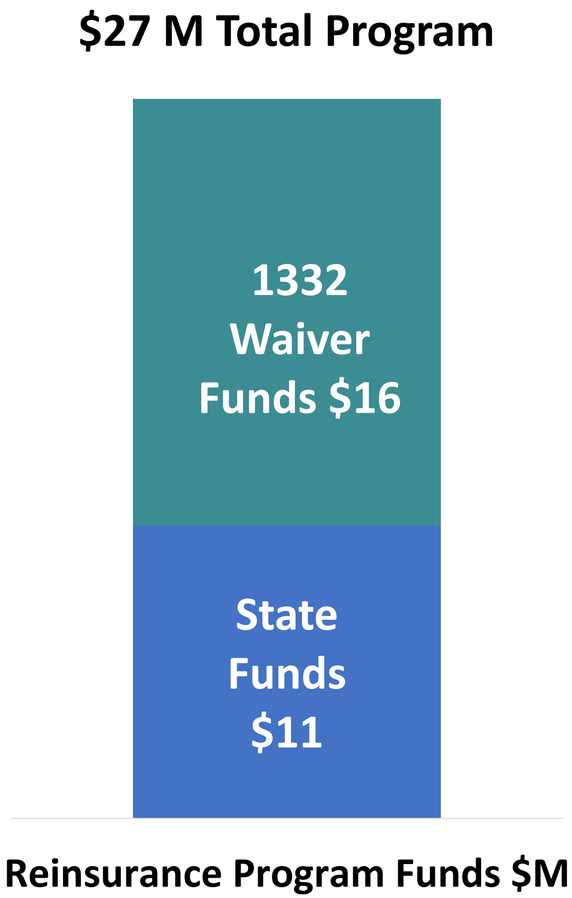
- $52 pmpm premium reduction
- 44,000 individual market size
- *Assumes no change in enrollment from reinsurance program*

(1) This is estimate of on-exchange average premium based on 2019 rates and 2018 enrollment characteristics. Total individual market average premiums are slightly higher.

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

(3) State Share of Funds: Estimated $11 M

The 1332 Waiver allows RI to use APTC savings from reduced on-exchange premiums to fund the reinsurance program.



Estimated $16 M federal contribution to Reinsurance (59%)

- $52 pmpm APTC reduction
- 26,000 subsidized enrollees
- *Likely that unsubsidized market enrollment will vary depending on premiums and other regulations*

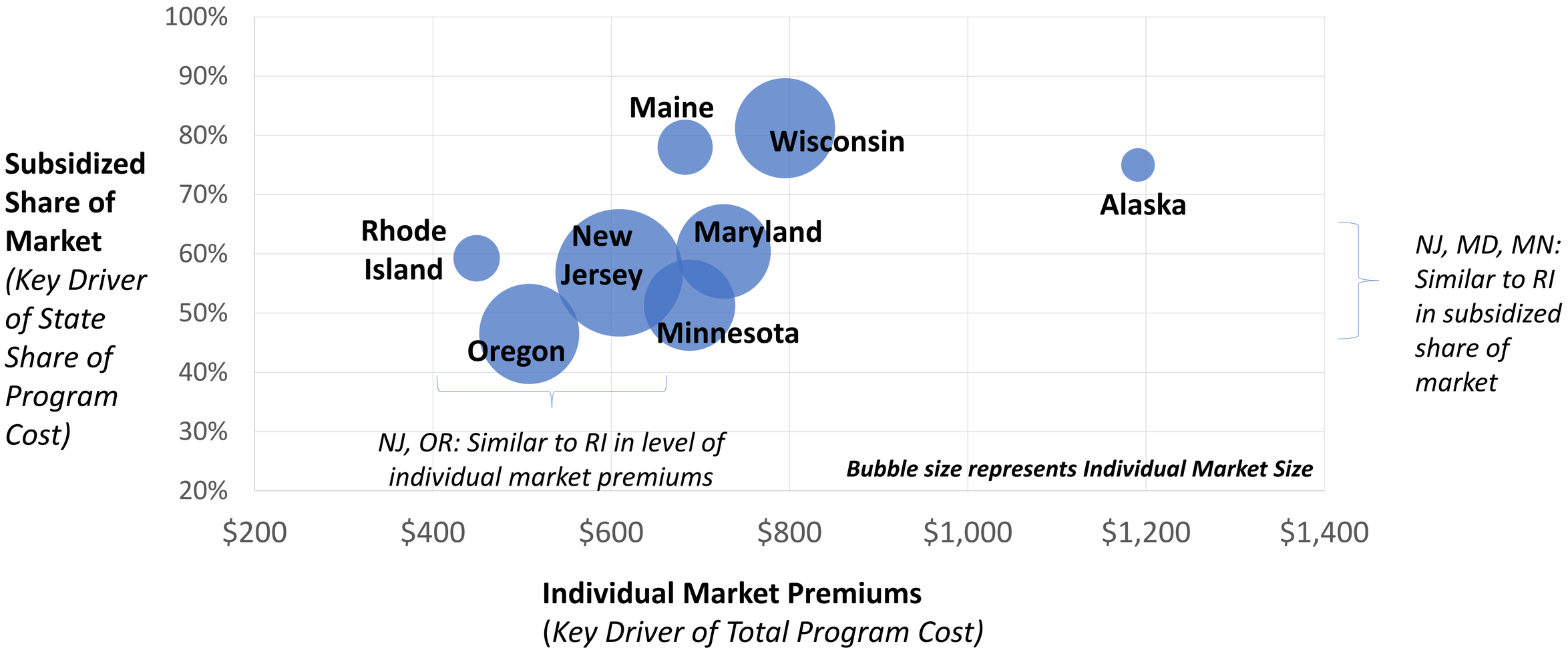
Estimated $11 M state share (41%)

- State must fund remainder

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

Comparable Benchmarks from other States

RI reinsurance program cost and state share will likely resemble that of other states with similar market characteristics.



*Individual market statistics are for the with waiver scenarios projected in the 1332 waiver applications for each state.

Today’s Agenda: Reinsurance Programs

- **How Much Does it Cost:** Reinsurance Program Cost
  - How much might a Reinsurance Program Cost in RI
  - State share
- **How might we fund it:** Potential Sources of Funds
  - Lessons from other states
  - Factors to consider
  - Potential revenue
- **Discussion**

Reminder: Reinsurance Funding Mechanisms from Other States

State	Source of State Funding for Reinsurance
Alaska	• Premium tax applied to all lines of insurance
Maine	• One-time nominal $500 insurer license fee • Insurer/TPA fee of up to $4 PMPM based on insured lives (excludes state/fed employees) • Ceding premium (90% of premium received) paid by insurers ceding covered persons to Maine reinsurance program • Optional assessments to cover Net losses – up to $2 PMPM
Maryland	• Assessment on insurers and MCOs that are regulated by the state (2.75%)
Minnesota	• State general funds • Portion of the 2% state provider tax (applies to hospitals and other providers)
New Jersey	• State individual mandate • Annual general fund appropriation
Oregon	• Premium assessment on fully insured commercial major medical (1.5%), includes premiums for self insured public plans • 2018 also funded by balance of 2 existing funds - Oregon Health Insurance Marketplace (OHIM) operating budget and Oregon Medical Insurance Pool (OMIP)
Wisconsin	• State general purpose funds

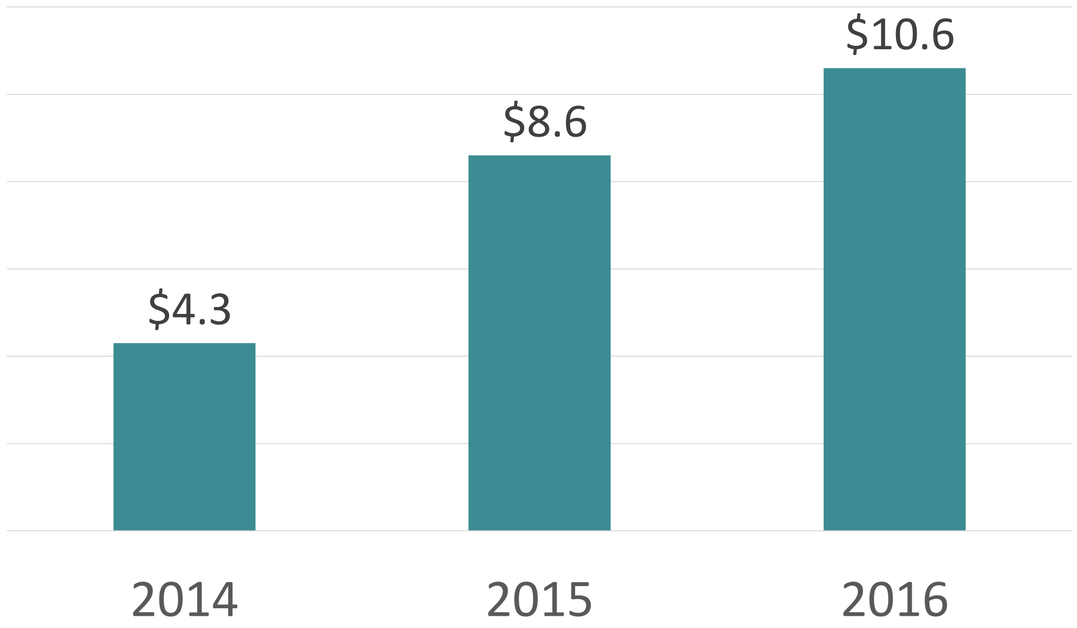
Reinsurance Funding Mechanisms: Summary

Funding Mechanism	ME	AK	MD	OR	MN	NJ	WI
Shared Responsibility Payment (SRP)						X	
Premium based Assessment		X	X	X			
Covered lives based assessment	X				X		
Sin Tax (Tobacco, other)							
State General Revenue					X	X	X

Anticipated Revenue from Shared Responsibility Payment (SRP)

The Shared responsibility payment, as currently structured could generate ~$10.6 M in 2020

RI Shared Responsibility Payment Revenue ($M)



Larger of:	**$95/person** or 1% of income	**$325/person** or 2% of income	**$695/person** or 2.5% of income

Revenue for 2017 & 18 expected to be similar/slightly lower

2018 refinements

- Forms revised for easier exemptions
- Federal tax reform increased filing threshold
- Changes may result in more exemptions, more disregarded income, thus lower SRP revenue

2019

- No federal nor state SRP

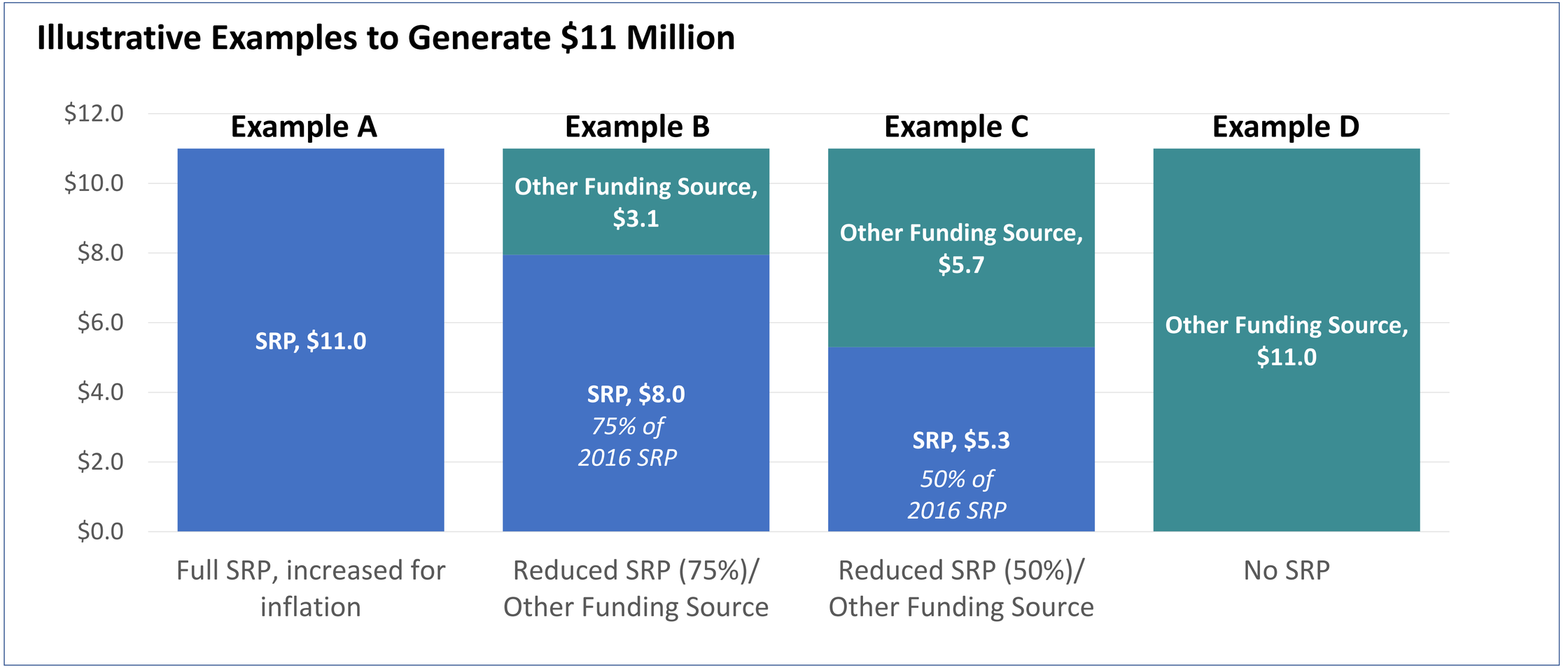
2020

- State SRP could generate similar revenue, depending on structure/exemptions

Note: Assumes enrollment/uninsured rate stays at current levels.

Combination of funding methods

Rhode Island could use a combination of funding mechanisms to generate state share.

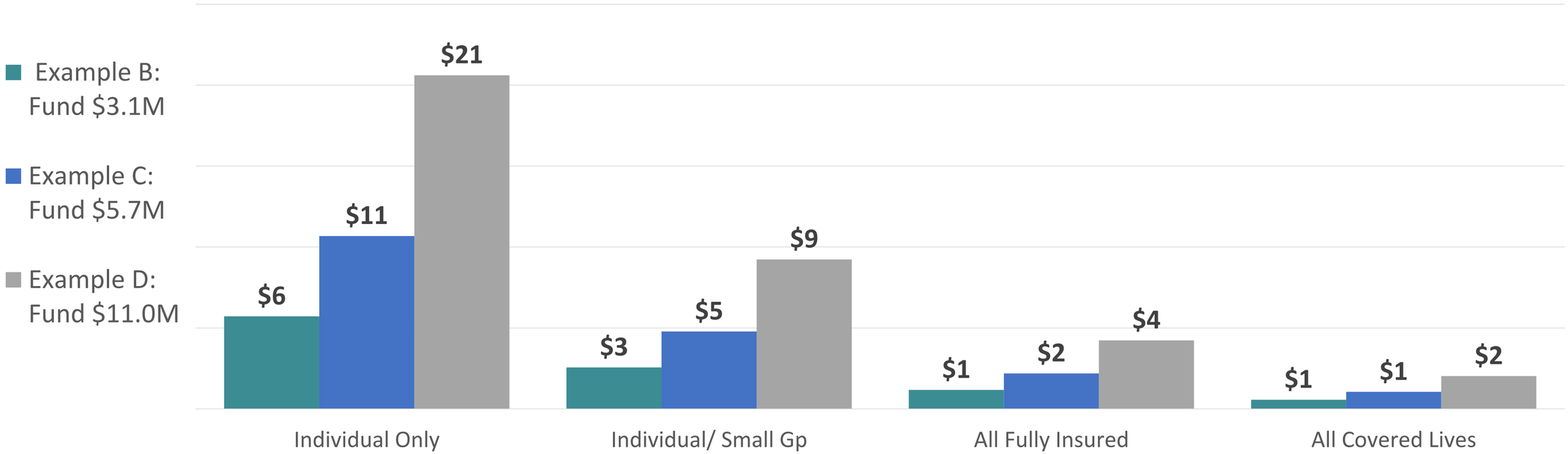


These are illustrative estimates for policy discussion only – actuarial projections of these numbers to be completed in early 2019.

Other Assessments: Who Pays?

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

Estimated Range of PMPM Assessment to Fund Remaining State Share



% Premium	0.9%	1.8%	3.4%	0.6%	1.1%	2.1%	0.3%	0.5%	1.0%	0.1%*	0.2%*	0.5%*

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

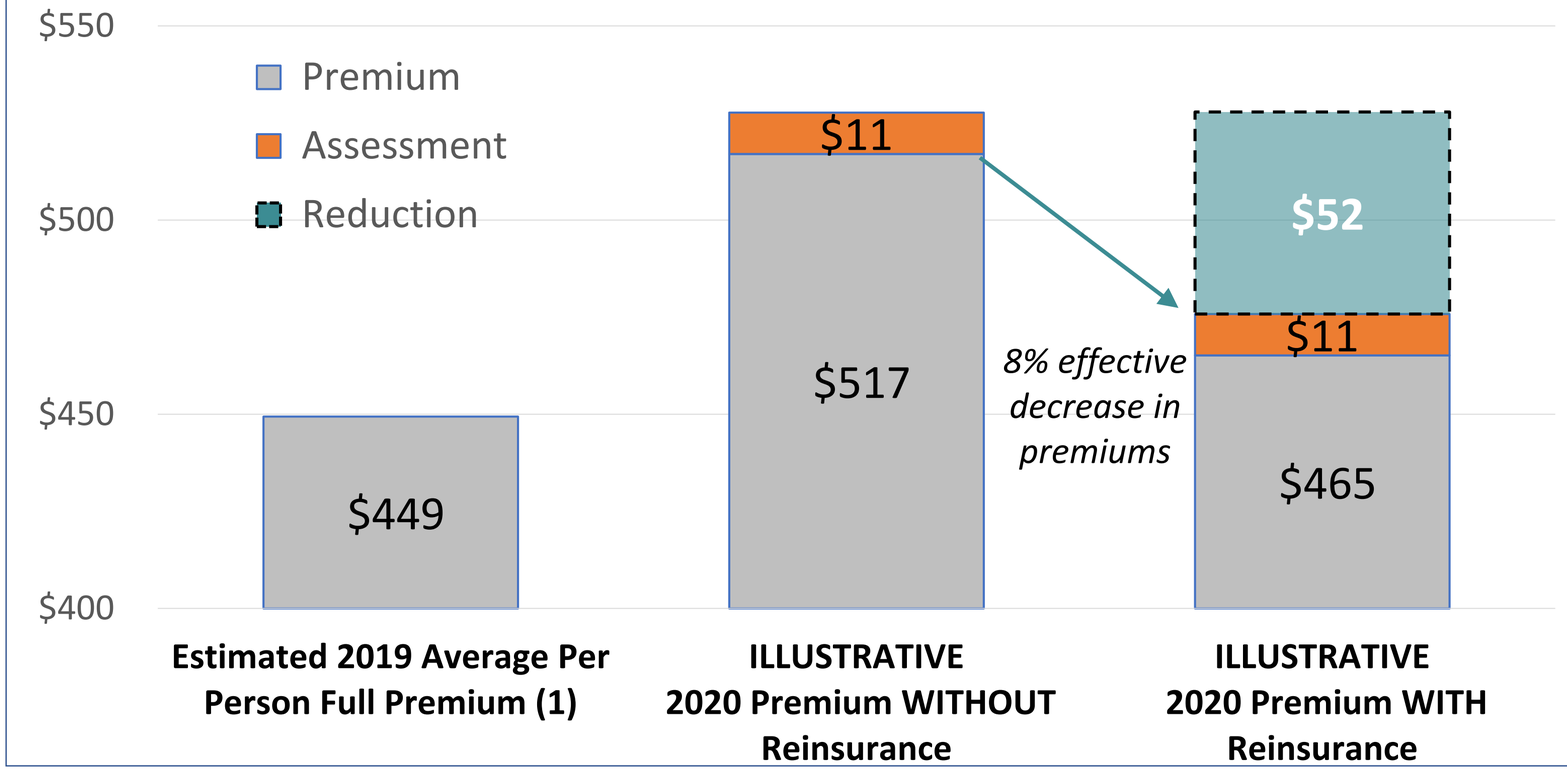
These are illustrative estimates for policy discussion only – actuarial projections of these numbers to be completed in early 2019.

Illustrative Impact of Individual-only Assessment

An assessment on the individual market would reduce the effective impact of the reinsurance program from the target of 10%.

Illustrative Example of Individual Market Assessment

Example C: Fund $5.7 M via Individual Market Assessment



Considerations

- Need premium assessment in place regardless of reinsurance program – otherwise impact federal pass-through funding available via 1332 waiver.
- Risk of getting federal approval if using only individual market to fund state share of reinsurance.
- A larger assessment would be needed to produce a 10% effective impact.

(1) This is estimate of on-exchange average premium based on 2019 rates and 2018 enrollment characteristics. Total individual market average premiums are slightly higher.

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

Reinsurance Funding Mechanisms: Key Considerations

Key Considerations	Shared Responsibility Payment (SRP)	Premium based Assessment	Covered lives based Assessment	Tobacco Tax	State General Revenue
Who Pays	Uninsured Individuals	Insurers Includes fully insured only	Insurers Includes self insured	Tobacco users	State/taxpayers
Contributes to Market Stability					
Administratively Feasible					
Low Impact to State Financials					
Sustainable					

A greater proportion of shading indicates greater positive impact.

Discussion

- Is shared responsibility payment the primary source of funds?
- Do we want to include other supplementary sources of funds?
- If so:
  - Which other sources and in which order of preference?
  - Who pays: individual market only or all commercially insured?

Next Steps

The objectives for our work ahead include forming recommendations for policymaker's consideration, including:

- A method (or methods) for funding the RI Reinsurance Program;
- **Whether RI should pursue other initiatives to address health coverage affordability and, if so, what programs;**
- Aspects of design & implementation for a state-level shared responsibility requirement; and
- A package of consumer and/or market-based protections for codification in RI law.

The final work product may take the form of draft budget article language and/or legislative language, accompanied by an executive summary.

PUBLIC COMMENT?

THANK YOU

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Back Up

October 16, 2018

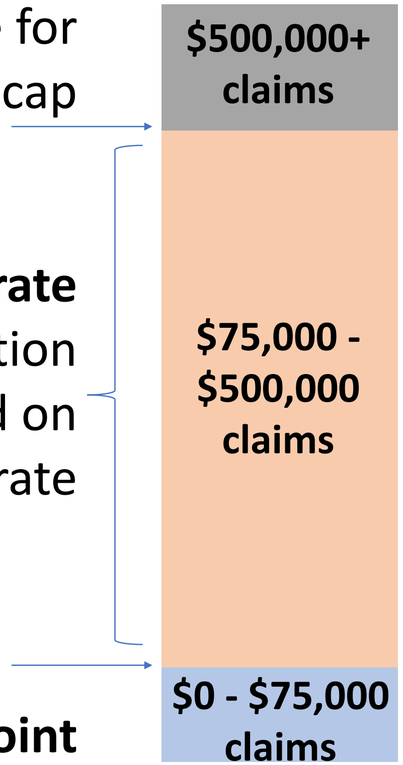
FCG | Faulkner Consulting Group

Reminder: 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
- Reduces rate uncertainty, volatility
- Attachment point + coinsurance rate can be adjusted each year
- **Scalable – program cost can be adjusted to match available funding**

Estimated Program Cost: Range

Targeted Premium Impact has a large proportional impact to reinsurance program cost, while the size of the “baseline” premium increase has only a slight effect.

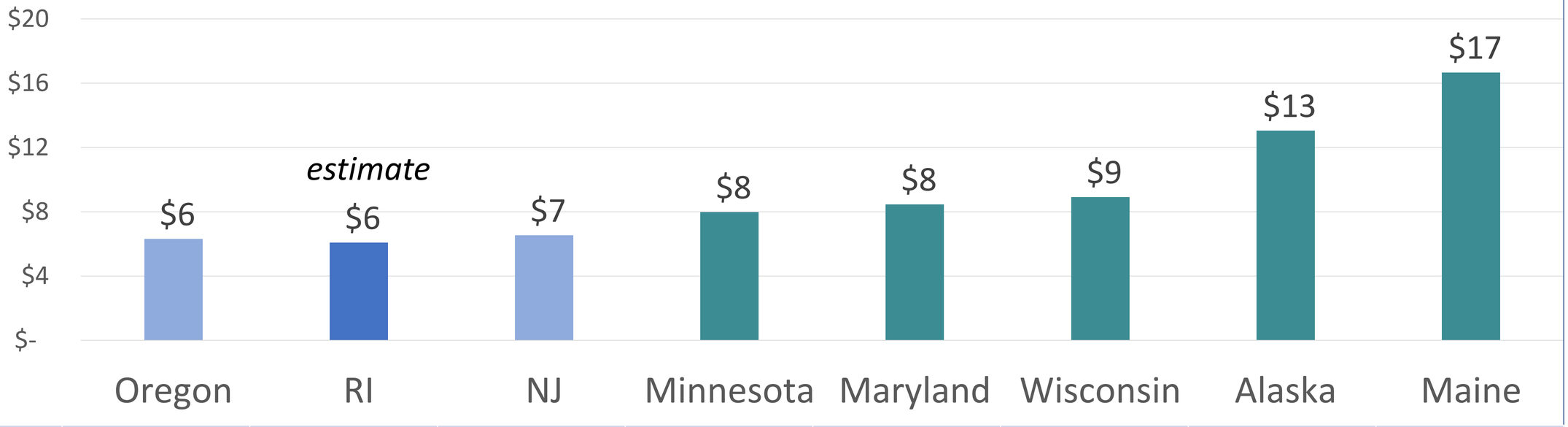
Estimated Reinsurance Program Cost $M *(state share $M)*		Targeted Premium Impact		
		5%	**10%**	**15%**
“Baseline” 2019-2020 Estimated Premium Increase	**5%**	$13 *($5)*	$25 *($10)*	$38 *($15)*
	10%	$13 *($5)*	$26 *($11)*	$40 *($16)*
	15%	$14 *($6)*	$27 *($11)*	$40 *($17)*
	20%	$14 *($6)*	$29 *($12)*	$43 *($18)*

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

Benchmarks: Normalized Total Program Cost

RI estimated reinsurance program normalized cost is similar to the costs of states with similar premium levels, after adjusting for market size and target premium impact.

"Normalized" Reinsurance Program Cost: $M Cost per 10,000 enrollees for a 10% premium impact



	Oregon	RI	NJ	Minnesota	Maryland	Wisconsin	Alaska	Maine
Premium Level*	$508	$449	$609	$688	$726	$795	$1,191	$683

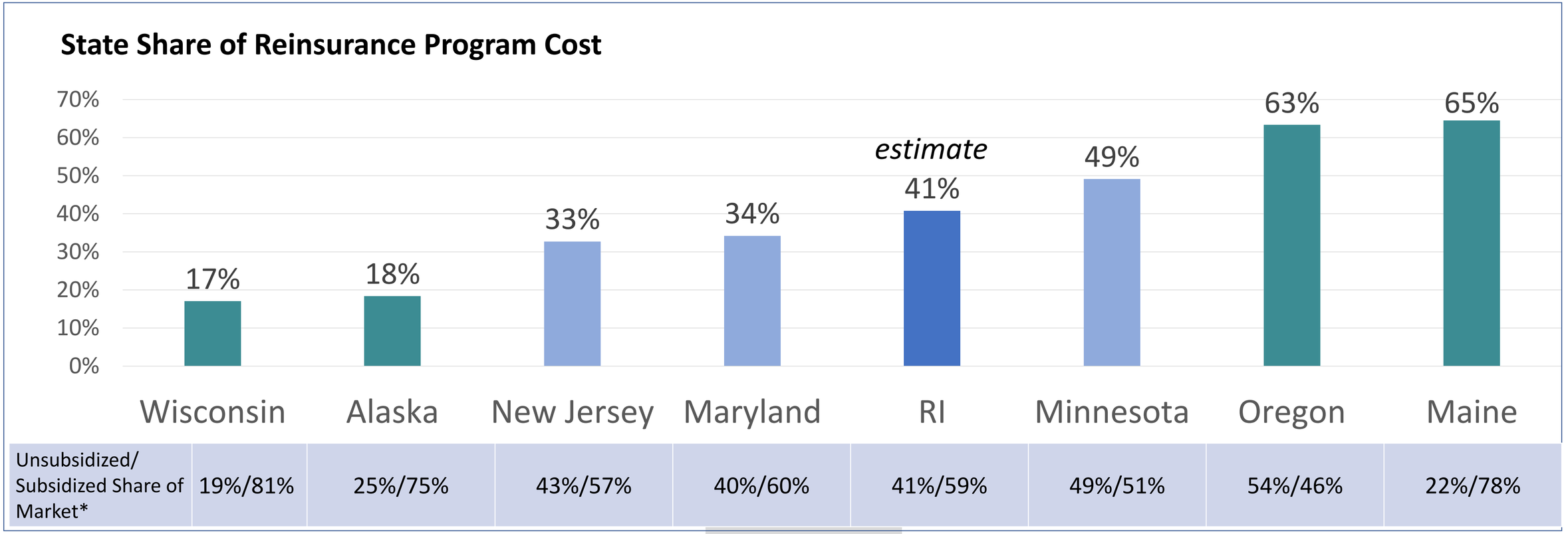
*Note: MN and Oregon data are from applications submitted in 2018, all other state's data are from applications submitted in 2019.

RI estimate of $6 M per 10,000 enrollees for 10% impact similar to states with similar premiums.

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

Benchmarks: State Share

RI estimated state share of program cost is similar to states with comparable subsidized share.



	Wisconsin	Alaska	New Jersey	Maryland	RI	Minnesota	Oregon	Maine
Unsubsidized/ Subsidized Share of Market*	19%/81%	25%/75%	43%/57%	40%/60%	41%/59%	49%/51%	54%/46%	22%/78%

*Note: MN and Oregon data are from applications submitted in 2018, all other state's data are from applications submitted in 2019.

RI estimate of 41% state share is similar to states with similar levels of subsidized share.

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

Comparison of Subsidy Approaches

TABLE 4.
Comparison of Subsidy Approaches

	Per enrollee reinsurance	Invisible high risk pool
Reduces idiosyncratic risk (random variation in costly claims)		
Reduces pricing risk (imprecise forecasts of medical cost trends)		
Reduces incentives for risk selection		
Maintains incentives for care management, coordination, and cost control		
Minimizes administrative cost and complexity		

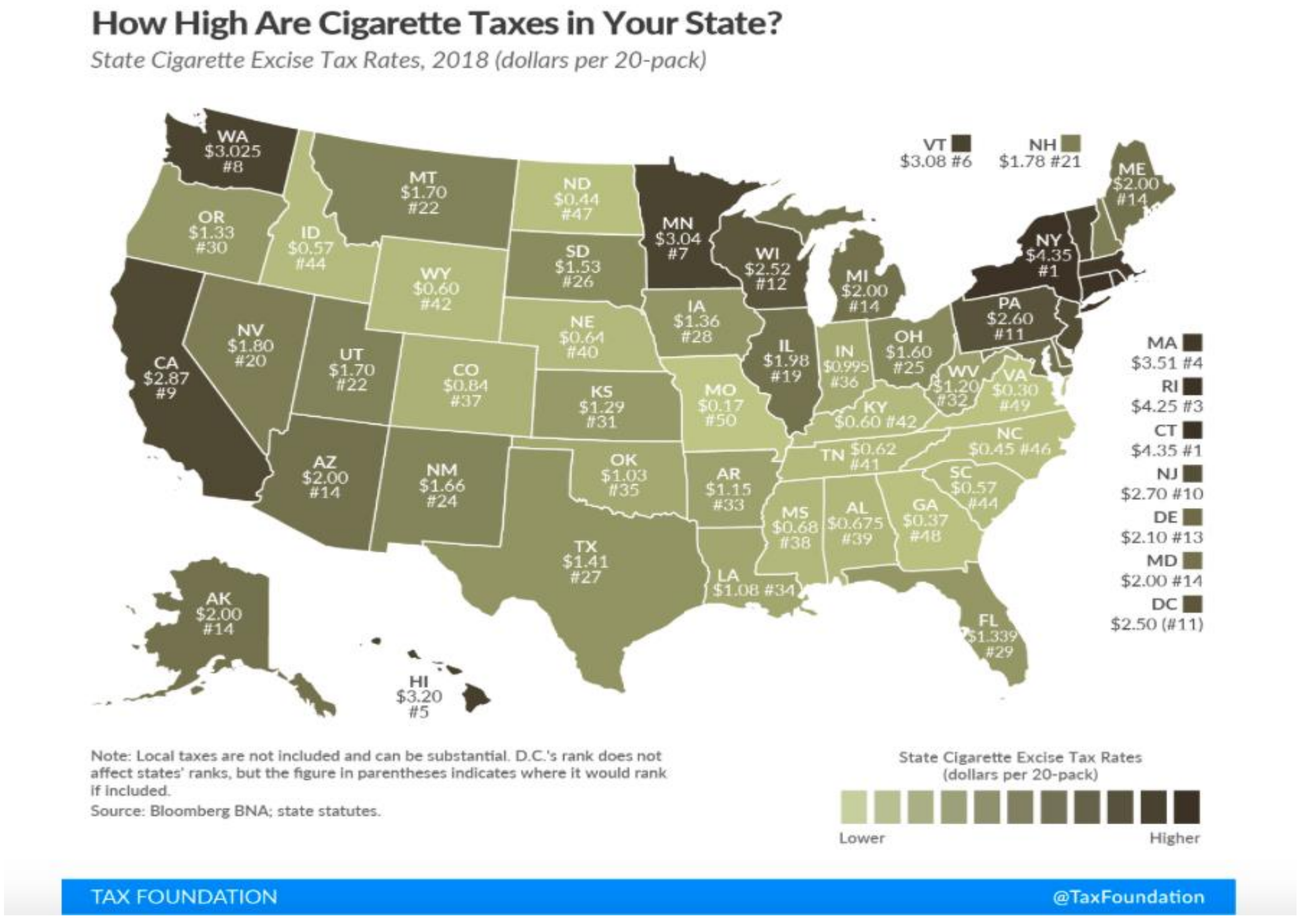
Note: Greater shading indicates greater potential effectiveness.

Per enrollee reinsurance = Attachment Point Reinsurance
Invisible high risk pool = Conditions-based Reinsurance

Source: STABILIZING INDIVIDUAL HEALTH INSURANCE MARKETS WITH SUBSIDIZED REINSURANCE, Scott E. Harrington, PhD. U Penn Leonard Davis Institute of Health Economics. September 2017.

Sin Tax Example: Tobacco

Increasing RI's already high cigarette tax may not be an effective method to raise funds for reinsurance.



Source: https://taxfoundation.org/state-cigarette-tax-rates-2018/

Considerations

- RI cigarette tax ranked #3 in US - $4.25/pack
- Raising tax further drives sales to neighboring states
- Difficult to restrict revenue raised
- Not sustainable – higher taxes reduce usage

APPENDIX

COMMON HEALTHCARE REFORM TERMS

Terms Pertinent to Today's Discussion	
Reinsurance	1) public policy developed to stabilize a market ***(definition used in today's discussion)*** 2) a policy purchased by insurers/employers to mitigate risk of unexpected high claims
Individual market	Also called direct-pay, individuals purchasing insurance directly from insurers or the marketplace, not as part of an employer group
Fully insured	Includes large and small group employer based insurance, and individual market
Self insured	Employers/organizations who use a third party administrator (TPA) to administer claims, but the employer/organization is at risk for paying actual claims.
Covered lives	Includes all fully insured and self insured enrollment

Other Terms	
Advance Premium Tax Credit (APTC)	A tax credit you can take in advance to lower your monthly health insurance payment (or "premium"). When you apply for coverage on HealthSource RI, you estimate your expected income for the year. If you qualify for a premium tax credit based on your estimate, you can use any amount of the credit in advance to lower your premium.
Cost Sharing Reduction (CSR)	A type of financial assistance provided for under the ACA to lower copayments, coinsurance and deductibles for households between 100% - 250% of the Federal Poverty Level ($12k-30k individual; $24k-60,750 family of four). These payments are made by the federal government to insurance companies. Those who qualify for CSRs must enroll in a plan in the Silver category to get these extra savings.
Essential Health Benefits (EHB)	The ACA requires health plans on HealthSource RI offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Plans must offer dental coverage for children. Dental benefits for adults are optional.
Qualified Health Plan (QHP)	Under the ACA, an insurance plan that is certified by HealthSource RI provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage."
Shared Responsibility Requirement	A provision of the ACA (also known as the "individual mandate") which requires each individual to: maintain a minimum essential coverage, qualify for an exemption, or make an individual shared responsibility payment (also known as the "individual mandate penalty") when filing their federal income tax returns.
Short Term Limited Duration (STLD) plan	A type of health policy primarily designed to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage. Current federal rules limit these policies to three months, but as a result of a Presidential Executive Order there may be changes that allow these policies to last a full year. Short-term health insurance policies offer lower monthly premiums compared to ACA-compliant plans because short-term policies offer less insurance protection.

Market Stability Workgroup

Date of Meeting: October 16, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St Providence, RI 02909

Workgroup Members Present: Cristina Amedeo, Mark Backon, Stephen Boyle, David Burnett, Al Charbonneau, Lauren Conway, Ralph Coppola, Marie Ganim (co-chair), Jane Hayward, Peter Hollmann, Hon. Joshua Miller, Monica Neronha, Janet Raymond, Samuel Salganik, John Simmons, Zachary Sherman (co-chair), John Simmons, Susan Storti, Larry Warner, Teresa Paiva-Weed

Workgroup Members Absent: Hon. Gayle Goldin, Bill Wray

Minutes

I. Meeting was called to order at approximately 8:40am.

a. The minutes of the October 3, 2018 meeting were approved unanimously with no changes.
b. New member introductions – Zach Sherman welcomed new members Marc Backon, President of Commercial Products, Tufts Health Plan and Lauren Conway, Chief Financial Officer, UnitedHealthcare. Zach mentioned that it is very important to have broader voices from commercial care. Zach thanked both Lauren and Marc for their willingness to participate.
Lauren Conway introduced herself, stating she's been with UHC for 14 years and is the CFO covering New England states as well as Pennsylvania and Delaware.
Marc Backon introduced himself as the President of Commercial Products at Tufts Health Plan for RI, MA and NH. He has been with Tufts three years and has worked in the industry for over 30 years.
c. Meeting One follow-ups – Zach said that based on the commentary from last time there will be built-in time for discussion and ample opportunity for all to participate and weigh in on the material. The goal is to reach some sort of consensus and recommendations. At the request of the group, they should have received the parameters of the Federal reinsurance program in 2014, 2015 and 2016. Zach gave an overview of the chart regarding parameters. Zach stated the focus on the second meeting is financing options for a reinsurance program.

II. Objectives for today's meeting

a. Marie Ganim reviewed the agenda and asked if there are any questions regarding last week's discussion. The group did not have any questions. Zach mentioned that included in the slide deck is an appendix with common terms related to the current meeting and broader ACA terms.
b. Focus of today's meeting: How to finance reinsurance programs – Marie stated the impact we want to have is related to the cost of reinsurance. The group is charged with discussing potential funding sources, we've looked at what other

states have done, those options will be looked at in more detail, with the data points for Rhode Island. The hope is to build some consensus about at least what considerations we should be thinking about and discussing the best path forward. Marie thanked legislative staff from both from the House and Senate, and they were encouraged to ask questions or comment.

Marie notified the group that HealthSource RI (HSRI) has been working on the reinsurance waiver. We have moved forward with legislative approval of the state to apply for a 1332 waiver for reinsurance purposes. Part of that process is an actuarial assessment as to what reinsurance would look like for RI. The actuarial request for proposals (RFP) was released, the responses have come in, and there has been a selection, and HSRI is working to finalize that contract.

III. Reinsurance

a. Cost analysis, potential funding sources – Deb Faulkner reviewed the four objectives of the workgroup, (1) identifying the amount of funds needed and where we might fund it, (2) whether RI should pursue other initiatives to address health coverage and affordability (next meeting), (3) aspects of design and implementation for a state level shared responsibility requirement (future meetings) and finally (4) ending with a package of consumer and market protections for codification in RI law. Deb reviewed the Workgroup recommendations: we want a reinsurance program, and we want to do a state-based shared responsibility requirement. The shared responsibility requirement has the advantage of two pieces: it is both a market stabilizing effort by itself, and it is also a source of funds. Deb explained that the group is going to consider and discuss the shared responsibility requirements as a source of funds, and later discuss the shared responsibility requirements. The two big questions are: how much does it cost? Also, how might we fund it? Deb broke down the estimated total program cost; estimated at $27 million to achieve a 10% premium impact, based on a 44,000-individual market size.

   What drives the cost is the starting point of the premium. Some of these states have very expensive programs because their premiums are high. Deb added that they provided examples of the different scenarios in the backup. Deb said it's going to cost $27 million, so what's the state's share? The state's share is dependent on the state's subsided share of the market. Deb noted that the Federal partners are contributing because they get the benefit of a reduced tax credit, that 60% of the individual market is subsidized. Reduced premiums for the subsidized individuals causes tax credits to decrease, in turn, the federal government gains. On average the federal government contributes the subsidized share plus five percent. Let's say the Federal government contributes about 59%, we contribute 41%, which would cost us $11 million.

   i. Sam Salganik said that the Federal contribution is based on the benchmark premium changes. In a market where we have two carriers who may see differently on the reinsurance program or in the way, the market is split up. Sam asked how average premiums can be reduced without touching benchmark premiums. Deb explained that that is some of the work the actuaries will do, saying it would be surprising if

the actuaries come back with numbers that are very different from those presented. Deb emphasized that two big drivers are first, the total program cost which is driven by the premium, and second, the state's share which is driven by the subsidized share of the market. When we consider the states with approved 1332 waivers, those that are very similar to Rhode Island, on a total cost perspective are Oregon and New Jersey. We have similar individual market premiums, therefore, we will likely have a similar total program cost; depending on the targeted impact. Similarly, if you look at the subsidized share of the market New Jersey and Maryland should be similar to us concerning the amount of what the federal government would be willing to contribute.

ii. Teresa Paiva-Weed asked if the actuaries are going to provide examples for the different target impacts whether 7%, 10%, 12%. She agreed that 10% seems reasonable as a place for policy discussion. Deb said the actuaries would look at multiple options.

iii. Ralph Coppola offered that the point of this is finding the optimal amount that will get you the best bang for your buck and suggested a focus on mitigating the price curve. Deb said that much depends on the starting point, using Maryland as an example of a state that has had to take more aggressive steps because their market is already degraded. Contrast this with Rhode Island, where the goal is to prevent rates going up so much that the healthy people leave. The actuaries have seen more of this and can give us better estimates of how much to spend.

iv. Marie pointed out a complicating factor regarding Ralph's question: if the source of revenue is tied to the shared responsibility commitment, it would be cost effective because it keeps people in the market. If the source of revenue is tied to a premium that is consolidated in the individual market, then that raises prices even more in that market.

v. Ralph asked if a shared responsibility would make more sense due to potential to keep people in the market to avoid a penalty. Deb recalled that the Workgroup previously agreed to both a reinsurance program and a shared responsibility payment, but that the question now revolves around the structure of the shared responsibility payment and the allocation of the funding. Deb pointed out that the shared responsibility payment has the advantage of being both a market stabilizer and generating revenue, whereas the other sources of funds are mostly cost and not benefit.

vi. Sam said that a shared responsibility raises money, at least under the Federal structure, mostly from low-income people, while the reinsurance program is mostly to the benefit of higher income people.

vii. David Burnett asked about the long-term effect on rates. Deb explained that reinsurance programs tend to offer a one-time benefit of bringing down rates initially. After that, the program's benefit is the stabilizing effect of reducing the volatility of rating.

viii. David asked which of the examples is the most mature? Deb said all the programs are new, two years old at most.

ix. Marie recalled Monica's example from the last meeting, of how Blue Cross set their rates during the previous cycle for 2019, they segmented out some of the very high-cost cases and were able to attach a percentage of the premiums relative to those cases. With reinsurance, we will not have to do that.

x. Deb continued to discuss options on how to fund the $11 million in state funds and reviewed how other states are funding their reinsurance programs. She noted that New Jersey is using revenue collected from its shared responsibility requirement as the primary funding source, with state general revenues as back up. Other states are using either a premium-based assessment (applied to the entire fully-insured market) or a covered lives-based assessment (applied to both fully-insured and self-insured) as the primary funding source. Deb offered examples of application of a covered lives-based assessment: on a PMPM basis, or on a provider basis; you could assess hospitals stays; they would be obtained or collected by the insurers and therefore asses all lives in the market based on utilization. Deb noted that Rhode Island already has a covered lives-based assessment that funds an immunization program which could be built upon. A tobacco tax was also mentioned as a funding source in some states, but Deb pointed out that Rhode Island already has the third highest tobacco tax in the nation – and increase is therefore unlikely to raise much more revenue.

xi. In response to a query by Jane Hayward, Deb explained Maine and Oregon's reinsurance funding sources. Maine uses a version of a covered lives-based assessment, but also has a general assessment, a small nominal fee per insurer. Oregon appears to be using existing health insurance funds and added to the already existing structure, in addition to their primary source which appeared to be a premium assessment. Deb stated that states tend to build on what they have and use a mix of funds.

xii. Ralph asked what the impact is of the covered live assessment on a percentage basis of the premium? Also, why aren't we considering marijuana, as we could use that as tax revenue? Deb mentioned that "Tobacco" was an example title for that category. A marijuana tax would be included in that category. Deb explained the difficulty of earmarking tobacco, marijuana, alcohol or similar tax funds to a reinsurance program, instead of a health program or smoking cessation program.

xiii. Teresa said that if we are going to be looking at revenue we should invite house and senate fiscal office to make a presentation as to provider tax, cigarette tax, premium tax, what the state currently has, and any other sources we should be considering, since it was mentioned that other states have built on what they have. She

mentioned being hesitant to have a meaningful discussion without knowing what provider taxes and other taxes are already being paid.

xiv. John Simmons said he would like to know if any other states have a program like this and how their tax structure is set up.

xv. Zach – we can take that route.

xvi. Steve said he thought there carve-outs in the covered-lives assessment for the immunization program, that Lifespan, cities and towns and others were not included. Monica said that Lifespan had been phased in, and that all self-insured plans were participating with the exception of municipal plans.

xvii. Deb directed the conversation to shared responsibility payments and emphasized that they would later discuss other sources. She reminded the Workgroup that in the spring session the assumption was that we'd model it exactly as the federal program. In 2016 the federal individual mandate penalty generated $10.6 million in Rhode Island. This is close to the $11 million identified as a possible state share of a reinsurance program. Deb recalled the conversations around shared responsibility payment and its impact on lower-income populations, mentioned that we might want to mitigate how to revise and restructure that, which could bring revenue down. Deb clarified that the 2014 and 2015 revenue numbers were a lot smaller because the penalties were smaller. The penalties were increased over time, from $95 to $325 to $695, where it was intended to stay. Some tax reform elements underway that may have a modest impact; however, at the same time revenue and incomes are going up. It seems reasonable to assume that if you model it after the federal program, we get somewhere around $11 million.

xviii. Peter Hollman said that if funds are mostly from low-income people, then they would mostly be subsidized. So, for every person you enroll, you're going to get more federal subsidy? Deb answered yes.

xix. Peter recalled a discussion from the spring; that some states were taking the money and just essentially buying insurance. It appears that in this group; you're going to get federal savings money almost 1 to 1 for what you spend on paying those enrolled. Having more people enrolled is not going to cost the program any money. Deb explained that this does not consider any advantage or any impact of increased enrollment because of the shared responsibility payment. There are indeed pros but also costs to the federal partner.

xx. Peter shared his thoughts on enrollment; that if everyone enrolled, the program would not take, we would be fine, we would get the federal match which would be exactly what we would lose in the penalty. Sam stated that we would still need the state's share for reinsurance.

xxi. Zach added that if the majority of the uninsured are in that 60% that receive the subsidy, perhaps that makes the federal/states share split more favorable.

xxii. John asked if this is something the actuaries would research? Deb said the actuary would look at different scenarios, concerning enrollment, the APTC. If the Feds assume a large increase in the subsidized population, that may be why we do not see them giving an exact share of unsubsidized, they typically give the unsubsidized plus 5%, in part because they are anticipating the benefit of an increase in enrollment.

b. **Other assessments and considerations.** Deb noted that one of the things the Workgroup wanted to talk about was other affordability programs.
   i. Sam asked for a breakdown of where the revenue from a shared responsibility requirement would come from, what portion of it would come from Medicaid eligible households, and if the actuaries would examine this. Zach said that there is good data available, it won't come from the actuaries but the IRS and the Division of Taxation, and that the group is scheduled to look into that in meeting four.
   ii. In response to questions from Senator Miller and Teresa Paiva Weed regarding the employment status, demographics and other information about who has paid the penalty in Rhode Island, Zach said that the data show the income and household size but does not include specifics on employment. Zach said they would provide as much information as they can about who paid the penalty for meeting four.
   iii. Ralph noted that if you keep everyone insured who is currently insured, then you don't need a reinsurance program. Everyone would be staying in because you don’t see rates go up. Deb replied that rates have gone up 8% this year.
   iv. Deb presented potential combinations of different funding sources, with examples of various assessments how they might be combined to fund a reinsurance program at $11 million. A reinsurance program funded entirely by an assessment on individual market premiums alone would apply to only 44,000 people. If funded it out of all covered lives, including the self-insured, it would apply to 600k lives, spreading the cost on a PMPM basis. For example, if 75% of estimated shared responsibility payments collected were used to fund the reinsurance program, $3.1 million would still be needed. If all of that $3.1 million were funded out of the individual market, it would cost approximately $6 PMPM; if it were funded out of individual and small group markets, it would be approximately $3 PMPM; if all full insured, $1 PMPM; and if it were funded from all covered lives it would be less than $1, approximately 0.1% of premium.
   v. Monica Neronha said there is currently a 2% premium tax on health insurance and noted that Alaska’s model is an assessment on on all lines of insurance, not just health. She asked if it would be worth modeling that in Rhode Island, spreading the cost as broadly as possible. Mark Backon asked if that included self-insured plans as well; Monica said it did not. Deb noted that Alaska is an anomaly for a lot of reasons.
   vi. Teresa Paiva Weed noted that convincing self-insured groups to participate in the immunization program was difficult. John Simmons

added that they would have to be shown a causal relationship between their contribution to an assessment and a reduction in their costs. Monica said that self-insured groups would not only oppose a covered lives-based assessment but may also attempt to pull out of the immunization program as well, creating a larger problem.

vii. Senator Miller said he would like to ask providers and hospitals what is more expensive for them now: the uninsured, the underinsured or the low-quality insurance plans with high co-pay or deductibles? Teresa said she could look into this, but that she imagined that South County Health and Rhode Island Hospital would have different information.

viii. Monica commented that self-funded employers are more likely to have higher deductible plans mainly due to budgetary reasons, while small group employers tend to buy higher quality insurance – gold and platinum level plans. Individual market purchasers will buy more towards the lower level; the bronze and silver, primarily the silver. To that point, she said, we can't change the cost sharing in a bronze-level plan and it still be bronze. She said she wouldn't expect large employers start to offer richer plans as a result.

ix. Senator Miller said that those larger employers become an expense to providers, and that expense is then passed on in the cost that is added to the premiums, and that is passed on no matter now the person is insured.

x. Zach apologized for cutting the conversation short, but urged the group to move on from this topic due to time.

xi. Deb spoke on the challenges of funding a reinsurance program an assessment on the individual market. She quoted Jason Levitis: "Funding the state share in large part from an individual market assessment will reduce the federal matching rate, because the same amount of state money will have less impact on premiums, and the premium reduction is what gets you federal matching funds." Deb said that no other state has done this, so we do not have an example, and whether CMS would approve it is in question.

xii. Sam agreed, saying he could see why the Federal officials would be skeptical. John Simmons said he would like to have that analysis from the federal side, looking the cost for the feds now vs. the future, as well for the state and the individual. He said we was not sure that there would not a reduction for the feds as well. Deb said that it would cost the federal partners more, because they're going to fund the revenue side as well as the use side. Sam said that the way states typically do this, whether using a premium tax or a mandate, is to separate the source of funds from the reinsurance program because you want that source to be part of your baseline. He added that the feds might be skeptical of this.

xiii. Deb presented the different funding options discussed with ratings as to their impacts in four areas – contribution to market stability, administrative feasibility, and sustainability. She noted that only the shared responsibility payment had the advantage itself being a stabilizing mechanism.

xiv. Monica said that it was important to consider whether the state has the functionality when assessing administrative feasibility. She also noted that estimating the cost of the reinsurance program must include the cost of administering the program.
xv. Deb noted that, from a cost perspective, the shared responsibility payment would be a new function that would have to be created. new, it's a function we have to create. Contrast this with a tobacco tax, which is already in place, but has the drawback of being less likely to collect more revenue as the tax is increased.
xvi. Teresa said that in the same category, marijuana would probably be more viable than tobacco in terms of potential for expansion and taxation.

IV. Discussion/Consensus Building

a. Deb reminded that Workgroup that they agreed at the end of the spring session that there should be both a reinsurance program and a shared responsibility payment. What remained to be determined was (a) The structure of that program, how to best do it in a way that minimizes the burden on lower income populations, and (b) should some the revenue generated from that shared responsibility payment be used to fund the reinsurance program? She then asked the group, based on the information and estimates they had been presented, whether some of the shared responsibility payment funds, once defined, should be used to fund a reinsurance program.
    i. Sam said he wanted to withhold final judgement until after meetings three and four, when the Workgroup would dig deeper into who that revenue comes from. He said that to the extent to which that revenue comes from people who are not eligible for the tax credits and would therefore benefit from the reinsurance program, that would be a reasonable proportion of that funding source to put towards reinsurance.
    ii. Lauren said her concern was that she did not have enough information because only New Jersey is doing this. Sam mentioned that he has spoken to consumer advocates about this, including in New Jersey, and most of them expressed the same concern that he had.
    iii. John said that he had no ability to give an answer until he saw more data and actuarial report. He had questions regarding the actual cost of the program and whether it would have any impact. He said thought the answer to this question should not be sought until the end of the Workgroup process.
    iv. Peter Hollman said that some portion of the shared responsibility payment should be used to fund a reinsurance program.
    v. Monica commented that when BCBSRI submitted their most recent individual market filings, one of the things they were asked to do was to consider and put into their rates an estimate of the impact of the elimination of the individual mandate penalty in 2019. She said that BCBSRI's estimation based on their population was that the largest driver of the stability of the market was not the mandate penalty but the availability of subsidies. A large percentage of people are getting subsidy

and the non-subsidized population has stayed relatively stable. She acknowledged that insurance premiums are going up by an unsustainable percentage but said she did not think that was driven by the mandate. She said BCBSRI supports a mandate, but the she would not opine on where that money should go or how much it should be. She said BCBSRI wouldn't argue that the mandate is a stabilizing factor.

vi. Ralph asked if there were data on how much of the penalty came from subsidized vs unsubsidized individuals? Sam said that would be presented at meeting four.

vii. Zach said that he did not thing the Workgroup was saying that the individual mandate is the sole driver of market stability, but that the point was that it is a key factor alongside several other factors. Zach said the mandate plays a role in incentivizing or penalizing the healthier risk to staying in the market. The mandate plays a role in market stability but is not the only thing that drives it.

viii. David Burnett agreed with Monica but also that Zach was right, the mandate is a component of market stability. For that reason, he said, NHP would support a state based individual mandate, but he said he was not sure how much impact it will have on the stability of the market.

ix. Deb noted that it was difficult to break apart different market stability components and determine which is a greater driver than the others. She said the intent of the combination of the factors was to keep all pieces working – support low-income populations, keep everyone healthy, keep the healthy population in the pool and keep the products stable. She added that the revenue source is not a piece that we are waiting on actuarial analysis; the revenue part is based on the existing structure of the individual mandate, which is known to be in the $10.6 – $11 million range.

x. Teresa said it had been suggested to include a check box on the RI tax form this year in order to collect data on the impact. Marie responded that the Division of Taxation has said that it is not easy for them to make what may sound like simple adjustments and be able to accumulate and collect data. It would take time. Teresa said if that is the case, now would be the time to put it in motion. Marie noted that it would require legislation. Teresa asked if this administration would be opposed to it on a voluntary basis – was there any way to start gathering the data this tax year? Zach said it was a great question that would have to be brought back to the Division of Taxation. Zach also noted that 2017 tax data would be available from the IRS by the middle of next year.

xi. Jane Hayward said that shared responsibility payments should conceptually be looked at as a revenue source for a reinsurance program, but until she saw more data she couldn't say what percentage of the funding should come from shared responsibility and what that population looks like and what programs are already there. She added that she wanted to maximize every federal dollar the state can get.

xii. Senator Miller said that there was a case to be made that the reinsurance program should not be an impact to any one sector but considered a general benefit, and therefore funding the reinsurance program from the state's general revenue should be considered.

xiii. Monica said that it had been mentioned that the fastest way to get a federal approval is to follow an existing model, one that has already been approved. She asked in light of this what effect choosing a funding source that had not been considered previously – such as an individual market-only assessment – would have on the application's timeline. Zack said that exploring an option that hadn't been done before would likely require more conversations with the feds, but he couldn't say exactly how much time it would add to the process. Zach said HSRI needed to go back to the feds sooner rather than later to open a dialogue about the viability of this and other options. Monica added that it would also be helpful to know if any funding mechanisms that had been put forth by other states had been shot down.

xiv. Larry Warner said that it had been mentioned in the last meeting that there haven't been any states that have had their application denied. Deb said no state whose application for reinsurance only had been denied. Zach added that California withdrew their application.

xv. Ralph asked if there was anything that we should be looking at that will drive enrollment? Something in addition to the penalty, or not using the penalty? Some other inducement to get people to enroll in the program. Deb said that this will be discussed in the next meeting. Larry said that this was also his question, and that nationally about 45% of individuals who remain insured say it is because of cost. It's not because their employer is not offering it.

xvi. Jane said that cost is one factor, but of the 45,000 people in the state who remain uninsured, cost is not the only factor. She said the question is how much we should invest to subsidize people who may not be willing to come forward or who are so mobile in their life that they can't make that commitment.

V. Public Comment – No members of the public made comments.

VI. Adjourn

a. The meeting was adjourned at 10:30 AM.

Market Stability Workgroup

Notice Posted: October 26, 2018
Date of Meeting: October 31, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Agenda

I. Call meeting to order
   a. Motion to approve October 16, 2018 meeting minutes
   b. Meeting two follow-ups
   c. Review Workgroup recommendations, guiding principles, and goals
   d. Brief review of new CMS guidance related to 1332 Waivers and HRA

II. Objectives for today's meeting
   a. Review agenda
   b. Affordability programs in other states

III. Affordability Programs to Increase Access to Health Insurance

IV. Public Comment

V. Adjourn

United Way of Rhode Island is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Lindsay Lang at 401.383.5124 or email her at lindsay.lang@exchange.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP 2.0

Meeting #3

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

UPDATES SINCE OUR LAST MEETING

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TODAY'S AGENDA

Affordability Programs

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

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

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

Affordability Program Options

October 31, 2018

FCG Faulkner Consulting Group

Reminder: Workgroup Recommendations

Excerpted from Final Report of the Workgroup

…near-term recommendations:

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

In addition… The Workgroup therefore also recommends the following:

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

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

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

Reminder: Workgroup Guiding Principles

Guiding Principles

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

Goal

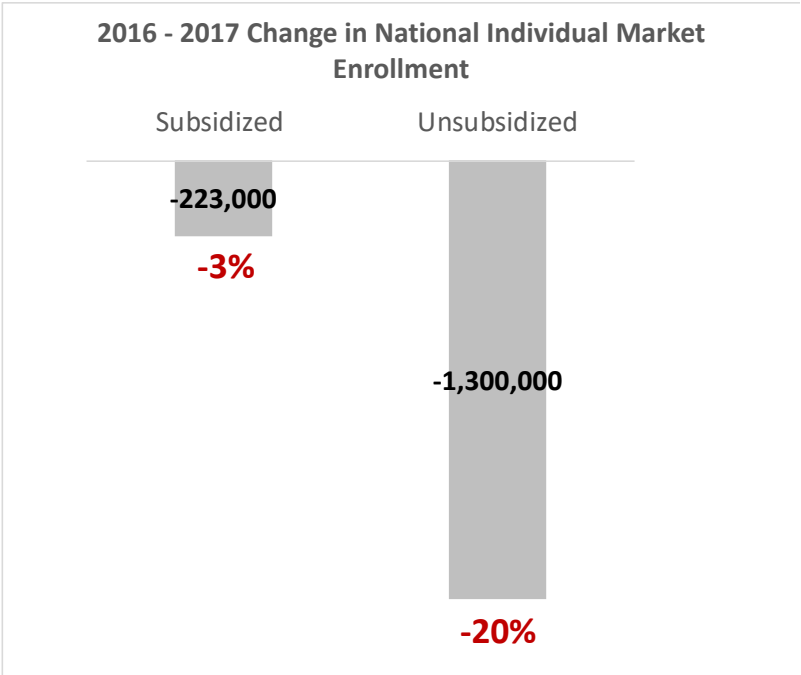
Identify and propose sensible, state-based policy options for RI that will be in service to those Principles

Reminder: What Are We Protecting Against?

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

2016 – 2017 National Example

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

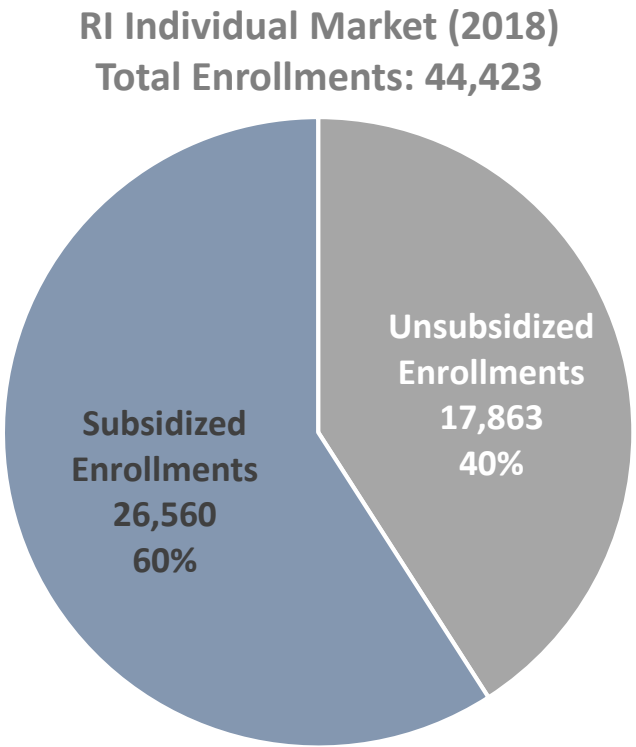


Sources: CMS Issue Brief, July 2018, *Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment*

Starting Point: RI Individual Market

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

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

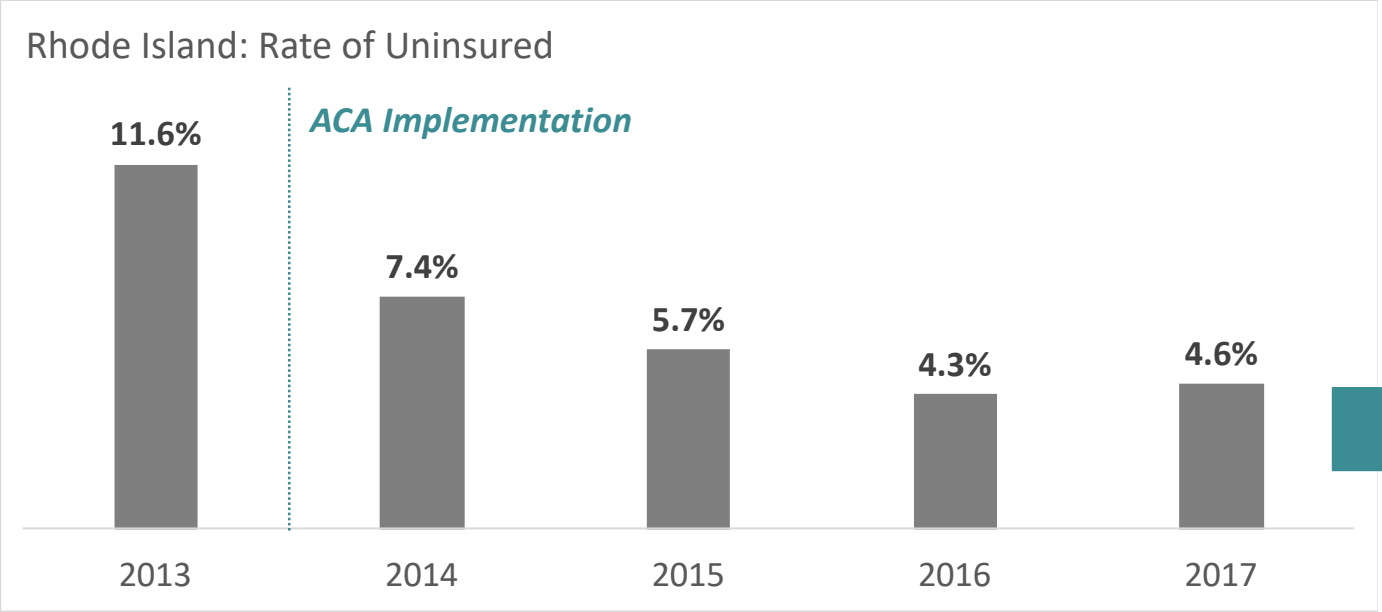


Reinsurance addresses stability of premium costs for unsubsidized enrollees

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

Starting Point: RI Uninsured

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



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

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

Today's Agenda

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

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

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

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

Learnings from Other States

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

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

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

* See next slide for additional details

Details: Learnings from Other States

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

Rhode Island Options

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

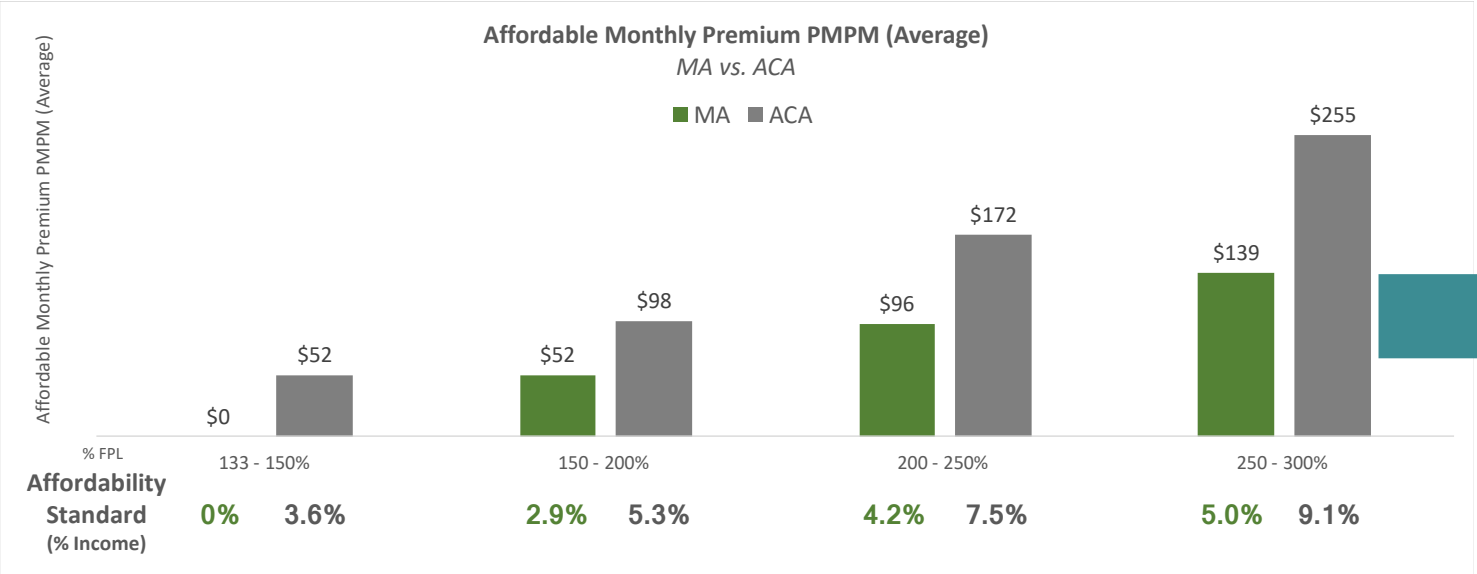
	Example 1	Example 2	Example 3
Target Population:	Low income populations APTC/CSR eligible	Unsubsidized Populations	Subsidy Eligible Young Adults APTC/CSR eligible
Description:	Supplemental premium subsidy or CSR	Premium rebate program or other premium subsidy	Supplemental premium subsidy
Benchmark States: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

Guiding Principles

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

The Massachusetts ConnectorCare Program

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



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

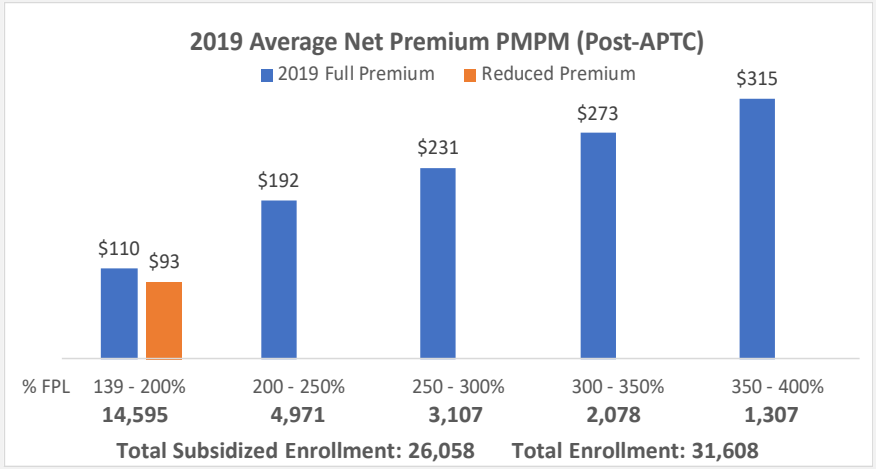
- Based on comparison of MA CY 2019 Individual Affordability Schedule and ACA CY 2019 Affordability Schedule – note that MA has three separate affordability schedules: Individuals, Couples, and Families - the schedule for individuals has been compared to the standard ACA schedule in the above
- Funding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

Example 1: Target Low Income Populations

(A) Target the lowest income bracket only

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

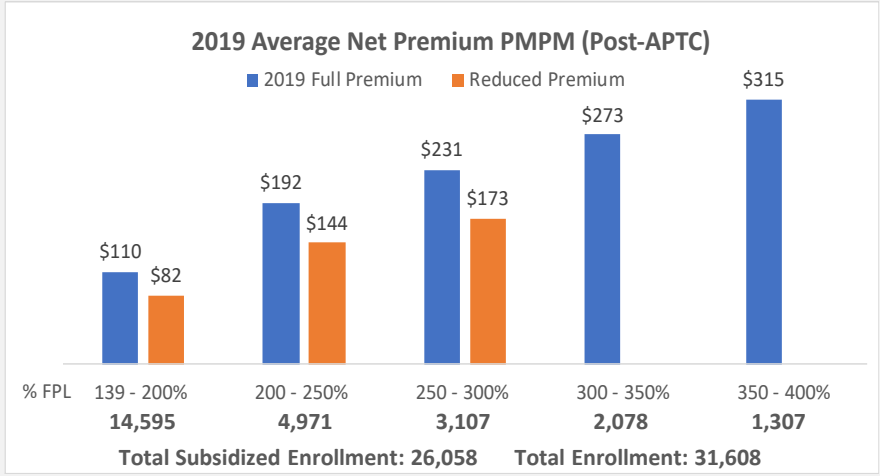
Est. Cost: **$2.9 Million**



(B) Target the population up to 300% FPL

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

Est. Cost: **$9.8 Million**



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

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

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

Do these options support the Workgroup's Guiding Principles:

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

Example 2: Target Unsubsidized Population

Minnesota Example

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

Estimated Cost: $22.3 Million

Considerations

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

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

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

Example 3: Target Subsidy Eligible Young Adults

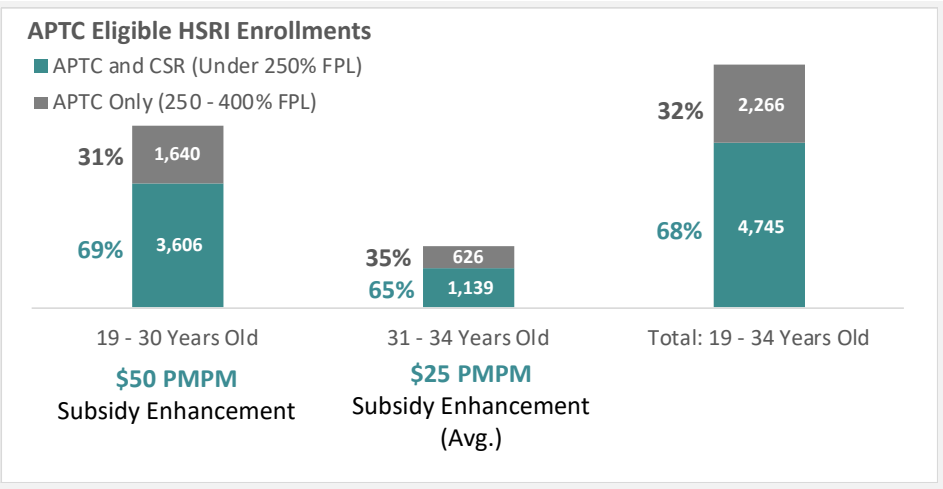
Obama Administration/ Senator Tammy Baldwin Proposal

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

Estimated Cost: $3.7 Million*

Considerations

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



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

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

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

Discussion

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

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

Guiding Principles

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

Next Steps

Meeting 4: Shared Responsibility Payment

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

PUBLIC COMMENT?

THANK YOU


HealthSourceRI
WE WORK FOR YOU


OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

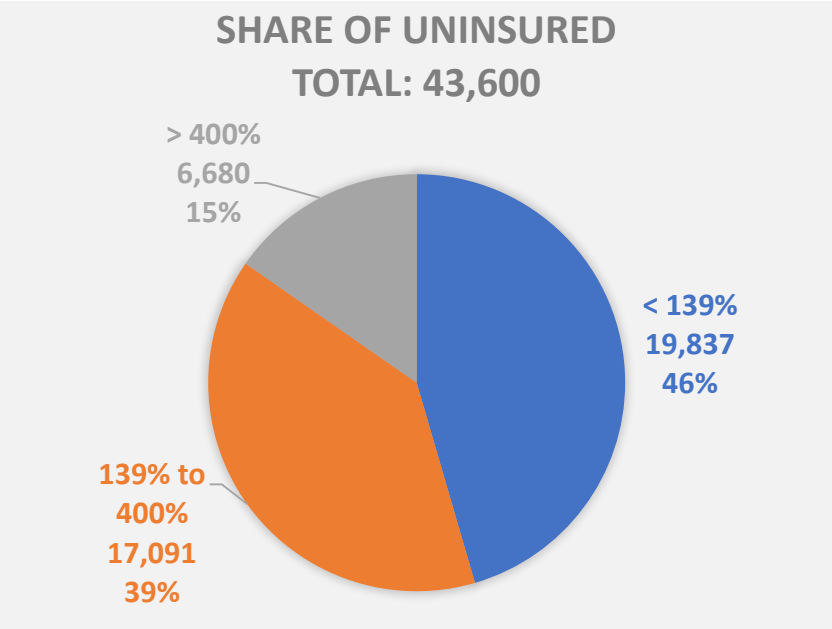
FCG Faulkner Consulting Group

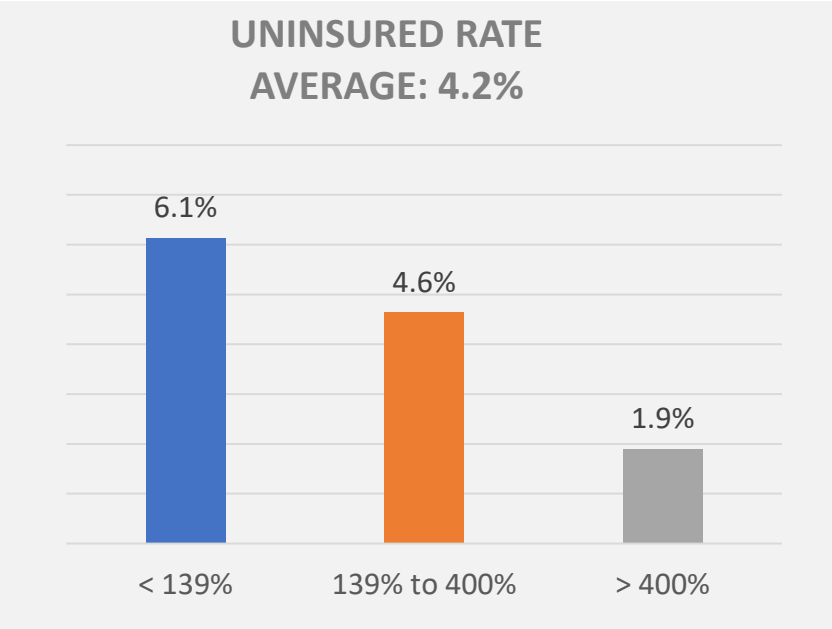
Back Up

October 31, 2018

Who Are the Remaining Uninsured? (by Income)

The remaining uninsured are disproportionately low income

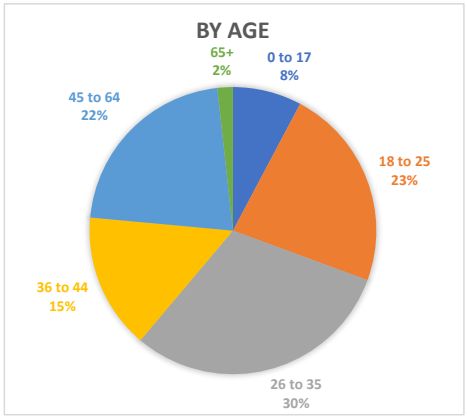


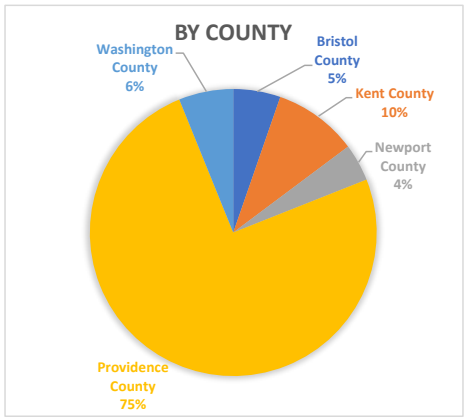


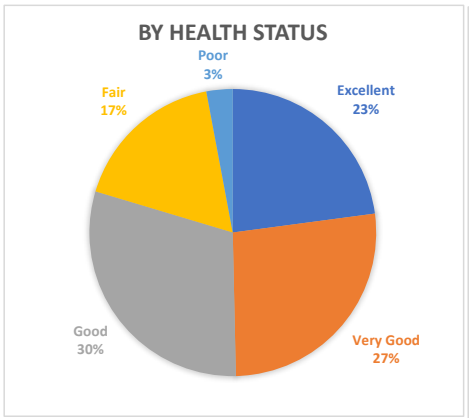
Note: Uninsured counts include undocumented individuals ineligible for Medicaid or subsidized coverage
See appendix for additional details on the remaining uninsured
Source Data: RI Health Insurance Survey, 2016

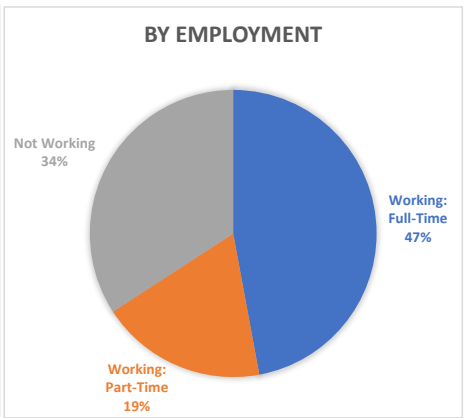
Who Are the Remaining Uninsured?

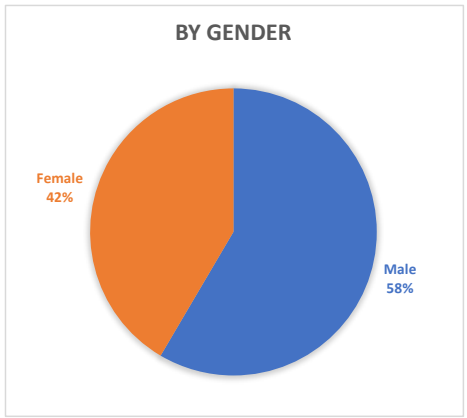
Total RI Uninsured: 43,609

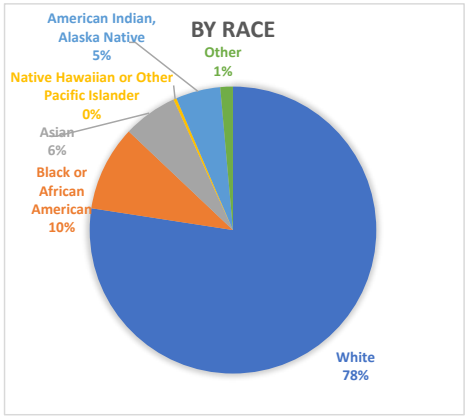


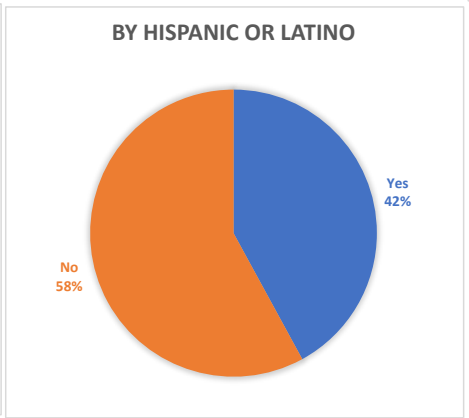


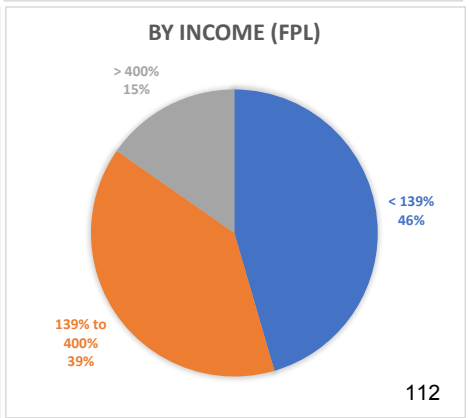








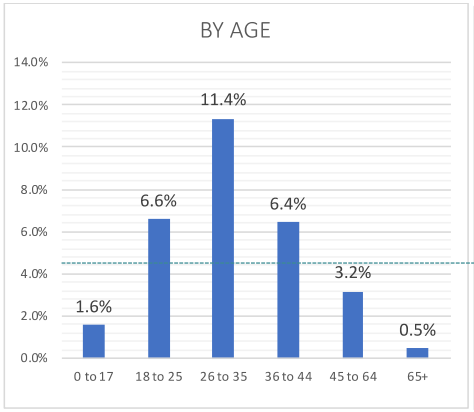


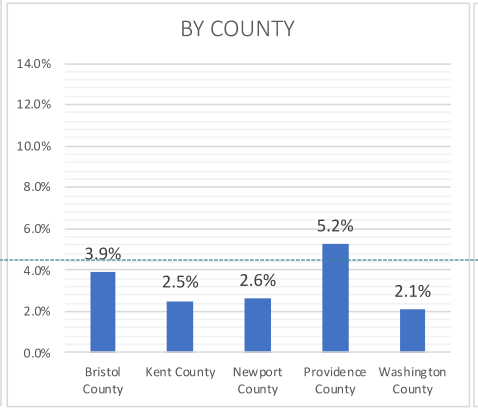


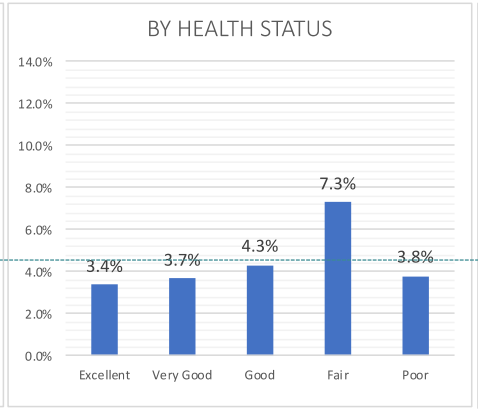
Source Data: RI Health Insurance Survey, 2016

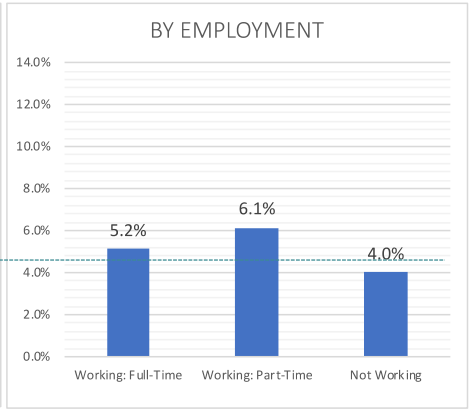
Uninsured Rates by Demographic

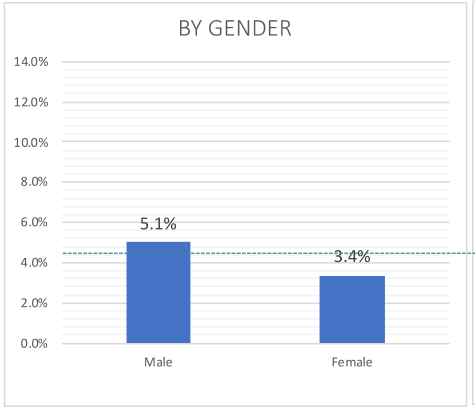
RI Uninsured Rate: 4.2%

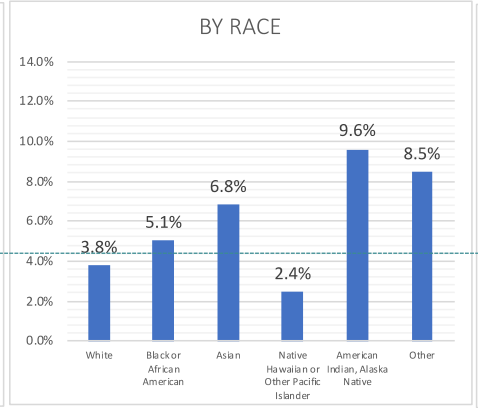


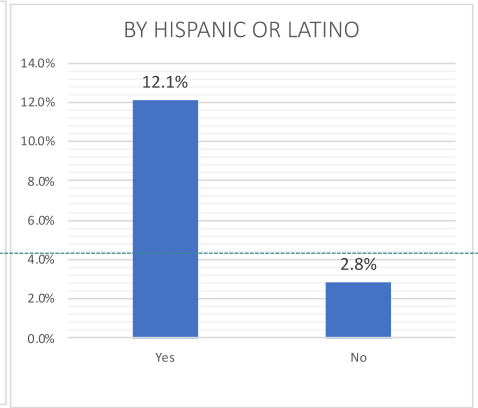


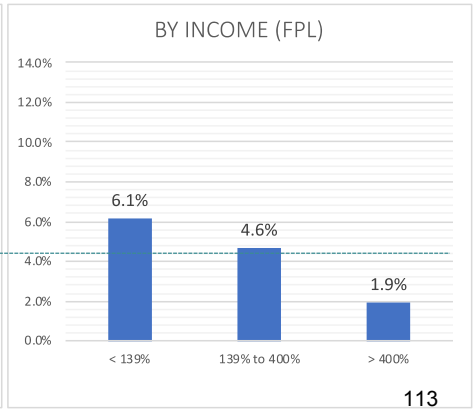












Source Data: RI Health Insurance Survey, 2016

Affordability: Subsidized Enrollees

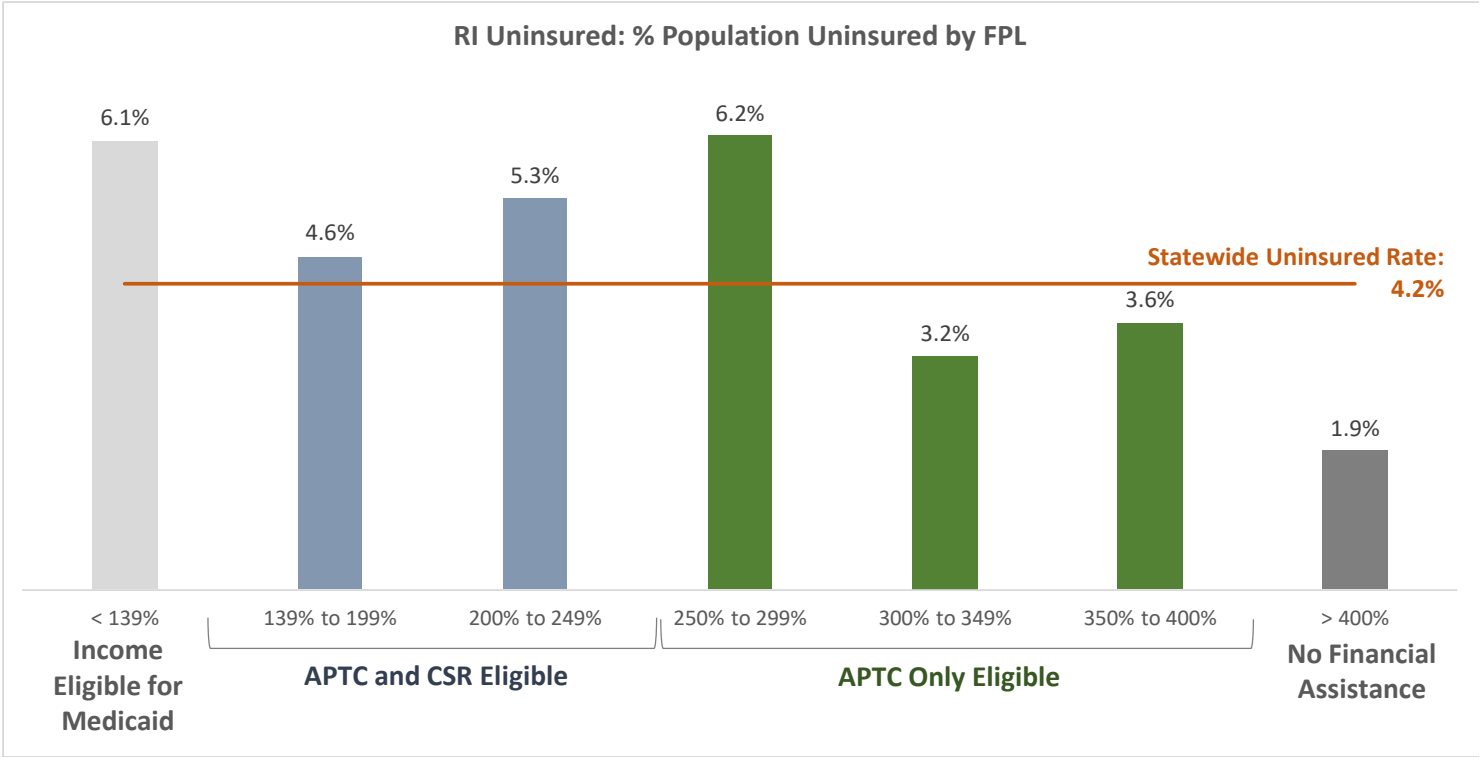
139-250% FPL => eligible for premium subsidies (APTCs) and cost sharing reductions (CSRs)
250-400% FPL => eligible for premium subsidies (APTCs) only

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

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

Rate of Uninsured by Segment

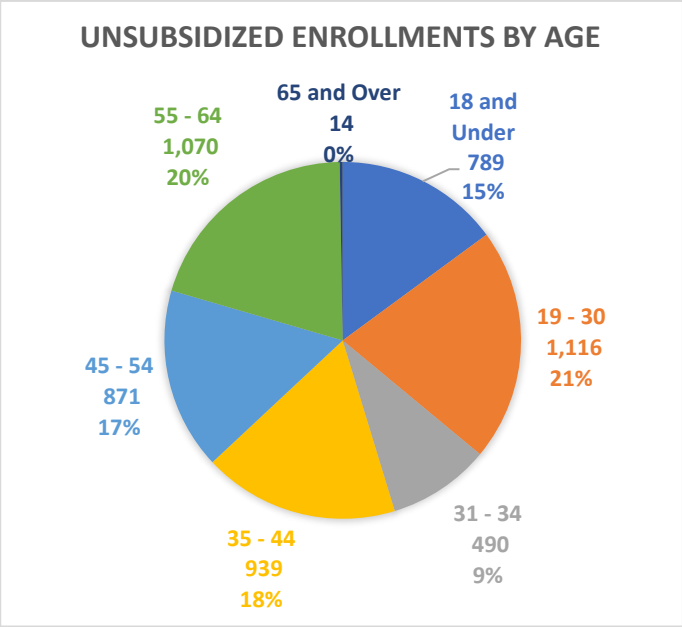
The rate of uninsured by segment is one indicator of affordability.

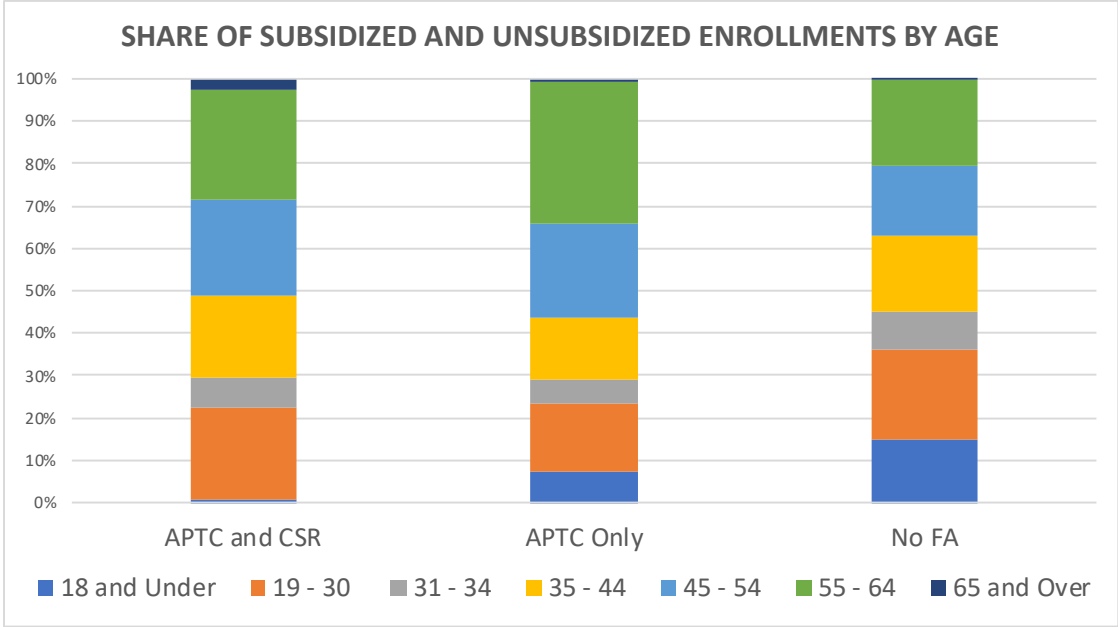


The subsidy eligible population ***139 – 300% FPL*** *has a higher than average uninsured rate.*

Source Data: RI Health Insurance Survey, 2016

Unsubsidized Enrollments by Age





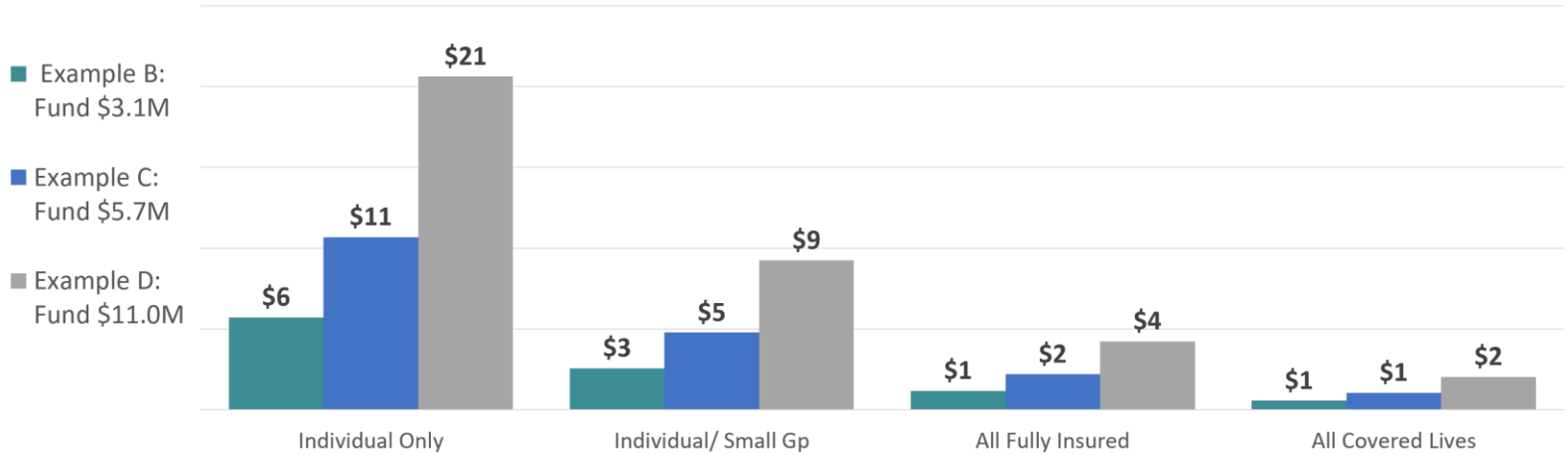
Source Data: HSRI Enrollment Data, April 2018

APPENDIX

Other Assessments: Who Pays?

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

Estimated Range of PMPM Assessment to Fund Remaining State Share



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

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

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

Market Stability Workgroup

Date of Meeting: October 31, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St Providence, RI 02909

Workgroup Members Present: Cristina Amedeo, Marc Backon, David Burnett, Al Charbonneau, Lauren Conway, Ralph Coppola, Marie Ganim (co-chair), Jane Hayward, Peter Hollmann, Hon. Joshua Miller, Monica Neronha, Tinisha Richards (for Lauren Conway), Samuel Salganik, Zachary Sherman (co-chair), John Simmons, Susan Storti, Larry Warner, Teresa Paiva-Weed, Bill Wray

Workgroup Members Absent: Stephen Boyle, Hon. Gayle Goldin, Janet Raymond

Minutes

I. Meeting was called to order at approximately 8:37am.

a. The minutes of the October 16, 2018 meeting were approved with the following change: Sam Salganik asked that a comment attributed to him expressing that federal officials may be "skeptical" of an aspect of the waiver application be amended to reflect that he was suggesting federal officials may wish to closely review said aspect of the waiver application.

b. Follow-ups from previous meeting – Director Sherman spoke on the following items from meeting 2:

   i. Statistics on the remaining uninsured population in Rhode Island from HSRI's 2016 Health Information Survey were sent to Workgroup members via email

   ii. Workgroup staff are conducting a "deep dive" into who pays certain insurance assessments and different assessment options in response to questions from meeting 2. A question from meeting 2 regarding what federal officials would be willing to consider in terms of assessments and federal passthrough savings has been brought to CMS. CMS must consult with Treasury, Director Sherman said he hopes to have further answers on this topic for the next meeting.

   iii. There was a correction to slide 32 from meeting 2's presentation: the baseline total premium used to calculate the percentage of premium assessment on the individual market only was incorrect; the corrected slide was included in this meeting's presentation.

c. Commissioner Ganim reviewed the Workgroup's spring 2018 recommendations, guiding principles, and goals. The Workgroup has recommended the state pursue a 1332 waiver to establish a state reinsurance program; a state law to regulate short-term, limited duration health plans; and the establishment of a state shared responsibility requirement. Additionally, the Workgroup recommended exploring other affordability measures that also support market stability.

d. New CMS guidance - Two recently published guidance documents from the federal government – one regarding 1332 waiver applications, the other regarding health reimbursement arrangements – were being analyzed by HSRI staff, but they were not ready to speak to them at length. The goal is to address them at the next meeting. A summary of the 1332 waiver guidance was sent to the Workgroup via email.

II. Objectives for today's meeting

a. Marie Ganim reviewed the agenda. Based on feedback from the last meeting, Director Sherman indicated that the Workgroup would not be asked to rank any initiatives presented today.
b. Deb Faulkner presented to the Workgroup information on affordability initiatives in other states.

She began with a review of the Workgroup's 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 under the ACA.

There are not many supplemental affordability programs in other states due to the fact that there are no federal funds available for these programs, states must fund them on their own. The exception is Massachusetts, which had instituted an affordability program prior to enactment of the ACA.

Minnesota, facing average premium increases of up to 50%, established a 25% premium rebate for their unsubsidized population.

Vermont established a state-based cost sharing reduction program.

Deb also noted a program that was proposed during the Obama administration but was not enacted that targeted low-income young adults. Younger adults have a higher uninsured rate than the general population – the uninsured rate among 26-34-year-olds is 11.1%. The program that was considered would have included an enhanced subsidy to targeted to low income young adults.

III. Affordability programs to increase access to health insurance.

Deb continued with by reviewing each of these affordability programs in depth, and in the context of the Rhode Island market and the principles of the Market Stability Workgroup. An enhanced subsidy for the population under 300% of the federal poverty line, similar to what was instituted in MA, would cost the state of RI at least $17.5 million.

Sam Salganik acknowledged what Deb has said about state's having to bear the full cost of an affordability program, but he inquired as to whether an enhanced low-income subsidy would qualify for federal passthrough savings under a 1332 waiver by bringing healthier people into the risk pool, thereby lowering the

benchmark premium. Deb said this might be possible but the case for federal savings would have to be made. Sam agreed that this was an actuarial question.

Noting that without any federal match $17.5 million was a lot of money, Deb presented some examples on how RI might make such a program less expensive. Option (A) would target only the lowest income bracket with an effective 15% premium reduction consumers between 139-200% FPL and would cost an estimated $2.9 million annually. Option (B) targeted the population up to 300% FPL with an effective 25% premium reduction at an estimated cost of $9.8 million annually.

Peter Hollman asked if the 15% reduction was significant enough for that low-income population to entice them to purchase insurance. Deb noted that the cost estimate was based on number of enrollees already in the individual market, and that, for example, a 50% increase in enrollment would raise the estimate by $455,000. Teresa Paiva Weed said the goal was to maintain current enrollment, although if it came with the added benefit of getting new enrollees that would be good. Teresa then asked about changes at the federal level, and which of these populations were most impacted by them, where was the greatest risk of loss to the individual market, suggested that that population be prioritized. Deb said she thought this logical but did not have any facts or data. Teresa also asked if the federal government had done anything positive to support the market with recent policy changes. Deb replied that opening the door to state-based reinsurance programs could be considered a positive move. She added that some would argue that the expansion of short-term plans was a positive in that having poor coverage was better than no coverage all. Commissioner Ganim pointed out that short-term plans had no positive impact at all and only fragmented the risk pool while leaving consumers with effectively useless coverage.

Deb continued with an example of an affordability program that would target the unsubsidized population. MN provided a 25% premium rebate to unsubsidized enrollees. If were RI were to do the same, it would cost the state an estimated $22.3 million. Deb noted that this program in MN was a one-year stop gap measure as the state faced a dramatic 50-66% rate increase for 2017. In 2018, MN implemented a reinsurance program.

John Simmons asked what the pool of unsubsidized enrollees was. Deb replied that it was around 18,000 lives, compared to 45,000 lives in the overall individual market.

Deb next gave an alternative example of a potential premium rebate – if RI were to implement a 10% premium rebate to the same population of unsubsidized enrollees, it would cost an estimated $9.5 – 10 million. She noted that this would be targeting the same population as a reinsurance program, and that reinsurance protects the market from seeing premium increases whereas subsidy or rebate programs mitigate the impact of increases that have already occurred.

Sam said his experience with consumer assistance led him to suspect that most of the uninsured whose income are above 400% FPL do not have incomes that are much higher than 400% FPL. They are only just over the line to qualify for subsidies and for them the insurance costs might be 15-20% of household income. He said it would make sense to consider tailoring extra subsidy support to this population.

David Burnett said the fundamental question was where is there more risk for loss of enrollment: at the lower income levels or at the higher income levels where consumers are unsubsidized. Director Sherman said that one the Workgroup's guiding principles was to protect coverage gains. Director Sherman noted that the state had been able to shield subsidized consumers from large premium increases brought about by federal policy changes but that the unsubsidized were most at risk. David said that for the vast majority of Neighborhood's plan members, a 15% increase would be meaningful. Deb said that since those consumers are subsidized, they wouldn't see the 15% increase. David said that while this was true now, it could change.

John Simmons said that without knowing where the funding for any initiatives would be coming from, the three guiding principles of the Workgroup were inadequate. He said it was important to understand the consequences of who would pay for any initiatives – for example, if an assessment on employers to fund an enhanced subsidy would lead to fewer employers offering health insurance.

Deb presented one more example of an affordability program that would target subsidy-eligible young adults. Providing an additional subsidy of $50 to low income 19-30-year-olds would cost the state and estimated $3.7 million. If you dropped the income requirement and give all adults in that age bracket a $50 subsidy, it would add $800,000 to the cost. This would support market stability by bringing more healthy young adults into the risk pool.

Sam said this idea was interesting and might potentially draw a federal match – acknowledging that further actuarial analysis would be needed, he suggested that by bringing healthy young enrollees into the risk pool, it could lower the benchmark premium and qualify for federal funds. He also noted that it potentially created a more appropriate age curve, as the 3-to-1 premium age curve is essentially flattened by the subsidy.

Monica Neronha said that BCBSRI had a subsidy program in place prior to the ACA that granted larger subsidies to younger enrollees. She noted that it resulted in higher enrollment of younger adults but that the pre-ACA environment was much different – it was difficult to say what the results of a similar program would look like when the uninsured rate is already very low.

Deb briefly recapped the three example affordability programs presented and asked if the Workgroup had any questions. Director Sherman asked if there were any ideas that were not presented that the Workgroup would like to see.

Sam said that offering a Medicaid-like product to undocumented residents would be much more expensive than the example programs presented today but wondered if offering it to undocumented children would be feasible - it would be a smaller, lower-cost population. He noted that this had been done in Rhode Island in the past.

Monica said that offering a catastrophic plan with a "lead" level actuarial value may be helpful in countering the impact of short-term limited duration plans. Currently, none of these plans are offered in Rhode Island. Monica said BCBSRI used to offer a catastrophic plan, but it became too complex to administer due to age and eligibility requirements under the ACA. She wondered if changing the eligibility requirements via 1332 waiver and creating a new lead-level/catastrophic plan offering that covers EHBs might help attract or retain enrollees who might otherwise choose a short-term plan.

Senator Miller said the defunding of HealthSource RI outreach and enrollment efforts had a negative impact. When HSRI had more outreach funding, they were able to enroll a greater number of younger adults. Director Sherman said that there was still an outreach and enrollment program administered through RIHCA, but it is not as robust as in the past.

Ralph Coppola asked how many of the uninsured were working. Sam said approximately 2/3 of them are working, approximately half of those working full-time. Senator Miller said a large percentage of "full-time" workers were actually working part-time at multiple jobs, never allowed to reach full-time hours at any one job.

Monica asked how long a 1332 waiver approval would last, and if there was any opportunity to amend the waiver after it was approved. John Cucco from HealthSource RI said the approval is for up to 5 years, with annual reporting requirements and continuous adjustments throughout, but he was not sure about amendments.

Larry Warner asked if there was much take up of direct primary care arrangements and if that was contributing to lack of enrollment. Neither OHIC nor HSRI had any data or information on this.

Director Sherman asked if the Workgroup were interested in eliminating from consideration any of the affordability program examples presented.

Teresa spoke to the overarching goals and principles of the Workgroup, asking if they should be looking at supplemental subsidies if the goal is to prospectively

stop market erosion and stop or slow increases in premiums (rather than address increased premiums after the fact).

Sam made the point that a "prospective vs. retrospective" construct makes some sense but is not necessarily useful in all aspects of the conversation. He said he felt subsidies lowering premiums had their own market-stabilizing effect.

With the Workgroup broadly supporting a reinsurance program, which primarily supports the unsubsidized portion of the market, Commissioner Ganim asked if the 2nd example affordability program – a rebate targeted at unsubsidized consumers – should be removed from consideration.

Sam noted that example 3 – a supplemental subsidy targeted at younger adults – may or may not yield federal savings but would certainly bring downward pressure on individual market premiums. Deb said that example 3 would help protect the risk pool.

Director Sherman said it seemed example 2 could be comfortable taken off the table. Several Workgroup members voiced assent. John Simmons said that removing something from consideration at this point was premature. Director Sherman agreed to keep it for consideration.

IV. Public Comment – No members of the public made comments.

V. Adjourn

a. The meeting was adjourned at 10:20 AM.

Market Stability Workgroup

Notice Posted: November 7, 2018
Date of Meeting: November 13, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Agenda

I. Call meeting to order
   a. Motion to approve October 31, 2018 meeting minutes
   b. Meeting Three follow-ups
   c. Review Workgroup recommendations, guiding principles, and goals
   d. Review today's agenda

II. Review federal individual shared responsibility payments
   a. Structure of federal shared responsibility payments
   b. Impact of federal shared responsibility payments

III. Variations for consideration of a shared responsibility payment at the state level
   a. Present alternative state-based options
   b. Discuss potential impacts of state-based alternatives

IV. Consideration of variations in context of market stability recommendations and guiding principles

V. Next steps and upcoming meetings

VI. Public comment

VII. Adjourn

United Way of Rhode Island is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Lindsay Lang at 401.383.5124 or email her at lindsay.lang@exchange.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP "2.0"

Tuesday, November 13, 2018
8:30 – 10:30 a.m.
The United Way of Rhode Island

UPDATES SINCE OUR LAST MEETING

- Meeting 3 Follow-ups:
  - 1332 Guidance
  - HRA rule
  - Brief overview of each in appendix

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TODAY'S AGENDA

1. **Individual Shared Responsibility Payment**
   - Review federal penalty structure and discuss impact
   - Present alternative options and discuss impact
   - Discuss pros/cons of alternatives in the context of all market stability recommendations and the guiding principles

2. **Next Steps**

RECOMMENDATION FROM JUNE

- **“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.”
- **“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.”

From Market Stability Workgroup June report, page 1-2.

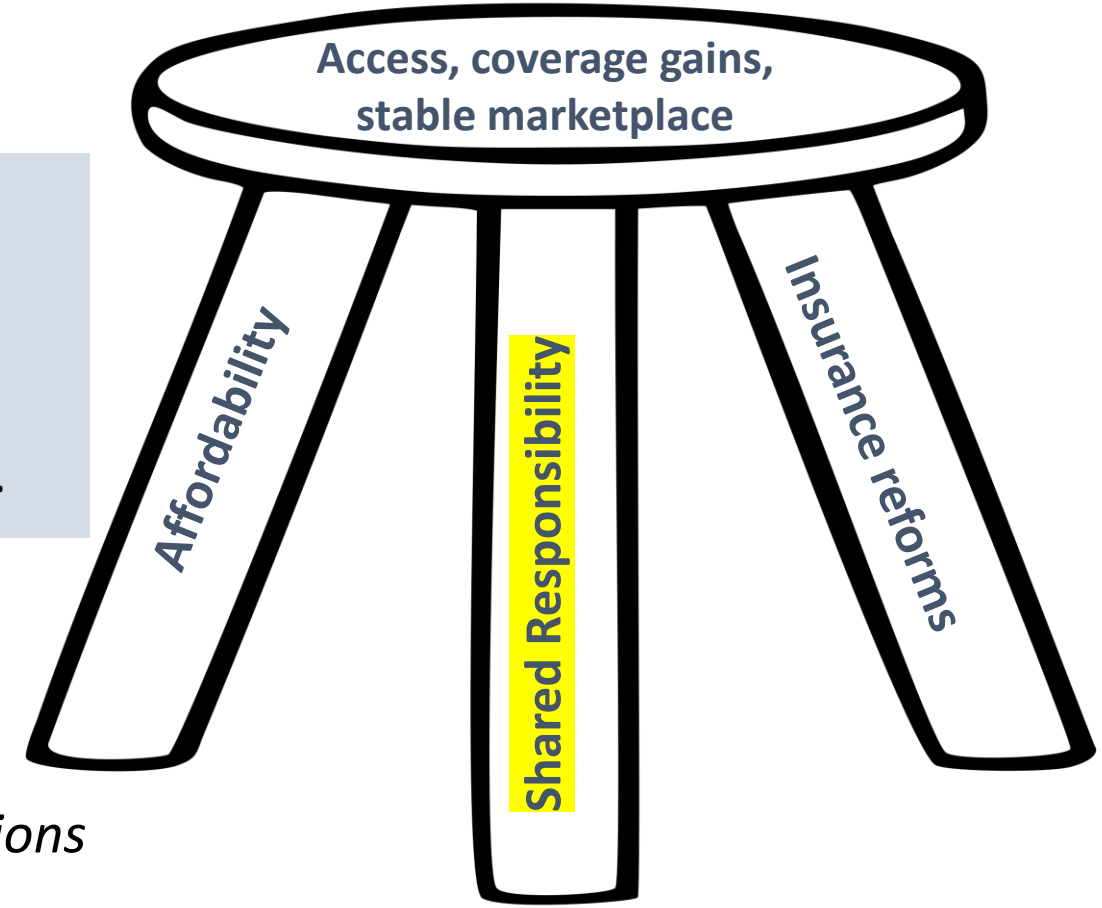
REMINDER: WORKGROUP GUIDING PRINCIPLES

Guiding Principles

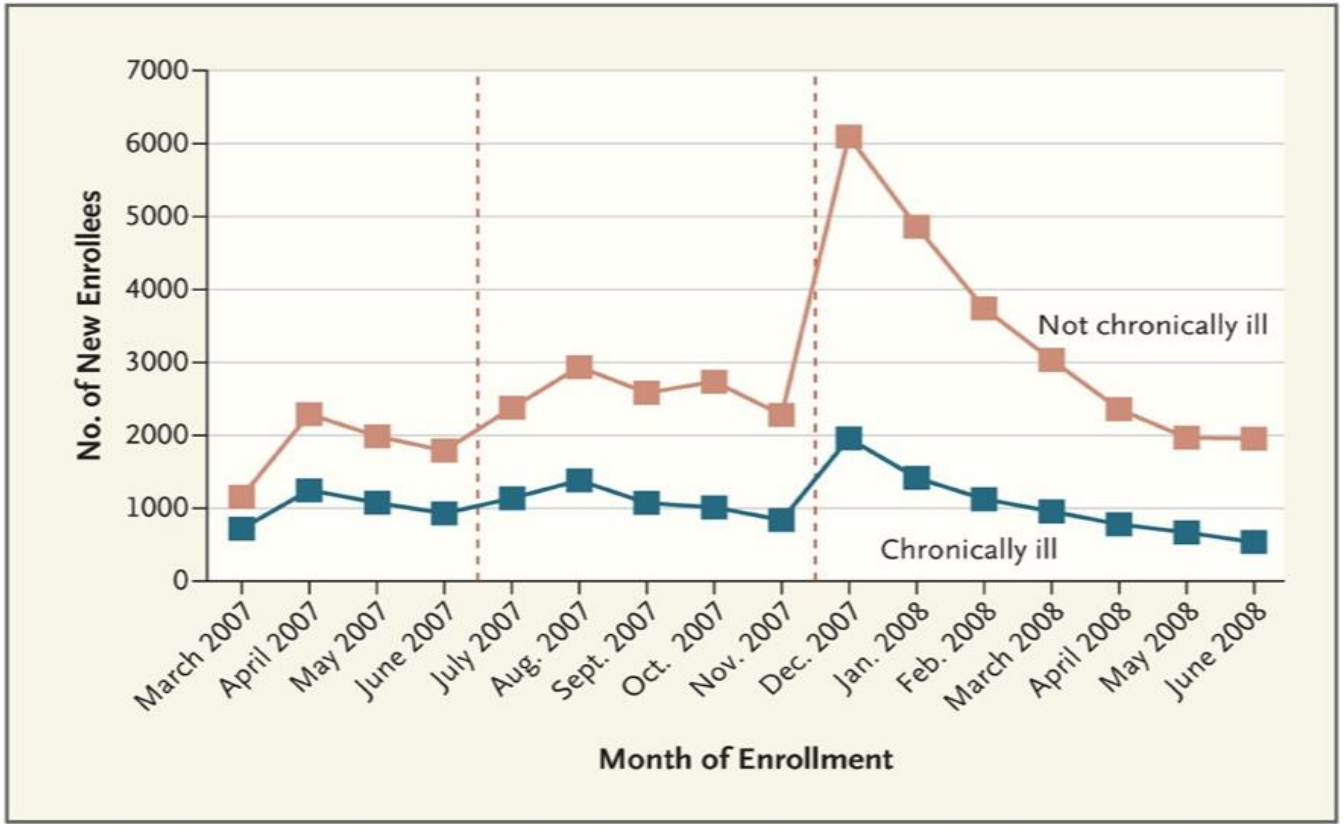
1. Sustain a balanced risk pool;
2. Maintain a market that is attractive to carriers, consumers and providers; and
3. Protect coverage gains achieved under the ACA.

Goal

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



REMINDER: WHY A REQUIREMENT TO BUY INSURANCE?



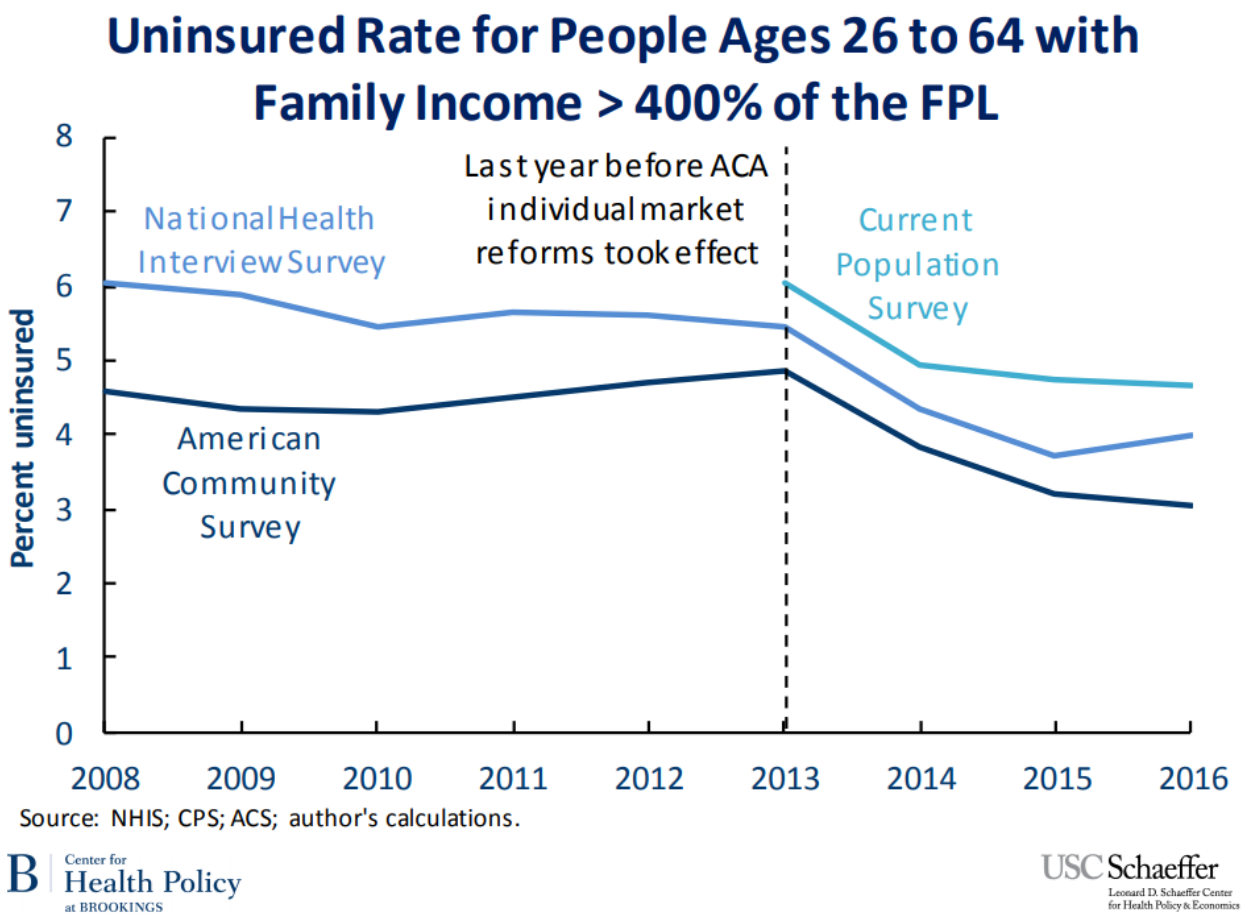
Number of New Enrollees in Commonwealth Care, According to Chronic-Illness Status.

The two vertical dashed lines represent the start of the mandate phase-in period (from July through November 2007) and the start of the period when the mandate became fully operational (from December 2007 onward)

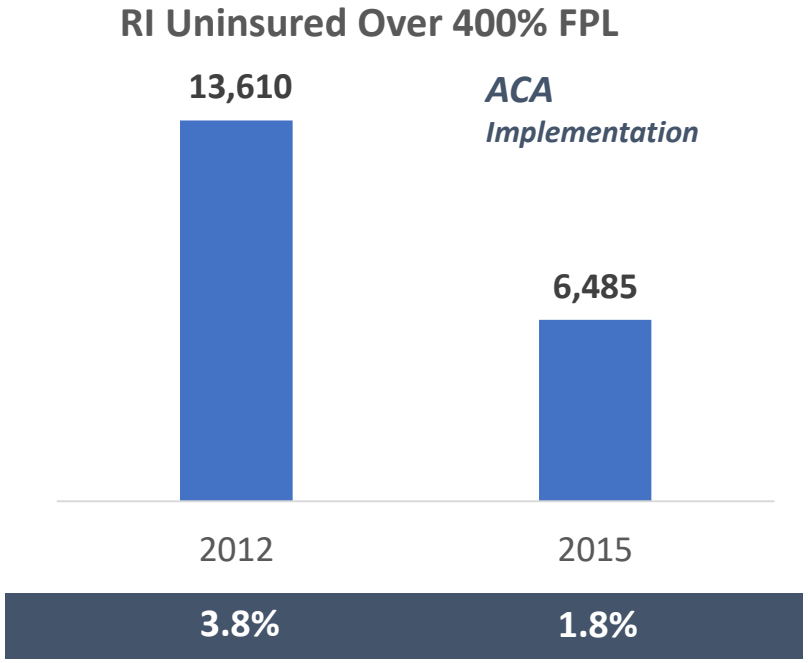
- Phased in separately from subsidies
- Increased enrollment in general
- Significant and disproportionate effect on healthy population
- MA rollout accompanied by messaging campaign

Source: https://www.nejm.org/doi/full/10.1056/NEJMp1013067

REMINDER: WHY A REQUIREMENT TO BUY INSURANCE?



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



Sources: https://www.brookings.edu/wp-content/uploads/2018/02/fiedlerslidesfor030618-for-posting.pdf; 2016 RI Health Insurance Survey (RI HIS)

SHARED RESPONSIBILITY REQUIREMENT COMPONENTS

Affordability Exemption

Penalty Structure

Definition of Qualifying Coverage

Hardship/ Other Exemptions

Reporting Requirements

Outreach to Uninsured

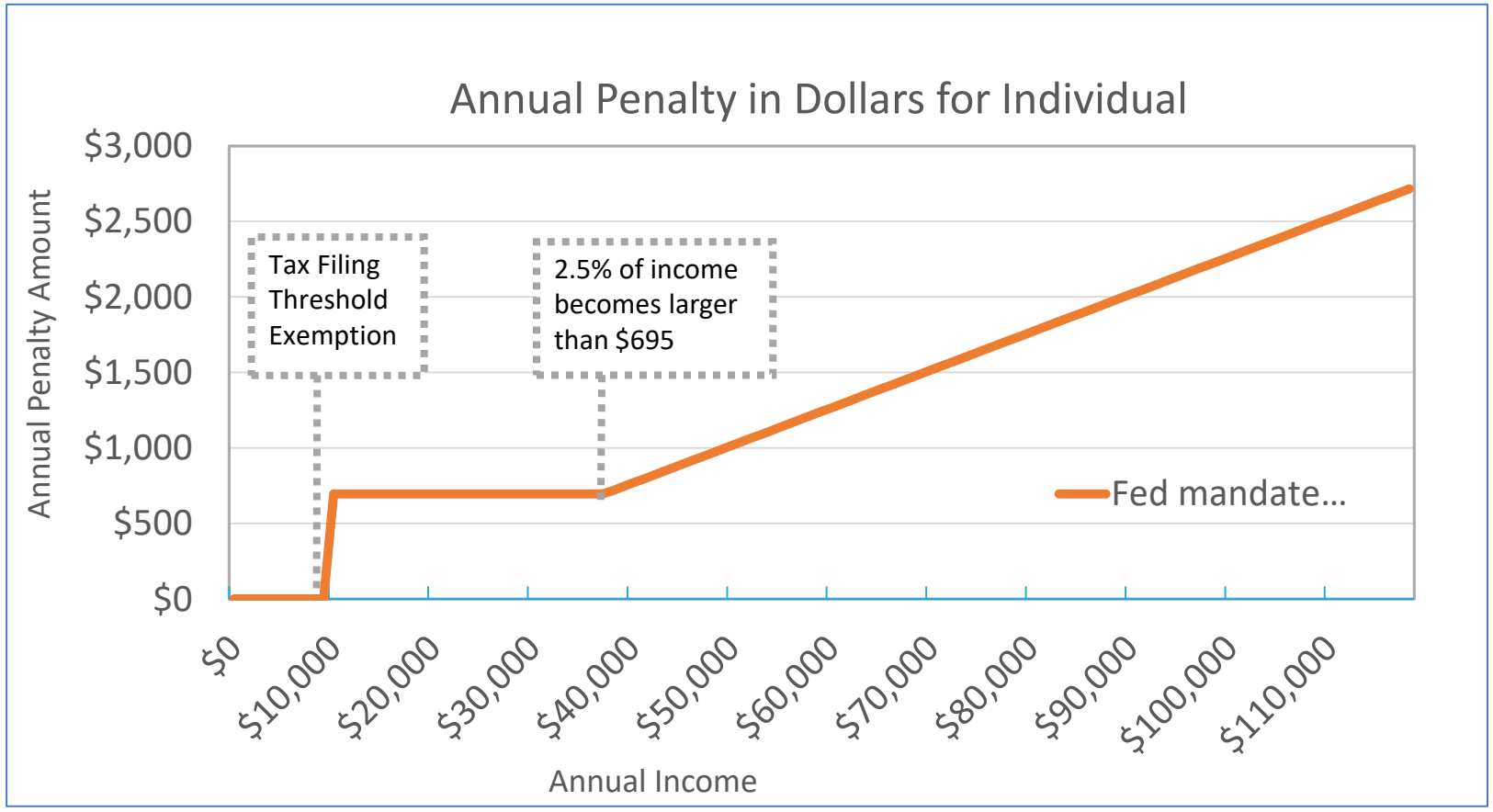
Focus of Today's Discussion
Explore Alternative Options

- Should RI revise the main federal exemption structure?
- Should RI change the structure of the penalty amount?
- Using 2016 revenue as a baseline, how would potential changes affect revenue?

Mimic Current Federal Structure for Smooth State Transition
No Need for Changes to Federal Parameters

FEDERAL PENALTY STRUCTURE (ending 12/31/18)

Larger of 1) $695 per adult, or 2) 2.5% of income above filing threshold*



KEY EXEMPTIONS

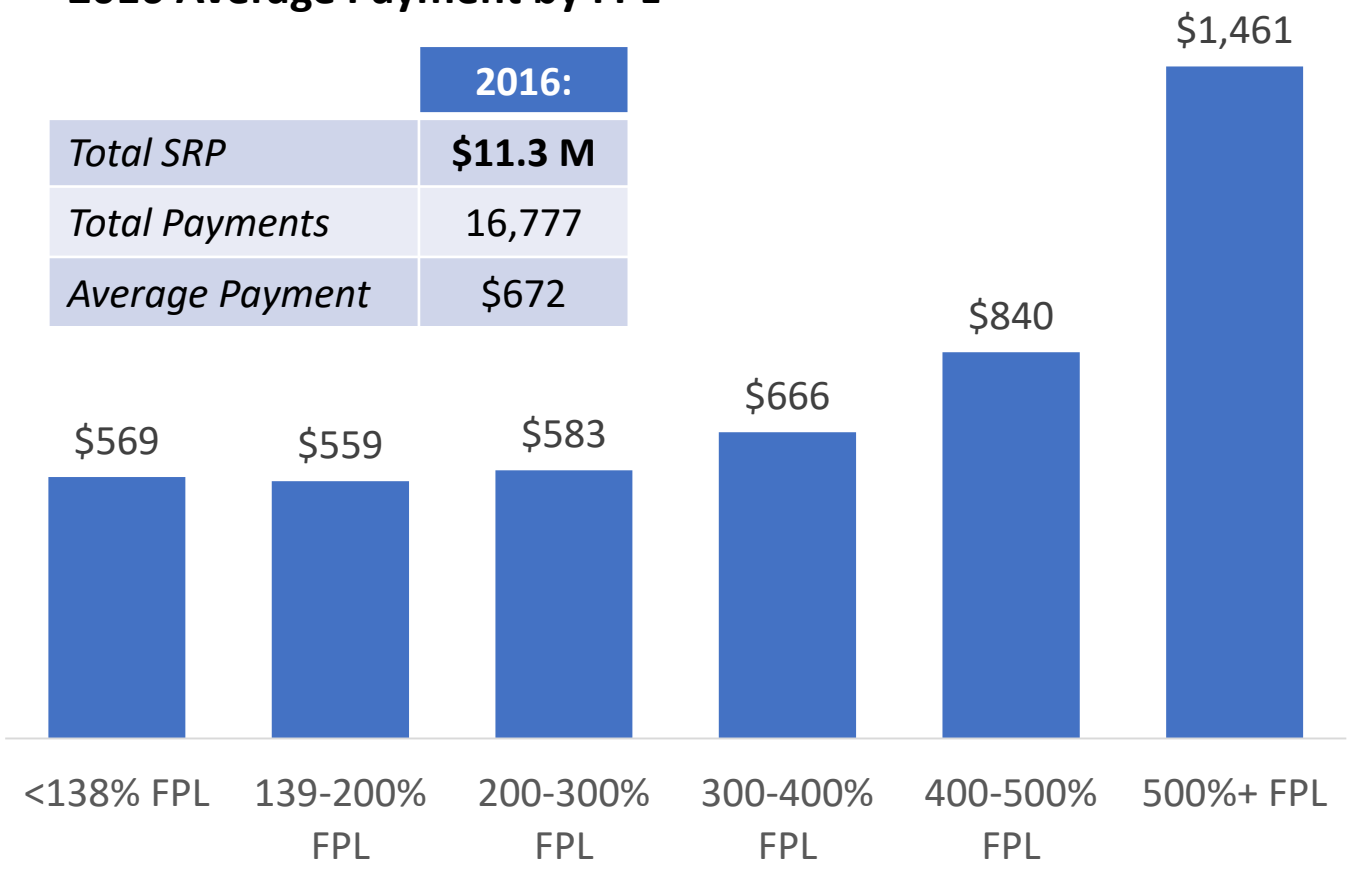
- **Income Exemption** if income below tax filing threshold
- **Affordability Exemption** if coverage costs more than 8.13% of income
- **Hardship Exemption** in case of bankruptcy, flood/fire, death in family, etc.

**Half dollar amount for children, and max per family is equivalent of 3 adults. Overall max set at bronze plan cost*

RI SHARED RESPONSIBILITY PAYMENTS: 2016

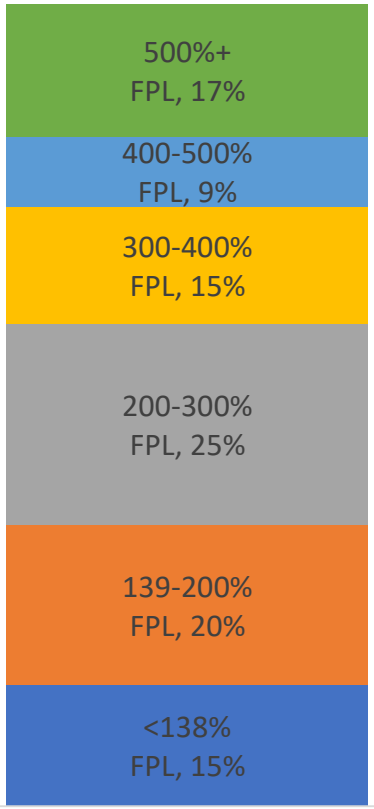
2016 Average Payment by FPL

	2016:
Total SRP	**$11.3 M**
Total Payments	16,777
Average Payment	$672



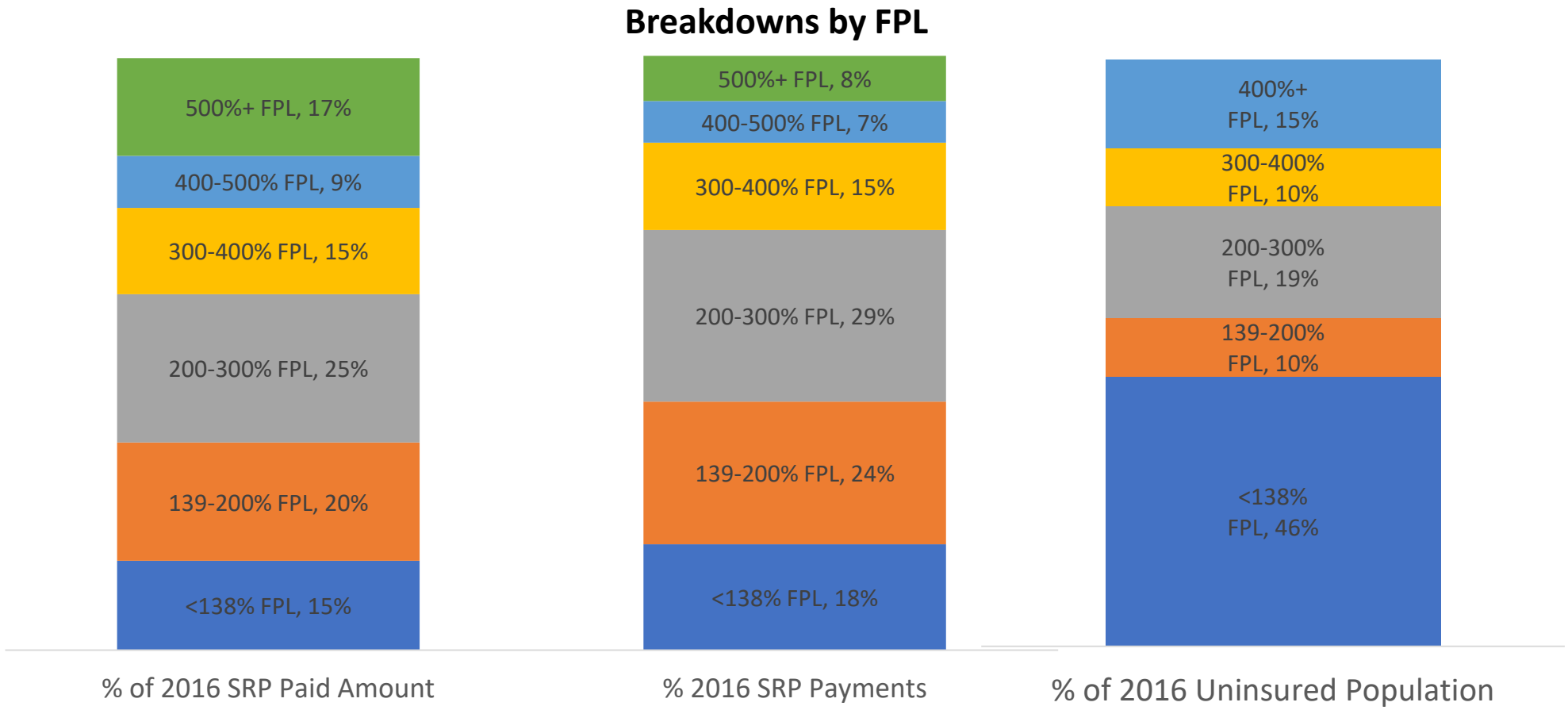
# Payments	2,993	4,027	4,840	2,467	1,177	1,274

Share of Total Paid Amount by FPL



% of 2016 SRP Paid Amount

SHARE OF PAYMENTS VS. SHARE OF UNINSURED

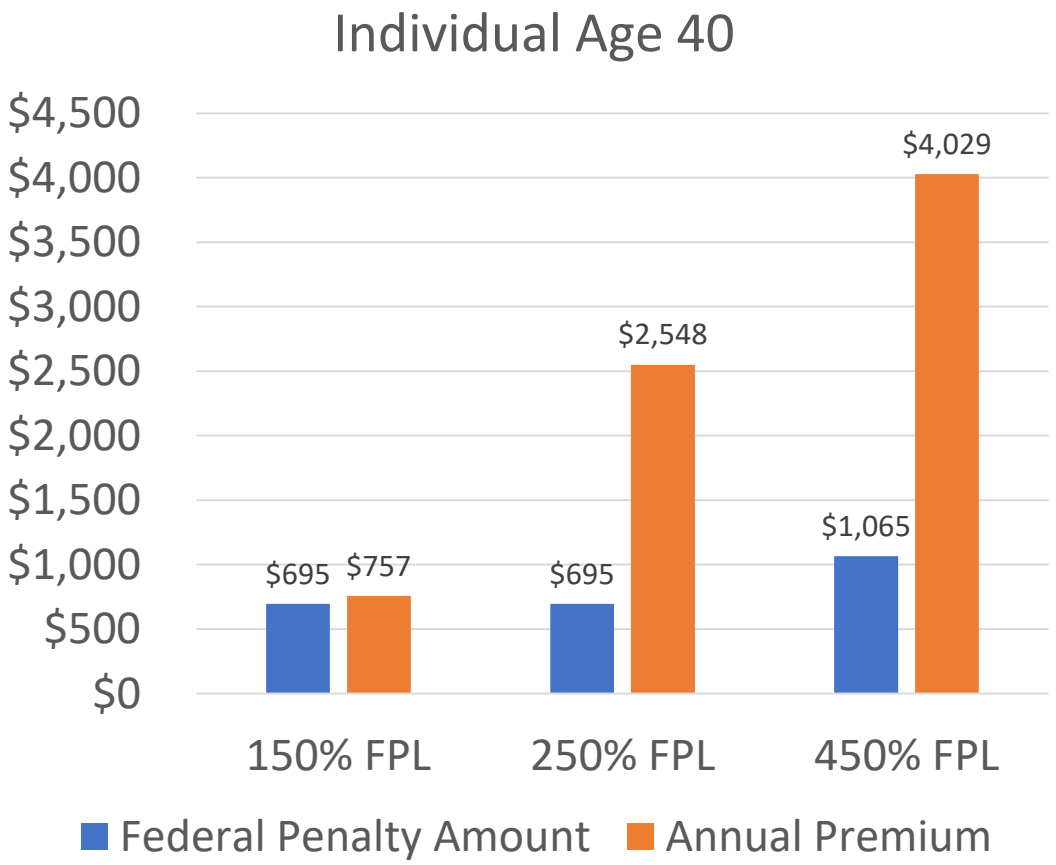


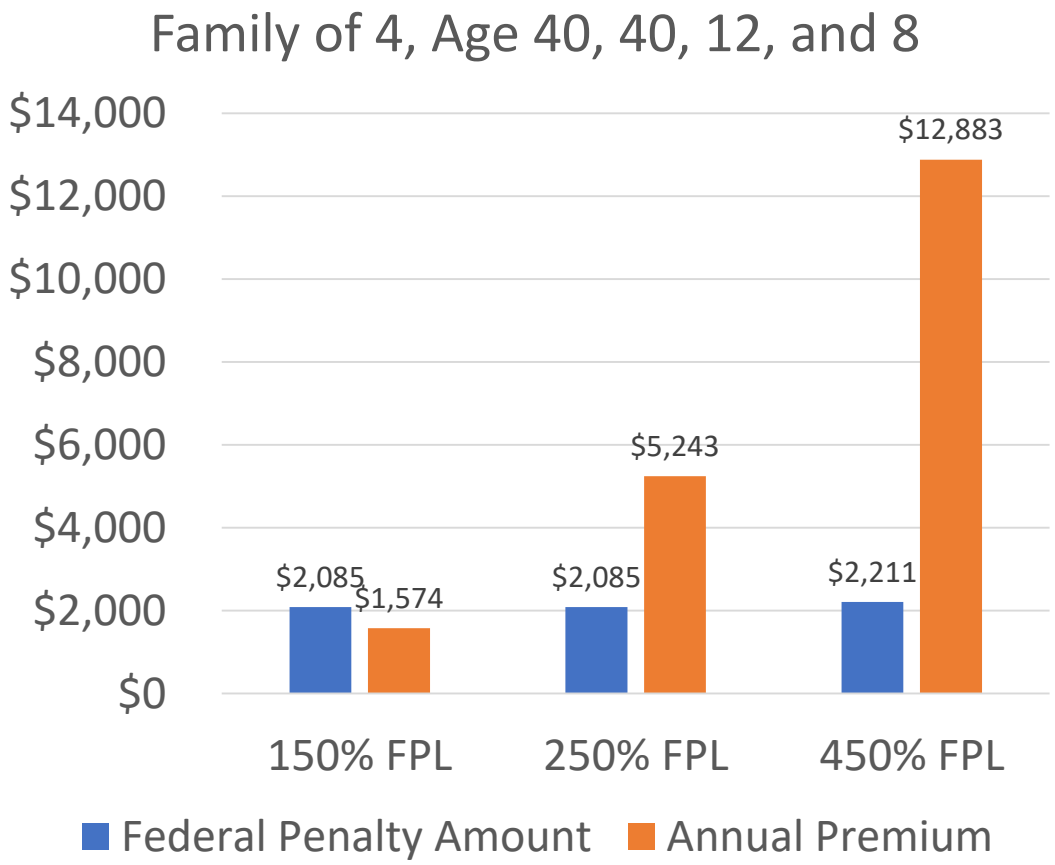
Total 2016 SRP Paid Amount = $11.3 Million	Total 2016 SRP Payments = 16,777	Total 2016 Uninsured Population = 43,609

Source for Uninsured Population: RI Health Insurance Survey, 2016

FEDERAL PENALTY AMOUNTS VS. ANNUAL PREMIUM

2019 benchmark plan, after APTC if eligible





DISCUSSION

- Is the penalty overly burdensome on certain income groups? Or is it appropriate as an incentive for coverage?

- Any other specific concerns (other than impact across income groupings) to look at in more detail in a future meeting?

ALTERNATIVE OPTIONS FOR SRP

Levers Available:

- Income Based Exemption
- Flat Penalty Amount ($695)
- % of Income Penalty Amount (2.5%)

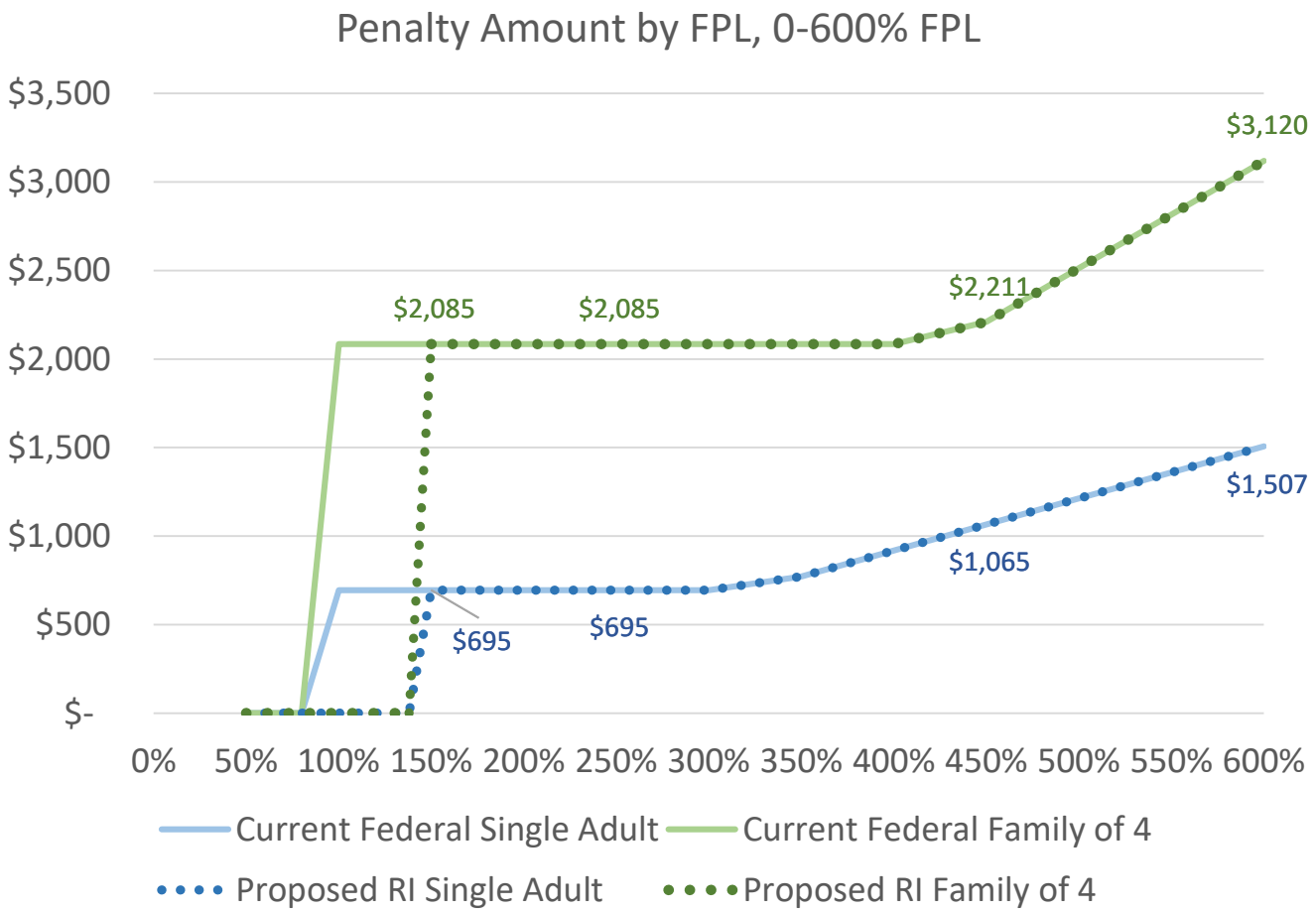
Variations Modeled:

1. Exemption under 138% FPL
2. Flat Penalty Amount reduced by half ($350)
3. Flat Penalty Amount eliminated ($0)
4. Exemption under 138% FPL combined with increased income percentage to 3.5%

About the model:

- Developed by DOR using IRS and RI tax filing data.
- Aggregates 2016 filers into categories based on their family size and FPL
- Models a change by applying an estimate to each category
- See appendix for assumptions

VARIATION 1: EXEMPTION UNDER 138% FPL



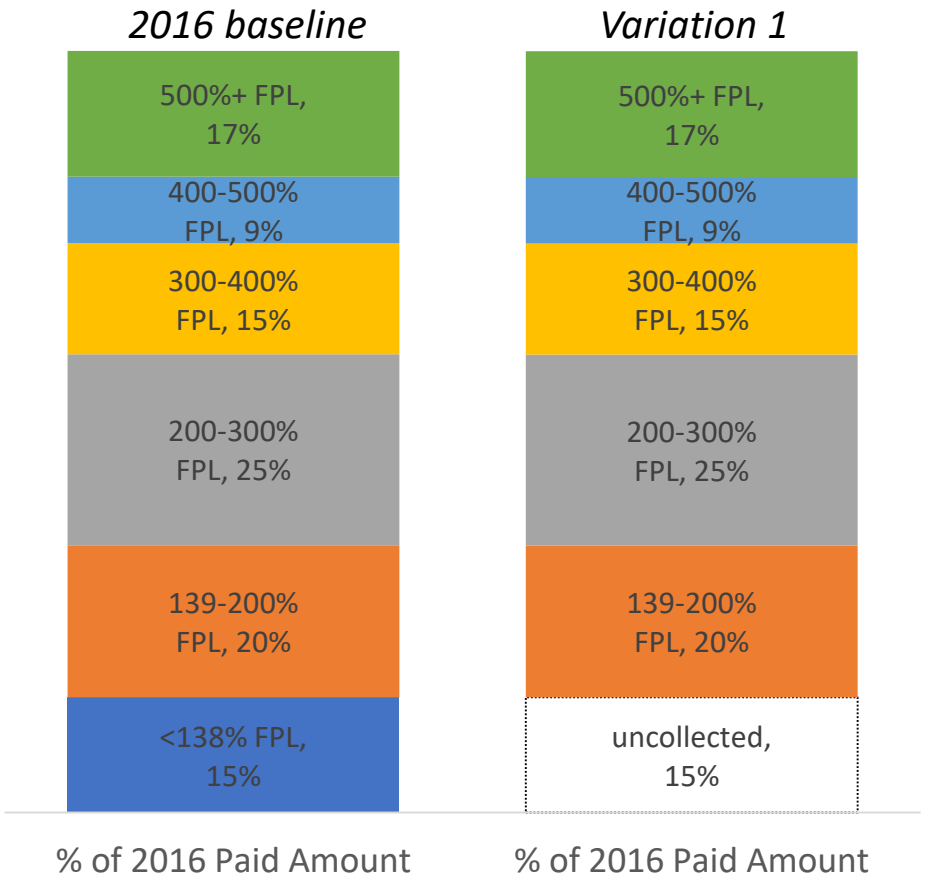
- Corresponds with Medicaid eligibility for most adults
- Many ought to be exempt via affordability exemption, but simplification may make it easier to avoid being penalized
- Estimated revenue reduction of $1.7M
- 100% reduction at lowest income ranges. No impact above that
- Could be “revenue neutral” if the percentage were also increased to 3.5%

VARIATION 1: EXEMPTION UNDER 138% FPL

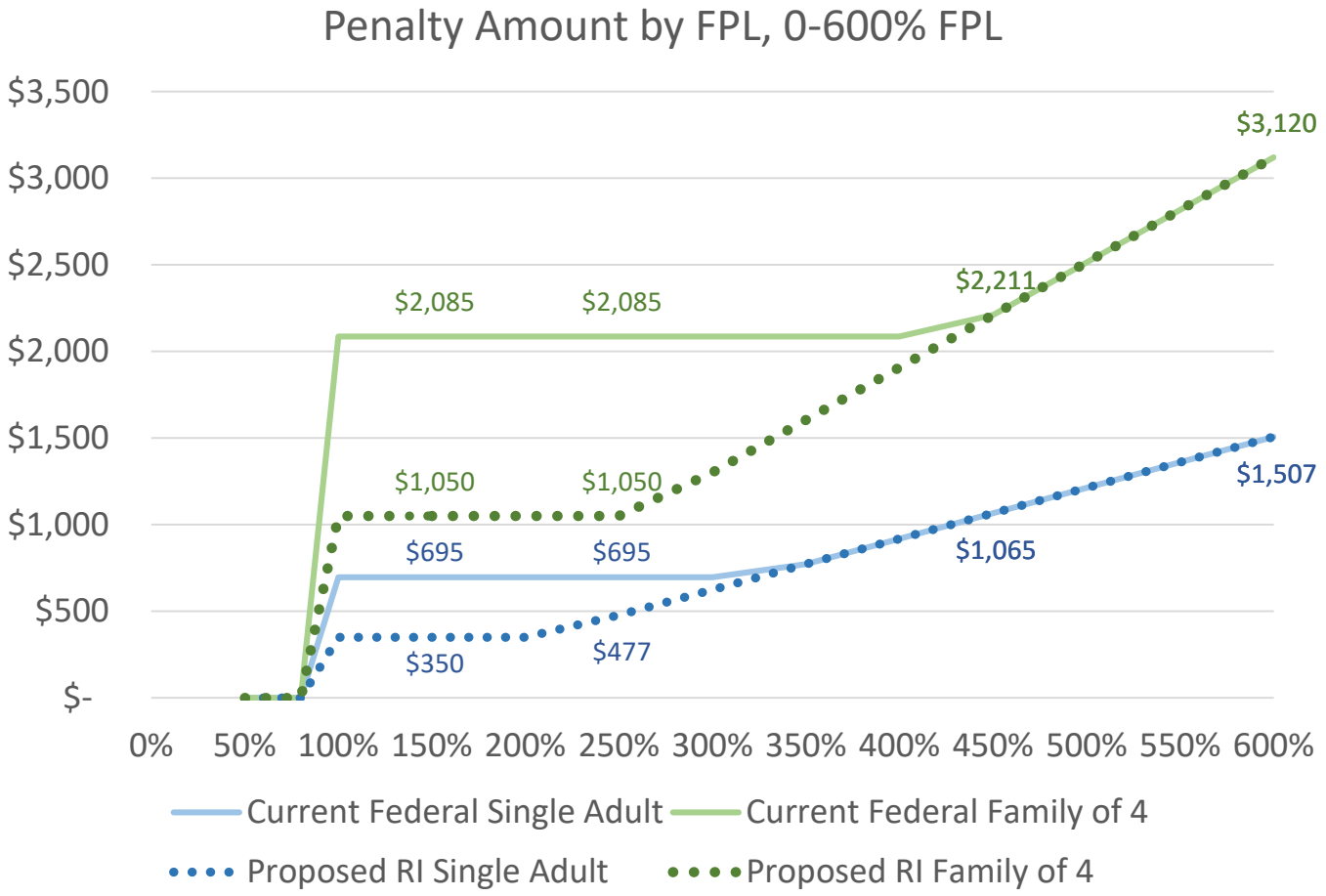
Payment by FPL: 2016 vs. Variation 1

	2016:	Variation 1:	Difference
Total SRP	$11.3 M	$9.6 M	-$1.7 M
Total Payments	16,777	13,784	-2,993
Average Payment	$672	$694	+$22

Share of 2016 Paid Amount by FPL



VARIATION 2: CUT FLAT PENALTY AMOUNT IN HALF



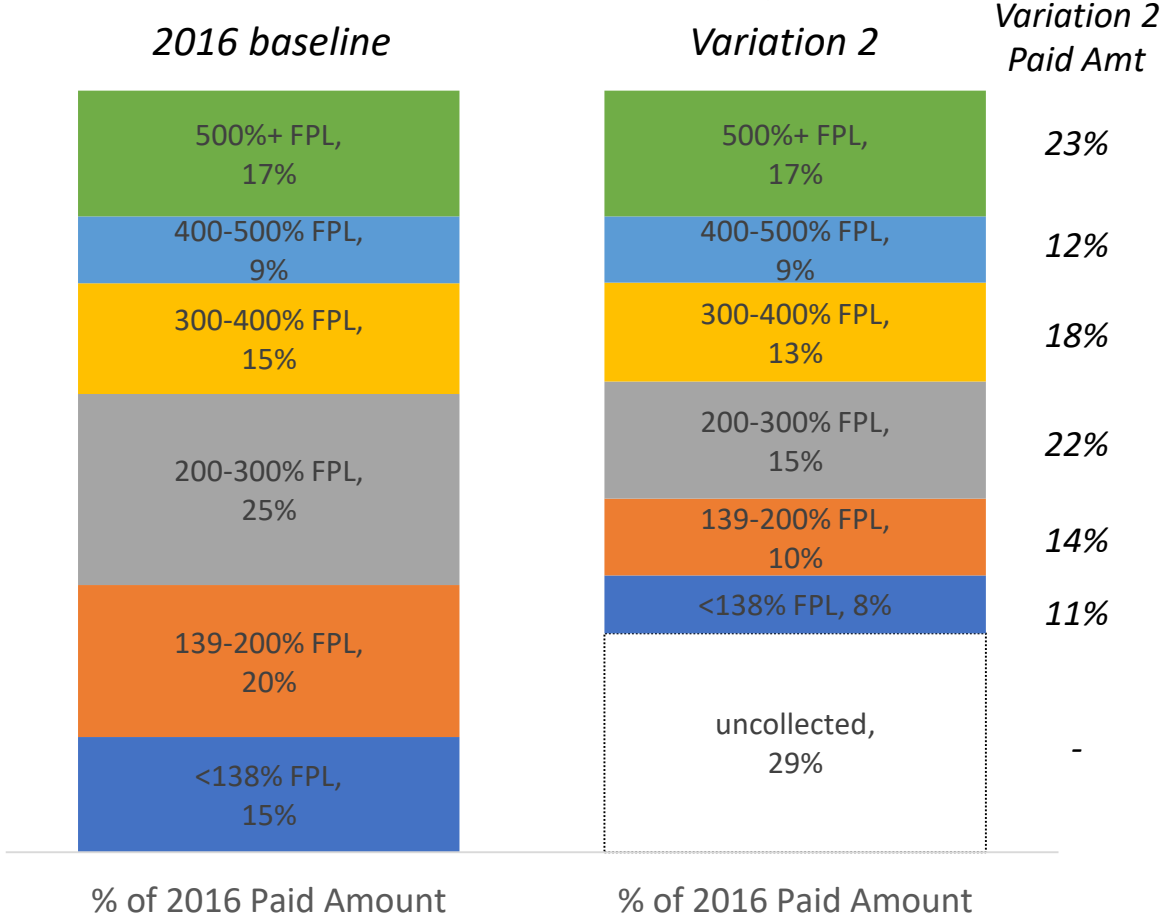
- Estimated revenue reduction of $3.3M
- Impact largest at lowest income ranges—aggregate 50+% reduction below 200% FPL
- Modification phases out as income increases—aggregate 30-44% reduction for 200%-300% FPL
- No impact above 450% FPL
- Could be “revenue neutral” if the percentage were also increased to 3.9%

VARIATION 2: CUT FLAT PENALTY AMOUNT IN HALF

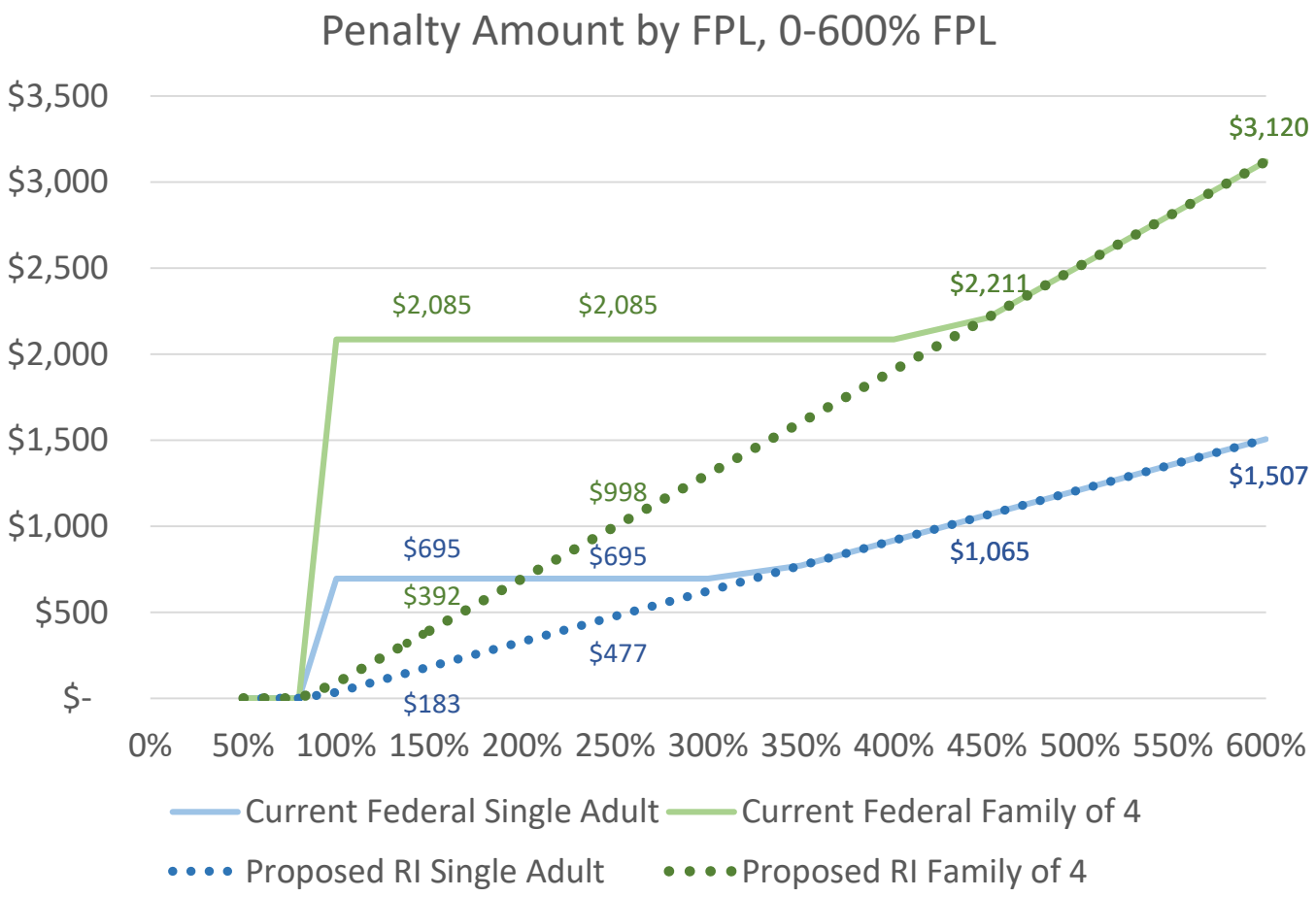
Payment by FPL: 2016 vs. Variation 2

	2016:	Variation 2:	Difference
Total SRP	$11.3 M	$8.1 M	-$3.3 M
Total Payments	16,777	16,777	-
Average Payment	$672	$479	-$193

Share of 2016 Paid Amount by FPL



VARIATION 3: REMOVE FLAT PENALTY AMOUNT



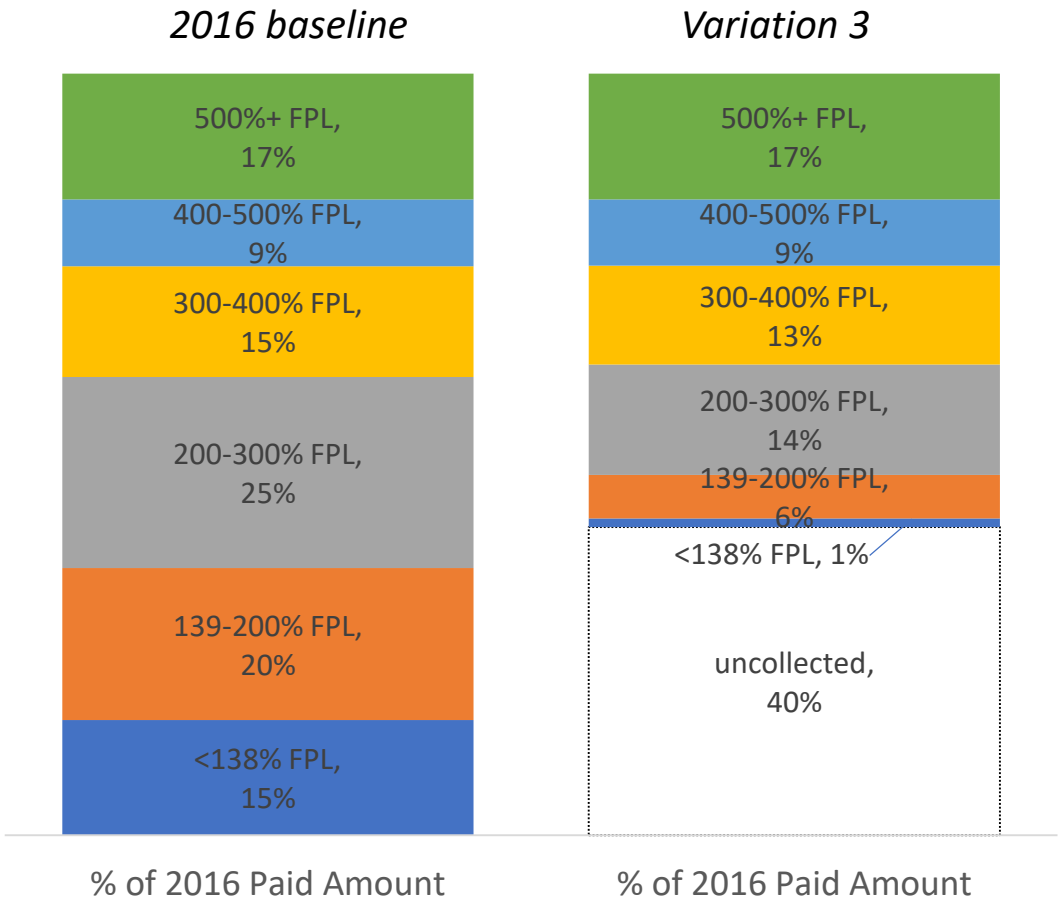
- Slightly simplifies filing process
- Estimated revenue reduction of $4.6M
- Impact largest at lowest income ranges—aggregate 80+% reduction below 150% FPL
- Modification phases out as income increases—aggregate 31-50% reduction for 200%-300% FPL
- No impact above 450% FPL
- Could be “revenue neutral” if the percentage were also increased to 4.25%

VARIATION 3: REMOVE FLAT PENALTY AMOUNT

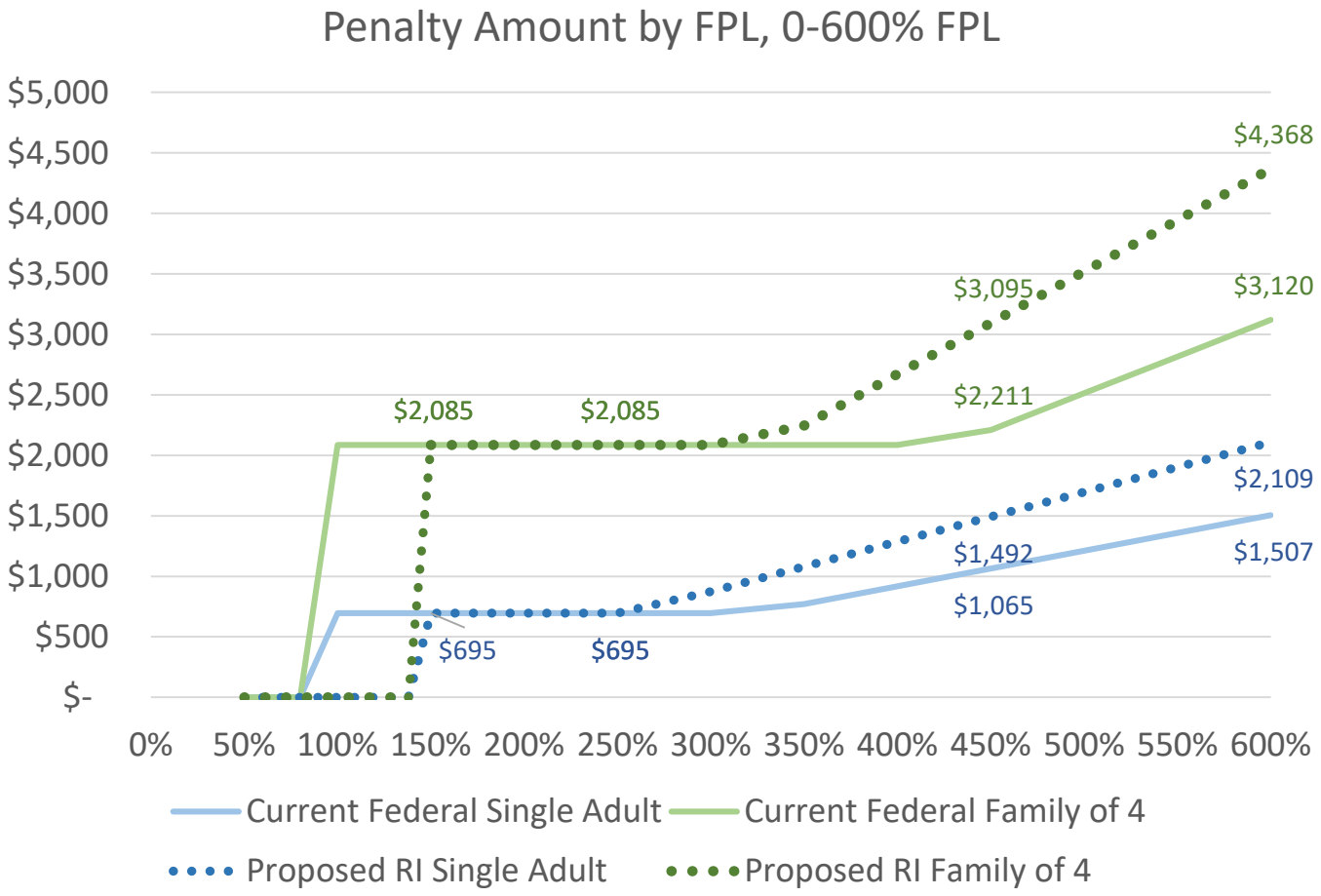
Payment by FPL: 2016 vs. Variation 3

	2016:	Variation 3:	Difference
Total SRP	$11.3 M	$6.7 M	-$4.6 M
Total Payments	16,777	16,777	-
Average Payment	$672	$400	-$272

Share of 2016 Paid Amount by FPL



VARIATION 4: EXEMPTION UNDER 138% FPL COMBINED WITH INCREASED INCOME PERCENTAGE TO 3.5%



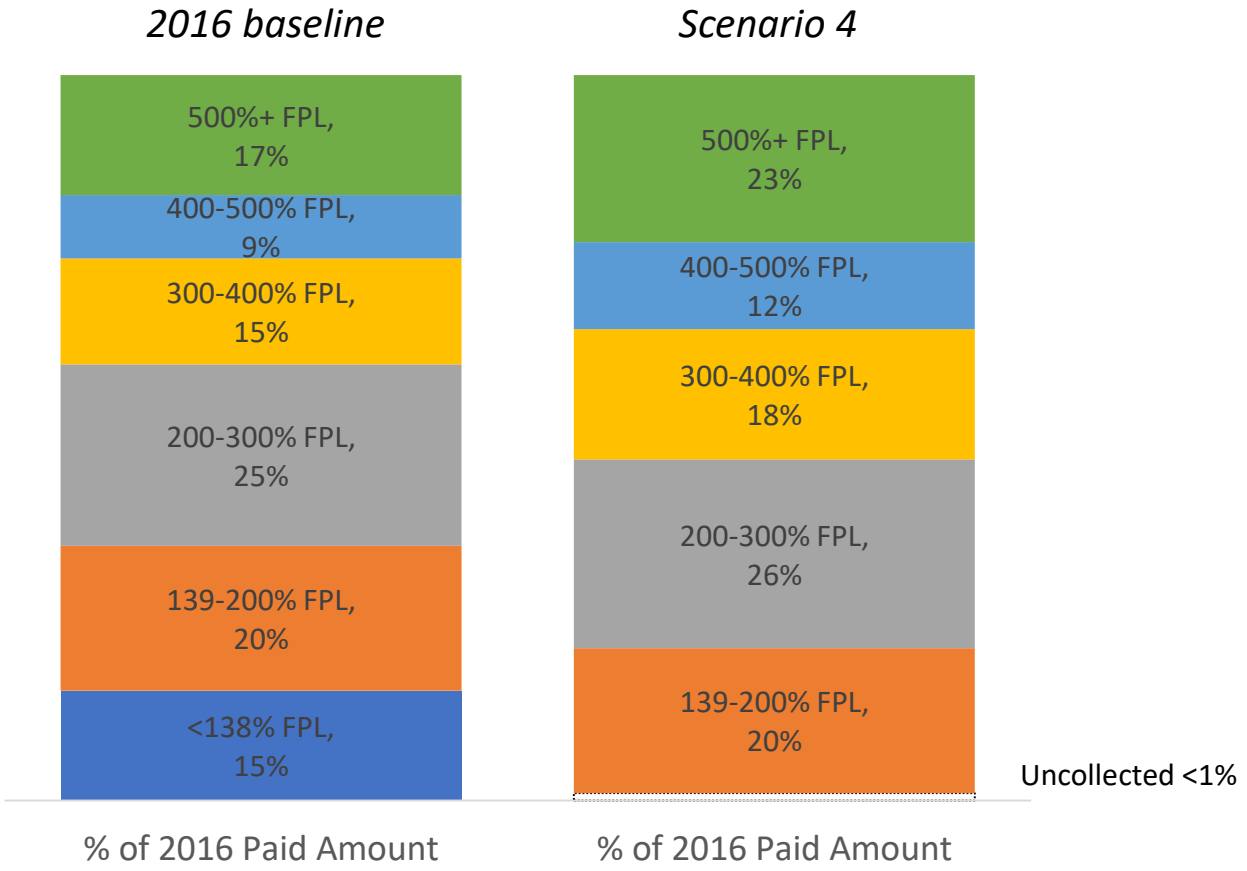
- Estimated revenue reduction of $0.1M
- Exemption matches Medicaid eligibility for most adults
- 100% reduction at lowest income ranges
- Increased penalty begins at 300% FPL and phases in fully by 450% FPL
- Penalty 40% higher for those above 450% FPL

VARIATION 4: EXEMPTION UNDER 138% FPL COMBINED WITH INCREASED INCOME PERCENTAGE TO 3.5%

Average Payment by FPL: 2016 vs. Scenario 4

	2016:	Scenario 4:	Difference
Total SRP	$11.3 M	$11.2 M	-$0.1 M
Total Payments	16,777	13,784	-2,993
Avg Payment	$672	$813	+$142

Share of 2016 Paid Amount by FPL



SUMMARY OF VARIATIONS + DISCUSSION

Variation	Revenue Change from $11.3M	Description
Use federal model	N/A	• No change
1. <138% Exemption	-$1.7M	• 100% reduction at lowest incomes (Medicaid level) • No impact above 138%
2. Half Flat Amount	-$3.3M	• Phased impact • 50+% reduction below 200% FPL • No impact above 450%
3. No Flat Amount	-$4.5M	• Phased impact • 80+% reduction below 150% FPL • No impact above 450%
4. <138% Exemption + increase to 3.5%	-$0.1	• 100% reduction at lowest incomes (Medicaid level) • Higher payments above 300% FPL

- Which options, if any, seem attractive to you?
- How do the options, including revenue impacts, fit in with other priorities for market stability?
  - reinsurance program funding and/or
  - additional affordability programs

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

NEXT STEPS AND UPCOMING MEETINGS

- What tradeoffs are worthwhile across the three areas identified as needing further work:
  - Funding source for reinsurance
  - Additional affordability programs
  - SRP modifications
- How to combine options into a workable package?
- What have we not covered that you need to be comfortable making recommendations?

PUBLIC COMMENT?

1332 WAIVER GUIDANCE UPDATES

- Name Change:
  - 1332 Waiver now known as “State Relief and Empowerment Waivers”
- Budget Neutrality:
  - Total impact must be budget neutral as opposed to each year
- Comprehensiveness and affordability shift:
  - Shift in focusing on covered lives to how many have **access** to affordable and comprehensive insurance
  - Could open door to STLD and AHPs being offered in marketplaces

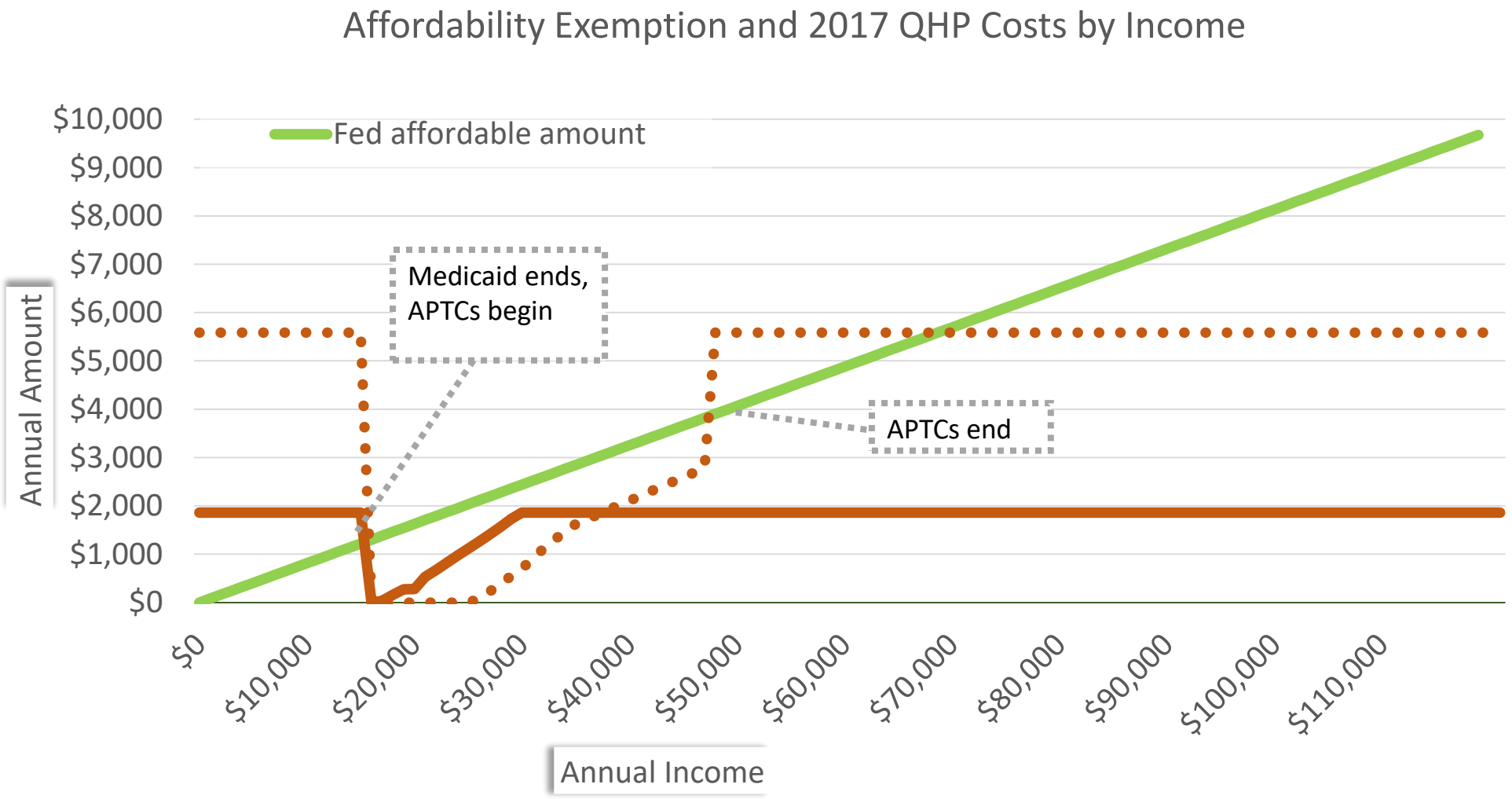
HRA RULE UPDATES

- Creates Two New HRAs
  - “Integrated HRA”
    - Funds used to purchase health insurance on the individual market
    - Not eligible for APTC if affordable; still susceptible to family glitch
    - Eligibility creates Special Enrollment Period
  - “Limited Excepted Benefits HRA”
    - Used to purchase limited plans: dental, vision, or long-term care benefits
    - Limited in scope; could be used for STLD plan purchase

Revenue model assumptions

- Makes assumptions about breakdown of children and adults in family
- Does not consider annual cap at national bronze premium
- Averages all filers that share both an FPL and household size category
- Estimates impact of a change on the 2016 revenue for the category as a whole
- 2016 has generally same structure as 2017 and 2018, but federal tax changes may have an impact
  - Forms revised for easier exemptions
  - 2017 Federal tax reform increased filing threshold
- Other factors, such as uninsured population, may change from 2016 to 2020+
- State implementation may not produce same results as federal implementation

FEDERAL AFFORDABILITY EXEMPTION



Definition of Coverage

- The federal definition of coverage that counts as satisfying the requirement to purchase health insurance is referred to as Minimum Essential Coverage (MEC)
- MEC includes:
  - Employer plans
  - Exchange plans
  - Medicare
  - Medicaid
  - Etc.
- When the federal penalty was set to $0, none of the related definitions and requirements were changed
  - MEC is still defined under federal law and would not require RI to define its own standard
- Because the federal definition of MEC is standardized across the country and does not require plan-by-plan review, it is simpler to retain the definition of MEC rather than creating a new definition specific to RI.

Current Federal Exemptions

Income Related Exemptions
Income is below the filing threshold
The cheapest available plan was unaffordable
Hardship Exemptions
You were homeless
You were evicted or were facing eviction or foreclosure
You received a shut-off notice from a utility company
You experienced domestic violence
You experienced the death of a family member
You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property
You filed for bankruptcy
You had medical expenses you couldn't pay that resulted in substantial debt
You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member
You claim a child as a tax dependent who's been denied coverage for Medicaid and CHIP for 2017, and another person is required by court order to give medical support to the child. In this case you don't have to pay the penalty for the child.
As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace in 2016
You had another hardship. If you experienced another hardship obtaining health insurance, describe your hardship and apply for an exemption.

Health Coverage-Related Exemptions
You were uninsured for less than 3 consecutive months of the year.
You lived in a state that didn't expand its Medicaid program and your household income was below 138% of the federal poverty level.
Group Membership Exemptions
You're a member of a federally recognized tribe or eligible for services through an Indian Health Services provider.
You're a member of a recognized health care sharing ministry.
You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare. Application required.
Other Exemptions
You're incarcerated (serving a term in prison or jail).
You're a U.S. citizen living abroad, a certain type of non-citizen, or not lawfully present.
A member of your tax household was born or adopted during the year. This exemption applies only to the month of the event and the month before. You can claim this exemption only if you're also claiming another exemption.
A member of your tax household died during the year. This exemption applies only to the month of the death and the month before. You can claim this exemption only if you're also claiming another exemption.

Hardship Exemptions (Not Relevant In RI)
You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid in 2017 under the Affordable Care Act
Your "grandfathered" individual insurance plan (a plan you've had since March 23, 2010 or before) was canceled because it doesn't meet the requirements of the Affordable Care Act and you believe other Marketplace plans are unaffordable

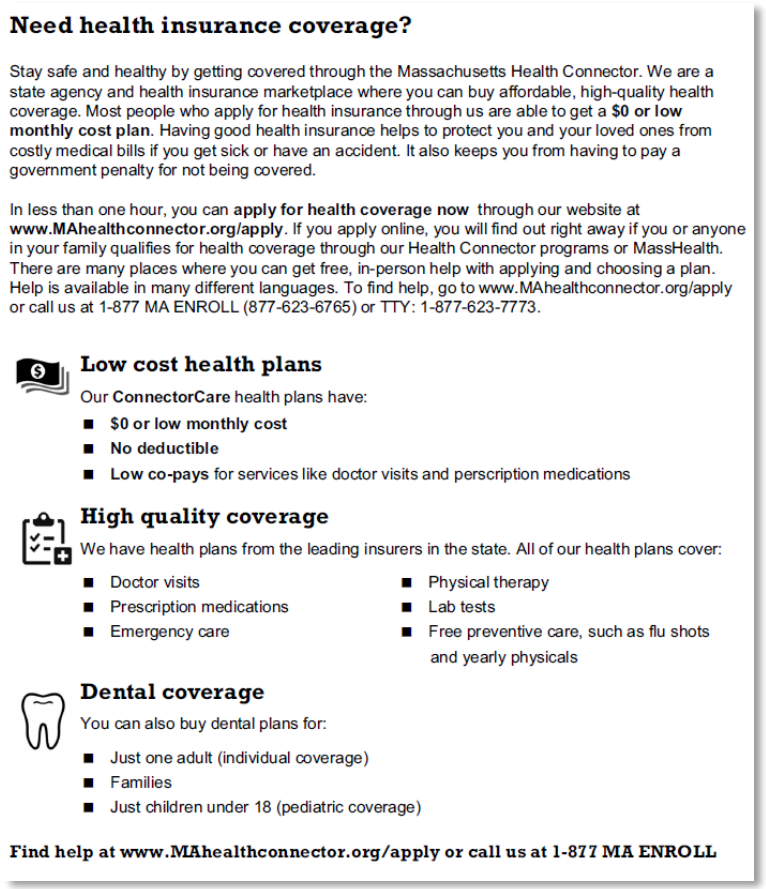
Required Reporting

- Employer and carrier reporting to currently in place to IRS and to covered subscriber (e.g. 1095 A, B, or C form)
- Retain this requirement to state tax authority to encourage compliance with state-level requirement

Outreach Uses of State Mandate

Administration of a state-level individual mandate has afforded Massachusetts the opportunity to analyze and use detailed administrative data on health insurance coverage of its residents.

- Analyses of state tax data has allowed the Health Connector to better understand the demographics of adult tax filers who remain without coverage. These insights have allowed us to further tailor our outreach and communications to the uninsured
- Starting in 2015, Massachusetts began sending direct mail to individual tax filers who reported being without MCC to provide them practical information about how to get coverage, allowing the ability to move from proxy-based general outreach to targeted outreach
- In December, the Commonwealth sent a mailing (see right) to ~129K residents who had reported full-year uninsurance during 2016



Need health insurance coverage?

Stay safe and healthy by getting covered through the Massachusetts Health Connector. We are a state agency and health insurance marketplace where you can buy affordable, high-quality health coverage. Most people who apply for health insurance through us are able to get a **$0 or low monthly cost plan**. Having good health insurance helps to protect you and your loved ones from costly medical bills if you get sick or have an accident. It also keeps you from having to pay a government penalty for not being covered.

In less than one hour, you can **apply for health coverage now** through our website at **www.MAhealthconnector.org/apply**. If you apply online, you will find out right away if you or anyone in your family qualifies for health coverage through our Health Connector programs or MassHealth. There are many places where you can get free, in-person help with applying and choosing a plan. Help is available in many different languages. To find help, go to www.MAhealthconnector.org/apply or call us at 1-877 MA ENROLL (877-623-6765) or TTY: 1-877-623-7773.

Low cost health plans

Our **ConnectorCare** health plans have:

- **$0 or low monthly cost**
- **No deductible**
- **Low co-pays** for services like doctor visits and perscription medications

High quality coverage

We have health plans from the leading insurers in the state. All of our health plans cover:

- Doctor visits
- Prescription medications
- Emergency care
- Physical therapy
- Lab tests
- Free preventive care, such as flu shots and yearly physicals

Dental coverage

You can also buy dental plans for:

- Just one adult (individual coverage)
- Families
- Just children under 18 (pediatric coverage)

Find help at www.MAhealthconnector.org/apply or call us at 1-877 MA ENROLL

2016 Federal Poverty Level (FPL) Chart

Household Size	138%	150%	250%	450%	600%
1	$16,243	$17,655	$29,425	$52,965	$70,620
4	$33,465	$36,375	$60,625	$109,125	$145,500

Market Stability Workgroup

Date of Meeting: November 13, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St Providence, RI 02909

Workgroup Members Present: Cristina Amedeo, Stephen Boyle, Liz McClaine (for David Burnett), Lauren Conway, Ralph Coppola, Marie Ganim (co-chair), Hon. Joshua Miller, Rich Glucksman (for Monica Neronha), Samuel Salganik, Lachen Chernyha (for John Simmons), Zachary Sherman (co-chair), Teresa Paiva-Weed

Workgroup Members Absent: Marc Backon, Al Charbonneau, Hon. Gayle Goldin, Jane Hayward, Peter Hollmann, Janet Raymond, Susan Storti, Larry Warner, Bill Wray

Minutes

I. Meeting was called to order at 8:40 am.

a. The minutes of the October 31, 2018 meeting were approved with the following change: Stephen Boyle and Janet Raymond were inadvertently listed as both "present" and "absent." The minutes were updated to reflect that they were both absent.
b. Follow-ups from previous meeting – Director Sherman spoke on the following items from meeting 3:
    i. The 1332 waiver guidance released a few days prior to the October 31 meeting removed the requirement that state legislatures authorize the pursuit of 1332 waivers. Zach thanked the Workgroup for their hard work in securing this authorization in June when it was still a requirement. The guidance also changed federal budget neutrality requirements for 1332 waivers.
    ii. The proposed health reimbursement arrangement (HRA) rules also released shortly before the October 31 meeting would allow employers to invest tax free in HRAs for their employees which the employees could then use to purchase individual market coverage.
    iii. Summaries of both of these were included in this meeting's materials.
c. Commissioner Ganim reviewed the Workgroup syllabus.
d. Commissioner Ganim then reviewed the agenda for today's meeting within the context of the Workgroup's previous recommendations, goals, and guiding principles.

II. Review federal individual shared responsibility payments

a. John Cucco, Director of Strategy for HealthSource RI, presented to the workgroup on the structure of the federal shared responsibility requirement or "individual mandate."
    i. John began with the Workgroup's recommendation from June – "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…. Rhode Island should focus next on how to fund a state reinsurance program and how to best design and implement a shared responsibility requirement."

ii. He next reminded the Workgroup how a shared responsibility requirement supports market stability by incentivizing consumers who are healthy to buy insurance, thus supporting the risk pool. He showed data from Massachusetts which implemented its shared responsibility requirement prior to the enactment of the ACA – when it took effect, Mass. saw a spike in enrollment, disproportionately high among healthy populations. He also showed that both Rhode Island and the nation saw a big decline in the uninsured rate among the population earning above 400% FPL – and therefore not eligible for/incentivized by subsidies – when the ACA mandate took effect.

iii. Referring back to the previous round of Workgroup meetings this spring, John focused the discussion today on two specific components of a shared responsibility requirement: affordability exemptions and penalty structure.

Sam Salganik said that Rhode Island is the only state that allows the hardship exemption of the ACA's individual mandate to apply to serious technological problems, i.e. state technology systems creating a barrier to insurance enrollment. He said it was important to make sure statutory language granted the authority to make hardship exemptions. John noted that most of the federal hardship exemptions were established through regulation; a state statute for a shared responsibility requirement would establish appropriate regulatory authority over exemptions at the state level.

Teresa Paiva Weed expressed concern that granting "regulatory authority" in a state statute might be too broad. She understood the importance of allowing for hardship exemptions but pointed out that who promulgates regulations today is not necessarily who will do so in the future. Director Sherman acknowledged that the ACA law did not spell out specific hardship exemptions but that these were further defined in regulations.

iv. John continued with the structure of the federal penalty – not having qualifying health insurance for more than 2 months out of the year carries a penalty of $695 or 2.5% of household income, whichever is greater. He noted again the hardship exemptions, and also that the penalty did not apply to anyone who did not meet the federal income tax filing threshold, currently around $10,000.

Sam noted that federal tax reform law passed in 2018 would raise the filing threshold.

b. Impact of federal shared responsibility payments - John showed data from the 2016 tax year, the most recent year where data is available. About 16,700 tax filers in Rhode Island paid a combined $11.3 million in shared responsibility payments that year. The average payment was $672. He showed payments by income level and noted that while 60% of the amount of penalty paid came from the segment below 300% of FPL, with 74% coming from the segment under 400% FPL, only 35% of penalty revenue came from the group under 200% FPL, but this same group makes up approximately 56% of the uninsured population. The penalty itself is progressive, and less burdensome on lower income populations than expected when considering the uninsured rate. John also showed charts comparing the penalty amount to the cost of insurance for different populations.

III. Variations for consideration of a shared responsibility payment at the state level

a. Alternative state-based options: The RI Department of Revenue and Division of Taxation worked with HSRI to model four alternative versions of a state-based shared responsibility requirement based on the available 2016 numbers.

i. Variation 1: Exemption from the shared responsibility penalty under 138% of FPL. This is the level of Medicaid eligibility for most adults. John noted that penalizing Medicaid-eligible uninsured does not help individual market stability since that population would not be in the individual market. This exemption would reduce estimated revenue collected by $1.7 million.

Sam noted that the filing threshold being raised as he had mentioned could also reduce the revenue collected somewhat.

ii. Variation 2: Cut the flat penalty amount of $695 in half to $350. This would have the largest impact on lower income ranges and phases out as you climb the income scale. There would be no impact above 450% FPL. This variation would reduce revenue collected from the penalty by an estimated $3.3 million – from $11.3 million to $8.1 million, a difference of 29%.

Rich Glucksman asked if any of this modeling took into account the impact of the changed penalty on consumers' decision to buy insurance. John replied that this was not taken into account.

Sam said that his experience with consumers showed that people can relate to and better understand the flat dollar amount penalty vs. the percentage, and that messaging around the penalty amount would be important. Steve Boyle added that when the ACA penalties first took effect they were smaller and less likely to impact decision-making, but when they increased to $695 or 2.5% of income it had more of an impact –

it is important to consider the effect of cutting the penalty on driving enrollment.

Ralph Coppola asked what the "optimal amount" of penalty was to impact enrollment. John answered that this was a difficult question and that as yet there was no analysis available. Ralph then suggested taking the penalty paid by the uninsured and just giving them a bronze plan. Director Sherman noted that there would have to be some consent from the consumer, and Sam said that auto-enrollment has proved technically challenging in terms of keeping enrollee data up to date.

iii. Variation 3: Remove the flat penalty amount. John noted that this would make the process simpler as well as significantly reduce the penalty paid at the lowest income levels. This variation would reduce estimated revenue collected by $4.6 million – from $11.3 million to $6.7 million, a reduction of 40%.

Commissioner Ganim said that a potential impact of getting rid of the flat penalty might be people deciding to drop their insurance.

iv. Variation 4: Penalty exemption under 138% of FPL, combined with an increase in the income percentage penalty to 3.5%. John noted that this would be roughly "revenue neutral" relative to the previously presented 2016 baseline. The penalty paid by the lowest income population would be eliminated and made up for with penalties on higher incomes. Penalties collected on incomes above 450% of FPL would increase 40%.

Sam said it was important to note that all of these scenarios in fact represented gains in revenue to the state. Director Sherman said this was a fair point but that the intent was to show the change in the burden on the taxpayer, and available revenue for implementation of affordability programs.

b. The Workgroup discussed potential impacts of state-based alternatives.
Ralph asked what do we need to do to induce young people to buy insurance? Sam said that the penalty is relevant to decisions making, but also noted that young enrollees are subsidizing older enrollees to some extent. Sam added that messaging, marketing, and outreach were also very important in driving enrollment and that we should be thoughtful of the cost of making sure people know that a penalty is in place, whatever it may be.

IV. Consideration of variations in context of market stability recommendations and guiding principles

Steve Boyle said that bottom line is identifying a funding source for a state reinsurance program and that the closer a state shared responsibility payment is to

the existing ACA individual mandate the less we have to look for alternative funding sources.

Sam disagreed, saying that it was not only about funding reinsurance but about crafting a suite of policy proposals to support market stability.

Teresa said she agreed with Steve, that her understanding was that the Workgroup's goal was to work out details of the previously made recommendations – not that she wouldn't support affordability programs, but she felt it was important to hew closely to the ACA model, supporting and protecting market stability and responding to federal actions. She added that it was important to clearly define the Workgroup's objectives here.

John Cucco said that there were clear tradeoffs. A reduced shared responsibility penalty may be attractive, but it came with less revenue collected and possible impacts on consumer decision making. Choices would have to be made as to the size and scope of a reinsurance program.

Ralph asked if what we have has been working, why change it?

Sam said that the change was that a state-based mandate would create state revenue, and decisions would have to be made by the state as to how to use that revenue to support the health insurance market. He said that the amount of revenue raised by the current mandate penalty being close to the cost of funding a reinsurance program as proposed was a coincidence, that the mandate itself supports the individual market, and that it was not wise to have ¾ of the penalty revenue collected coming from consumers eligible for tax credits.

Teresa said that those are the people who are paying now, that the purpose of the Workgroup was to stabilize the market for the unsubsidized consumer population and address recent changes at the federal level.

Sam said based on the Workgroup's guiding principles a good case could be made that additional affordability programs achieve similar goals.

Steve said that while we may want to help every group, not establishing and funding a reinsurance program would hurt everyone. Ralph agreed.

Lauren Conway also voiced agreement with staying close to the federal model but added that she struggled with assessing a penalty on the population earning less than 138% of FPL since they are not contributing to the individual market anyway. She said she would lean toward variation 1 as presented. She also spoke to the importance of educating the under-138% FPL population as to their eligibility for Medicaid. Zach noted this and Sam's comments from earlier and agreed that public outreach and education campaign would be an important component of any policy changes.

Zach then asked if there were any options Workgroup members felt could be taken off the table, or any options that had not been represented that they would like to see.

Sam said that the question for him is where the money will be spent, that it was impossible for him to say in a vacuum which is the right model without more information. He asked when actuaries would be available. Zach replied that he was hopeful that actuaries would be available to speak to the Workgroup at meeting 6, but he cautioned at expecting too much from the actuaries, that they would likely not be able to provide answers as to how to best design a shared responsibility requirement/penalty.

Teresa asked what the impact would be on Medicaid enrollment if the penalty on that population were eliminated. Director Sherman said there wouldn't be a negative impact on the individual market risk pool, since that population is not eligible for individual market insurance, but the risk is that they would become uninsured altogether.

Teresa said that all of the insurers agreed that the subsidies were an incentive to enroll but that the mandate was not. Commissioner Ganim replied that while statements were made that the penalty may not have had as big of an impact as the mandate, OHIC approved Neighborhood Health Plan's 2019 premium rate increases, 2% of which was based on the mandate being eliminated.

V. Next steps and upcoming meetings

a. Director Sherman asked the group what they would like to see as they work out how to combine different options.

Liz McClaine asked if there was any data available from other states showing the impact of their state-based shared responsibility requirements. John said the only other state implementing a requirement was New Jersey and that it would not take effect until 2019. Director Sherman noted that Massachusetts, which had instituted a requirement prior to the ACA, has the lowest premiums in the country for 2019. Sam added that Massachusetts also offers additional subsidies beyond those available under the ACA.

Teresa said that Massachusetts also had systems in place to cross-check employers and assess penalties on them.

VI. Public Comment

a. Karen Malcolm of Protect Our Healthcare Coalition said, in response to Senator Paiva Weed earlier questioning "why change?" that a response from the community would be that it seems to be unreasonable to put a penalty burden on low-income populations, particularly those at 138% FPL and below, and we have an opportunity to do better, to take a look at the federal model and, as a state, do a

better job. She asked, what is the group that can afford to purchase insurance but isn't participating? Eliminating the penalty below 138% FPL and maybe adjusting the percentage of income penalty might make sense. She said she agreed with adopting rules around hardship exemptions, and she said her experience in the community has shown that young adults referred to as "young invincibles" also tend to be thought of as economically invincible, but they face a very high burden of student loan debt.

VII. Adjourn – meeting adjourned at 10:32 AM.

Market Stability Workgroup

Notice Posted: November 21, 2018
Date of Meeting: November 27, 2018
Meeting Time: 8:30 AM
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Agenda

I. Call meeting to order
   a. Motion to approve November 13, 2018 meeting minutes
   b. Edit to meeting schedule
   c. Review agenda
II. Follow-ups from previous meetings
III. Review of Objectives of this Workgroup
IV. Variations for Consideration:
   a. Presentation of potential combinations for final recommendation package
V. Next Steps and Upcoming Meetings
   a. Next meeting is December 11, 2018, 8:30am, at United Way
VI. Public comment
VII. Adjourn

United Way of Rhode Island is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Jonelie Cardoza at 401.462.6428 or email her at jonelie.cardoza@ohic.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP 2.0

Meeting #5

Tuesday, November 27, 2018
8:30 – 10:30 a.m.
The United Way of Rhode Island

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

Topic(s) for Discussion	Meeting Date
Break for the holidays	Mid-December – early January
Meeting 8 **Possible Codification of ACA Consumer and Market Protections**	Tuesday, January 8th
Meeting 9 **Legislative Recommendations**	Tuesday, January 22nd
Meeting 10 **Legislative Recommendations (*reserved if needed*)**	Tuesday, February 5th

TODAY'S AGENDA

1. Follow-up Items from Previous Meetings
2. Review Workgroup Objectives
3. Packages of Options

FOLLOW-UP ITEMS FROM PREVIOUS MEETINGS

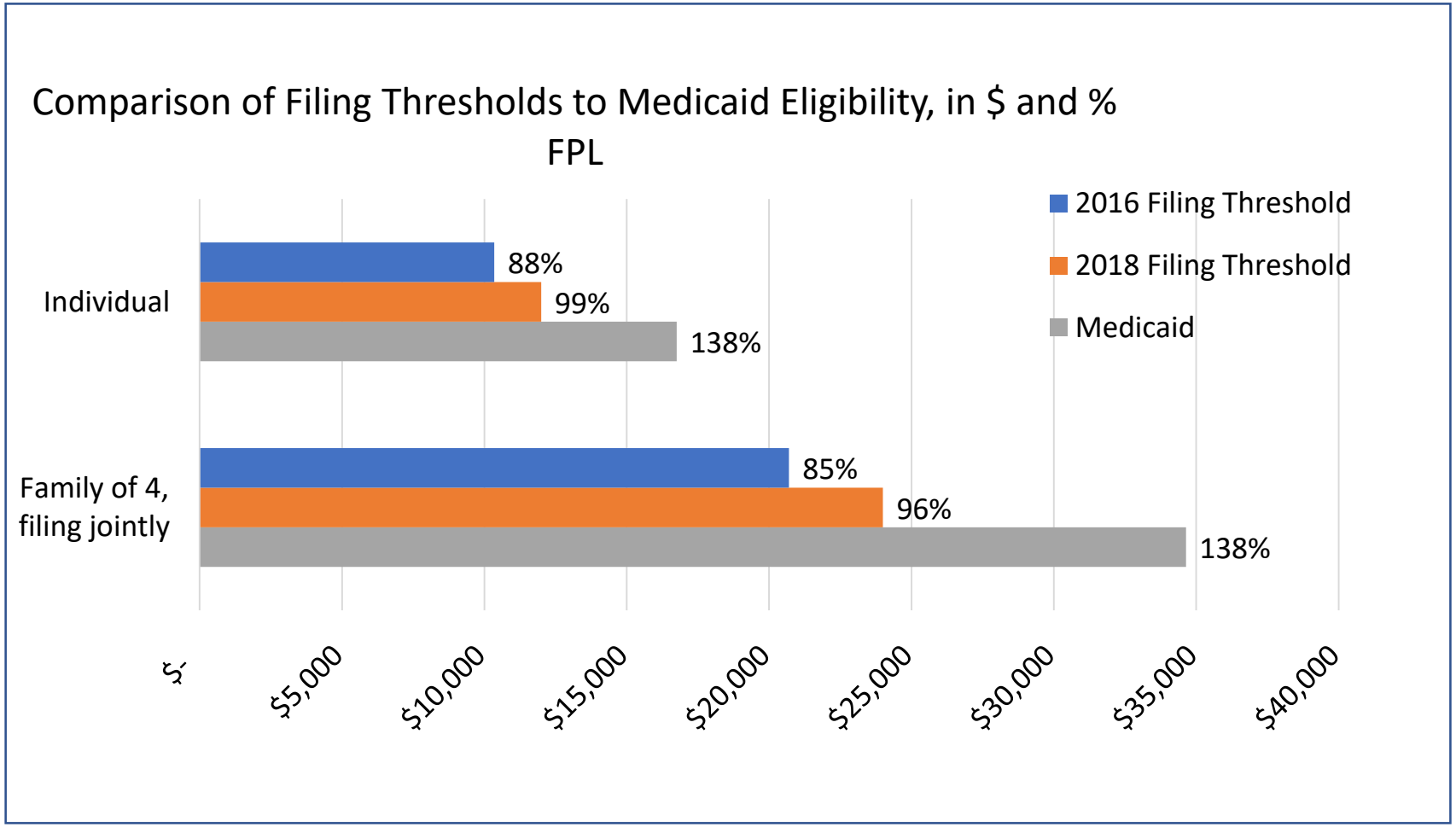
1. **Effect of Change of Federal Tax Filing Threshold on Medicaid Eligible Population**

2. **Existing Insurance Taxes and Fees**

3. **Premium Tax – All lines of Insurance**

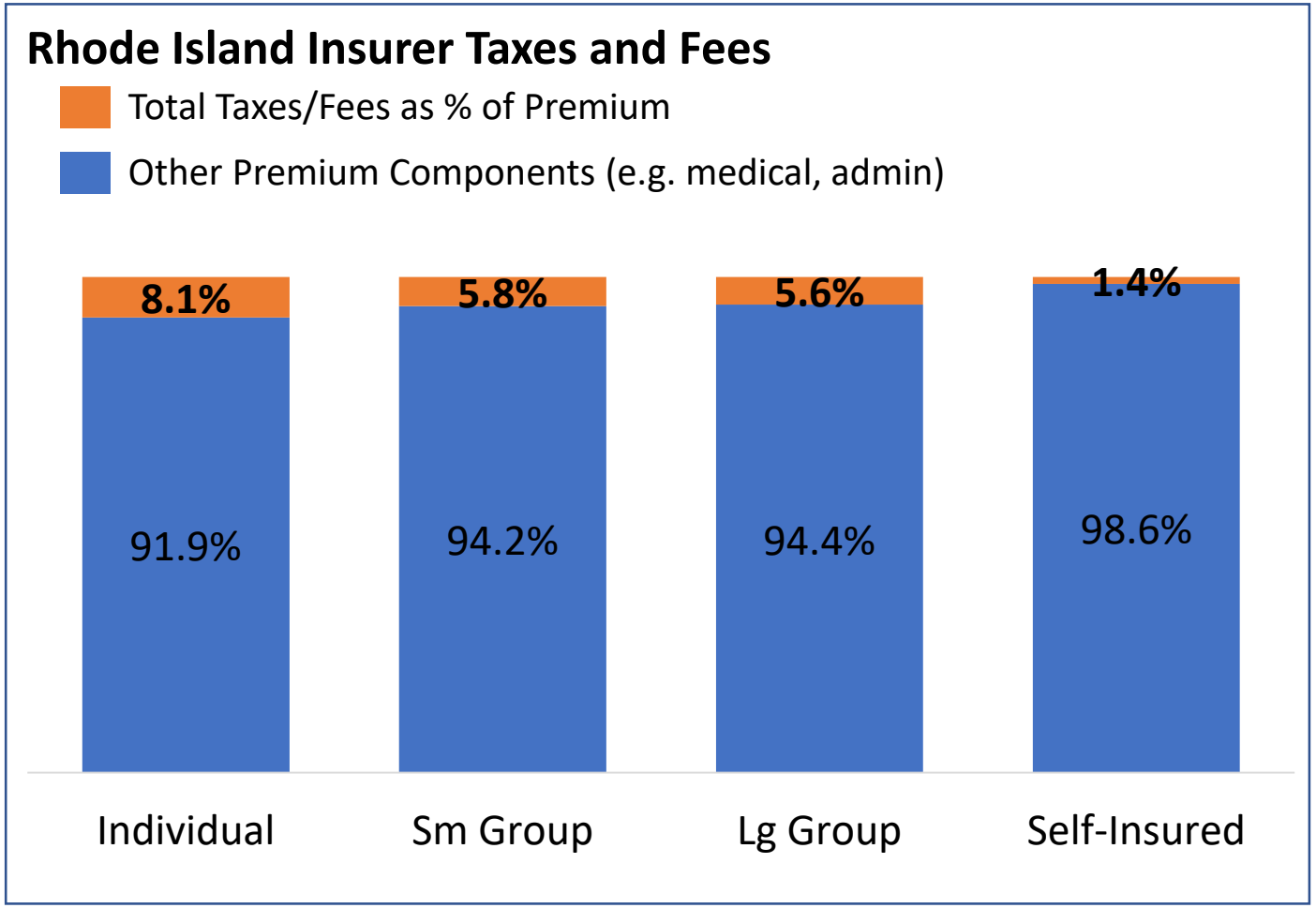
FOLLOW-UP ITEMS

How does the updated tax filing threshold compare from 2016 to 2018?



FOLLOW-UP ITEMS

What taxes and fees are health insurers currently paying?



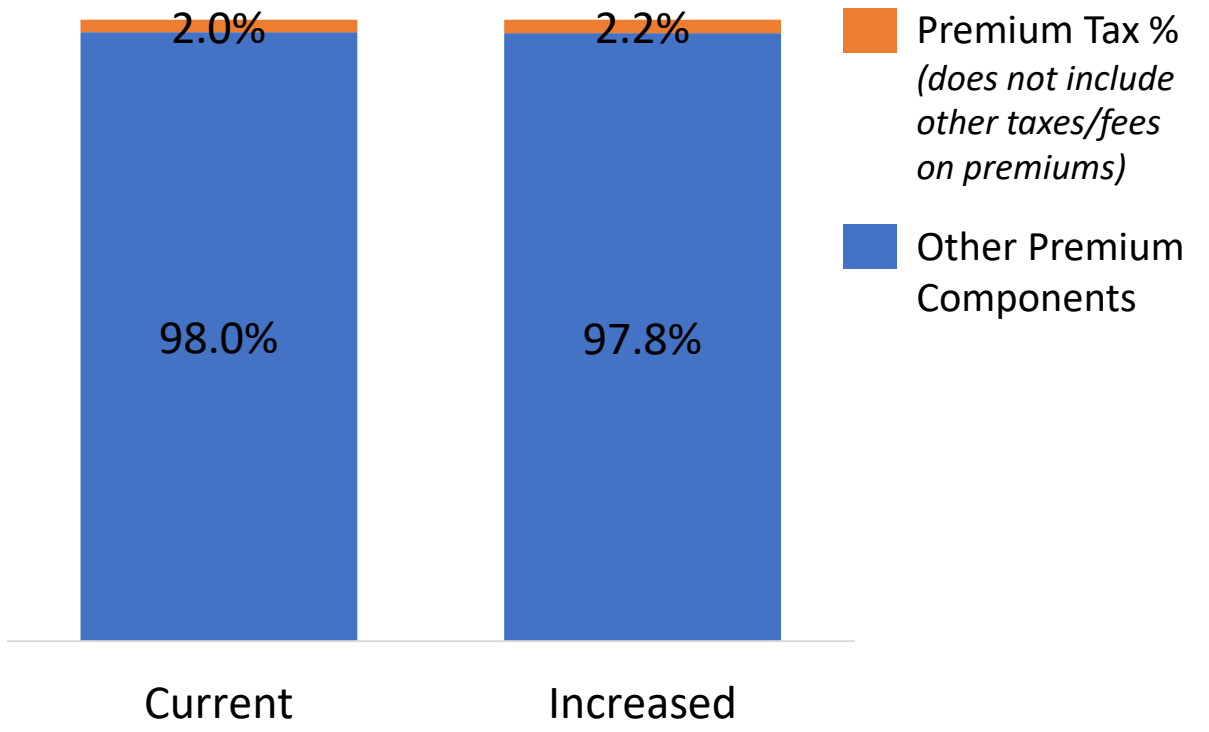
Healthcare Services Funding Contribution *(all)*	• Immunization Assessment $16.35 PMPM (children), $3.03 (adults) • Children's Health Account Assessment $8.23 PMPM (children only) • 1.3-1.4% of premium for both assessments
ACA Heath Insurer Tax (HIT) *(all fully insured)*	• Suspended for 2019. • Estimated at 2.2% for 2020 by Oliver Wyman
Premium Tax *(all fully insured)*	• 2% on fully insured plans
HSRI Fee *(Ind/Sm Gp only)*	• 3.5% of premium weighted by on-exchange enrollment • 2.53% of Individual Market and 0.34% of Small Group after weighting by exchange enrollment (avg across plans)

FOLLOW-UP ITEMS

What increase to the RI insurance premium tax would be required to fund Reinsurance?

Rhode Island Insurance Premium Tax

All lines of business (property/casualty, life/health)



Assumptions:

- 2% of premium currently charged for all insurance written in state, $126 M collected
- $11 M needed for 10% reinsurance program

Raising $11 Million in additional premium tax revenue would require an increase from 2% to 2.2% of premium

This would NOT include self insured market

Source: Q1 Revenue Estimating Conference - Table 3 - November 2018 Results

RECONVENING THE RI MARKET STABILITY WORKGROUP

The objectives for our work ahead include forming recommendations for policymaker's consideration, including:

- A method (or methods) for funding the RI Reinsurance Program;
- Whether RI should pursue other initiatives to address health coverage affordability and, if so, what programs;
- Aspects of design and implementation for a state-level shared responsibility requirement; and
- A package of consumer and/or market-based protections for codification in RI law.

The final work product may take the form of draft budget article language and/or legislative language, accompanied by an executive summary.

OBJECTIVES - OVERVIEW

Shared Responsibility Payment

- Design and implementation strategy

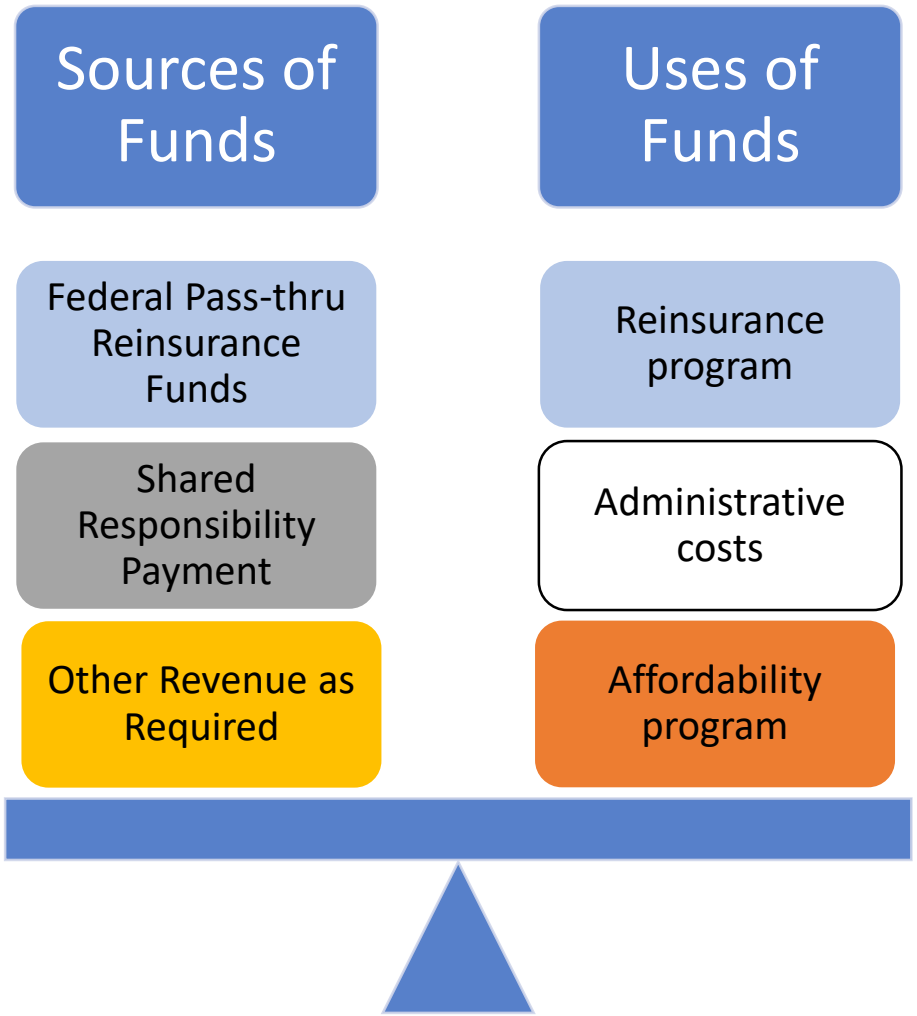
RI Reinsurance Program

- Recommend funding source(s)

Additional Affordability Programs

- What programs, if any, are recommended?

OVERVIEW OF OPTIONS



- Balanced combinations of **Sources of Funds** and **Uses of Funds**
- Goal is to **illustrate tradeoffs required** to achieve market stability objectives

COMPONENTS OF POTENTIAL OPTIONS

Reinsurance Program

- **Three Scenarios:** 10%, 8%, and 5%
- **Use of Funds:** Total cost of Targeted reduction in Individual Market premium
- **Source of Funds:** Federal pass-thru funding shown as a source of funds

Shared Responsibility Payment

- **Three Scenarios**
  - Federal structure
  - <138% FPL exempt
  - Cut flat penalty in half
- **Source of Funds:** Estimated penalty collected for each scenario

Affordability Programs

- **Use of Funds:** Analysis based on Young Adult Tax Credit (YATC) affordability option
- **Two Scenarios:** funding YATC or not funding YATC
- Other programs discussed would require higher funding

Other Revenue Sources

- **Source of Funds:** Makes up difference in sources/uses by option
- Modeled as needed by option
- Options include premium assessment or state general revenue

OVERVIEW OF OPTIONS: KEY POLICY CHOICES

Option	Reinsurance Target	SRP Model	Added Affordability?	Added Revenue Needed?
1	10%	Fed Model	**Yes**	Yes
2			No	
3		<138 Exempt	**Yes**	
4			No	
5		1/2 Flat Penalty	**Yes**	
6			No	
7	8%	Fed Model	**Yes**	Yes
8			No	**None**
9		<138 Exempt	**Yes**	Yes
10			No	**None**
11		1/2 Flat Penalty	**Yes**	Yes
12			No	Yes
13	5%	Fed Model	**Yes**	**None**
14			No	**None**
15		<138 Exempt	**Yes**	Yes
16			No	**None**
17		1/2 Flat Penalty	**Yes**	Yes
18			No	**None**

SELECTED OPTIONS

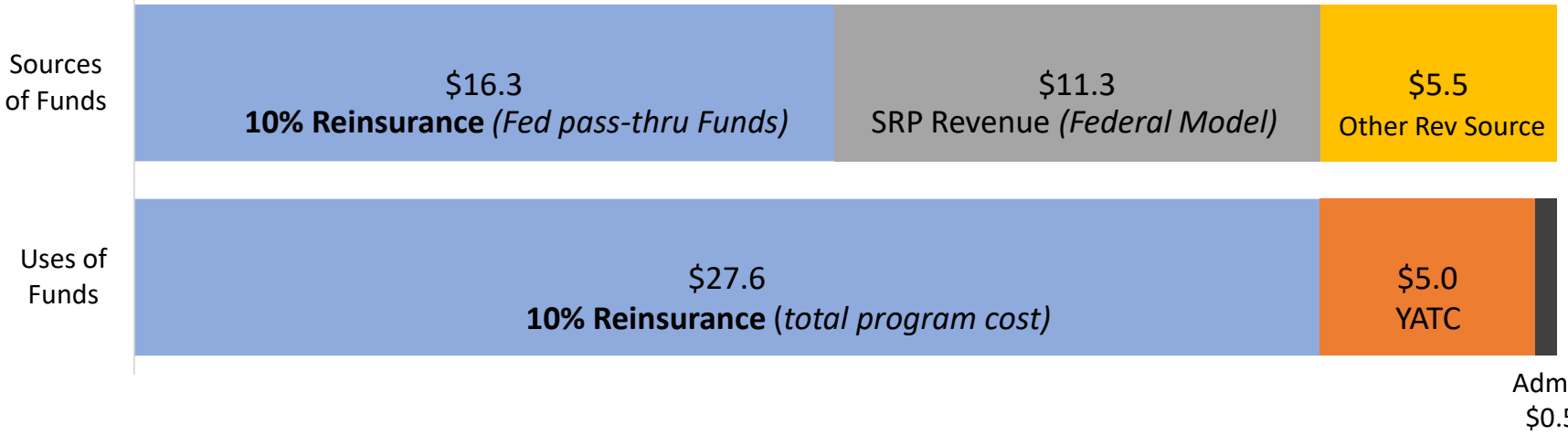
Selected range of combinations to best illustrate tradeoffs for discussion.

	Policy Choice			Use of Funds $M				Source of Funds $M				
Option	Reinsurance Target	SRP Model	YATC?	Reinsurance	YATC	Admin	Excess Funds	Federal Pass-thru Reins Funds	SRP	Other Rev Source	Total Funds	*% Fed Funds*
1	10%	Fed Model	Yes	$27.6	$5.0	$0.5		$16.3	$11.3	$5.5	**$33.1**	*49%*
2	10%	Fed Model	No	$27.6		$0.5		$16.3	$11.3	$0.5	**$28.1**	*58%*
10	8%	<138 Exempt	No	$22.1		$0.5	$0.1	$13.1	$9.6	**None**	**$22.7**	*58%*
11	8%	1/2 Flat Penalty	Yes	$22.1	$5.0	$0.5		$13.1	$8.1	$6.4	**$27.6**	*47%*
13	5%	Fed Model	Yes	$13.8	$5.0	$0.5	$0.2	$8.2	$11.3	**None**	**$19.5**	*42%*
15	5%	<138 Exempt	Yes	$13.8	$5.0	$0.5		$8.2	$9.6	$1.5	**$19.3**	*42%*

OPTIONS FOR 10% REINSURANCE PROGRAM

Option 1: Total Funds = $33.1 M

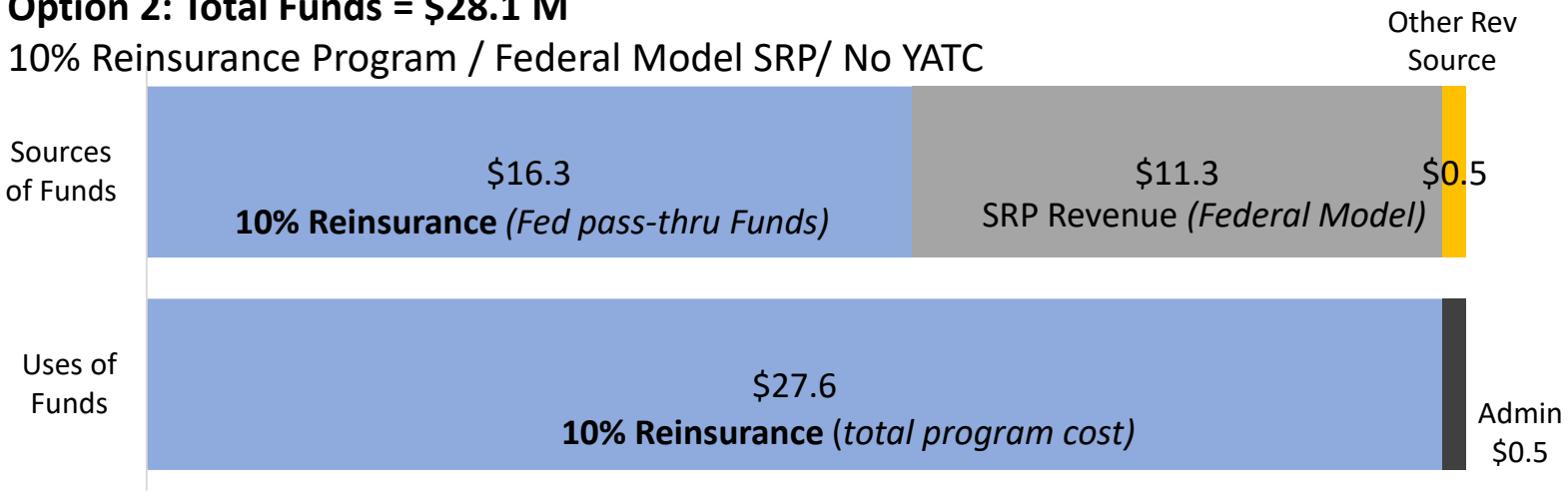
10% Reinsurance Program/ Federal Model SRP/ YATC



- Other Revenue Req'd: $5.5 M
- SRP: Federal model
- Other Affordability Programs: Fund Young adult tax credit (YATC)

Option 2: Total Funds = $28.1 M

10% Reinsurance Program / Federal Model SRP/ No YATC

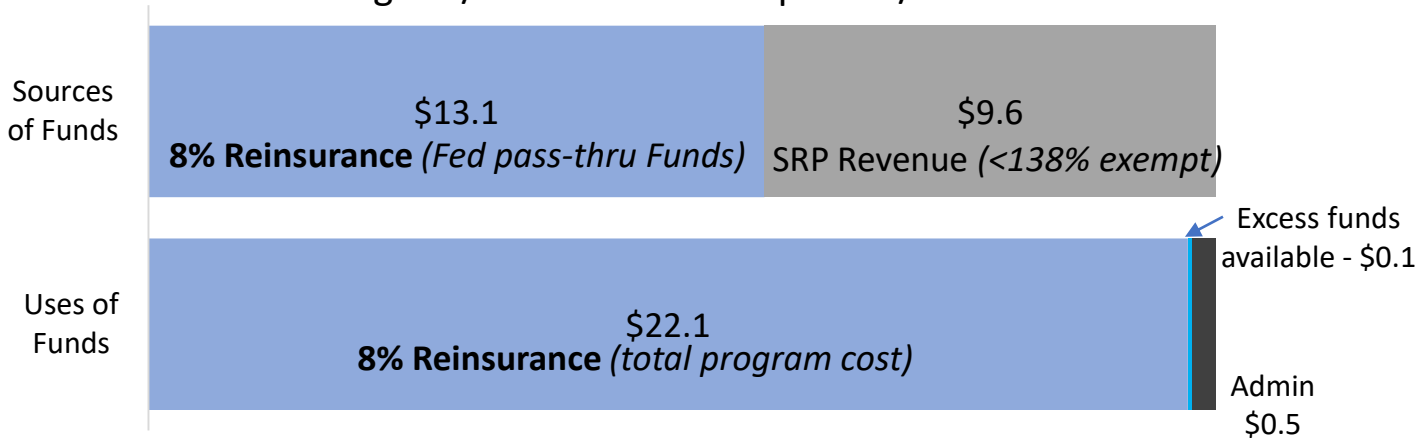


- Other Revenue Req'd: $0.5 M
- SRP: Federal model
- Other Affordability Programs: NONE

OPTIONS FOR 8% REINSURANCE PROGRAM

Option 3: Total Funds = $22.7 M

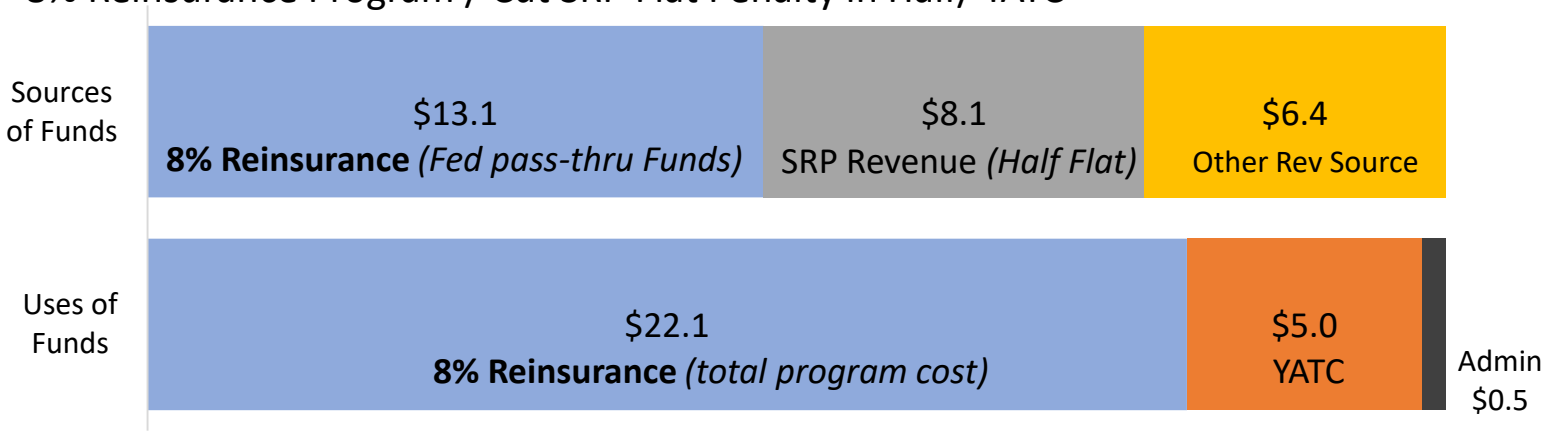
8% Reinsurance Program/ <138% FPL Exempt SRP /No YATC



- Other Revenue Required: NONE
- SRP: Under 138% FPL exempt
- Other Affordability Programs: NONE
- Excess funds of $0.1 M may be available

Option 4: Total Funds = $27.6 M

8% Reinsurance Program / Cut SRP Flat Penalty in Half/ YATC

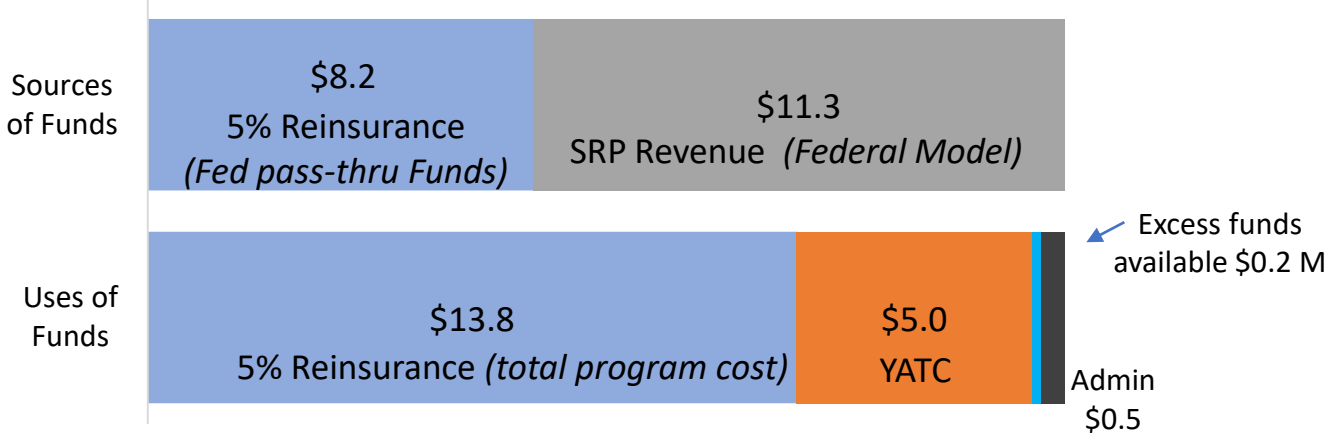


- Other Revenue Req'd: $6.4 M
- SRP: Flat penalty cut in half
- Other Affordability Programs: Fund Young adult tax credit (YATC)

OPTIONS FOR 5% REINSURANCE PROGRAM

Option 5: Total Funds = $19.5 M

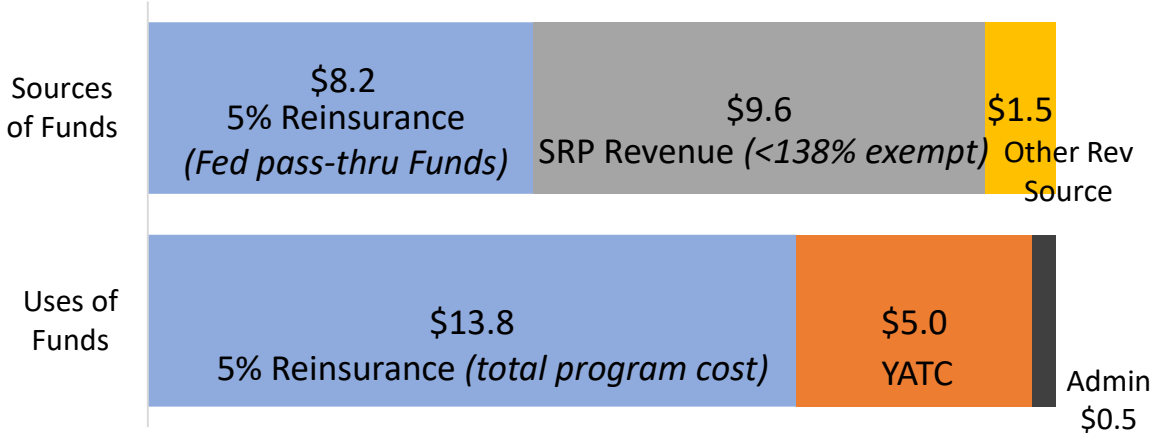
5% Reinsurance Program/ Fed Model SRP / YATC



- Other Revenue Required: NONE
- SRP: Federal structure
- Other Affordability Programs: Young adult tax credit (YATC)
- Excess funds of $0.2 M may be available

Option 6: Total Funds = $19.3 M

5% Reinsurance Program / <138% FPL Exempt SRP / YATC



- Other Revenue Required: $1.5 M
- SRP: Under 138% FPL exempt
- Other Affordability Programs: Fund young adult tax credit (YATC)

DISCUSSION

- Are there additional options we should consider?
- Should we consider options that require alternative sources of funds?
  - If so, what type of assessment?
- Which option(s) best meet our market stability goals?

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

NEXT STEPS AND UPCOMING MEETINGS

- How to combine options into a workable package?
- What have we not covered that you need to be comfortable making recommendations?

PUBLIC COMMENT?

THANK YOU

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

APPENDIX

UNIVERSE OF OPTIONS

Of 18 potential combinations - selected 6 to illustrate and discuss...

	Policy Choice			Use of Funds $M				Source of Funds $M				
Option	Reinsurance Target	SRP Model	YATC?	Reinsurance	YATC	Admin	Excess Funds	Federal Pass-thru Reins Funds	SRP	Other Source	Total Funds	*% Fed Funds*
1	10%	Fed Model	**Yes**	$27.6	$5.0	$0.5		$16.3	$11.3	$5.5	**$33.1**	*49%*
2	10%	Fed Model	No	$27.6		$0.5		$16.3	$11.3	$0.5	**$28.1**	*58%*
3	10%	<138 Exempt	**Yes**	$27.6	$5.0	$0.5		$16.3	$9.6	$7.2	**$33.1**	*49%*
4	10%	<138 Exempt	No	$27.6		$0.5		$16.3	$9.6	$2.2	**$28.1**	*58%*
5	10%	1/2 Flat Penalty	**Yes**	$27.6	$5.0	$0.5		$16.3	$8.1	$8.7	**$33.1**	*49%*
6	10%	1/2 Flat Penalty	No	$27.6		$0.5		$16.3	$8.1	$3.7	**$28.1**	*58%*
7	8%	Fed Model	**Yes**	$22.1	$5.0	$0.5		$13.1	$11.3	$3.2	**$27.6**	*47%*
8	8%	Fed Model	No	$22.1		$0.5	$1.8	$13.1	$11.3	None	**$24.4**	*54%*
9	8%	<138 Exempt	**Yes**	$22.1	$5.0	$0.5		$13.1	$9.6	$4.9	**$27.6**	*47%*
10	8%	<138 Exempt	No	$22.1		$0.5	$0.1	$13.1	$9.6	None	**$22.7**	*58%*
11	8%	1/2 Flat Penalty	**Yes**	$22.1	$5.0	$0.5		$13.1	$8.1	$6.4	**$27.6**	*47%*
12	8%	1/2 Flat Penalty	No	$22.1		$0.5		$13.1	$8.1	$1.4	**$22.6**	*58%*
13	5%	Fed Model	**Yes**	$13.8	$5.0	$0.5	$0.2	$8.2	$11.3	None	**$19.5**	*42%*
14	5%	Fed Model	No	$13.8		$0.5	$5.2	$8.2	$11.3	None	**$19.5**	*42%*
15	5%	<138 Exempt	**Yes**	$13.8	$5.0	$0.5		$8.2	$9.6	$1.5	**$19.3**	*42%*
16	5%	<138 Exempt	No	$13.8		$0.5	$3.5	$8.2	$9.6	None	**$17.8**	*46%*
17	5%	1/2 Flat Penalty	**Yes**	$13.8	$5.0	$0.5		$8.2	$8.1	$3.0	**$19.3**	*42%*
18	5%	1/2 Flat Penalty	No	$13.8		$0.5	$2.0	$8.2	$8.1	None	**$16.3**	*50%*

SUMMARY OF SRP VARIATIONS

Variation	Expected Revenue $M	Revenue Change from $11.3 M	Description
Use federal model	$11.3	N/A	• No change
1. <138% Exemption	$9.6	-$1.7M	• 100% reduction at lowest incomes (Medicaid level) • No impact above 138%
2. Half Flat Amount	$8.1	-$3.3M	• Phased impact • 50+% reduction below 200% FPL • No impact above 450%
3. No Flat Amount	$6.8	-$4.5M	• Phased impact • 80+% reduction below 150% FPL • No impact above 450%
4. <138% Exemption + increase to 3.5%	$11.2	-$0.1	• 100% reduction at lowest incomes (Medicaid level) • Higher payments above 300% FPL

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

ALTERNATIVE OPTIONS FOR SRP

Levers Available:

- Income Based Exemption
- Flat Penalty Amount ($695)
- % of Income Penalty Amount (2.5%)

Variations Modeled:

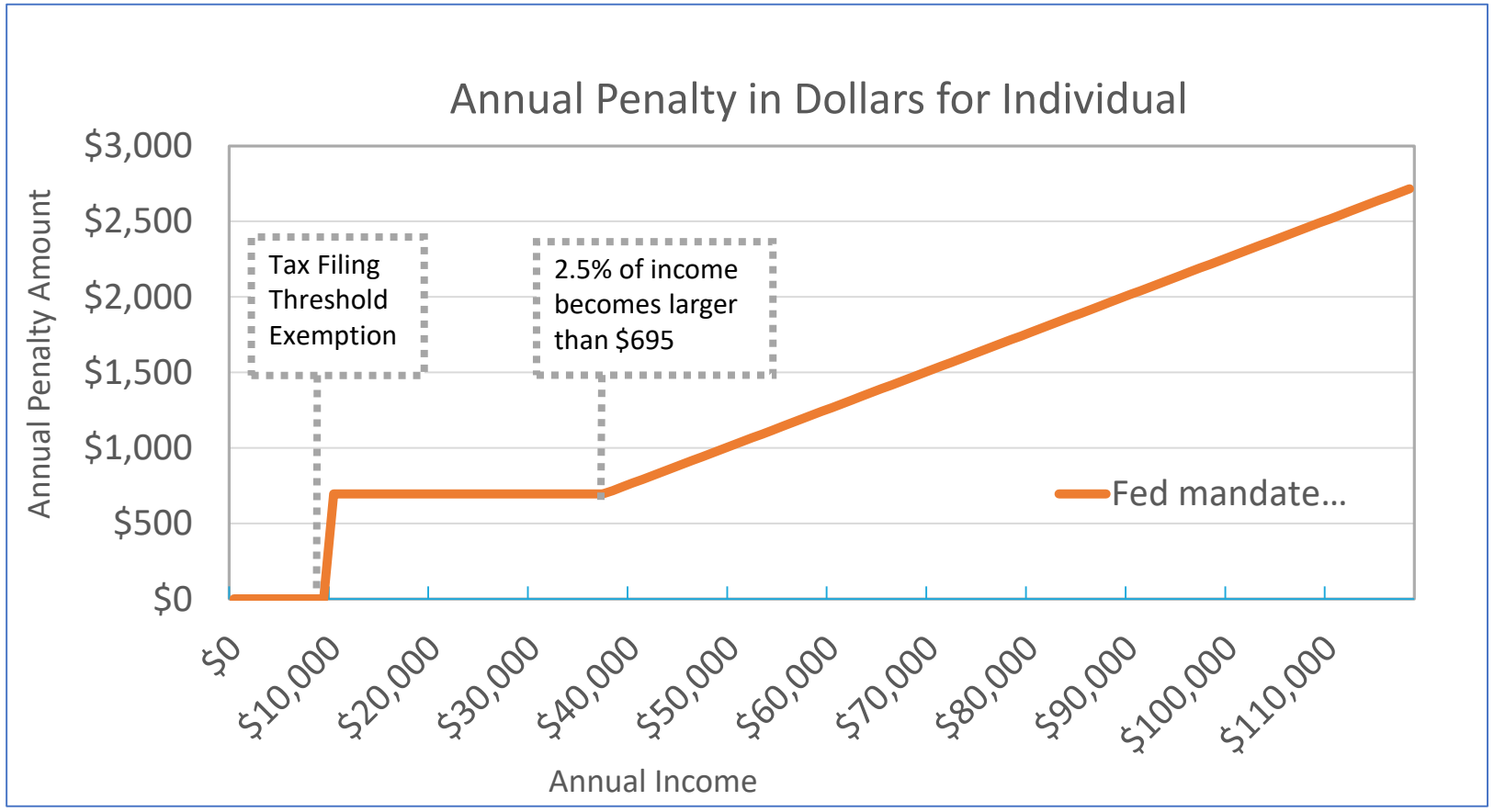
1. Exemption under 138% FPL
2. Flat Penalty Amount reduced by half ($350)
3. Flat Penalty Amount eliminated ($0)
4. Exemption under 138% FPL combined with increased income percentage to 3.5%

About the model:

- Developed by DOR using IRS and RI tax filing data.
- Aggregates 2016 filers into categories based on their family size and FPL
- Models a change by applying an estimate to each category
- See appendix for assumptions

FEDERAL PENALTY STRUCTURE (ending 12/31/18)

Larger of 1) $695 per adult, or 2) 2.5% of income above filing threshold*



KEY EXEMPTIONS

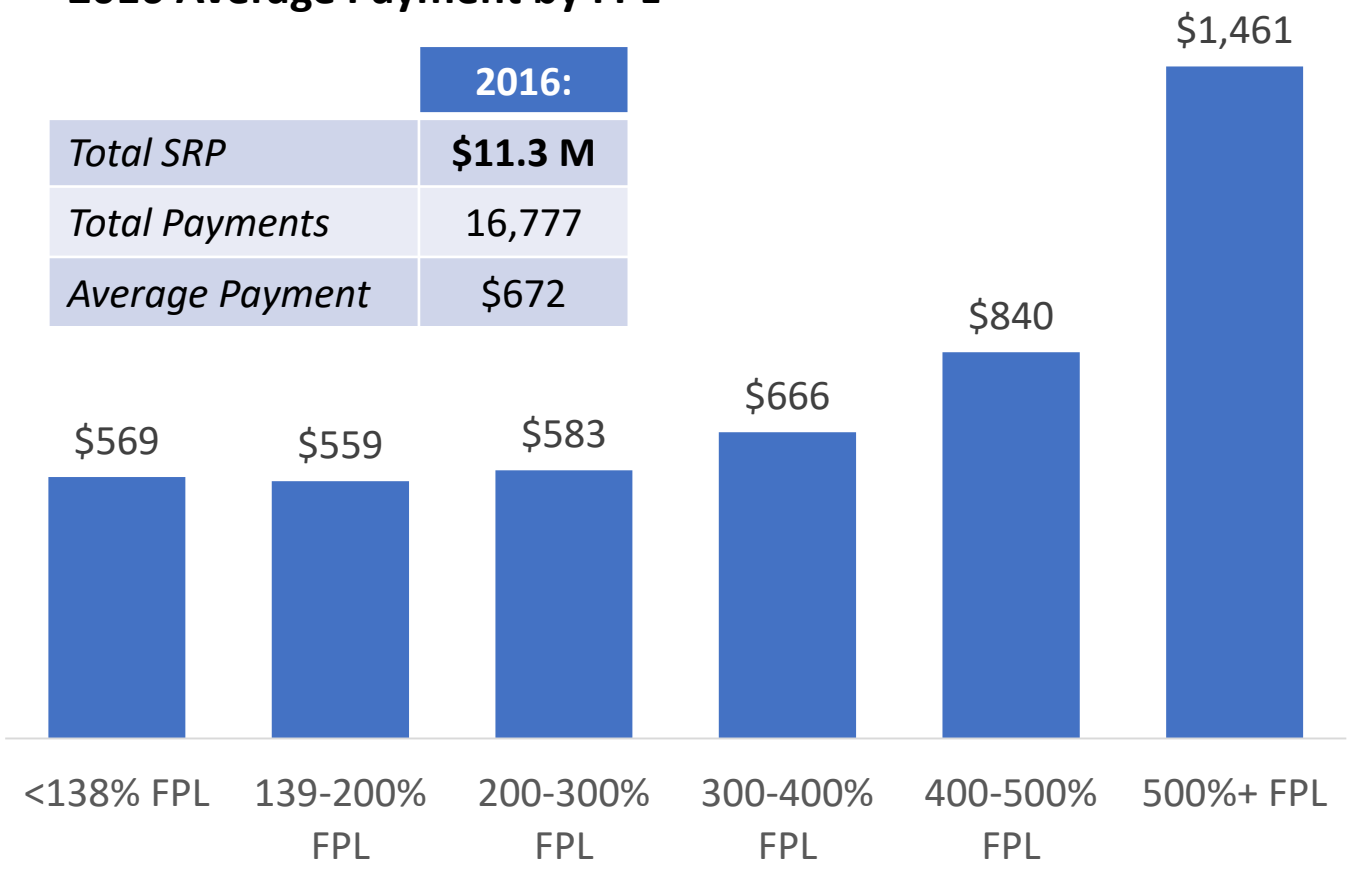
- **Income Exemption** if income below tax filing threshold
- **Affordability Exemption** if coverage costs more than 8.13% of income
- **Hardship Exemption** in case of bankruptcy, flood/fire, death in family, etc.

**Half dollar amount for children, and max per family is equivalent of 3 adults. Overall max set at bronze plan cost*

RI SHARED RESPONSIBILITY PAYMENTS: 2016

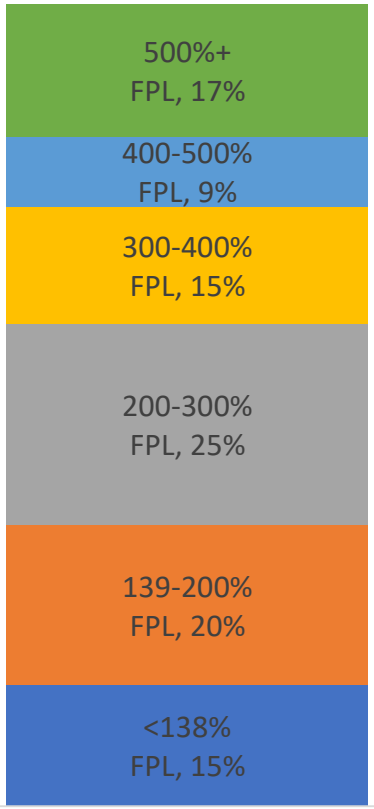
2016 Average Payment by FPL

	2016:
Total SRP	**$11.3 M**
Total Payments	16,777
Average Payment	$672



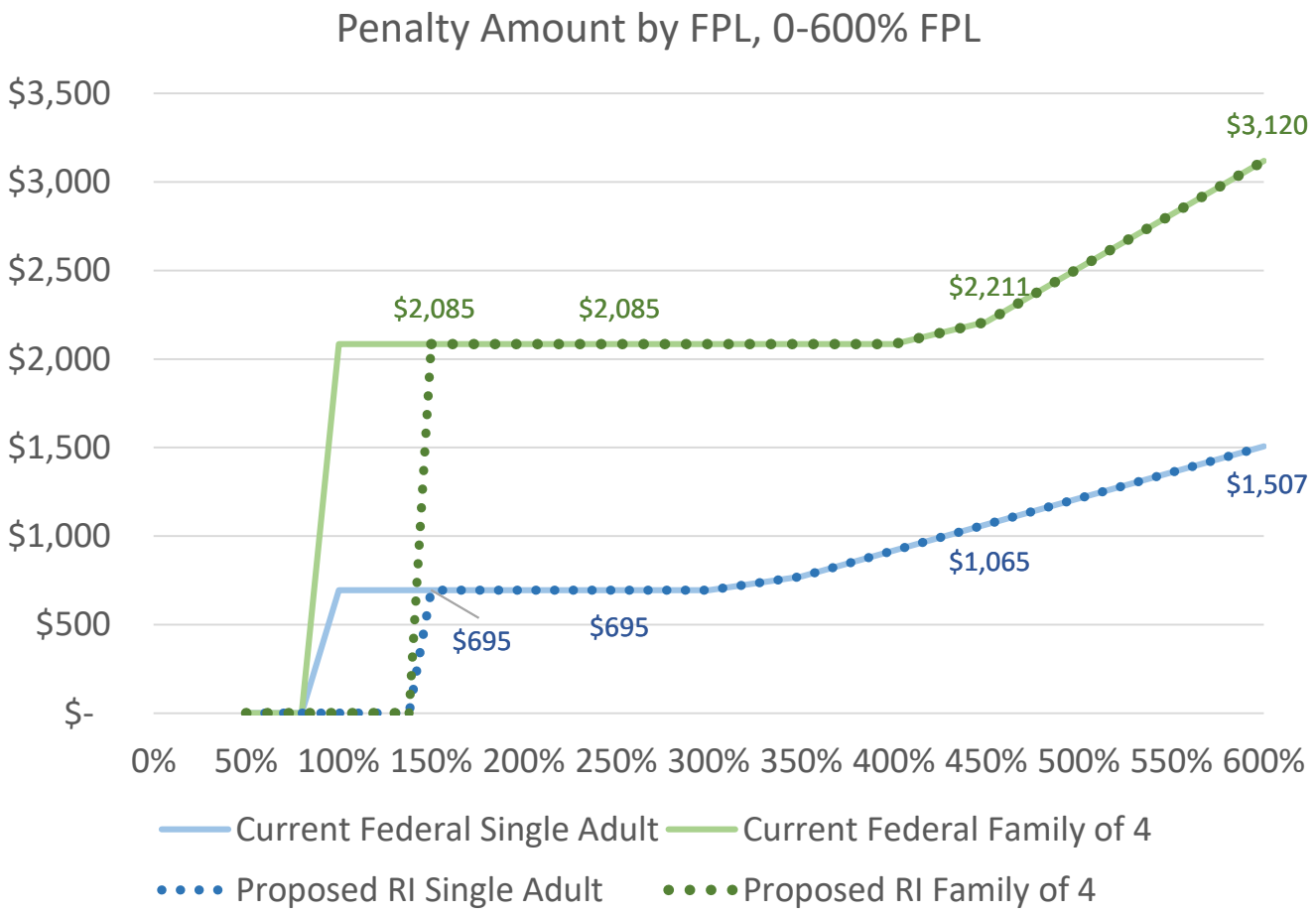
# Payments	2,993	4,027	4,840	2,467	1,177	1,274

Share of Total Paid Amount by FPL



% of 2016 SRP Paid Amount

VARIATION 1: EXEMPTION UNDER 138% FPL



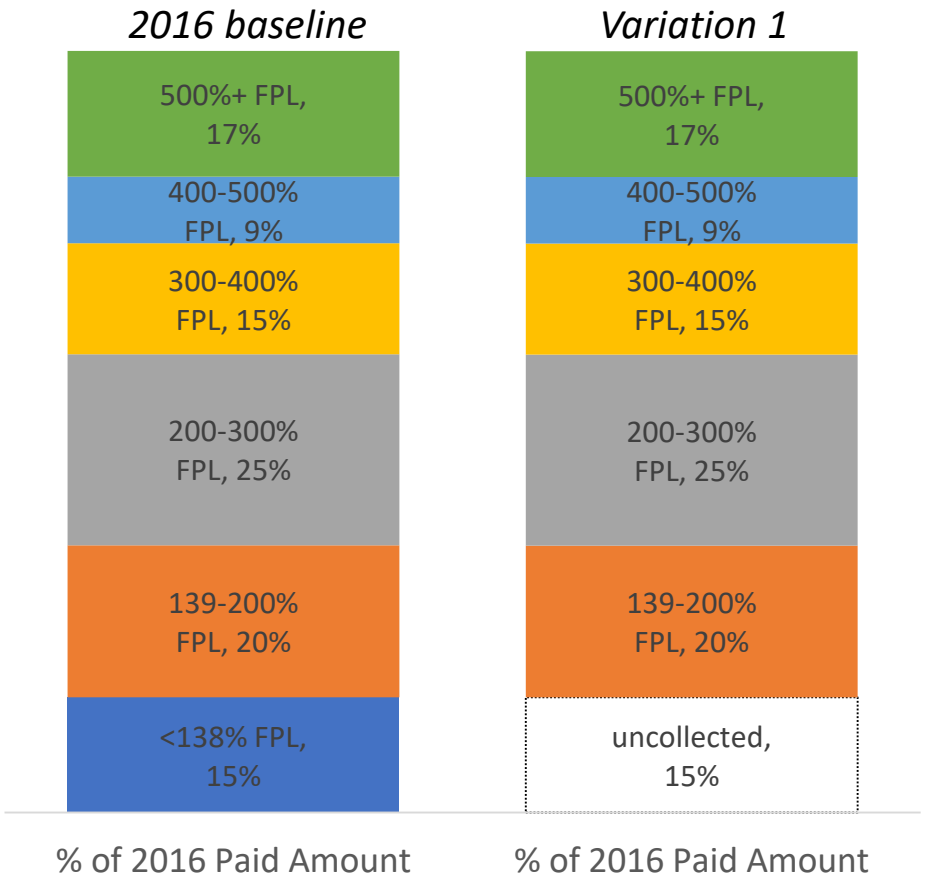
- Corresponds with Medicaid eligibility for most adults
- Many ought to be exempt via affordability exemption, but simplification may make it easier to avoid being penalized
- Estimated revenue reduction of $1.7M
- 100% reduction at lowest income ranges. No impact above that
- Could be “revenue neutral” if the percentage were also increased to 3.5%

VARIATION 1: EXEMPTION UNDER 138% FPL

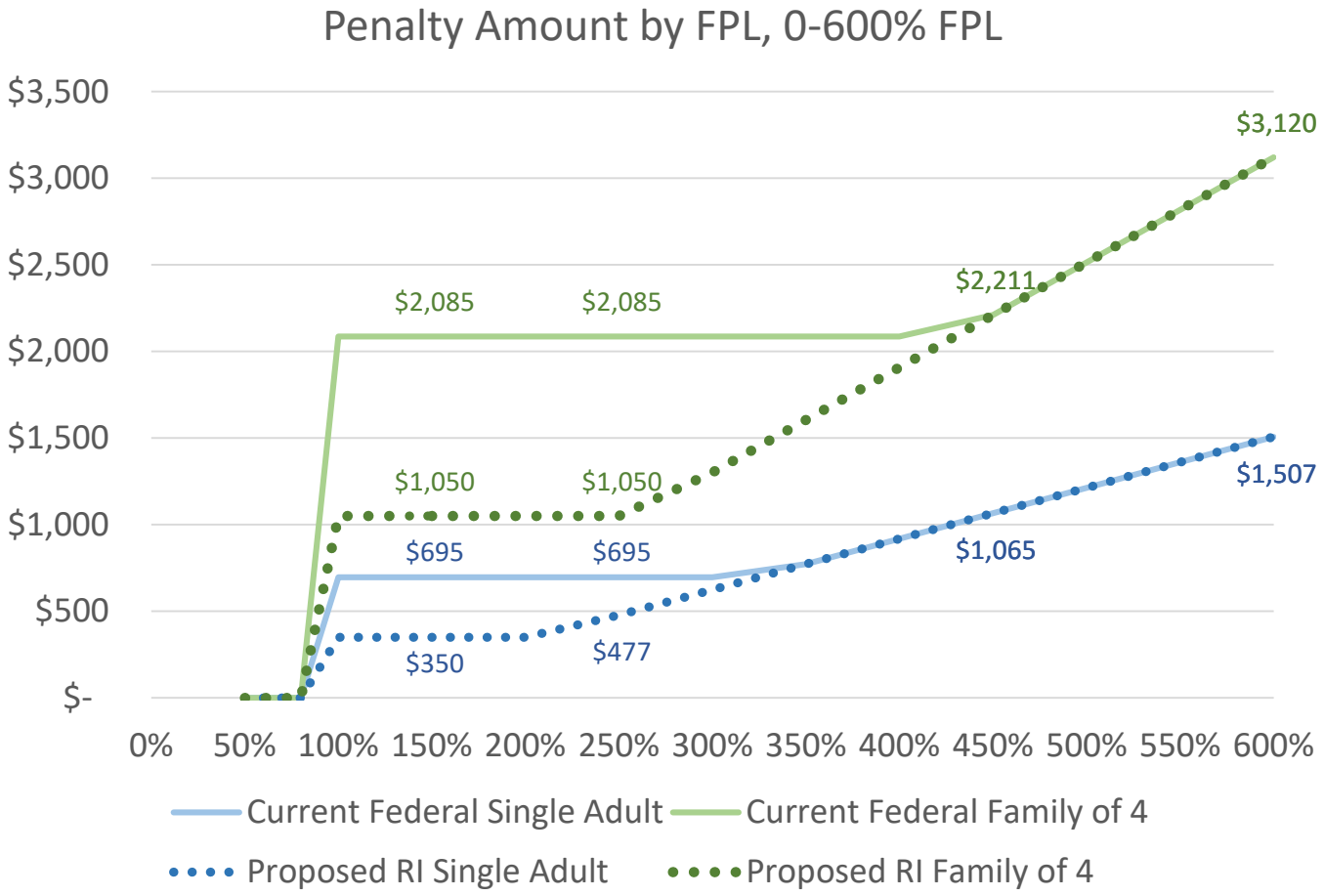
Payment by FPL: 2016 vs. Variation 1

	2016:	Variation 1:	Difference
Total SRP	$11.3 M	$9.6 M	-$1.7 M
Total Payments	16,777	13,784	-2,993
Average Payment	$672	$694	+$22

Share of 2016 Paid Amount by FPL



VARIATION 2: CUT FLAT PENALTY AMOUNT IN HALF



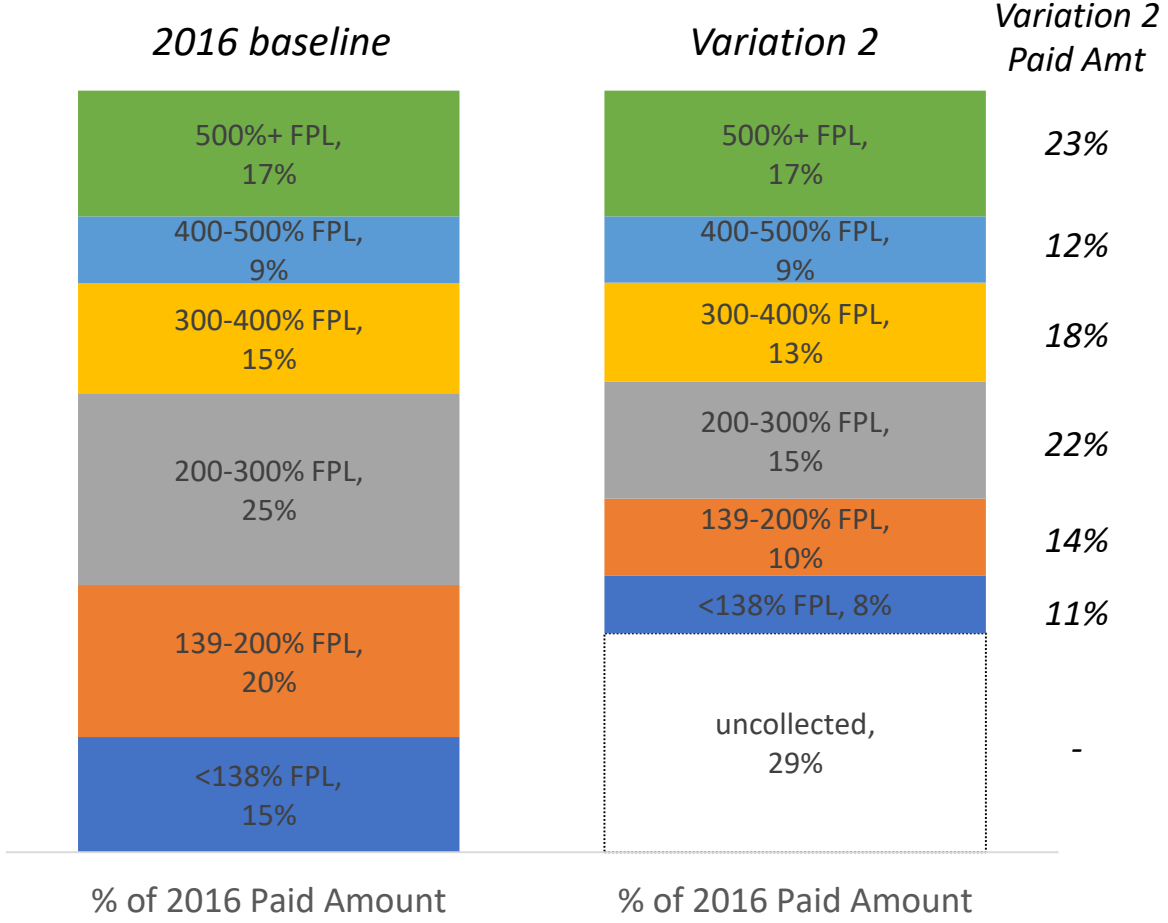
- Estimated revenue reduction of $3.3M
- Impact largest at lowest income ranges—aggregate 50+% reduction below 200% FPL
- Modification phases out as income increases—aggregate 30-44% reduction for 200%-300% FPL
- No impact above 450% FPL
- Could be “revenue neutral” if the percentage were also increased to 3.9%

VARIATION 2: CUT FLAT PENALTY AMOUNT IN HALF

Payment by FPL: 2016 vs. Variation 2

	2016:	Variation 2:	Difference
Total SRP	$11.3 M	$8.1 M	-$3.3 M
Total Payments	16,777	16,777	-
Average Payment	$672	$479	-$193

Share of 2016 Paid Amount by FPL



Cost for RI Reinsurance Program: Three Factors

(1) Targeted Impact

State sets key parameters to accomplish desired impact

- Scalable, budget dependent
- Typical: 7-20%

(2) Total Program Cost

To be developed by actuaries, estimates based on key market characteristics

- Individual Market Size
- Premium Levels
- Market Volatility

(3) State Share

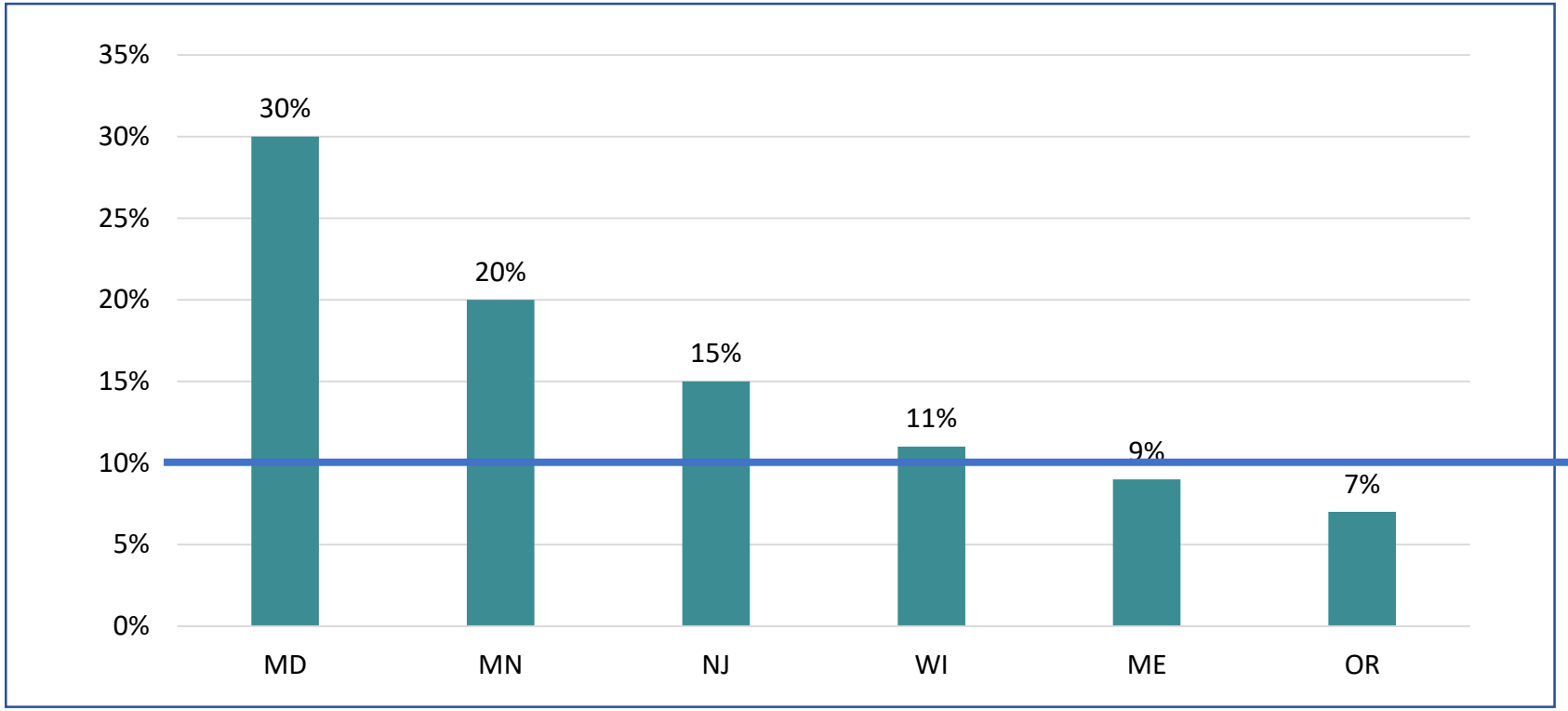
The 1332 Waiver allows RI to use APTC savings from reduced on-exchange premiums to fund the program

- Subsidized market as % of total market

Note: RI is in the process of contracting with an actuarial firm to provide detailed projections of total reinsurance program cost and anticipated federal pass-through funding from a 1332 Waiver.

(1) Reinsurance Programs: Targeted Premium Impact by State

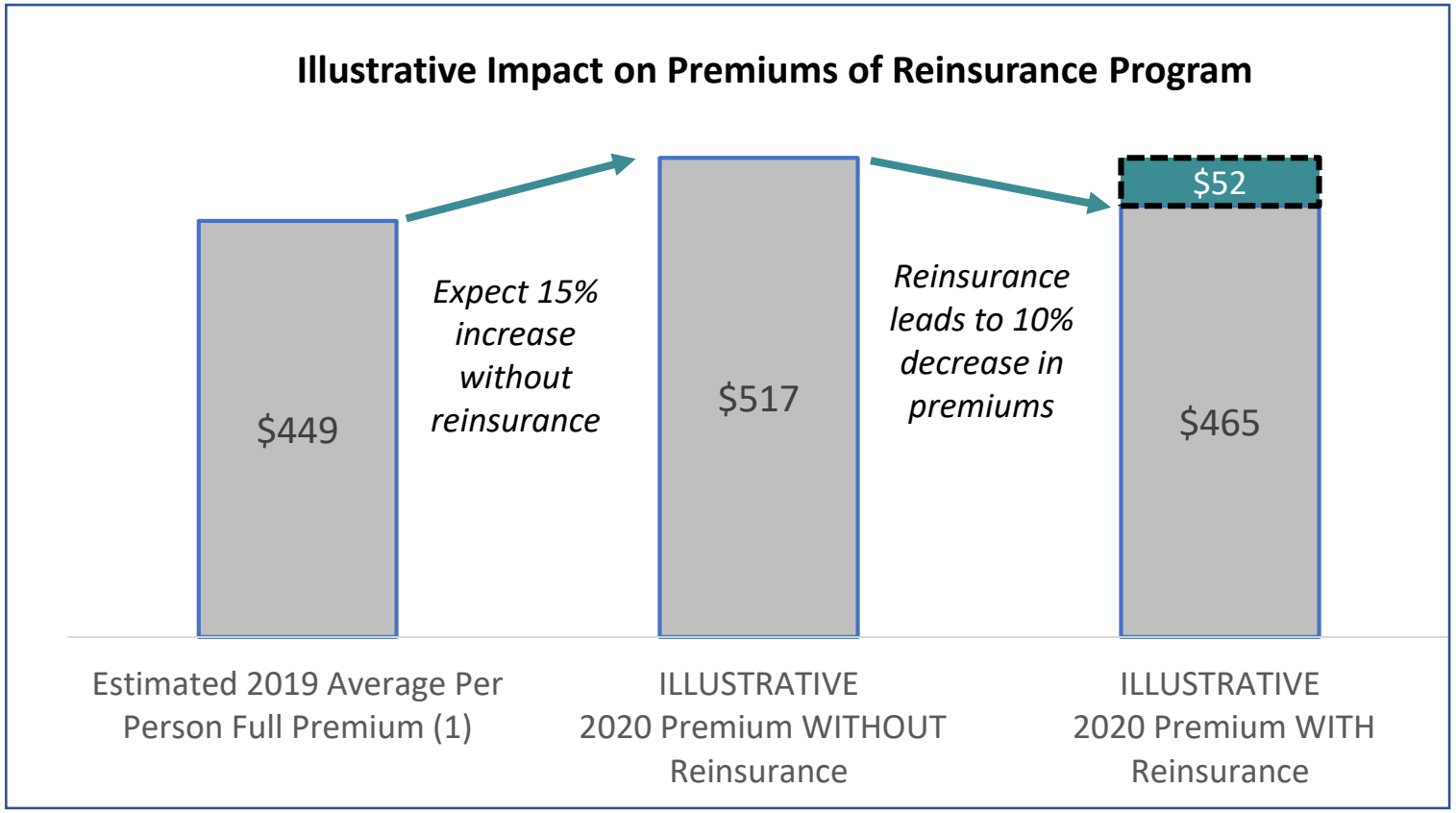
States with approved 1332 waivers have targeted between 7% and 30% premium impact from their reinsurance programs.



Illustrative Target for RI: 10% of projected 2020 Individual Market Premium

(2) Total Program Cost: Estimated $27.6 Million

We estimate that in order to achieve a 10% premium impact in 2020 we would need to develop a reinsurance program that would cost an estimated $27 M.



Total Cost: $27.6 M

- $52 pmpm premium reduction
- 44,500 individual market size
- *Assumes no change in enrollment from reinsurance program*

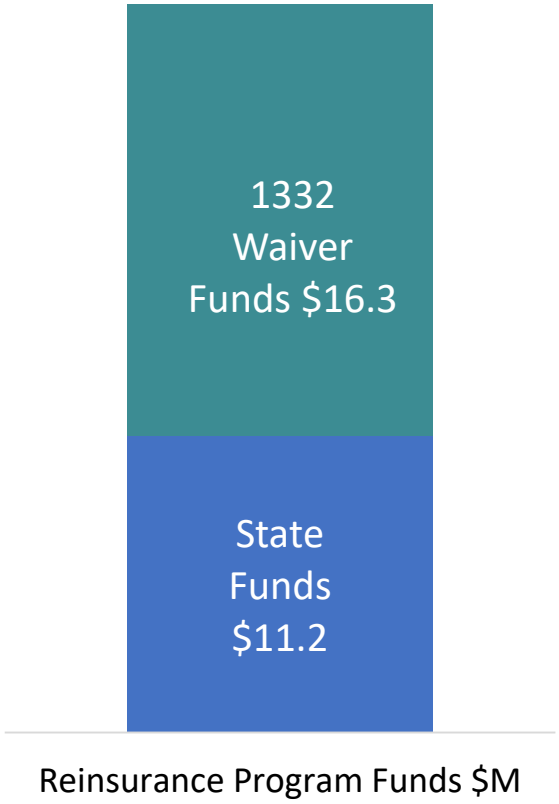
(1) This is estimate of on-exchange average premium based on 2019 rates and 2018 enrollment characteristics. Total individual market average premiums are slightly higher.

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

(3) State Share of Funds: Estimated $11 M

The 1332 Waiver allows RI to use APTC savings from reduced on-exchange premiums to fund the reinsurance program.

$27.6 M Total Program



Estimated $16.3 M federal contribution to Reinsurance (59%)

- $52 pmpm APTC reduction
- 26,000 subsidized enrollees
- *Likely that unsubsidized market enrollment will vary depending on premiums and other regulations*

Estimated $11.2 M state share (41%)

- State must fund remainder

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

Affordability Program Options Review

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

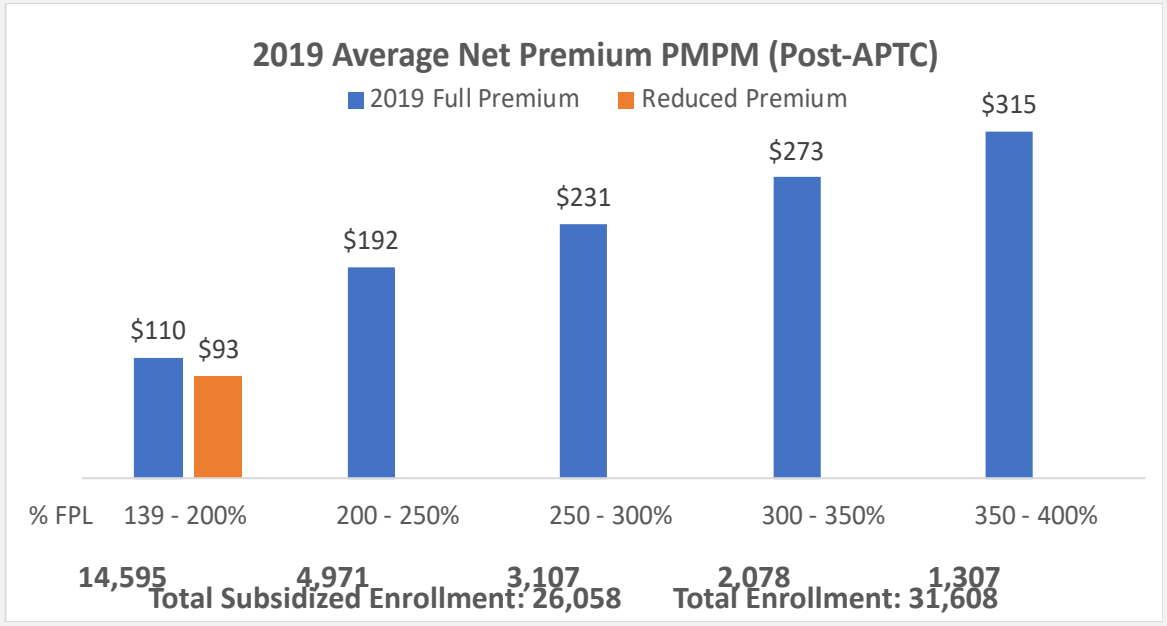
Do these options support the Workgroup's Guiding Principles:
(1) *Sustain balanced risk pool; (2) Maintain attractive market, or; (3) Protect coverage gains achieved under the*

Example 1: Target Low Income Populations

(A) Target the lowest income bracket only

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

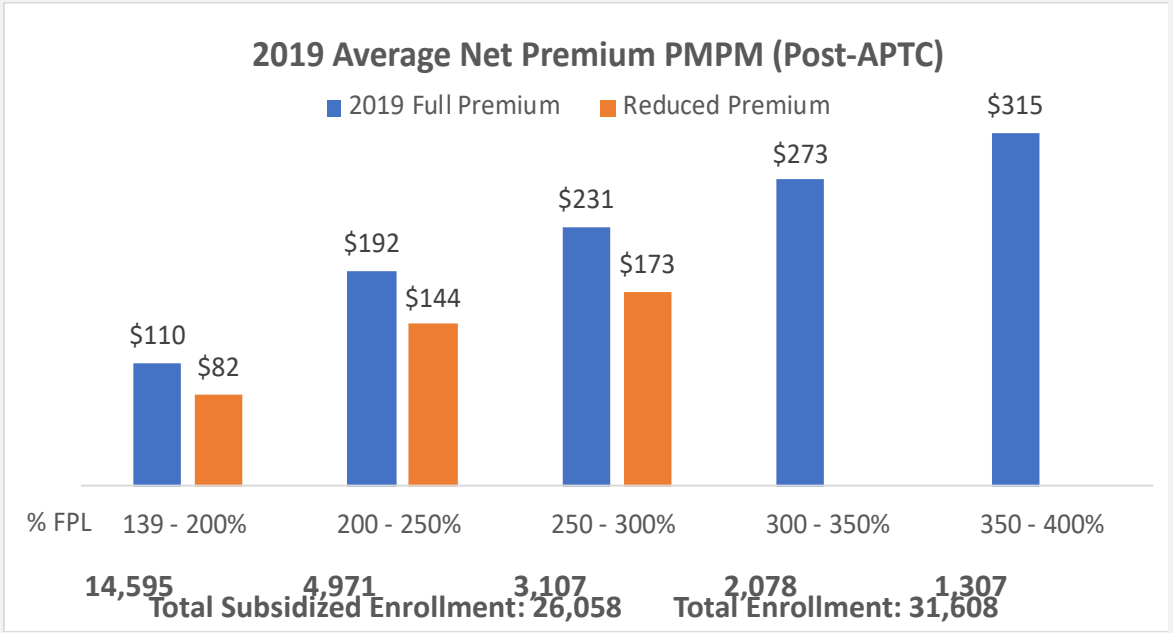
Est. Cost: **$2.9 Million**



(B) Target the population up to 300% FPL

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

Est. Cost: **$9.8 Million**



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

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

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

Example 2: Target Unsubsidized Population

Minnesota Example

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

Estimated Cost: $22.3 Million

Considerations

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

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

Example 3: Target Subsidy Eligible Young Adults

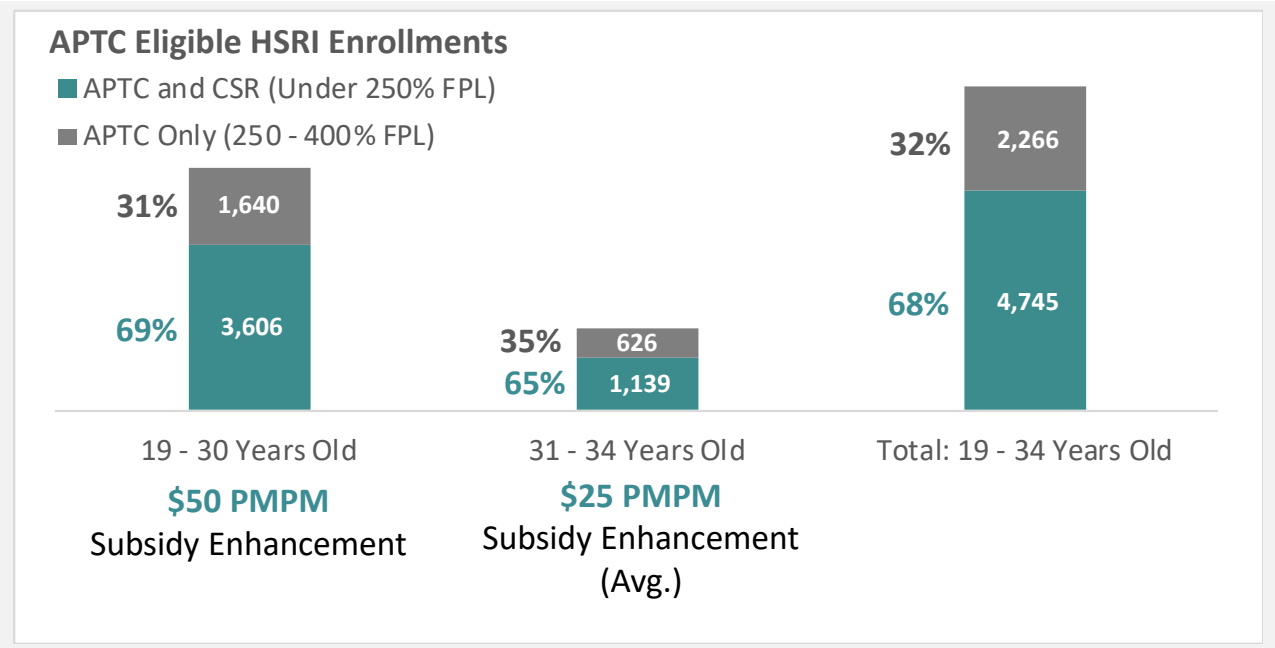
Obama Administration/ Senator Tammy Baldwin Proposal

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

Estimated Cost: $3.7 Million*

Considerations

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



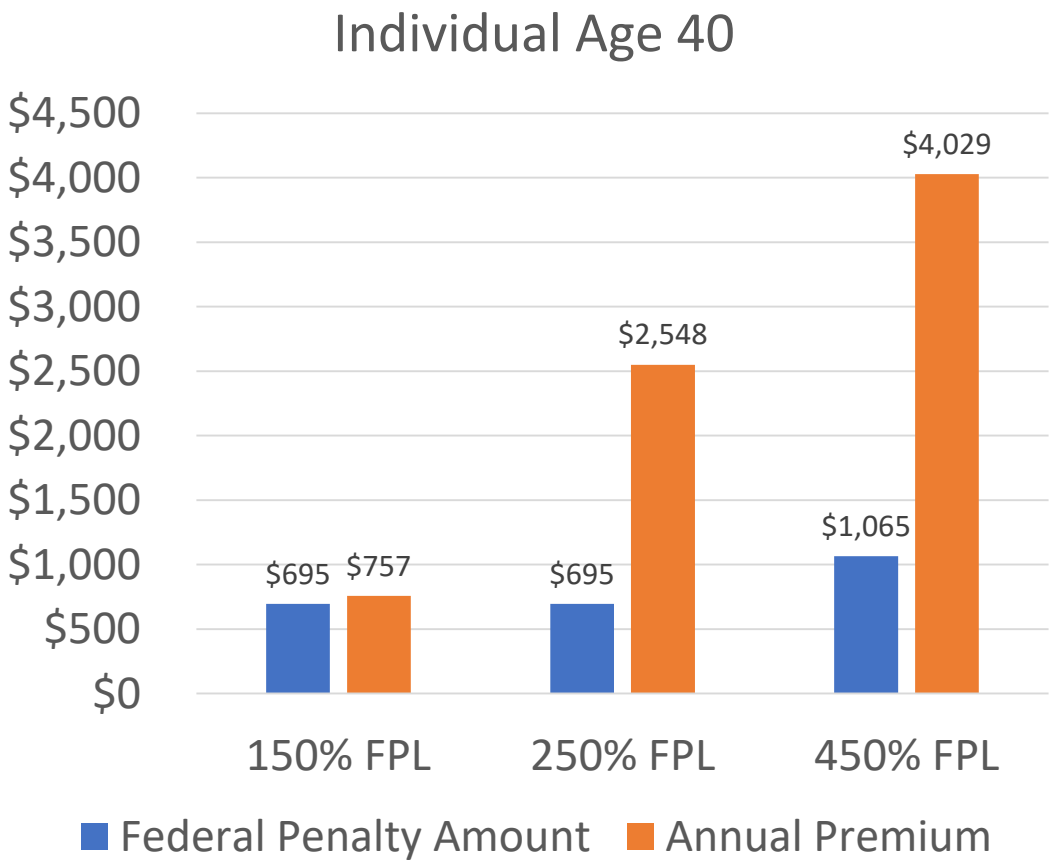
* Preliminary estimate shown is based on total proposed premium enhancement; the total tax credit (APTC + enhancement) cannot exceed the cost of the SLCSP; does not consider the intersection of the SLCSP cost and the total enhanced tax credit at the member level (cost estimate is overstated)

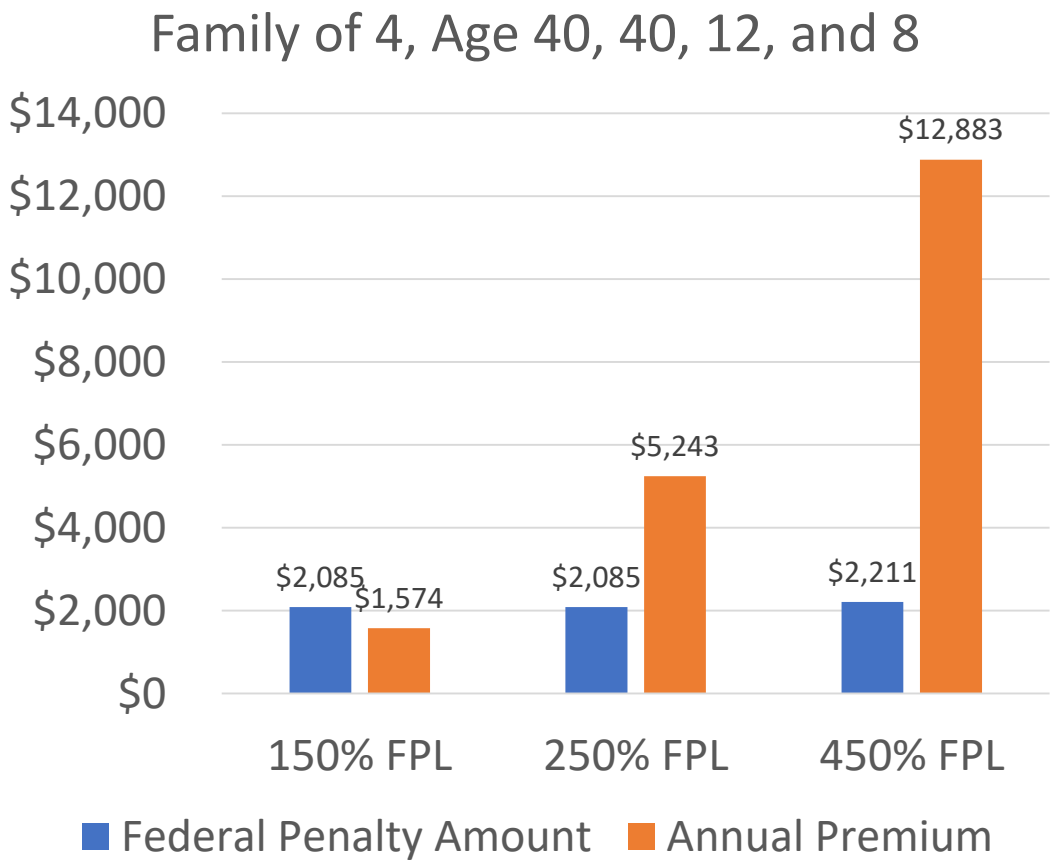
* Funding estimates are based on 2018 HSRI enrollments, and do not consider take-up of uninsured in the target segment – added cost for increased take-up: **$2.3 M** with 50% uninsured take-up (4,300 members; $527 PMPY)

Estimate for funding needed for 30% take-up = $5 million. Used in Scenario Options shown here.

FEDERAL PENALTY AMOUNTS VS. ANNUAL PREMIUM

2019 benchmark plan, after APTC if eligible

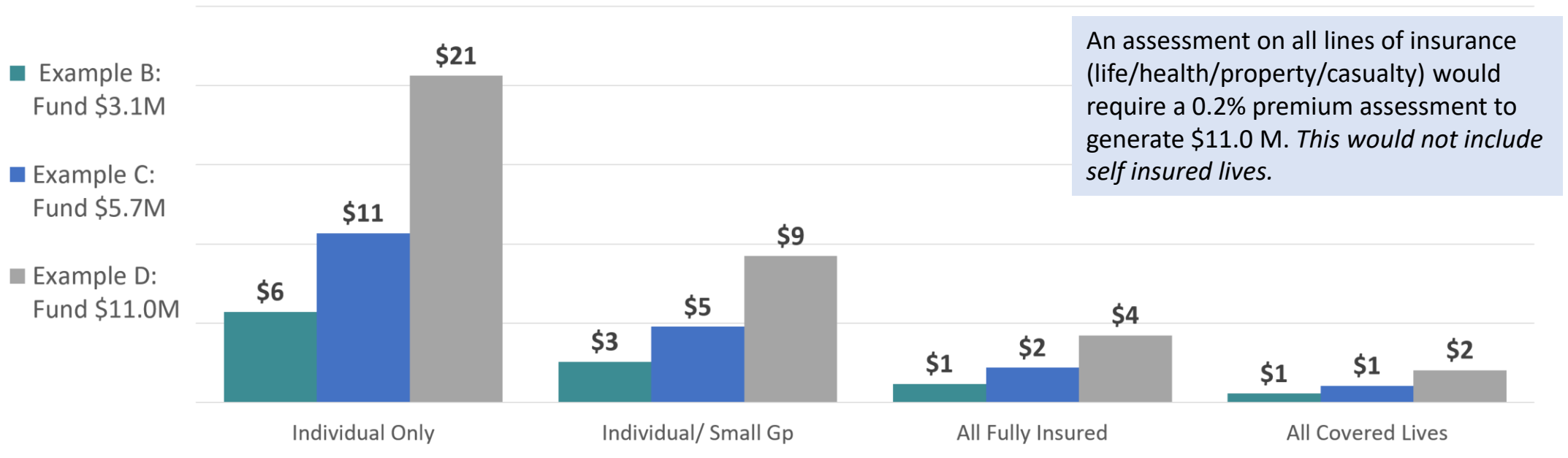




Other Assessments: Who Pays?

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

Estimated Range of PMPM Assessment to Fund Remaining State Share



An assessment on all lines of insurance (life/health/property/casualty) would require a 0.2% premium assessment to generate $11.0 M. *This would not include self insured lives.*

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

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

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

Market Stability Workgroup

Date of Meeting: November 27, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St Providence, RI 02909

Workgroup Members Present:

Workgroup Members Absent:

Minutes

I. **Meeting was called to order** at 8:36am.
   a. The minutes of the November 13, 2018 meeting were approved with no changes.
   b. Edit to meeting schedule – Commissioner Ganim said an incorrect date for a future meeting had been included in some previous meeting materials. Meeting 10 is scheduled for Tuesday, February 5.
   c. Commissioner Ganim reviewed the agenda for today's meeting.

II. **Follow-ups from previous meetings -** Katie Hall provided 3 follow-up items from previous meetings
   a. Question regarding how increase in federal tax filing threshold might impact those under 138% of FPL. In 2016, the tax filing threshold for an individual was 88% FPL; in 2018 it increases to 99% FPL. For a family of four, the threshold increases from 85% FPL in 2016 to 96% in 2018.
   b. Referring to meeting two, Katie presented data on taxes and fees currently assessed on insurance premiums. A healthcare services funding contribution of 1.4% is assessed on all commercial plans across all markets and self-insured plans. A federal health insurance tax is assessed on small group, large group, and individual plans; this tax has been suspended for 2019 but is estimated to be 2.2% in 2020. A 2% state premium tax is applied to all small group, large group, and individual plans. A HealthSource RI fee of 3.5% is assessed on individual and small group plans; this fee is weighted based on enrollment and equals 2.53% in the individual market and .34% on the small group market after weighting (average across plans).
   c. Also from meeting two, a question regarding premium taxes assessed on all forms of insurance. Katie said the current premium tax on all insurance is 2%. Raising this to 2.2% would generate the estimated $11 million needed to fund a state reinsurance program for a 10% premium reduction.
      i. Monica Neronha asked what the national average of insurance premium tax is. Lauren Conway said she believed it was around 2-2.5% but that she had data she could check to confirm. Director Sherman asked her to share this information.

III. **Review of Objectives of this Workgroup**
   a. Deb Faulkner reviewed the Workgroup's objectives: forming recommendations for policymakers' consideration regarding a method or methods for funding a state reinsurance program; whether RI should pursue other health insurance

affordability initiatives and, if so, what programs; aspects of design and implementation for a state-level shared responsibility requirement; and a package of consumer and/or market-based protections for codification in RI law.

IV. Variations for Consideration:

a. Deb presented a selection of potential combinations of policy options previously examined by the Workgroup. These combinations were presented based on 4 components: level of reinsurance (5%, 8%, or 10% premium reduction), type of shared responsibility program (either the same as the federal model or modified as discussed in prior meetings), whether or not to include an additional affordability program (with a young adult tax credit used as a program example), and whether or not other sources of state revenue would be needed.

b. 18 potential combinations of the above components were shown, six at each reinsurance level (5%, 8% and 10%).

   i. Teresa Pavia Weed asked if hardship exemptions for shared responsibility payments were the same in the modeled scenarios as under the current federal law. Deb said they were the same. Teresa said that it was a political concern and a complaint that many who change jobs and find themselves having to pay a penalty due to lack of qualifying coverage for more than 2 months. Teresa said these individuals often do not know about the exchange or that they qualify for an exchange plan. She said this was a concern that needs to be addressed. Larry Warner asked how people qualified for or took a hardship exemption from the penalty. Director Sherman said this data was not available as the penalty and exemptions are administered at the federal level.

   ii. John Simmons said it would be hard to explain charging somebody else for someone to get a 10% reduction – referring to the potential of a tax or premium assessment or other source of state revenue being put in place to fund a reinsurance program that yields a 10% offset in anticipated premium increase. Deb asked if his preference would be a program that did not need to raise additional state revenue. John replied by asking what would happen if the reinsurance program were fully funded by a premium tax assessed only on the individual market. Deb explained that for a 10% reinsurance program, the $11 million cost would equate a six percent premium tax if assessed on the individual market alone. This would effectively turn the 10% reduction in premium increase into a net 4% reduction.

   iii. Monica Neronha said that how to structure a state reinsurance program and whether and how to implement a state shared responsibility payment were two separate policy questions and that this was important to keep in mind. She added that the Workgroup's recommendation was to do both, which is why they were presented in combination.

   iv. Both Monica and Sam Salganik pointed out that the idea that all individuals eligible for tax credits are protected from any rate increases wasn't always accurate, that it depends on what plan those individuals purchase. Sam said that individuals who purchase a lower-level plan than the benchmark plan actually benefit from the rate increase as the absolute value of their tax credit rises as the benchmark premium rises. Director

Sherman agreed it was a very nuanced conversation but that it was fair to say the consumer's purchasing power stays the same.

v. Senator Miller added that more people "buy down" in a market without reinsurance than "buy up." He said in his experience he has seen people take the opportunity to buy a higher-level plan with better coverage. More consumers buying better plans improves the whole system, and speculated more consumers would buy up in a market that has been stabilized by a reinsurance program.

vi. Ralph Coppola said that if market enrollment stays the same there is no need for a reinsurance program, that as long as we can keep the amount of people insured that are currently insured, it would be enough to prevent large premium increases. Director Sherman said that the rate increases for 2019 were the largest we've ever seen and that the individual market is precarious. Commissioner Ganim added that in those 2019 rate filings, one insurer attributed 2% of their rate increase to estimates of losing health lives in the individual market; the other individual market insurer attributed 2% of the increase to high-cost (less healthy) individuals.

vii. Susan Storti asked how the underlying cost of health care, which continues to rise, was being taken into consideration. She expressed concern that RI would end up in a similar situation as Mass., where the highest percent of medical debt falls to the lowest income population. Deb said the underlying cost of care is a challenge for everyone but that this Workgroup's intent is not to address it. Teresa said it was an important conversation but that the Workgroup may not be the right venue, that there is another steering committee analyzing health care cost trends in the state and looking at the health care system, whereas this Workgroup is charged with looking specifically at insurance. Susan acknowledged this and suggested information from the cost trends group could possibly support decision making in the Market Stability Workgroup.

viii. Steve Boyle said he is in favor of a state SRP modeled after the federal individual mandate, saying that if the federal program had not changed the same individuals would be paying penalties regardless. Monica agreed with Steve but clarified her earlier statement regarding the SRP being a separate policy question by adding that her organization would not support a state SRP unless the funds collected were used to help health care costs. There was broad agreement among Workgroup members with this sentiment.

ix. Larry Warner said that while the ACA was the best policy that could have been enacted at the federal level at the time, it was expressed during the first round of Workgroup meetings in the spring that things could potentially have been done better at the state level. He said this was an opportunity to do better, not simply maintain ACA elements as they were.

x. David Burnett said that while it would be great if revenue collected from a state SRP went toward healthcare affordability, if the SRP does in fact change enrollment behavior then the money is almost irrelevant. Regarding the reinsurance target, he asked if a 5% premium increase offset was sufficient to stabilize the market, or if 10% would be. Commissioner Ganim said that actuaries retained by HSRI may be able to help answer this question. She mentioned that in New Jersey, rate filings

were recalculated after the introduction of a state reinsurance program there and the proposed rates decreased even more than anticipated.

xi. Bill Wray said that it was important to institute an SRP that was meaningful but that it was also important to mitigate any penalties on those for whom the mandate is a genuine hardship. He also expressed support for the federal model.

xii. Lauren Conway noted that the reinsurance target was only a one year impact, that it would only reduce premium increases for 2020. She asked about a potential phased-in reinsurance that allowed, for example, for 5% premium increase reductions for 3 years instead of 10% for a single year. Deb said that an insufficient first step with regards to reinsurance would not yield the same benefit of keeping enrollees in the risk pool. She said it is harder to attract enrollees back into the pool after they have left than it is to take steps to keep them in. Bill Wray noted that although the premium impact of reinsurance was only for one year, the market stabilizing effect of the reinsurance program would be last multiple years.

xiii. Responding to a comment by Teresa about the timing of a reinsurance program and state SRP's effect on rates, Director Sherman said that estimated revenue collected could be included in the reinsurance waiver application and would impact 2020 rates even before that revenue is collected since reinsurance payments would go out the following year.

xiv. The policy combinations presented by Deb included a young adult tax credit (YATC) as an example affordability program – not necessarily the specific affordability program to be implemented. Teresa said that she felt there had not yet been a meaningful discussion as to whether a YATC was the best affordability program to pursue. Even though the YATC was meant to serve as a proxy for the yes/no question of whether an additional affordability program or programs should be included in a recommendation, Teresa said the specifics of the affordability program mattered.

xv. John Simmons said that while he believed the numbers presented by Deb were directionally correct, he felt that any proposal or recommendation to the General Assembly would need a stronger cost/benefit and actuarial analysis to have a chance of being considered. Director Sherman said that actuaries retained by HSRI would be presenting to the Workgroup at the next meeting and that a complete analysis would be complete by February or March, well in time to be presented to the General Assembly. Monica expressed that Deb's numbers felt very reasonable based on her experience. Senator Miller noted that in terms of convincing the legislature that the case to submit a waiver was successful (legislation was passed to authorize the waiver) and that legislators understood the vulnerability to the ACA/health insurance markets.

V. Next Steps and Upcoming Meetings

a. Director Sherman outlined process for upcoming meetings – there are two meetings scheduled before a year-end holiday break. The first half of the first meeting, the Workgroup will hear from actuaries retained by HSRI; the second half of the meeting, and the last meeting of 2018, the Workgroup will use to reach

consensus on recommendations before the holiday break and the start of the legislative session.

i. Director Sherman asked if there was currently any consensus around example policy combinations presented – whether any could be noted as preferred or any ruled out. John Simmons did not want to take any off the table without more information. Teresa expressed some support for a 10% reinsurance program, or a 9.5% reinsurance program without the need for additional funds; she said she was uncomfortable with a YATC.
ii. Monica expressed a concern that a potential 20% or 30% premium increase occur due to lack of timely action. She said she did not want to be alarmist, but that it was possible and that she feared the Workgroup may defeat the goal by trying to find a perfect solution. Director Sherman said that even with actuarial support, we will not have the level of detail some Workgroup members may be seeking – the point is approaching where the Workgroup will have to act.

b. Next meeting is December 11, 2018, 8:30 AM at United Way

VI. **Public Comment** - No members of the public offered comment.

VII. **Adjourn** – The meeting adjourned at 10:37 AM.

Market Stability Workgroup

Notice Posted: December 6, 2018
Date of Meeting: December 11, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St
Providence, RI 02909

Agenda

I. Call meeting to order
   a. Motion to approve November 27, 2018 meeting minutes
   b. Review today's agenda

II. Preliminary actuarial estimates of a reinsurance program
   a. Current RI relevant data
   b. Baseline scenario for 2020 without reinsurance
   c. Analysis of premium impact and federal pass-through savings
   d. Limitations of estimates

III. Reaching recommendations
   a. Follow-up items from meeting five
   b. Review Workgroup recommendations, guiding principles, and goals
   c. Review text of potential recommendations

IV. Next steps and upcoming meetings

V. Public comment

VI. Adjourn

United Way of Rhode Island is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Jonelie Cardoza at 401.462.6428 or email her at jonelie.cardoza@ohic.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP 2.0

Meeting #6

Tuesday, December 11, 2018
8:30 – 10:30 a.m.
The United Way of Rhode Island

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

Topic(s) for Discussion	Meeting Date
Break for the holidays	Mid-December – early January
Meeting 8 **Possible Codification of ACA Consumer and Market Protections**	Tuesday, January 8th
Meeting 9 **Legislative Recommendations**	Tuesday, January 22nd
Meeting 10 **Legislative Recommendations (*reserved if needed*)**	Tuesday, February 5th

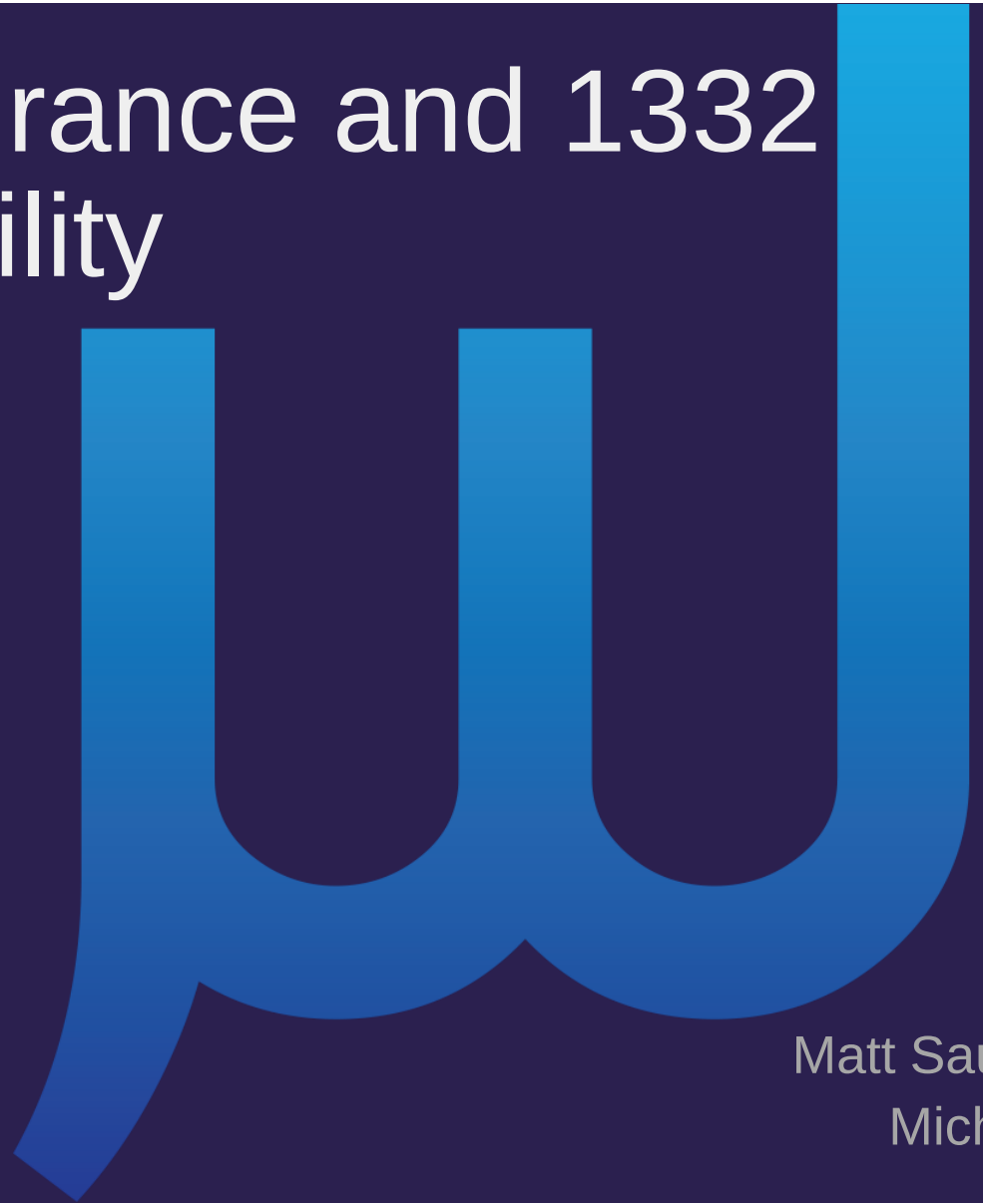
TODAY'S AGENDA

1. Actuarial Update
2. Follow-up Items from Previous Meetings
3. Reaching Recommendations

Wakely

BEYOND THE NUMBERS

Reinsurance and 1332 Feasibility



December 11, 2018

PRESENTED BY

Matt Sauter, ASA, MAAA

Michael Cohen, PhD

Which States Benefit Most from a 1332

- Through a 1332 waiver, a state can receive the net Federal savings that result from lower premiums (and thus lower Advance Premium Tax Credit, or APTC, amounts) from a reinsurance program
- These “net savings” are referred to as a “pass-through”. Pass-through funds can be used by the state to pay for the reinsurance program
- Some states will have a higher percent (pass-through rate) of Federal funding than others
- The primary driver of the pass-through rate is the portion of APTC enrollees in the market and how high the ATPC subsidy is on a per member per month (PMPM) basis

Feasibility Analysis for Rhode Island

- Wakely was retained to analyze the potential effects of a claims based reinsurance program on premiums for the year 2020 and the potential for a 1332 waiver, estimating the Federal pass-through amounts
- Wakely collected claims, enrollment, and premium data from Rhode Island issuers to create a baseline of the Rhode Island individual market
- Wakely also talked with Rhode Island issuers to gain qualitative insights into market dynamics

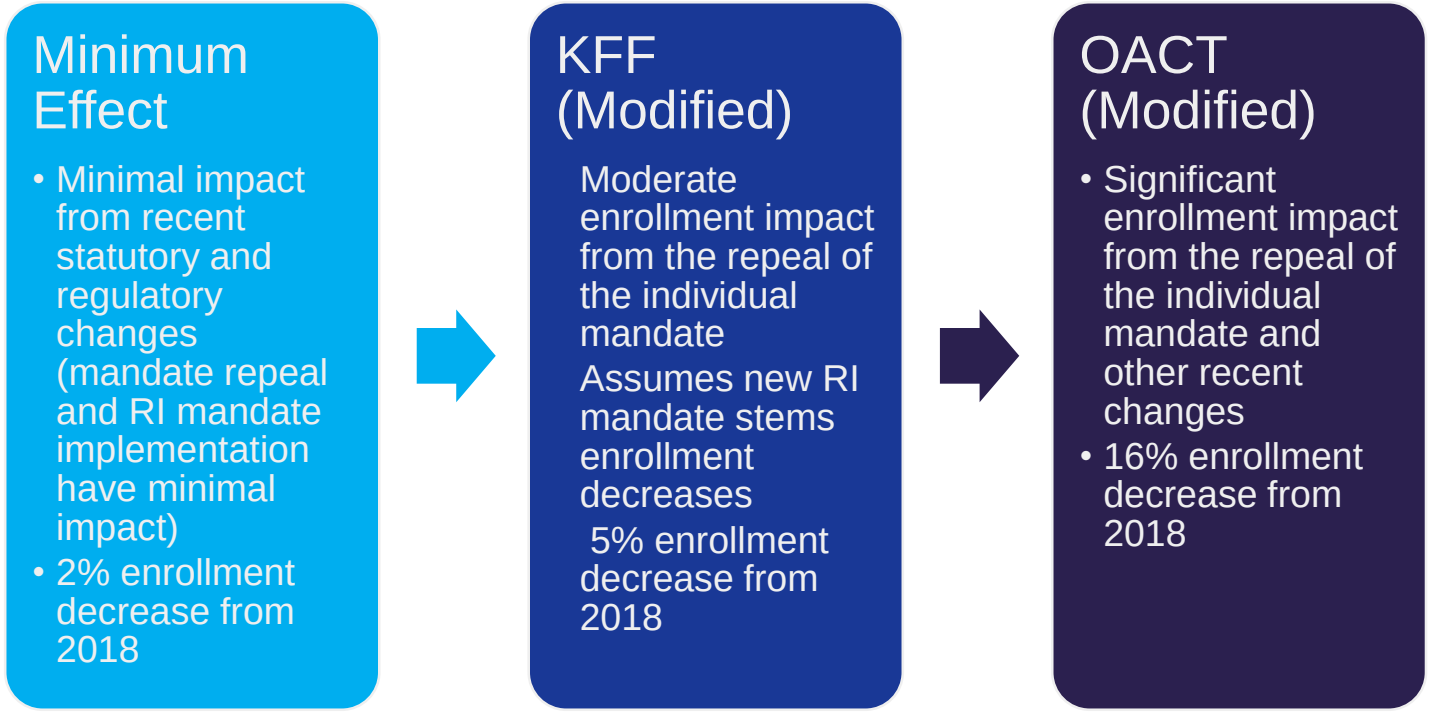
Rhode Island – Where we are now

- Average annual amounts for the entire Individual ACA market (all plans)
- Combined data from all Rhode Island issuers through August 2018
- 2018 average enrollment was adjusted for expected enrollment attrition throughout the year

Baseline	2017	2018	Change
Average Annual Enrollment			
Total Non-Group Enrollment	42,300	43,807	3.6%
Exchange Enrollment	29,385	31,666	7.8%
APTC Enrollment	23,375	26,179	12.0%
Non-APTC Exchange Enrollment	6,011	5,487	-8.7%
Off-Exchange Enrollment	12,914	12,141	-6.0%
Per Member Per Month (PMPM) Amounts			
Total Non-Group Premium PMPM	$383.46	$435.17	13.5%
APTC PMPM	$240.37	$305.49	27.1%
Total Annual Dollars			
Total Non-Group Premiums	$194,641,067	$228,762,613	17.5%
Total APTCs	$67,421,301	$95,968,219	42.3%

Key Assumptions for 2020 Baseline

- Enrollment scenarios[1] (impacts on premium & pass through)



- Premium increases
  - 2019 used the average of the filed rate increases (8.1%)
  - 2020 Wakely assumed slightly higher than trend increases (9% to 15%) due to morbidity differences and the return of the provider fee

[1] Minimum Effect Scenario – The mandate repeal has a minimal effect on enrollment.
KFF(Modified) – Kaiser survey where mandate repeal has a moderate effect on enrollment (modified to mute the impact).
OACT (Modified) – Relies on Office of the Actuary estimates the repeal has a substantial effect on enrollment – primarily on the unsubsidized enrollees.

Wakely

Rhode Island – 2020 Baseline

- Given the regulatory and statutory uncertainty, multiple scenarios for the 2020 average annual amounts were estimated for the entire Individual ACA market (all plans)
- Below are the baseline enrollment/premium estimates, before reinsurance

Baseline	2018	2020 Minimum Effect	2020 KFF	2020 OACT
Average Annual Enrollment				
Total Non-Group Enrollment	43,807	42,711	41,617	36,767
Exchange Enrollment	31,666	31,325	30,481	27,858
APTC Enrollment	26,179	26,179	25,449	23,832
Non-APTC Exchange Enrollment	5,487	5,146	5,032	4,026
Off-Exchange Enrollment	12,141	11,386	11,135	8,908
Per Member Per Month (PMPM) Amounts				
Total Non-Group Premium PMPM	$435.17	$511.87	$518.24	$542.21
APTC PMPM	$305.49	$374.50	$380.74	$404.22
Total Annual Dollars				
Total Non-Group Premiums	$228,762,613	$262,350,654	$258,810,044	$239,225,406
Total APTCs	$95,968,219	$117,648,759	$116,274,182	$115,602,435

Scenarios for Reinsurance Impact

Three different total funding levels were also analyzed (i.e., includes both the Federal and Rhode Island portions of the funding)

Key Findings (Impact on Premiums)

- Different assumptions on the size of the individual market, health of the individual market, and the assessment used to fund the program results in a reinsurance program having different levels of effects
- Reductions in premiums are estimated to increase enrollment by 1% to 2% compared to the baseline
- Premium Impacts*:

Funding Level	$13 million	$21 million	$26 million
Minimal Impact	-5.2%	-8.3%	-10.3%
KFF	-5.2%	-8.4%	-10.4%
OACT	-5.6%	-9.1%	-11.3%

* The premium impacts represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been. They do not show 2020 premium changes relative to 2019.

Key Findings (Funding)

- Different assumptions will also impact the estimated pass-through (Federal dollars)
- The greater the pass-through, the less state funding is needed
- Estimated Federal pass-through rates and needed state funding (in millions):

Funding Level	$13 million	$21 million	$26 million
Minimal Impact	60.7%	60.7%	60.6%
KFF	60.6%	60.5%	60.5%
OACT	64.0%	64.0%	64.0%

Funding Level	$13 million	$21 million	$26 million
Minimal Impact	$5.1 million	$8.3 million	$10.2 million
KFF	$5.1 million	$8.3 million	$10.3 million
OACT	$4.7 million	$7.6 million	$9.4 million

Alternative Scenarios (Impacts on Pass Through)

Various scenarios and factors can significantly impact these estimates. A few examples include:

- **CSR Spread**
  Starting in 2018, Silver premiums were increased to offset the government's defunding of CSRs. If CSR costs are spread across all metals, the pass through could decrease by around 7%.
- **Subsidized Member Changes**
  The proportion of subsidized (APTC) members could deviate from expectations due to a number of factors such as mandate repeal. Generally, a +/- 2% change in the percent of subsidized members results in an associated +/- 2% change in pass through.
- **Different 2020 SLCSP Premium Increase than Market**
  If premiums for the SLCSP differ by +/- 5% relative to estimated market average, the pass through will also vary by approximately +/- 3% (lower SLCSP, less pass-through and vice-versa).
- **Reinsurance Impact to SLCSP**
  It is possible that the impact of reinsurance for lower premium plans will be different than that of the market average. If the reinsurance impact to the SLCSP is +/- 2% relative to the market average, the pass through could change by +/- 12% to 24%.

Modeling Range and Best Estimates

Ultimately based on 2018 experience, carrier input, and current regulatory environment (e.g., Silver loading):

- Wakely estimates a pass through range of 60% to 64% assuming moderate assumptions
- However, the pass through estimates are extremely sensitive to various levers that could change the pass through significantly (more than 20%), which could increase needed state funding

Funding Level	$13 million	$21 million	$26 million
Premium Impact	-5.2% to -5.6%	-8.3% to -9.1%	-10.3% to -11.3%
Federal Pass-through	$7.9 to $8.3 million	$12.7 to $13.4 million	$15.7 to $16.6 million
Needed State Funding	$4.7 to $5.1 million	$7.6 to $8.3 million	$9.4 to $10.3 million
Federal Pass-through %	60.6% to 64.0%	60.5% to 64.0%	60.5% to 64.0%

Limitations and Next Steps

Estimates May Change

- ACA world forever changing
- Latest data and policy considerations should be updated before a waiver is submitted
- Operational implementation may influence results

Funding Uncertainty

- Ultimately the Federal Government (Treasury Department) calculates pass-through amounts
- Different assumptions by Treasury may alter actual amounts
- Wakely made assumptions on state funding amounts available but did not estimate mandate collections

Issuer Pricing

- Ultimately how issuers price reinsurance determines impact
- Understanding their concerns and considerations is paramount

Disclosures and Limitations

Responsible Actuary. Julie Peper and Matt Sauter are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows or Associates of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen, PhD, also contributed significantly to this report.

Intended Users. This information has been prepared for the State of Rhode Island to assess the feasibility and impact of a state-based reinsurance and 1332 waiver on the individual Affordable Care Act market in 2020.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. 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 the state or the issues will attain the estimated values included in this 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 both the state of Rhode Island and the issuers affected by the program.

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.

Subsequent Events. The analyses, assumptions and results may change based on discussions and if any new information is received that may influence the estimates. The 2020 benefit and payment parameters, any Federal or state regulatory or legislative changes, and other potential factors could impact the results significantly.

Contents of Actuarial Report. This document constitutes the entirety of actuarial communication and supersede any previous communications on the project.

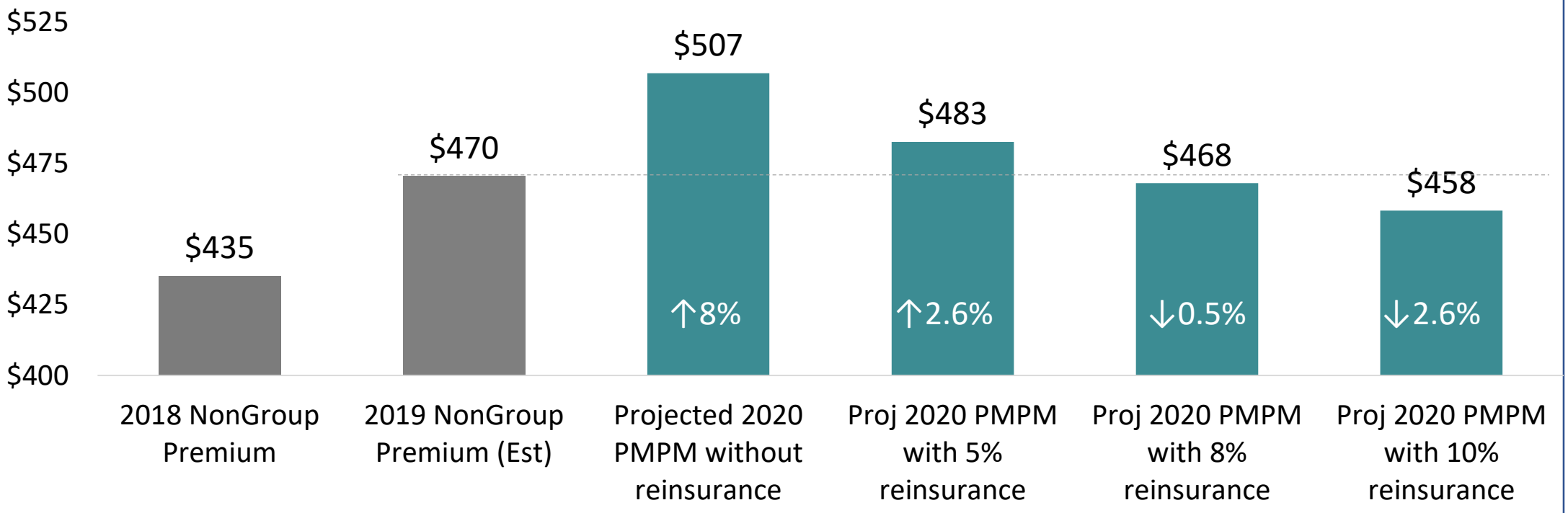
Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance will be included in the final report.

UPDATES SINCE OUR LAST MEETING

1. **Reinsurance in Context of Rate Scenarios**
2. **List of Exemptions Included in Appendix**
3. **Newest 1332 Guidance—Health Affairs summary was distributed**

ILLUSTRATIVE REINSURANCE EFFECT IN CONTEXT OF RATE INCREASE

Sample 2020 Per Member Per Months (PMPM) with and without Reinsurance



RECONVENING THE RI MARKET STABILITY WORKGROUP

The objectives for our work ahead include forming recommendations for policymaker's consideration, including:

- A method (or methods) for funding the RI Reinsurance Program;
- Whether RI should pursue other initiatives to address health coverage affordability and, if so, what programs;
- Aspects of design and implementation for a state-level shared responsibility requirement; and
- A package of consumer and/or market-based protections for codification in RI law.

OBJECTIVES - OVERVIEW

Shared Responsibility Payment

- Design and implementation strategy

RI Reinsurance Program

- Recommend funding source(s)

Additional Affordability Programs

- What programs, if any, are recommended?

HOW DID WE GET HERE?

Meeting Title	Information Covered
Meeting 1 **Regrouping: Workgroup "2.0" + Reinsurance Recap**	• Reinsurance Recap • Program Size in other states • Funding sources from other states
Meeting 2 **Reinsurance Financing Options**	• Premium impact, total cost, and state vs. federal share • Funding options—SRP, assessments narrow to broad, others • Assessments premium impact for partial/full funding
Meeting 3 **Affordability Programs in Addition to Reinsurance**	• RI uninsured characteristics • Affordability programs from other states • Cost of MA/VT subsidies, MN 400%+ subsidies, young adult subsidies
Meeting 4 **Shared Responsibility Requirement**	• Reasons for, effectiveness of, and structure of federal SRP • Impact of current federal SRP • 4 Variations with estimated revenue change and impact to payers
Meeting 5 **Wrap-Up/Opportunity for Follow-Up**	• Tax threshold changes, existing market assessments/taxes, RI premium tax • Different combinations of reinsurance, SRP, and affordability programs
Meeting 6 **Reaching Recommendations**	• Actuarial estimates for reinsurance • Updated scenarios

REACHING RECOMMENDATIONS

- In order to reach a consensus on recommendations, the following questions remain:
  1. Should the SRP structure include any additional exemptions, such as for income 138% FPL?
  2. Should there be an additional affordability program beyond reinsurance?
     - If yes, should it be “paid for” by reducing the size of reinsurance?
     - Or by finding additional revenue through an assessment?
- To that end, we’ve put together text of potential recommendations from this group
  - Aiming for agreement on policy recommendations which will inform cost estimates

POTENTIAL VERSIONS OF CORE WRITTEN RECOMMENDATIONS:

	Version A	Version B	Version C

SRP	• SRP should be implemented close to federal model,
	  • with the addition of an exemption for those with incomes less than 138% of the Federal Poverty Level
	  • with the addition of an exemption for those who were unable to obtain coverage due to a technical barrier.
	• SRP revenue should be specifically designated for healthcare programs.		

Additional Affordability Program	• *[No additional affordability program]*	• Additional affordability program
		  • Targeting young adults to maximize support of guiding principles
			• Additional affordability program
			  • Targeting young adults to maximize support of guiding principles
			  • Funded by an additional revenue source (general revenue or a premium assessment)

Reinsurance	• Reinsurance should be as meaningful as possible	• Reinsurance should be as meaningful as possible after funding an affordability program.	• Reinsurance should be as meaningful as possible

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

NEXT STEPS AND UPCOMING MEETINGS

- Clearly define items for further discussion next week
- Reach final recommendations

PUBLIC COMMENT?

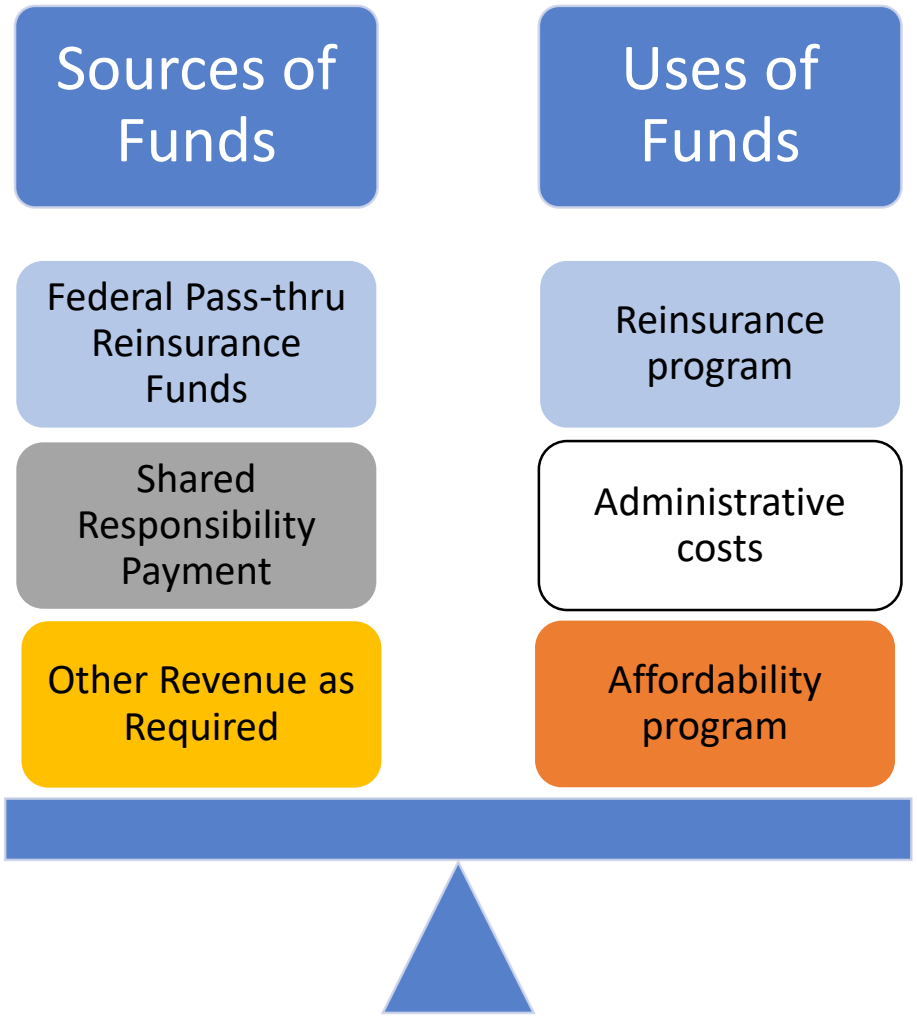
THANK YOU

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

APPENDIX

OVERVIEW OF OPTIONS



- Balanced combinations of **Sources of Funds** and **Uses of Funds**
- Goal is to **illustrate tradeoffs required** to achieve market stability objectives

SELECTED OPTIONS

Selected range of combinations to best illustrate tradeoffs for discussion.

	Policy Choice			Use of Funds $M				Source of Funds $M				
Option	Reinsurance Target	SRP Model	YATC?	Reinsurance	YATC	Admin	Excess Funds	Federal Pass-thru Reins Funds	SRP	Other Rev Source	Total Funds	*% Fed Funds*
1	10.3%	Fed Model	Yes	$26	$5.0	$0.5		$15.8	$11.3	$4.4	**$31.5**	*50%*
2	10.3%	Fed Model	No	$26		$0.5	$0.6	$15.8	$11.3	**None**	**$27.1**	*58%*
10	8.3%	<138 Exempt	No	$21		$0.5	$0.9	$12.8	$9.6	**None**	**$22.4**	*57%*
11	8.3%	1/2 Flat Penalty	Yes	$21	$5.0	$0.5		$12.8	$8.1	$5.6	**$26.5**	*48%*
13	5.2%	Fed Model	Yes	$13	$5.0	$0.5	$0.7	$7.9	$11.3	**None**	**$19.2**	*41%*
15	5.2%	<138 Exempt	Yes	$13	$5.0	$0.5		$7.9	$9.6	$1.0	**$18.5**	*43%*

UNIVERSE OF OPTIONS

Of 18 potential combinations - selected 6 to illustrate and discuss...

	Policy Choice			Use of Funds $M				Source of Funds $M				
Option	Reinsurance Target	SRP Model	YATC?	Reinsurance	YATC	Admin	Excess Funds	Federal Pass-thru Reins Funds	SRP	Other Source	Total Funds	% *Fed Funds*
1	10.3%	Fed Model	**Yes**	$26	$5.0	$0.5		$15.8	$11.3	$4.4	**$31.5**	*50%*
2	10.3%	Fed Model	No	$26		$0.5	$0.6	$15.8	$11.3	None	**$27.1**	*58%*
3	10.3%	<138 Exempt	**Yes**	$26	$5.0	$0.5		$15.8	$9.6	$6.1	**$31.5**	*50%*
4	10.3%	<138 Exempt	No	$26		$0.5		$15.8	$9.6	$1.1	**$26.5**	*60%*
5	10.3%	1/2 Flat Penalty	**Yes**	$26	$5.0	$0.5		$15.8	$8.1	$7.6	**$31.5**	*50%*
6	10.3%	1/2 Flat Penalty	No	$26		$0.5		$15.8	$8.1	$2.6	**$26.5**	*60%*
7	8.3%	Fed Model	**Yes**	$21	$5.0	$0.5		$12.8	$11.3	$2.4	**$26.5**	*48%*
8	8.3%	Fed Model	No	$21		$0.5	$2.6	$12.8	$11.3	None	**$24.1**	*53%*
9	8.3%	<138 Exempt	**Yes**	$21	$5.0	$0.5		$12.8	$9.6	$4.1	**$26.5**	*48%*
10	8.3%	<138 Exempt	No	$21		$0.5	$0.9	$12.8	$9.6	None	**$22.4**	*57%*
11	8.3%	1/2 Flat Penalty	**Yes**	$21	$5.0	$0.5		$12.8	$8.1	$5.6	**$26.5**	*48%*
12	8.3%	1/2 Flat Penalty	No	$21		$0.5		$12.8	$8.1	$0.6	**$21.5**	*60%*
13	5.2%	Fed Model	**Yes**	$13	$5.0	$0.5	$0.7	$7.9	$11.3	None	**$19.2**	*41%*
14	5.2%	Fed Model	No	$13		$0.5	$5.7	$7.9	$11.3	None	**$19.2**	*41%*
15	5.2%	<138 Exempt	**Yes**	$13	$5.0	$0.5		$7.9	$9.6	$1.0	**$18.5**	*43%*
16	5.2%	<138 Exempt	No	$13		$0.5	$4.0	$7.9	$9.6	None	**$17.5**	*45%*
17	5.2%	1/2 Flat Penalty	**Yes**	$13	$5.0	$0.5		$7.9	$8.1	$2.5	**$18.5**	*43%*
18	5.2%	1/2 Flat Penalty	No	$13		$0.5	$2.5	$7.9	$8.1	None	**$16.0**	*49%*

ALTERNATIVE OPTIONS FOR SRP

Levers Available:

- Income Based Exemption
- Flat Penalty Amount ($695)
- % of Income Penalty Amount (2.5%)

Variations Modeled:

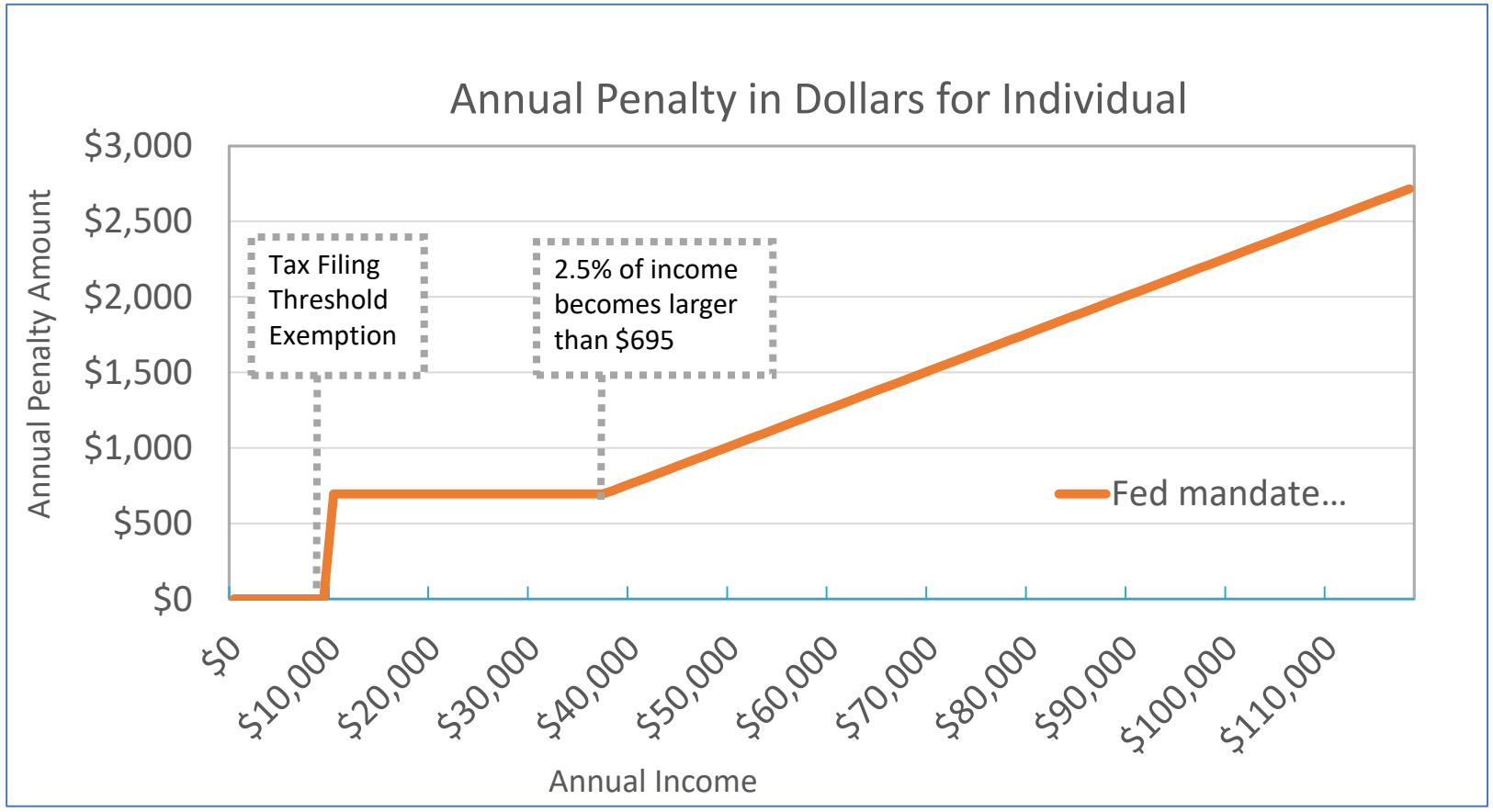
1. Exemption under 138% FPL
2. Flat Penalty Amount reduced by half ($350)
3. Flat Penalty Amount eliminated ($0)
4. Exemption under 138% FPL combined with increased income percentage to 3.5%

About the model:

- Developed by DOR using IRS and RI tax filing data.
- Aggregates 2016 filers into categories based on their family size and FPL
- Models a change by applying an estimate to each category
- See appendix for assumptions

FEDERAL PENALTY STRUCTURE (ending 12/31/18)

Larger of 1) $695 per adult, or 2) 2.5% of income above filing threshold*



KEY EXEMPTIONS

- **Income Exemption** if income below tax filing threshold
- **Affordability Exemption** if coverage costs more than 8.13% of income
- **Hardship Exemption** in case of bankruptcy, flood/fire, death in family, etc.

**Half dollar amount for children, and max per family is equivalent of 3 adults. Overall max set at bronze plan cost*

Current Federal SRP Exemptions

Income Related Exemptions
Income is below the filing threshold
The cheapest available plan was unaffordable
Hardship Exemptions
You were homeless
You were evicted or were facing eviction or foreclosure
You received a shut-off notice from a utility company
You experienced domestic violence
You experienced the death of a family member
You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property
You filed for bankruptcy
You had medical expenses you couldn't pay that resulted in substantial debt
You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member
You claim a child as a tax dependent who's been denied coverage for Medicaid and CHIP for 2017, and another person is required by court order to give medical support to the child. In this case you don't have to pay the penalty for the child.
As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace in 2016
You had another hardship. If you experienced another hardship obtaining health insurance, describe your hardship and apply for an exemption.

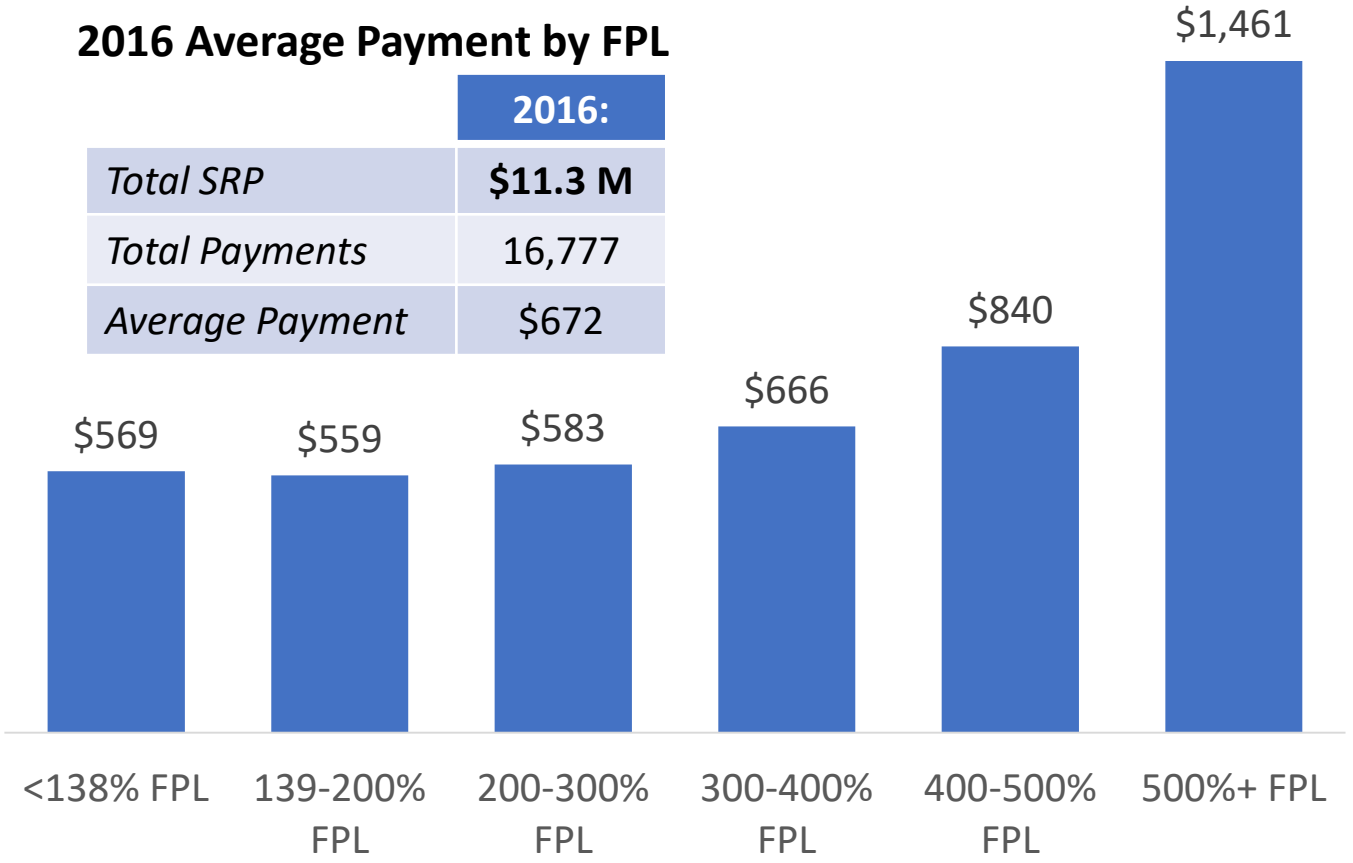
Health Coverage-Related Exemptions
You were uninsured for less than 3 consecutive months of the year.
You lived in a state that didn't expand its Medicaid program and your household income was below 138% of the federal poverty level.
Group Membership Exemptions
You're a member of a federally recognized tribe or eligible for services through an Indian Health Services provider.
You're a member of a recognized health care sharing ministry.
You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare. Application required.
Other Exemptions
You're incarcerated (serving a term in prison or jail).
You're a U.S. citizen living abroad, a certain type of non-citizen, or not lawfully present.
A member of your tax household was born or adopted during the year. This exemption applies only to the month of the event and the month before. You can claim this exemption only if you're also claiming another exemption.
A member of your tax household died during the year. This exemption applies only to the month of the death and the month before. You can claim this exemption only if you're also claiming another exemption.

Hardship Exemptions (Not Relevant In RI)
You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid in 2017 under the Affordable Care Act
Your "grandfathered" individual insurance plan (a plan you've had since March 23, 2010 or before) was canceled because it doesn't meet the requirements of the Affordable Care Act and you believe other Marketplace plans are unaffordable

RI SHARED RESPONSIBILITY PAYMENTS: 2016

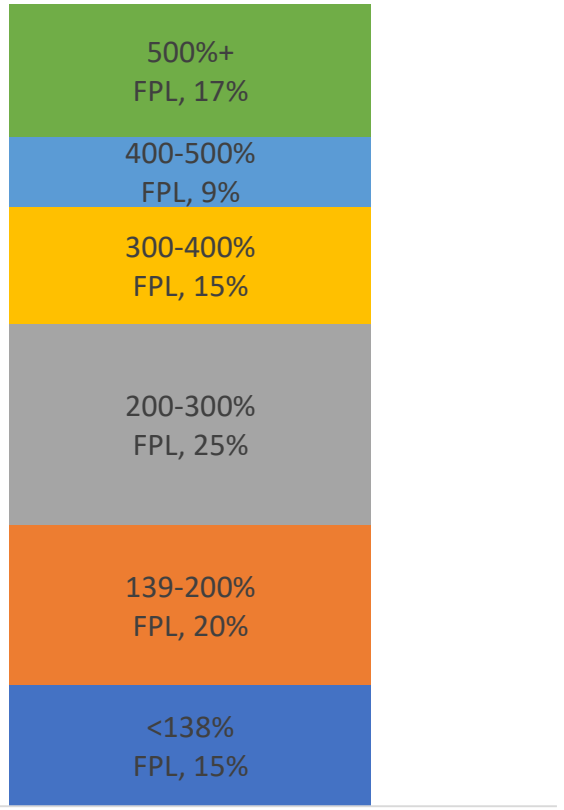
2016 Average Payment by FPL

	2016:
Total SRP	**$11.3 M**
Total Payments	16,777
Average Payment	$672

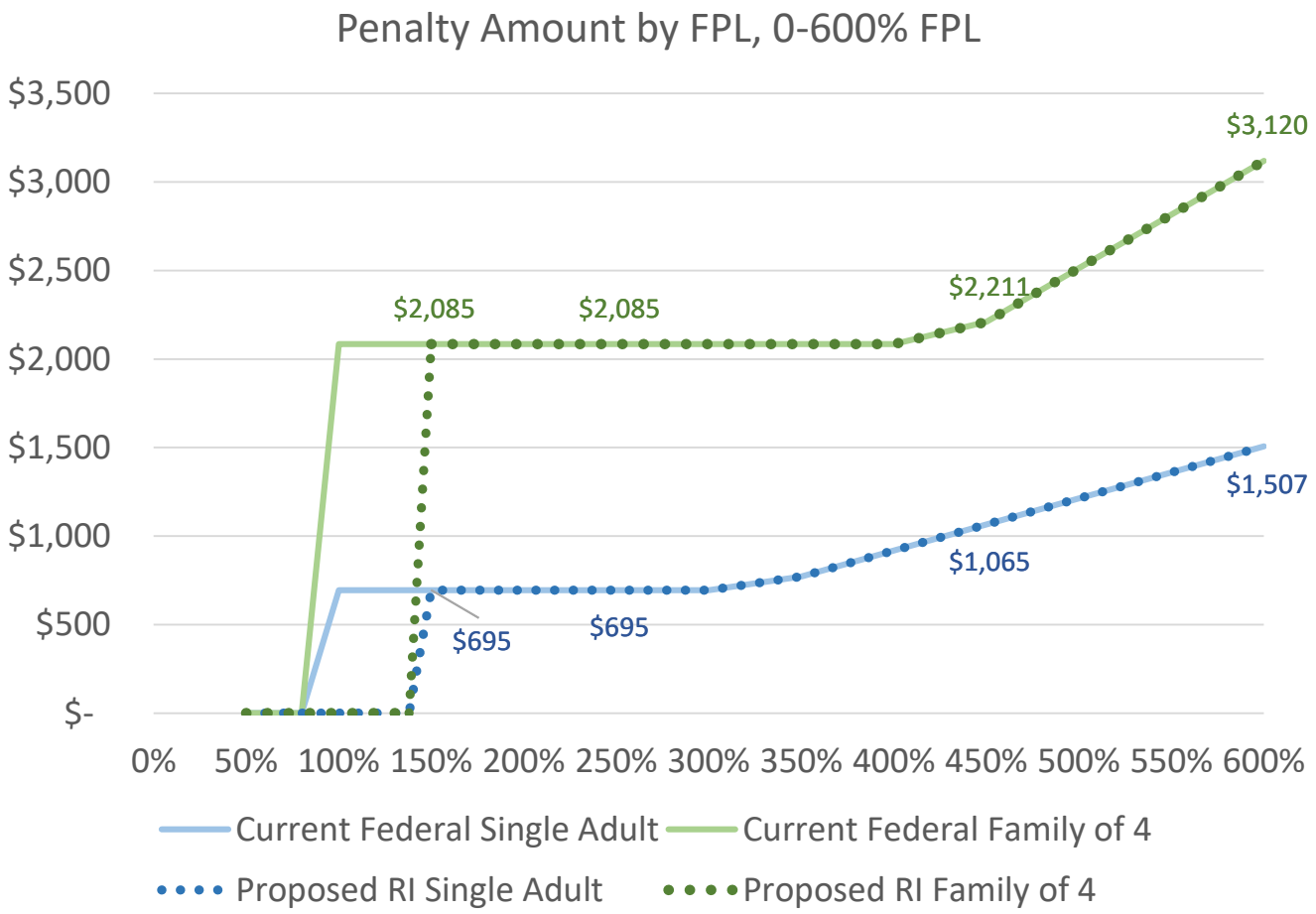


	<138% FPL	139-200% FPL	200-300% FPL	300-400% FPL	400-500% FPL	500%+ FPL
# Payments	2,993	4,027	4,840	2,467	1,177	1,274

Share of Total Paid Amount by FPL



VARIATION 1: EXEMPTION UNDER 138% FPL



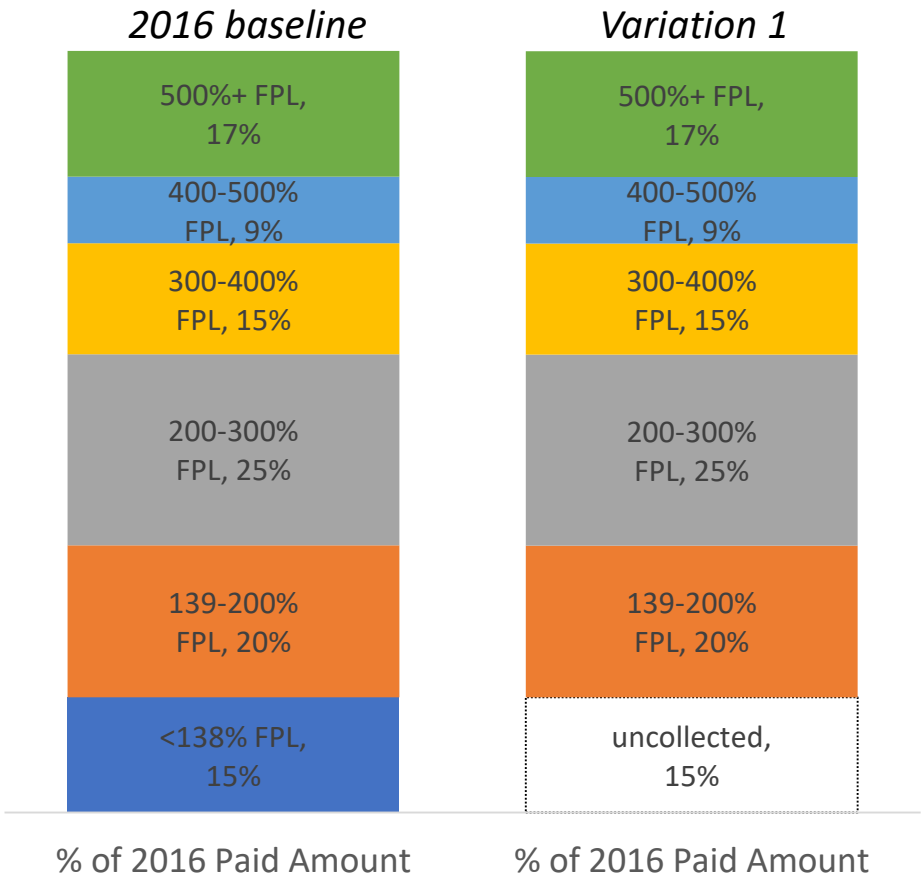
- Corresponds with Medicaid eligibility for most adults
- Many ought to be exempt via affordability exemption, but simplification may make it easier to avoid being penalized
- Estimated revenue reduction of $1.7M
- 100% reduction at lowest income ranges. No impact above that
- Could be “revenue neutral” if the percentage were also increased to 3.5%

VARIATION 1: EXEMPTION UNDER 138% FPL

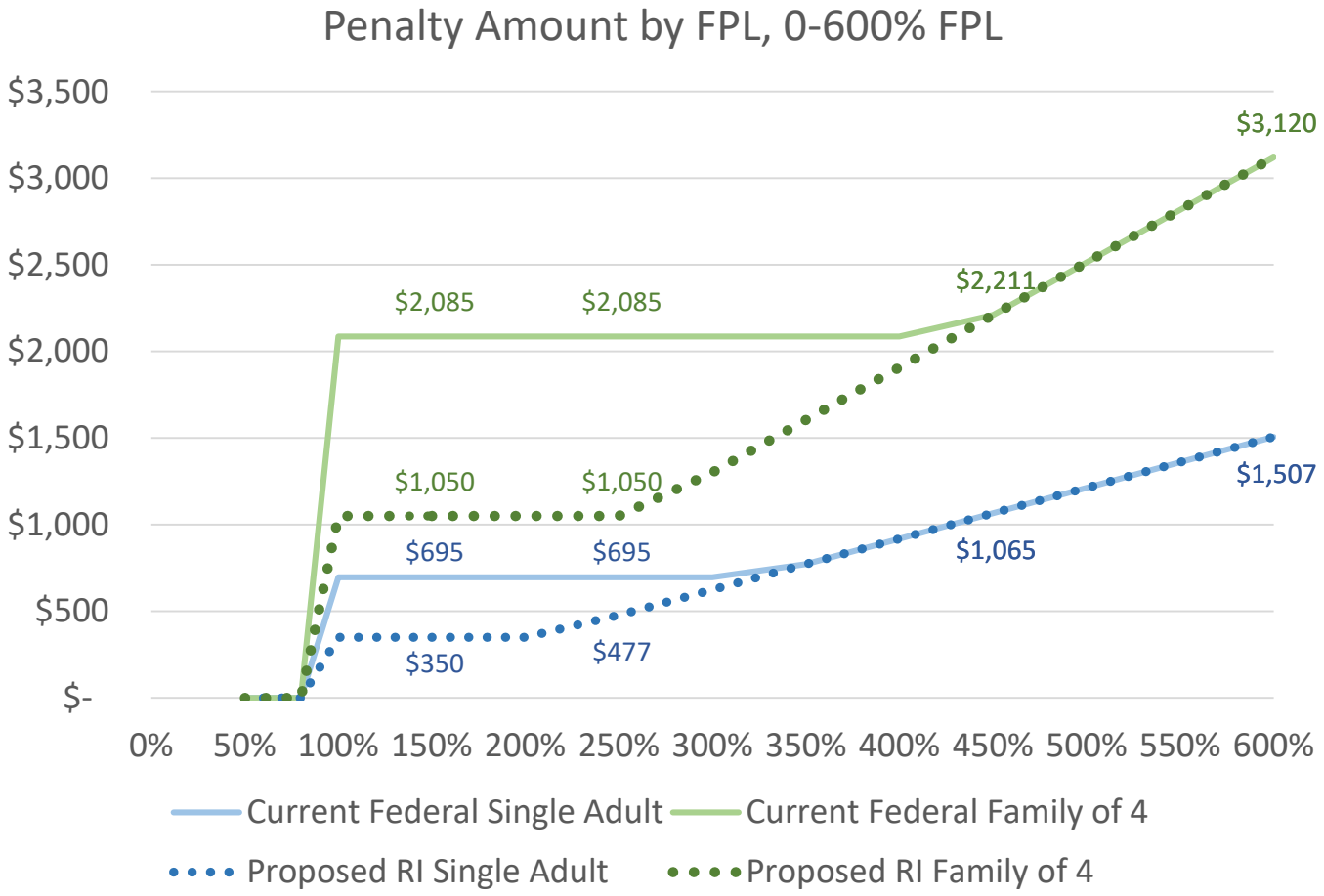
Payment by FPL: 2016 vs. Variation 1

	2016:	Variation 1:	Difference
Total SRP	$11.3 M	$9.6 M	-$1.7 M
Total Payments	16,777	13,784	-2,993
Average Payment	$672	$694	+$22

Share of 2016 Paid Amount by FPL



VARIATION 2: CUT FLAT PENALTY AMOUNT IN HALF



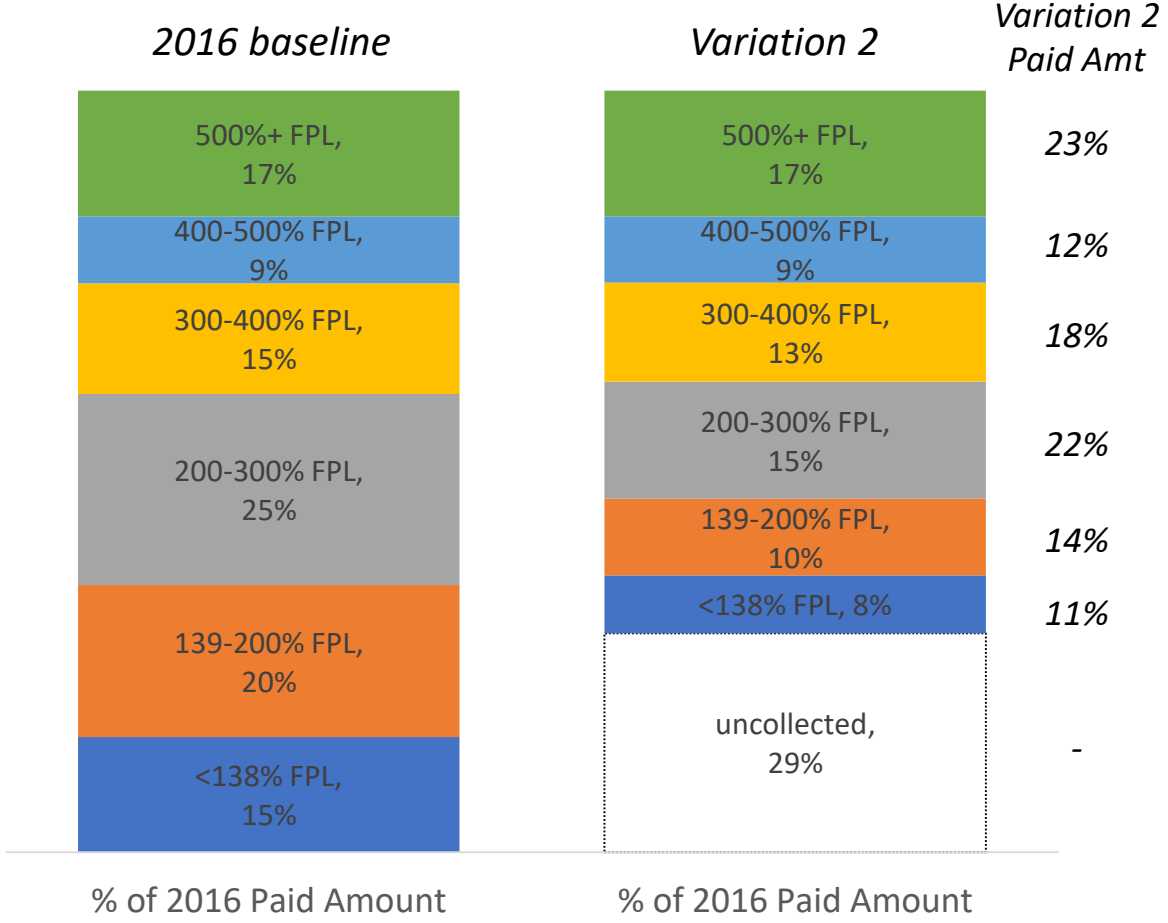
- Estimated revenue reduction of $3.3M
- Impact largest at lowest income ranges—aggregate 50+% reduction below 200% FPL
- Modification phases out as income increases—aggregate 30-44% reduction for 200%-300% FPL
- No impact above 450% FPL
- Could be “revenue neutral” if the percentage were also increased to 3.9%

VARIATION 2: CUT FLAT PENALTY AMOUNT IN HALF

Payment by FPL: 2016 vs. Variation 2

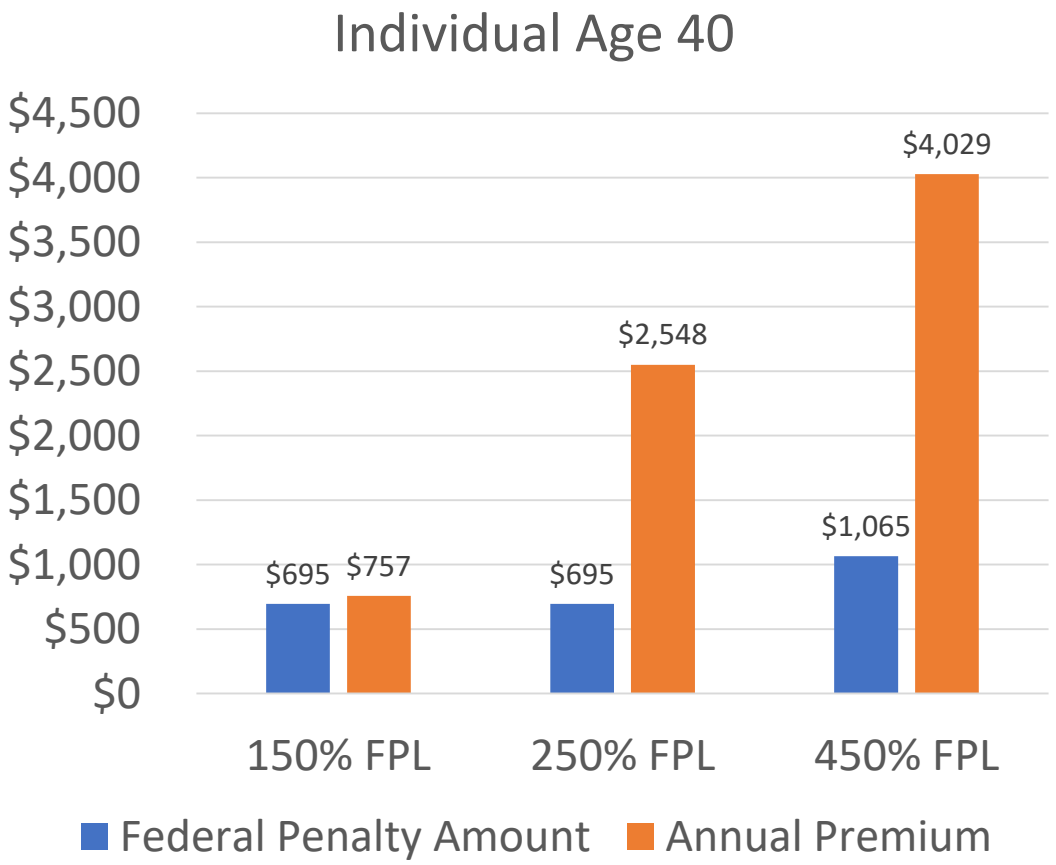
	2016:	Variation 2:	Difference
Total SRP	$11.3 M	$8.1 M	-$3.3 M
Total Payments	16,777	16,777	-
Average Payment	$672	$479	-$193

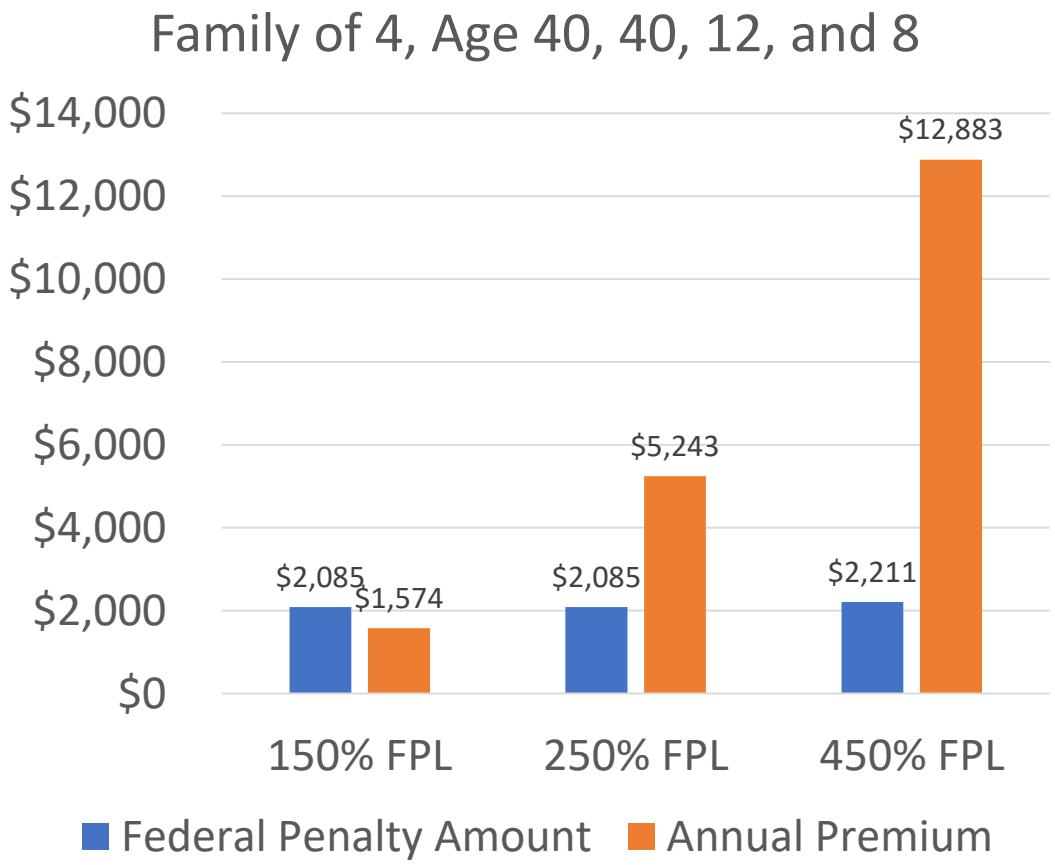
Share of 2016 Paid Amount by FPL



FEDERAL PENALTY AMOUNTS VS. ANNUAL PREMIUM

2019 benchmark plan, after APTC if eligible





Cost for RI Reinsurance Program: Three Factors

(1) Targeted Impact

State sets key parameters to accomplish desired impact

- Scalable, budget dependent
- Typical: 7-20%

(2) Total Program Cost

To be developed by actuaries, estimates based on key market characteristics

- Individual Market Size
- Premium Levels
- Market Volatility

(3) State Share

The 1332 Waiver allows RI to use APTC savings from reduced on-exchange premiums to fund the program

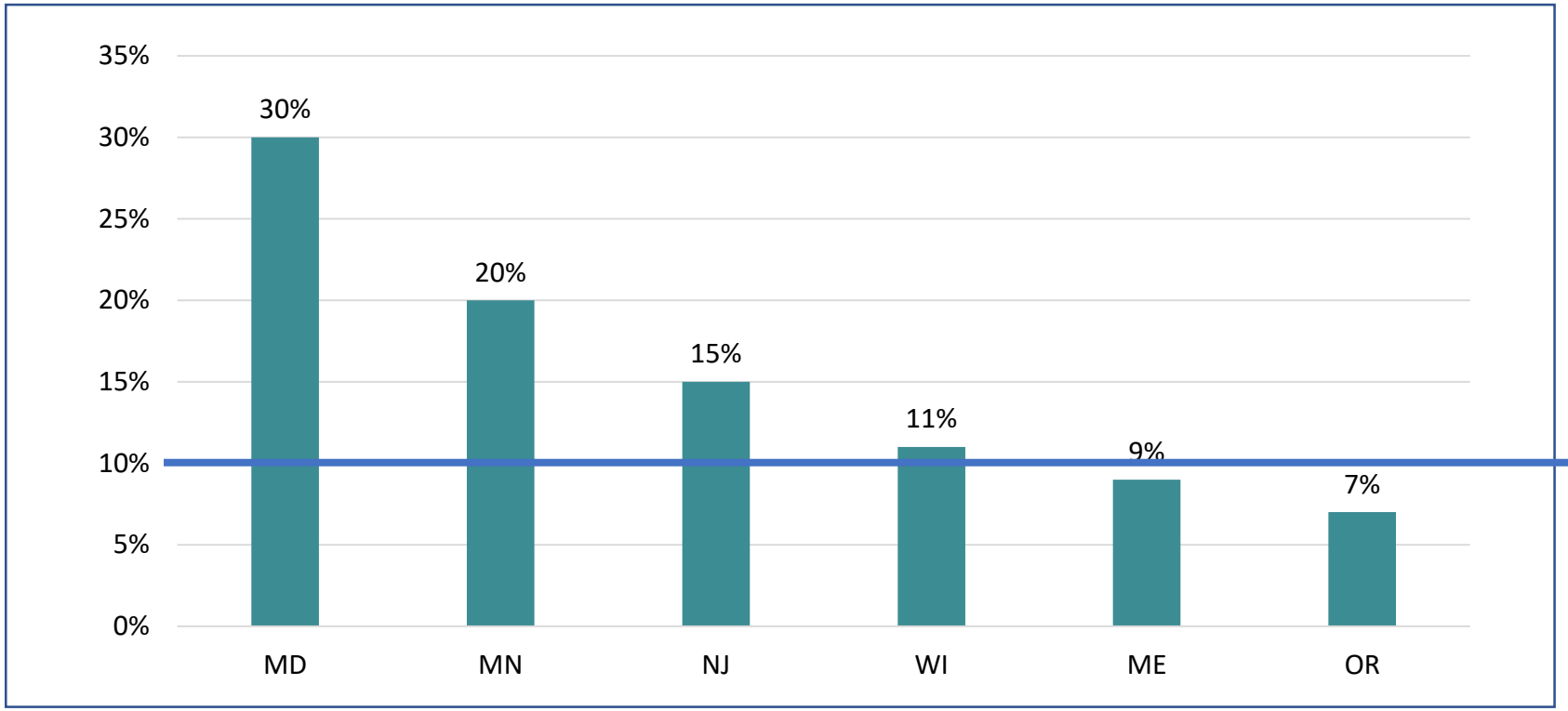
- Subsidized market as % of total market

Note: RI is in the process of contracting with an actuarial firm to provide detailed projections of total reinsurance program cost and anticipated federal pass-through funding from a 1332 Waiver.

Note: This slide from a prior meeting, not updated for Meeting 6

(1) Reinsurance Programs: Targeted Premium Impact by State

States with approved 1332 waivers have targeted between 7% and 30% premium impact from their reinsurance programs.

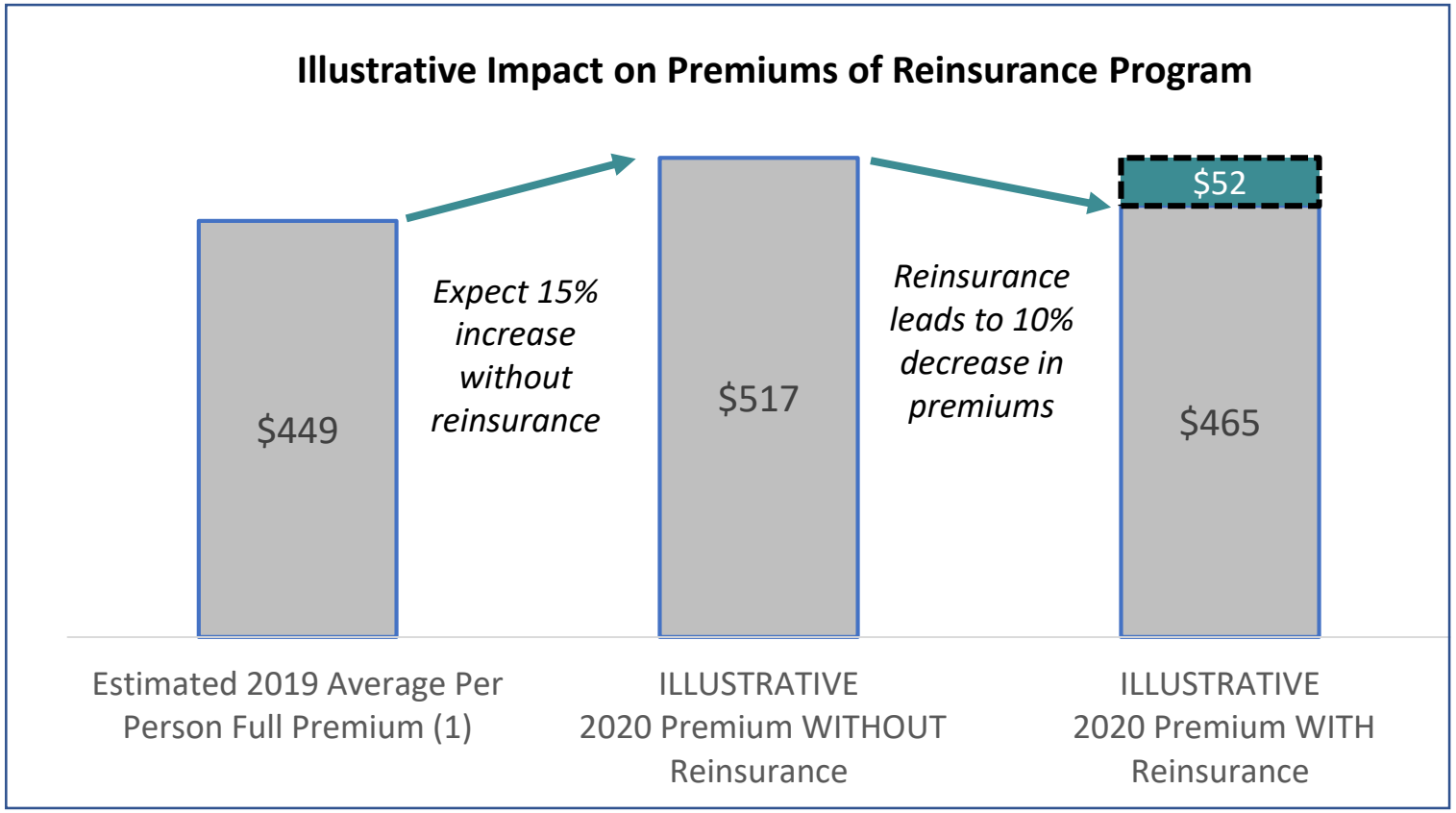


Illustrative Target for RI: 10% of projected 2020 Individual Market Premium

Note: This slide from a prior meeting, not updated for Meeting 6

(2) Total Program Cost: Estimated $27.6 Million

We estimate that in order to achieve a 10% premium impact in 2020 we would need to develop a reinsurance program that would cost an estimated $27 M.



Total Cost: $27.6 M

- $52 pmpm premium reduction
- 44,500 individual market size
- *Assumes no change in enrollment from reinsurance program*

(1) This is estimate of on-exchange average premium based on 2019 rates and 2018 enrollment characteristics. Total individual market average premiums are slightly higher.

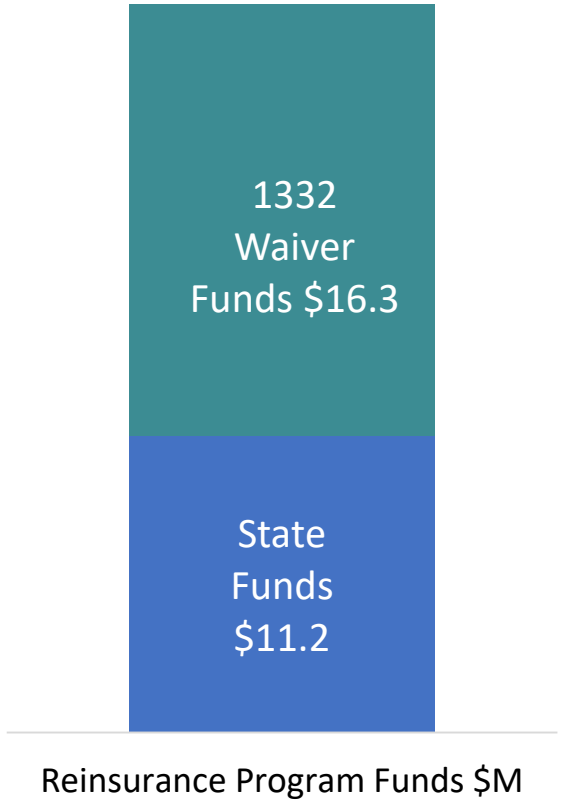
These are illustrative estimates for policy discussion only – actuarial projections of these numbers to be completed in early 2019.

Note: This slide from a prior meeting, not updated for Meeting 6

(3) State Share of Funds: Estimated $11 M

The 1332 Waiver allows RI to use APTC savings from reduced on-exchange premiums to fund the reinsurance program.

$27.6 M Total Program



Estimated $16.3 M federal contribution to Reinsurance (59%)

- $52 pmpm APTC reduction
- 26,000 subsidized enrollees
- *Likely that unsubsidized market enrollment will vary depending on premiums and other regulations*

Estimated $11.2 M state share (41%)

- State must fund remainder

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

Affordability Program Options Review

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

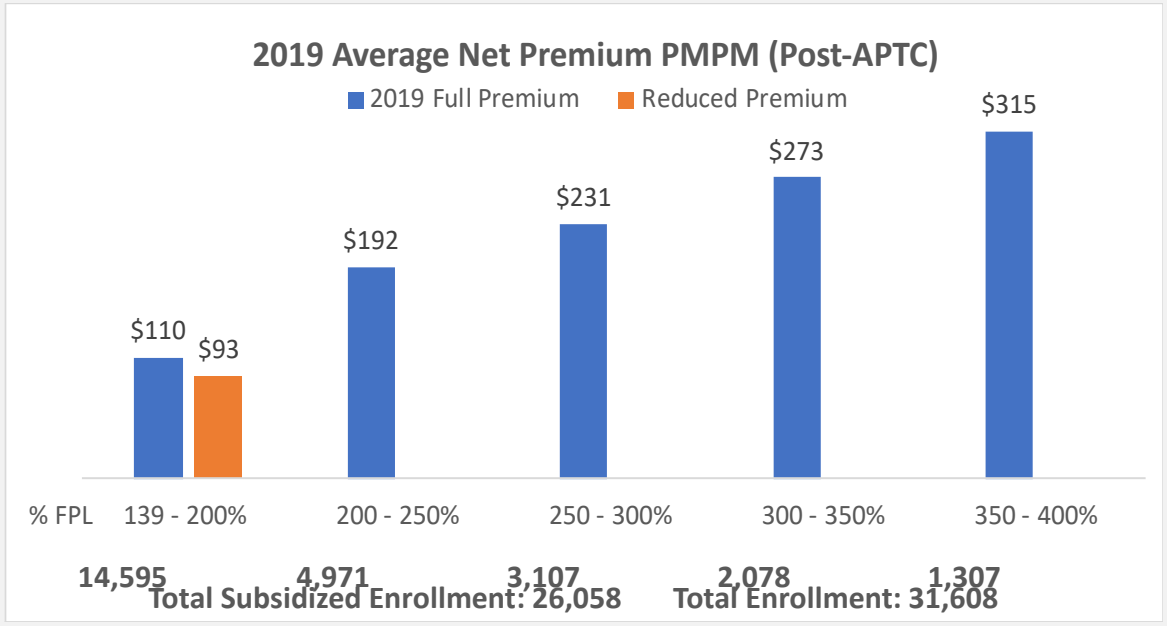
Do these options support the Workgroup's Guiding Principles:
(1) *Sustain balanced risk pool; (2) Maintain attractive market, or; (3) Protect coverage gains achieved under the ACA?*

Example 1: Target Low Income Populations

(A) Target the lowest income bracket only

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

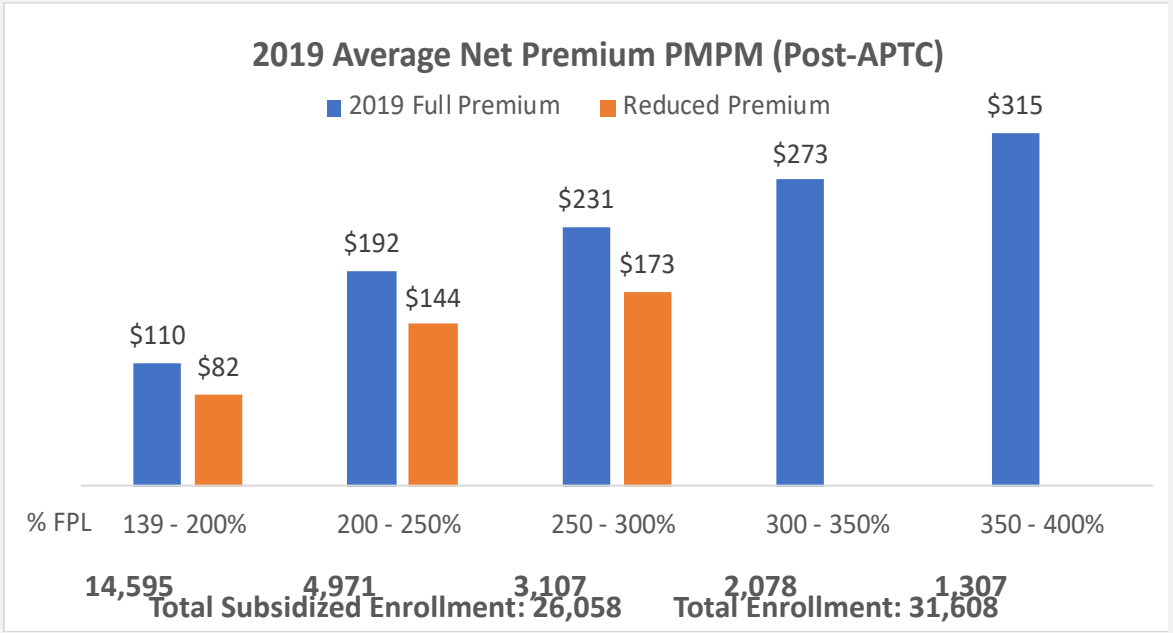
Est. Cost: **$2.9 Million**



(B) Target the population up to 300% FPL

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

Est. Cost: **$9.8 Million**



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

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

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

Example 2: Target Unsubsidized Population

Minnesota Example

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

Estimated Cost: $22.3 Million

Considerations

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

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

Example 3: Target Subsidy Eligible Young Adults

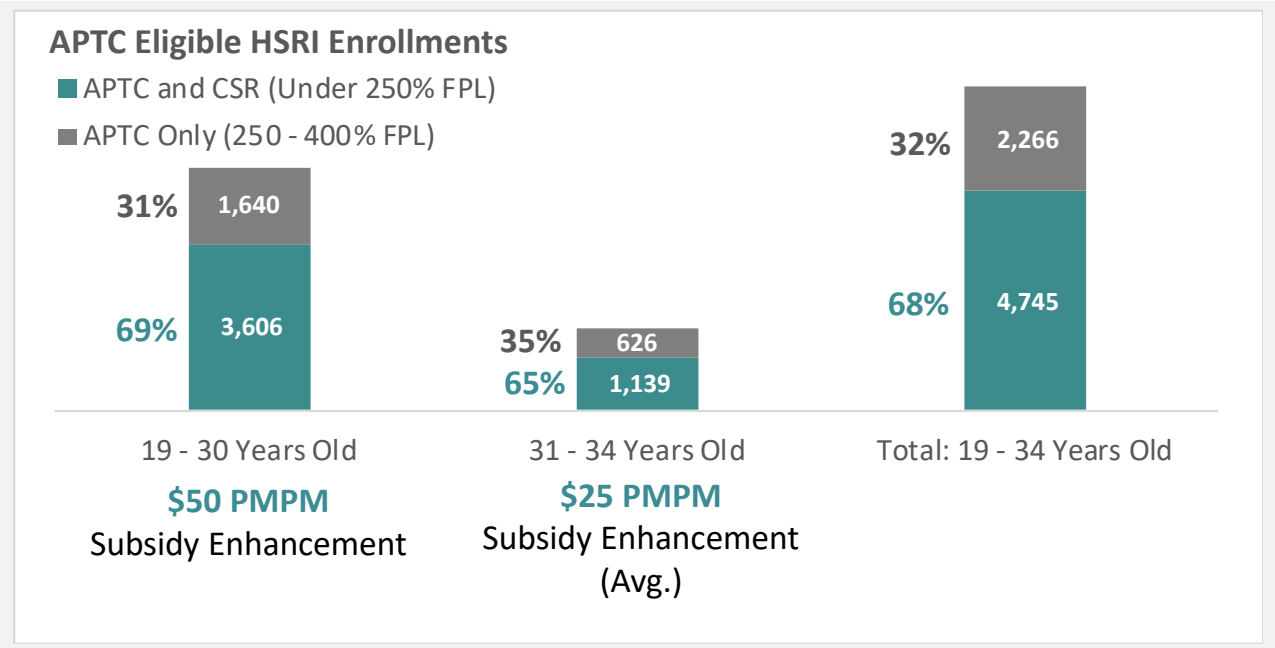
Obama Administration/ Senator Tammy Baldwin Proposal

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

Estimated Cost: $3.7 Million*

Considerations

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



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

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

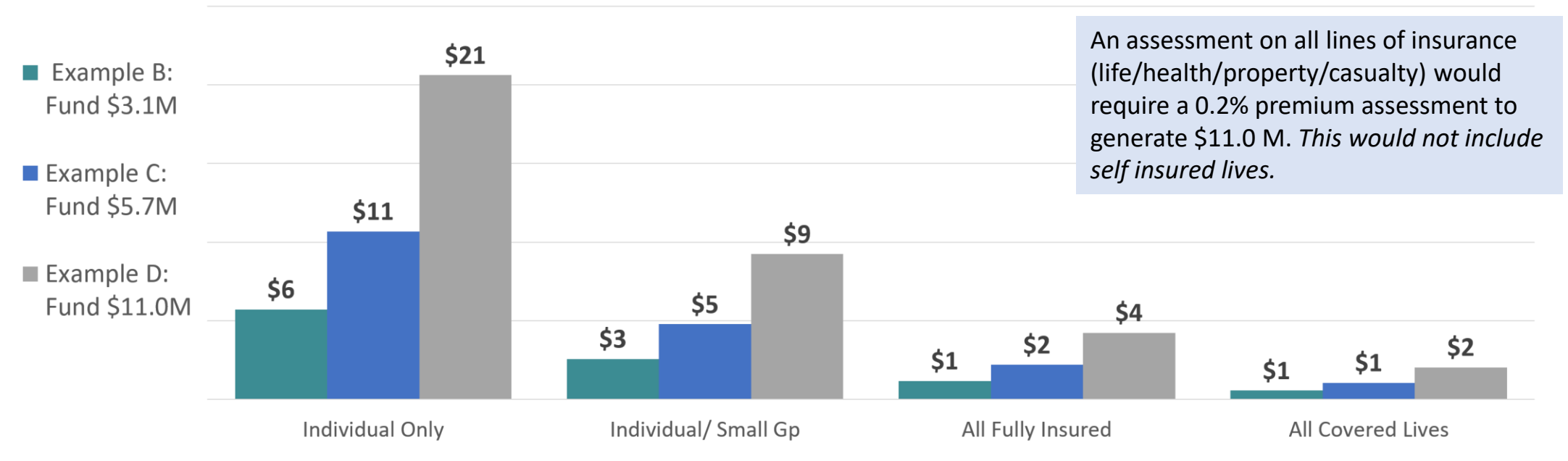
Estimate for funding needed for 30% take-up = $5 million. Used in Scenario Options shown here.

Note: This slide from a prior meeting, not updated for Meeting 6

Other Assessments: Who Pays?

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

Estimated Range of PMPM Assessment to Fund Remaining State Share



An assessment on all lines of insurance (life/health/property/casualty) would require a 0.2% premium assessment to generate $11.0 M. *This would not include self insured lives.*

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

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

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

Market Stability Workgroup

Date of Meeting: December 11, 2018
Meeting Time: 8:30 am
Meeting Location: United Way of Rhode Island
50 Valley St Providence, RI 02909

Workgroup Members Present: Co-Chair Marie Ganim, Co-Chair Zachary Sherman, Cristina Amadeo, Marc Backon, Stephen Boyle, David Burnett, Al Charbonneau, Lauren Conway, Ralph Coppola, Jane Hayward, Peter Hollman, Hon. Joshua Miller, Monica Neronha, Janet Raymond, Samuel Salganik, John Simmons, Susan Storti, Larry Warner, Teresa Paiva Weed, Bill Wray

Workgroup Members Absent: Hon. Gayle Goldin

Minutes

I. Meeting was called to order at 8:36am.

a. The minutes of the November 27, 2018 meeting were approved with no changes.
b. Commissioner Ganim reviewed the agenda for today's meeting.

II. Preliminary actuarial estimates of a reinsurance program – Matt Sauter and Michael Cohen, actuaries from Wakely, gave a presentation to the workgroup. Wakely was retained to perform actuarial analysis in support of Rhode Island's 1332 waiver application.

a. Wakely first presented 2017-2018 individual market data.
b. Using claims, enrollment, and premium data from Rhode Island issuers, as well as information from HSRI and OHIC, Wakely established 2020 baseline scenarios. They presented 3 potential baselines:
    i. A "minimum effect" baseline where they assumed the individual mandate repeal and RI mandate have a minimal impact -a 2% enrollment decrease from 2018.
    ii. A baseline using modified Kaiser survey data wherein mandate repeal has a moderate affect and a state mandate stems enrollment decreases – a 5% enrollment decrease from 2018 ("KFF").
    iii. A baseline scenario that relies on Office of the Actuary estimates where repeal has a substantial effect on enrollment – a 16% enrollment decrease from 2018 ("OACT").
c. The Wakely actuaries next presented modeled scenarios for reinsurance impact. They presented 3 different potential reinsurance funding levels—$13 million, $21 million, $26 million—and their impacts relative to the previously described 2020 baselines. They also presented estimated Federal pass-through rates and needed state funding for each baseline at each reinsurance funding level.
    i. Wakely estimates a 5.2% - 11.3% reduction in premiums relative to the 2020 baseline, depending on the level of reinsurance funding and the baseline scenario used.

ii. Wakely estimates a pass-through range of 60-64% assuming moderate assumptions
iii. State funding level numbers presented ranged from $4.7 million to $10.3 million, depending on overall level of reinsurance funding ($13 million, $21 million, or $26 million). These numbers are preliminary and not final but represent Wakely's current best estimates.

d. The actuaries presented limitations of their estimates: ACA policy changes, differences in assumptions made by US Treasury (which ultimately determines pass-through amounts), issuer pricing.
e. Questions and comments from workgroup members
    i. In response to a question from the Workgroup, Matt Sauter explained the impact that the elimination of silver loading (the practice of concentrating premium increases caused by the cessation of federal cost-sharing reduction payments on silver-level plans) would have on pass-through dollars. Spreading the CSR premium increase would lower the price of the second-lowest cost silver plan (the benchmark plan) which determines the value of the advance premium tax credit (APTC). A decrease in the APTC would mean a decrease in federal pass-through dollars – Wakely estimates the elimination of silver loading would decrease pass-through by 7%. Director Sherman said any decision on whether or not to allow silver loading on 2020 premiums would be included in forthcoming federal payment regulations.
    ii. Sam Salganik said that while maximizing federal dollars is usually a reasonable policy goal, he was not sure that maximizing federal dollars is the right goal for Rhode Island's market given the circumstances of the market position of the two individual market carriers, Blue Cross & Blue Shield of RI (BCBSRI) and Neighborhood Health Plan of RI (NHP).
    iii. Senator Miller asked if it was possible to adjust the reinsurance program each year. Director Sherman said yes, the waiver is approved for 5 years and can be adjusted annually as long as the program is not materially changed.
    iv. Sam asked if the Workgroup would have an opportunity to weigh in once a more detailed analysis has been completed by Wakely. Director Sherman said that was not originally part of the Workgroup syllabus but would be considered; he also noted that there is a public comment period as part of the waiver application process. John Simmons noted that legislative authority would be needed for the funding and that the timing of that process would allow for the Workgroup to see a more complete analysis.
    v. In response to a question regarding timing of the legislature approving funding and the waiver application process, Michael Cohen said that CMS will not consider an application final until a funding source has been established.
    vi. David Burnett asked whether the estimated premium impacts presented would be sufficient to stabilize enrollment. Michael Cohen said this was a hard question, noting that enrollment and premium impact are both factors

in market stability. Wakely estimates a 1-2% stemming of enrollment decrease. Director Sherman reiterated the Workgroup's definition of market stability: maintaining a balanced risk pool, a market that is attractive to insurers, and protecting coverage gains.

vii. John Simmons asked what the value of a reinsurance program was if the cost of reducing premiums was equal to the amount of the premium reduction. Monica Neronha said that the reinsurance program would be similar to the federal reinsurance program which she described as effective. She noted that data was available to compare years when the federal reinsurance program was active (2014-16) to years since it has been discontinued (2017-18). Marc Backon added that a state reinsurance program would bring back some stability lost as the federal reinsurance was discontinued. Bill Wray noted the stabilizing effect of potentially expanding the risk pool.
    1. Later in the meeting, Monica was able to provide some BCBSRI-specific numbers on the impact of the federal reinsurance program. In 2014, BCBSRI received $23 million from the program, the offset to premium was filed at 11% and the actual offset was 16%; in 2015, BCBSRI had half the market, received $11 million, filed an 8% and the actual offset was 10.6%; 2016 BCBSRI received $6 million and the actual offset was 4.4%. When the program was eliminated in 2017 rates went up approximately 5%.

viii. Sam Salganik mentioned an affordability program previously discussed by the workgroup to offer an additional tax credit to young adults. He asked if this would have an impact in reducing overall premium. Michael Cohen said yes, to the extent that adding more healthy young adults improves the risk pool, it would.

ix. Teresa Paiva Weed expressed concern about potential funding/revenue source for an additional affordability program, noting that there was not yet a revenue source to fund the reinsurance program.

x. Senator Miller asked if more subsidized enrollees would buy up from a silver to a gold plan in a market stabilized by a reinsurance program. Michael Cohen said Wakely has not modeled this. Director Sherman said that after silver loading a lot of enrollees bought up. Senator Miller said that more consumers buying gold plans would help the overall healthcare system by reducing provider expenses.

xi. Steve Boyle said he did not see the Workgroup as being anywhere different than before today, that there would be no "silver bullet" data that would make the Workgroup 100% of any proposal, that at some point the Workgroup would have to make a recommendation based on the information available, put together a program, and adjust it going forward.

III. Reaching Recommendations

a. Katie Hall provided follow-up items from meeting five
    i. Katie presented a chart illustrating the effect of a reinsurance program in context of rate increases on a per member per month (PMPM) basis. The

projected 2020 PMPM was $507 without reinsurance, an 8% increase from 2019. With a 5% reinsurance program, the projected PMPM was $483 or 2.6% increase from 2019. An 8% reinsurance program would yield a projected $468 PMPM for 2020 or a 0.5% decrease. A 10% reinsurance program would yield a projected $458 PMPM, a 2.6% decrease from 2019.

ii. The current list of federal exemptions to the individual mandate was included in this week's Workgroup materials.

iii. Health Affairs summaries of 1332 waiver guidance recently issued by CMS were distributed to the Workgroup.

b. Deb Faulkner reviewed the Workgroup's recommendations and guiding principles.

c. Deb Faulkner presented some possible text for potential policy recommendations. She began by saying that in order to reach a consensus on recommendations, the following questions remain: Should the SRP structure include any additional exemptions, such as for income 138% FPL? Should there be an additional affordability program beyond reinsurance? If yes, should it be "paid for" by reducing the size of reinsurance? Or by finding additional revenue through an assessment? With this introduction, Deb presented a selection of potential versions of core written recommendations.

i. Commissioner Ganim thanked Deb and added that the SRP in and of itself is a market stabilizer, regardless of the amount of revenue it generates. She noted that the Workgroup recommended the SRP at the end of its spring session and that it is similar to the requirement that all automobile drivers carry valid auto insurance.

ii. Lauren Conway asked if HSRI had seen an enrollment impact due to the loss of the federal mandate. Director Sherman responded that it was too soon to tell as open enrollment was still ongoing. It was noted that while national enrollment numbers were expected to be lower for 2019, states with their own state-based exchange (like Rhode Island) would not necessarily see the same trend.

iii. Monica Neronha, referring to the potential text for recommendations, said she liked option A, which did not include any additional affordability programs. She said additional affordability programs are worth exploring, but she felt they had been a bit of a distraction to the conversation about the waiver and did not feel they would lead to additional meaningful enrollment.

iv. Sam Salganik said it was important to look at the package as a whole, its impact on the market, and the extent to which it is regressive – that is, collecting more from low-income earners. He noted that under the federal mandate structure more low-income families may the flat dollar amount penalty than the percentage of income penalty and that the flat dollar amount penalty works out to be a greater percentage of a low-income family's income. Ralph Coppola asked how this compares to the cost of insurance. Sam noted that a family of 4 earning $40,000 a year would not be eligible for Medicaid and would be struggling to pay for child care,

auto insurance and other expenses in addition to health care. He agreed that from a policy perspective it was important to encourage them to coverage, and that a penalty might be a part of that, but asked if it was the right policy to penalize such a high percentage of a low-income family's earnings.

v. Teresa Paiva Weed said the penalty was a critical part of the ACA and that she felt the workgroup was only trying to uphold the original intent.
vi. Sam noted that the mandate as structured as part of the ACA was controversial, but it was part of a broad package of extremely progressive policies including tax credits, Medicaid expansion, increased capital gains tax. Sam said he was not saying these policy decisions were "right" or "wrong" but that he felt the Workgroup needed to be honest and clear eyed about the impact of policy decisions.
vii. Steve Boyle said lower income people qualify for Medicaid expansion so how are they penalized? Sam noted that individuals and families earning 150%, 200% of FPL did not qualify for Medicaid but even subsidized, private insurance could be difficult to afford.
viii. Bill Wray expressed support for option A, saying that evidence shows a decline in individual market enrollment could lead to a spiral that seriously destabilizes the market. He said ultimately what is needed is something simple and clear enough to get through the state legislature. He recommended putting a state SRP and reinsurance program in place while continuing to think about how to work on other areas to meet affordability goals. He said the risk of over-complicating the policy recommendations was getting nothing.
ix. Senator Miller noted that the group of low-income individuals who would be subject to SRP is a very small group due to the state's low rate of uninsured and that it is fluid, it is not the same people. He noted there may be employer behaviors contributing to this group not enrolling in health insurance and that there may be ways to regulate employers rather than attempting to regulate enrollee behavior.
x. John Simmons said it was important to look at whether the mandate was effective or not in its original purpose. He said he was more inclined to consider the mandate for the purpose of what it does for health coverage. He said we do not want to see lower-income people pay for those who are going to benefit.
xi. Teresa said subsidies were more important than the mandate in terms of driving enrollment. She would prefer to see a state reinsurance program funded by some other means. But she understood a mandate may be necessary and said that if there is one, it should have an exemption for those earning less than 138% FPL.
xii. Commissioner Ganim said that data show the mandate is effective in supporting/driving enrollment.
xiii. Steve Boyle asked if it was possible to "opt in" low-income individuals and families who qualify for Medicaid. Sam said this has been explored, but there are significant operational challenges. He noted that hospitals

often work to enroll uninsured patients who show up there who qualify for Medicaid.

xiv. Al Charbonneau asked what percentage of people were eligible for Medicaid but not taking it. Director Sherman said 15% of those who paid the penalty in 2016 were Medicaid eligible.

IV. Next steps and upcoming meetings

a. The goal of the next meeting is to get clarity on recommendations or areas of disagreement.
b. The next meeting is December 18, 2018 at RIPIN, 1210 Pontiac Ave, Cranston.

V. Public Comment - No members of the public offered comment.

VI. Adjourn – The meeting adjourned at 10:38 AM.

Market Stability Workgroup

Notice Posted: December 13, 2018
Date of Meeting: December 18, 2018
Meeting Time: 8:30 AM
Meeting Location: RIPIN
1210 Pontiac Ave
Cranston, RI 02920

Agenda

I. Call meeting to order
   a. Motion to approve December 11, 2018 meeting minutes
   b. Review Today's Agenda

II. Follow-ups from previous meetings
   a. 1332 Application Timeline Review
   b. Carrier Reinsurance Numbers 2014 -16

III. Discussion:
   a. Review Workgroup Objectives
   b. Options for Workgroup Recommendations
   c. Vote on options

IV. Next steps and upcoming meetings

V. Public comment

VI. Adjourn

RIPIN is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Jonelie Cardoza at 401.462.6428 or email her at jonelie.cardoza@ohic.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP 2.0

Meeting #7

Tuesday, December 18, 2018
8:30 – 10:30 a.m.
RIPIN, 1210 Pontiac Ave, Cranston, RI 02920

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

Topic(s) for Discussion	Meeting Date
Break for the holidays	Mid-December – early January
Meeting 8 **Possible Codification of ACA Consumer and Market Protections**	Tuesday, January 8th
Meeting 9 **Legislative Recommendations**	Tuesday, January 22nd
Meeting 10 **Legislative Recommendations (*reserved if needed*)**	Tuesday, February 5th

TODAY'S AGENDA

1. **Follow-up Items from Previous Meetings**
2. **Discussion:**
   a) **Review Workgroup Objectives**
   b) **Review Text of Potential Recommendations**

UPDATES SINCE OUR LAST MEETING

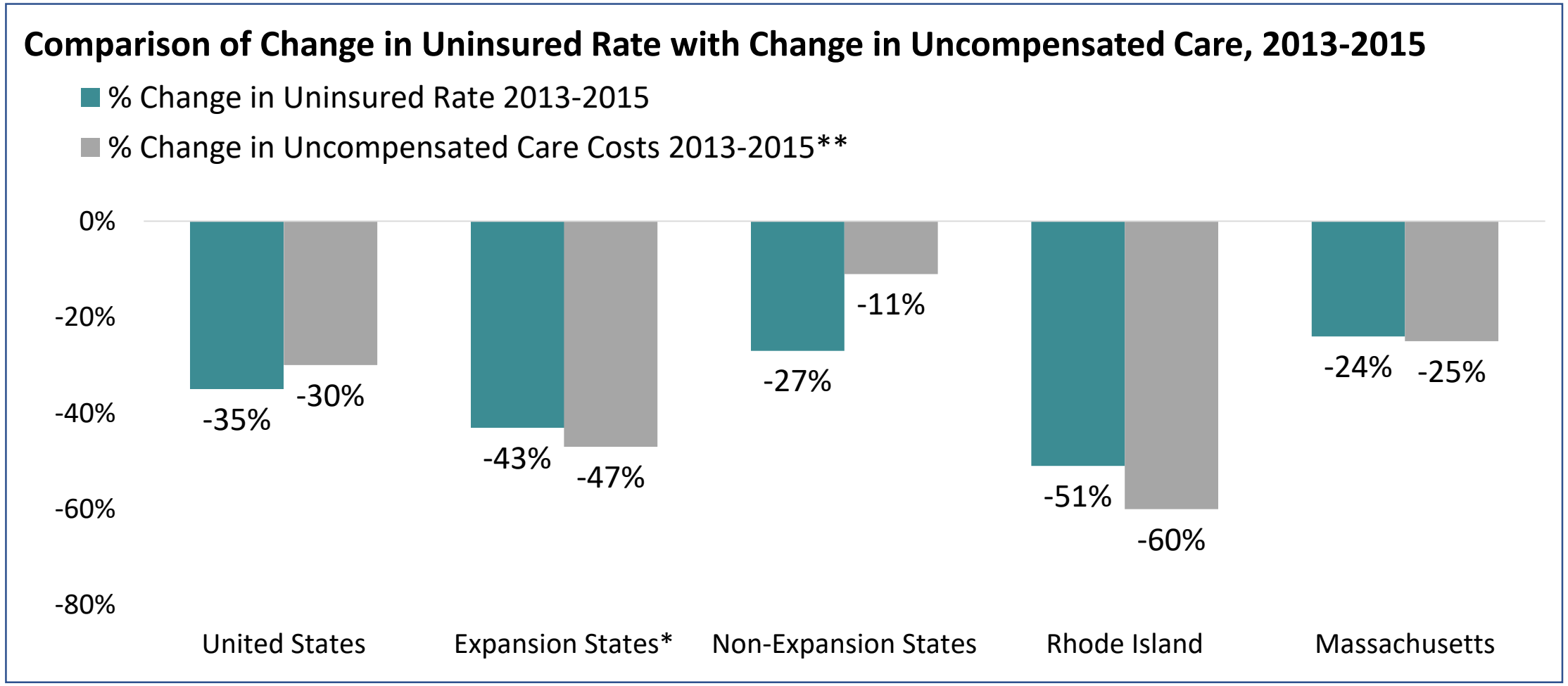
1. **Timeline of Application**
2. **Uncompensated Care**
3. **Impact of Federal Reinsurance Program on Carrier Rates 2014 – 16**

THE 1332 WAIVER PROCESS - UPDATE

Step	Target Timeline
1. Authorizing Legislation	✓ ***Complete***
2. RFP for Actuarial Work	✓ ***Complete***
3. Actuarial Work Begins	November 2018
4. 1332 Waiver Application Drafting • Public notice/comment period	Winter/*Spring 2019* • 30 days at minimum
2020 Rate development	Late winter, 2019
5. Application Submission	*A final application will be submitted if/when state funding is appropriated.*
2020 Rate filing	May 2019
6. HHS and Treasury Prelim. Review	Late Spring 2019 (30-45 days after application submission)*
7. Funding appropriated	Early Summer 2019
8. Final Decision of HHS and Treasury	Summer 2019 (2-6 months after the application completeness determination)*

**CMS has indicated that reinsurance program waivers will be reviewed and approved quickly if they are similar to approved waivers from other states.*

UNINSURED RATE IMPACT ON UNCOMPENSATED CARE



*Medicaid expansion state as of March 2015

**Uncompensated care costs defined as uncompensated care costs as percent of operating costs

Source: Center on Budget and Policy Priorities Report, May 23, 2019, Appendix Table 1

RECONVENING THE RI MARKET STABILITY WORKGROUP

The objectives for our work ahead include forming recommendations for policymaker's consideration, including:

- A method (or methods) for funding the RI Reinsurance Program;
- Whether RI should pursue other initiatives to address health coverage affordability and, if so, what programs;
- Aspects of design and implementation for a state-level shared responsibility requirement; and
- A package of consumer and/or market-based protections for codification in RI law.

OBJECTIVES - OVERVIEW

Shared Responsibility Payment

- Design and implementation strategy

RI Reinsurance Program

- Recommend funding source(s)

Additional Affordability Programs

- What programs, if any, are recommended?

HOW DID WE GET HERE?

Meeting Title	Information Covered
Meeting 1 **Regrouping: Workgroup "2.0" + Reinsurance Recap**	• Reinsurance Recap • Program Size in other states • Funding sources from other states
Meeting 2 **Reinsurance Financing Options**	• Premium impact, total cost, and state vs. federal share • Funding options—SRP, assessments narrow to broad, others • Assessments premium impact for partial/full funding
Meeting 3 **Affordability Programs in Addition to Reinsurance**	• RI uninsured characteristics • Affordability programs from other states • Cost of MA/VT subsidies, MN 400%+ subsidies, young adult subsidies
Meeting 4 **Shared Responsibility Requirement**	• Reasons for, effectiveness of, and structure of federal SRP • Impact of current federal SRP • 4 Variations with estimated revenue change and impact to payers
Meeting 5 **Wrap-Up/Opportunity for Follow-Up**	• Tax threshold changes, existing market assessments/taxes, RI premium tax • Different combinations of reinsurance, SRP, and affordability programs
Meeting 6 **Reaching Recommendations**	• Actuarial estimates for reinsurance • Updated scenarios

REACHING RECOMMENDATIONS

- In order to reach a consensus on recommendations, the following questions remain:
  1. Should the SRP structure include any additional exemptions, such as for income 138% FPL?
  2. Should there be an additional affordability program beyond reinsurance?
     - If yes, should it be “paid for” by reducing the size of reinsurance?
     - Or by finding additional revenue through an assessment?
- To that end, we’ve put together text of potential recommendations from this group
  - Aiming for agreement on policy recommendations which will inform cost estimates

POTENTIAL VERSIONS OF CORE WRITTEN RECOMMENDATIONS:

	Version A	Version B	Version C

SRP	• SRP should be implemented close to federal model,
	  • with the addition of an exemption for those with incomes less than 138% of the Federal Poverty Level
	  • with the addition of an exemption for those who were unable to obtain coverage due to a technical barrier.
	• SRP revenue should be specifically designated for healthcare programs.		

Additional Affordability Program	• *[No additional affordability program]*
	• Outreach and support for penalty payers regarding: enrollment options, tax season SEP, & Medicaid eligibility.
		• Additional affordability program
		  • Targeting young adults to maximize support of guiding principles
		• Outreach and support for penalty payers regarding: enrollment options, tax season SEP, & Medicaid eligibility.
			• Additional affordability program
			  • Targeting young adults to maximize support of guiding principles
			  • Funded by an additional revenue source (general revenue or a premium assessment)
			• Outreach and support for penalty payers regarding: enrollment options, tax season SEP, & Medicaid eligibility.

Reinsurance	• Reinsurance should be as meaningful as possible	• Reinsurance should be as meaningful as possible after funding an affordability program.	• Reinsurance should be as meaningful as possible

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

DISCUSSION

NEXT STEPS AND UPCOMING MEETINGS

- Next Meeting:
  - January 8, 2019, 8:30am – 10:30am

    Institute for the Study and Practice of Non-Violence (ISPN)

    265 Oxford Street

    Providence, RI 02905

PUBLIC COMMENT?

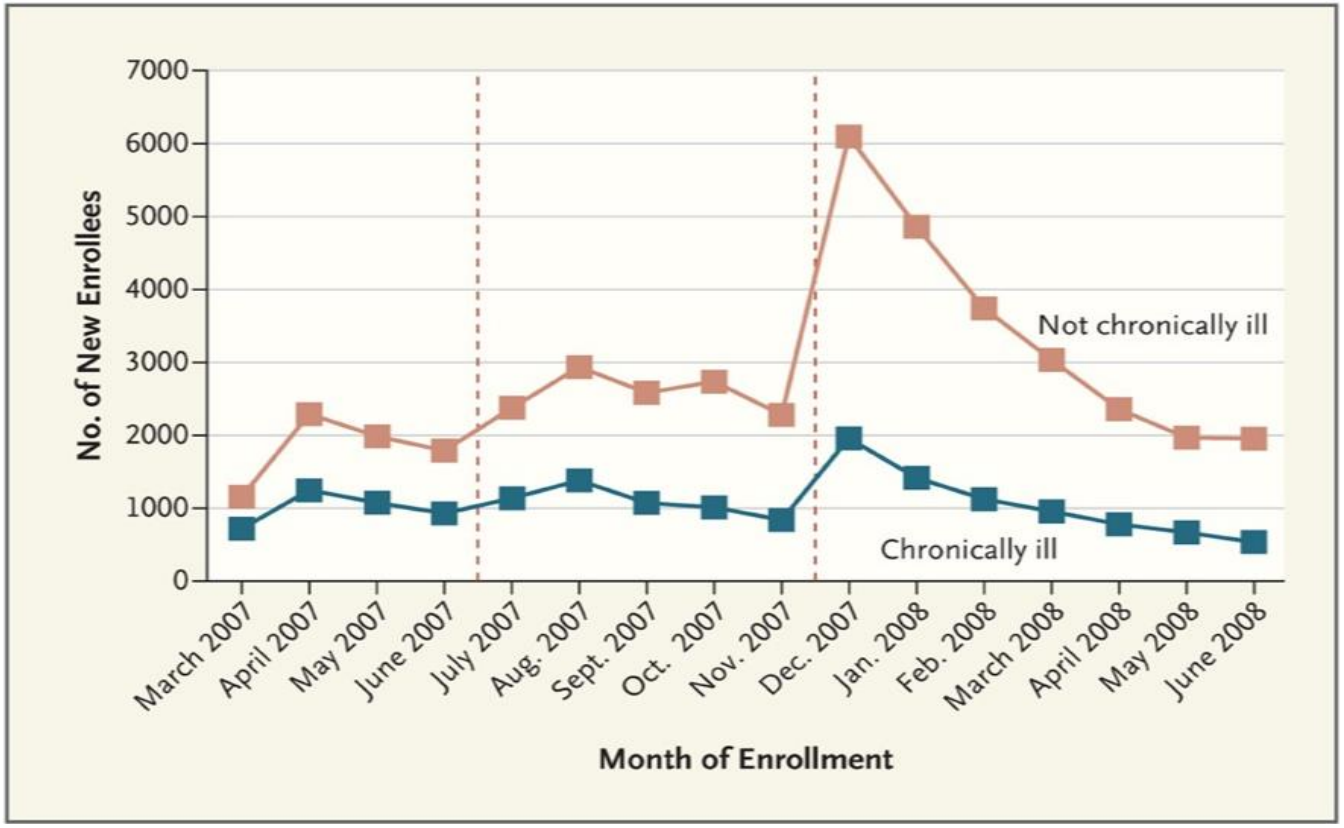
THANK YOU

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

APPENDIX

REMINDER: WHY A REQUIREMENT TO BUY INSURANCE?



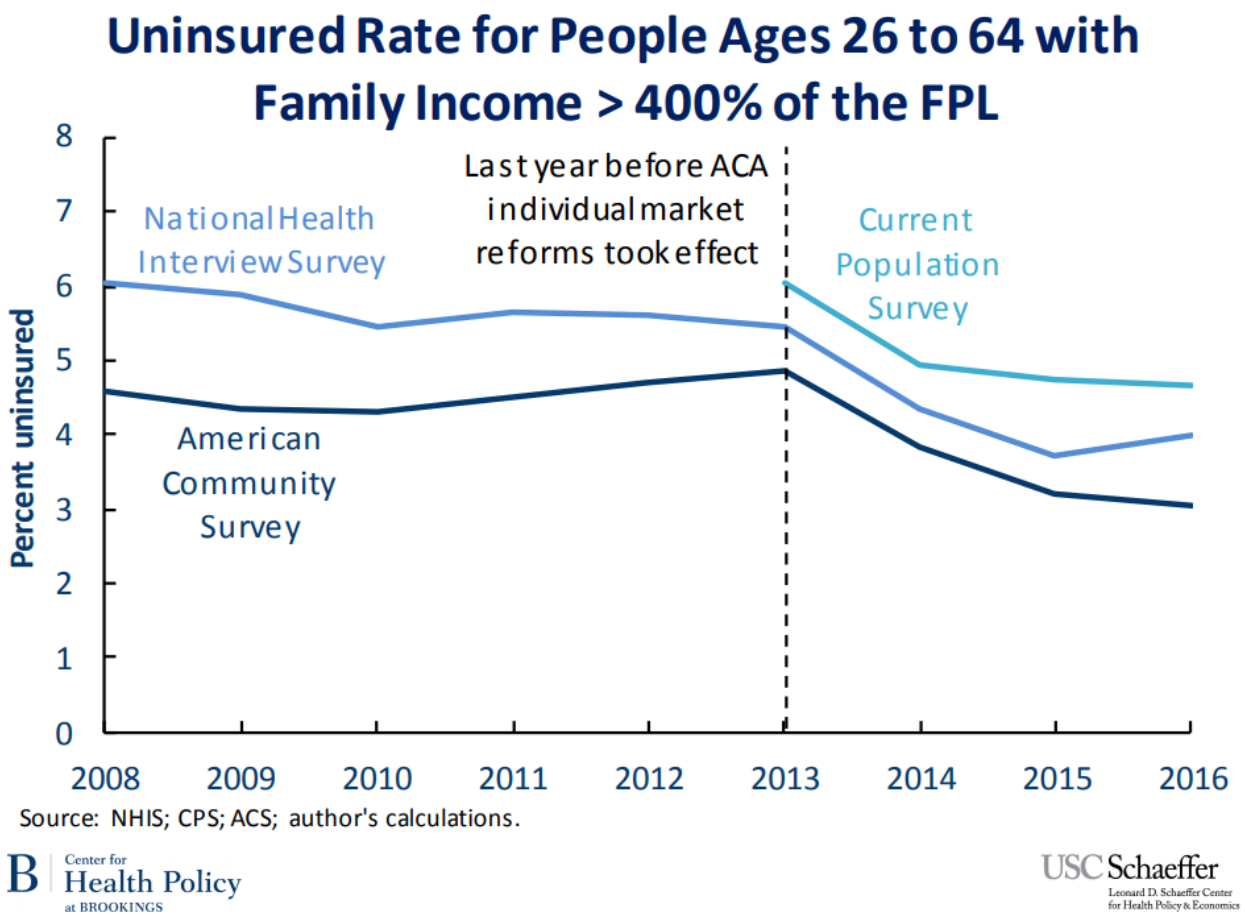
Number of New Enrollees in Commonwealth Care, According to Chronic-Illness Status.

The two vertical dashed lines represent the start of the mandate phase-in period (from July through November 2007) and the start of the period when the mandate became fully operational (from December 2007 onward)

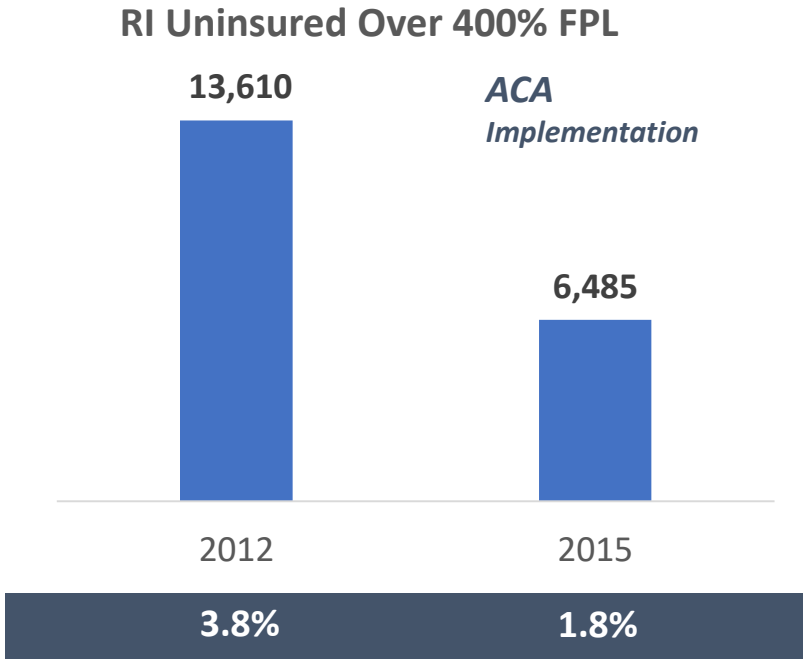
- Phased in separately from subsidies
- Increased enrollment in general
- Significant and disproportionate effect on healthy population
- MA rollout accompanied by messaging campaign

Source: https://www.nejm.org/doi/full/10.1056/NEJMp1013067

REMINDER: WHY A REQUIREMENT TO BUY INSURANCE?



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



Sources: https://www.brookings.edu/wp-content/uploads/2018/02/fiedlerslidesfor030618-for-posting.pdf; 2016 RI Health Insurance Survey (RI HIS)

Market Stability Workgroup

Date of Meeting: December 18, 2018
Meeting Time: 8:30 am
Meeting Location: RIPIN
1210 Pontiac Ave., Cranston RI 02920

Workgroup Members Present: Co-Chair Marie Ganim, Co-Chair Zachary Sherman, Stephen Boyle, Liz McClaine (for David Burnett), Al Charbonneau, Lauren Conway, Ralph Coppola, Jane Hayward, Peter Hollman, Hon. Joshua Miller, Monica Neronha, Lisa Tomasso (for Teresa Paiva Weed), Janet Raymond, Samuel Salganik, John Simmons, Susan Storti, Larry Warner

Workgroup Members Absent: Cristina Amadeo, Hon. Gayle Goldin

Minutes

I. Meeting was called to order at 8:34am.
- a. The minutes of the December 11, 2018 meeting were approved with no changes.
- b. Director Sherman reviewed the agenda for today's meeting.

II. Follow-ups from Previous meetings – Katie Hall from HealthSource RI provided follow-up items
- a. 1332 Application Timeline Review – drafting of the 1332 waiver application will continue into spring 2019. This will be followed by a public notice and public comment process which is open for a minimum of 30 days. The application cannot be officially submitted to CMS for consideration until the state legislature has appropriated necessary funds. However, HSRI staff have maintained regular contact with CMS and the application has been reviewed prior to its final official submission.
- b. Uninsured rate impact on uncompensated care – in response to a query from the previous meeting Katie presented a graph comparing change in uninsured rate with change in uncompensated care for the United States, Medicaid expansion states, non-expansion states, Rhode Island, and Massachusetts, for 2013-2015. The data were from the Medicaid and CHIP Payment and Access Commission (MACPAC). The uncompensated care rate was expressed as a percentage of hospitals' total operating costs. For all groups/states other than the non-expansion states, reduction in uninsured rate tracked closely with reduction in hospital uncompensated care during this period. For Rhode Island specifically, the period saw a 51% reduction in uninsured and a 60% reduction in uncompensated care. Commissioner Ganim said that this shows other possible benefits of a state shared responsibility requirement and/or reinsurance program – keeping enrollment high helps to keep uncompensated care low.
    - i. Steve Boyle asked what the dollar amount savings were for RI hospitals during this period, recalling that he read in the first year of the ACA that Lifespan's uncompensated care was $40 million lower, and $80 million

lower for the state overall. Katie did not have dollar-amount savings numbers for specific hospital entities.

c. Carrier Reinsurance Numbers 2014-16 –

III. Discussion

a. Deb Faulkner facilitated the discussion, beginning with a review of the Workgroup's previous recommendations and current objectives.

b. Deb next presented a set of questions for the Workgroup to answer in reaching consensus: Should the shared responsibility payment (SRP) structure include any additional exemptions, such as for income below 138% FPL? Should there be an additional affordability program beyond reinsurance? If yes to additional affordability program, should it be "paid for" by reducing the size of reinsurance, or by finding additional revenue through and assessment?

c. Deb presented 3 potential versions of core written recommendations.

   i. Director Sherman noted that a bullet had been added to this slide since previous meeting relating to the state doing additional outreach to penalty-payers to help them enroll in Medicaid or subsidized individual coverage. This was understood to be a recommendation where the Workgroup had reached consensus. Deb added that the advantage of a state-based SRP was that the state would have the information to target such outreach.

   ii. Steve asked for clarification of "technical barrier" as one of the SRP exemptions. Deb said that this is meant to not penalize individuals who could not enroll due to computer systems difficulties.

   iii. Jane Hayward mentioned that reinsurance would primarily impact rates only in the first year of its existence. Deb said this is true, but Ralph Coppola also pointed out that it reduces volatility for carriers as they develop rates. Larry Warner asked if this effect would be ongoing and Deb replied, yes, even beyond the impact on first year rates the reinsurance program has an ongoing market stabilization effect.

   iv. Sam Salganik expressed concern that he versions presented did not do enough to mitigate the impact of the SRP on lower income earners. Individuals and families below 400% FPL make up the majority of penalty payers.

   v. John Simmons asked if the intent of the SRP is to get people to buy insurance or generate revenue? Deb replied that it does both but the fundamental function is to bring people into coverage. John asked if the SRP would still work as a driver of enrollment even if it is lower? Sam said that a lower penalty would be less of a motivator to buy coverage, but that doesn't mean the penalty should be extremely high for low income earners. Jane Hayward agreed with Sam on this point.

   vi. Josh Miller said that the state SRP was an attempt to replace an element of the ACA which was itself a compromise. The individual mandate was based on that compromise and including something in the legislation that could be passed, not necessarily based on actuarial science or good tax policy. Larry Warner voiced agreement, saying there is an opportunity to achieve something better at the state level.

vii. Deb said that the Workgroup arrived at the recommendation of a state SRP in the Spring and now should consider how to structure it regardless of the revenue it generates. Should there be an exemption for incomes below 138% FPL? Should there be a penalty as percent of income and eliminate the flat dollar penalty? Or should it be structured the same way as the ACA's individual mandate?

viii. Steve said that politics cannot be disregarded and that the prospects of passage in the state legislature must be considered. Jane said she agreed, but also that she would like to that the recommendation to come out of the Workgroup represents the best policy, and let the legislators take it from there, adding that there would be a request for general revenue. Peter Hollman expressed that this could be risky.

ix. Sam said that 6 or 7 states have done reinsurance and out of those 5 funded it through a premium tax. He said he did not hear a lot of disagreement when the Workgroup discussed a premium tax early in this round of meetings. He acknowledged that no one wants their constituency to pay an unfair share for the program, but a premium tax is a legitimate revenue source for reinsurance in other states. Deb said that a lot of voices on the Workgroup said an additional premium assessment was unlikely to be passed due to opposition. Al Charbonneau added that it wasn't just a matter of any particular group or constituency's opposition, that any time a mandate or assessment is added it raises the cost of insurance and makes it less affordable.

x. Commissioner Ganim pointed out that there is a lot of support for keeping the state SRP close to the federal mandate's model because it is already known and understood, which helps with administration, is easier for consumers and employers to understand. Monica Neronha agreed, saying while she didn't want to have a political conversation either, state legislators will be more likely to understand the federal model than something else. She added that this was not a judgement on the merits of any alternative proposals, just a matter of ease of understanding. Larry Warner said that capacity would still have to be built at the state level, and that an argument could be made that a simple percentage penalty would also be easier for some to understand.

xi. The Workgroup revisited slides from previous meetings that showed who pays and how much under different SRP variations.

xii. Deb then reviewed potential recommendation options: federal model SRP with a reinsurance program; SRP adapted for low income populations, reinsurance as meaningful as possible with additional funding to enhance reinsurance; SRP adapted for low income, no additional funds, reduce scope of reinsurance accordingly.

xiii. Peter Hollman said he preferred not to reduce the scope of reinsurance.

xiv. John Simmons mentioned an assessment on the individual market only to fund reinsurance, expressing that he felt the beneficiaries of the program should be the first ones to pay for it. Director Sherman said that the big question was whether CMS would allow this due to the assessments

impact on the value of the reinsurance and the federal pass through funds. HSRI has asked about the feasibility of this and is awaiting a response from CMS. Director Sherman said making an application with this funding structure without a clear answer as to whether CMS would accept it ahead of time would be very risky.

xv. Senator Miller said he would always make the case that a robust reinsurance program to stabilize the market will have a wider impact than just on the individual market and individual plan consumers, and so an assessment outside of just the individual market is totally appropriate, as the entire healthcare system and all insurance markets benefit.

xvi. Senator Miller recommended that in order to get to a vote on potential recommendations that the components (reinsurance model, funding source, SRP structure, additional revenue/affordability programs) be considered separately. Monica Neronha said there would be some benefit to addressing them separately, but expressed concern that she was hearing the potential for a state SRP that creates general revenue and potentially not fund reinsurance

xvii. Commissioner Ganim said that the near term goal is to send recommendations to the Governor, possibly to be included in her budget proposal.

xviii. Sam said as a point of process he was hesitant to split up the different components of recommendations and vote on them separately, that the order is important to the outcome and that he would be hesitant to say anything without seeing a whole package. He suggested that maybe the Workgroup staff and leadership had heard enough from Workgroup members at this point that they could draft recommendation language.

xix. Director Sherman said that ideally they would have Workgroup members vote on the different recommendation components.

xx. Peter Hollman suggested a statement of principles that the Workgroup had already more or less built consensus around. He suggested that these might be

1. There should be a reinsurance program
2. There should a state shared responsibility payment
3. Shared responsibility payments should be the major source of revenue to have a reinsurance program
4. The reinsurance program should be of sufficient impact that it reduces premiums by some specific percentage.

He said you could then add some other statements, potentially, regarding other aspects such as SRP exemptions, flat vs. scaled penalties, etc., and then also include a couple of models that come close to these principles, noting that here is the strongest agreement on the first four items and less agreement on subsequent, which is why there are multiple models presented.

There was broad agreement with this among Workgroup members.

IV. Next Steps and Upcoming Meetings

a. Director Sherman said that a draft of principles would be distributed for the Workgroup's review before the next meeting.
b. The next meeting of the Market Stability Workgroup is January 8, 2019 at the Institute for the Study and Practice of Nonviolence, 265 Oxford Street, Providence, RI 02905.

V. **Public Comment**

a. Karen Malcolm of the Protect Our Healthcare Coalition said that she was really glad to see the outreach component as part of the potential recommendations because, from the Coalition's perspective, the primary factor for the SRP it to drive coverage, especially for lower income families. She said she also appreciated the conversation on the commitment to reinsurance, that the Coalition supports the concept of reinsurance for stability and to keep premiums low. She said she appreciated Larry, Sam, Jane and John's input re: making the SRP fair.

VI. **Adjourn** – The meeting adjourned at 10:30 AM.

Market Stability Workgroup

Notice Posted: January 3, 2018
Date of Meeting: January 8, 2018
Meeting Time: 8:30 AM
Meeting Location: Institute for the Study and Practice of Nonviolence
265 Oxford Street,
Providence, RI 02905

Agenda

I. Call meeting to order
   a. Motion to approve December 18, 2018 meeting minutes
   b. Review Today's Agenda
II. Follow-ups from previous meetings
III. Discussion:
   a. Recommendation Variations
   b. Vote on options
IV. Review of ACA Consumer Protections and State Law
V. Upcoming meetings
   a. January 22, 2018, 8:30am – 10:30 am,
      United Way of Rhode Island, 50 Valley Street, Providence, RI
VI. Public comment
VII. Adjourn

Institute for the Study and Practice of Nonviolence is accessible to persons with disabilities. Individuals requesting interpreter services for the hearing impaired or needing other accommodations, directions or assistance should call Jonelie Cardoza at 401.462.6428 or email her at jonelie.cardoza@ohic.ri.gov at least 48 business hours in advance of the meeting.

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MARKET STABILITY WORKGROUP 2.0

Meeting #8

Tuesday, January 8, 2018
8:30 – 10:30 a.m.
ISPN, 265 Oxford Street, Providence, RI 02905

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

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

TEN WEEK SYLLABUS

RI Market Stability Workgroup Schedule

Topic(s) for Discussion	Meeting Date
Break for the holidays	Mid-December – early January
Meeting 8 **Recommendations;** **Possible Codification of ACA Consumer and Market Protections**	Tuesday, January 8th
Meeting 9 **Legislative Recommendations**	Tuesday, January 22nd
Meeting 10 **Legislative Recommendations (*reserved if needed*)**	Tuesday, February 5th

TODAY'S AGENDA

1. **Review Text of Potential Recommendations (including comments received)**
2. **Vote on Recommendations**
3. **Review of ACA Consumer Protections and State Law**

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.

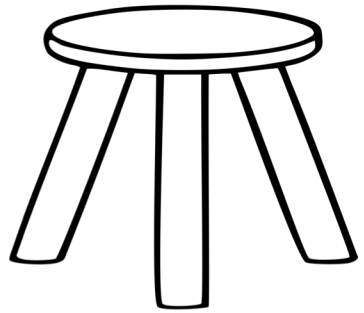
Those efforts resulted in providing **access to high-quality, affordable health coverage** to more Rhode Islanders than ever before.

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.



RECOMMENDATION VARIATIONS

	Option 1	Option 2	Option 3
Reinsurance	• **10.3% Reinsurance Program** • Cost: $26 M • State funding : $10.2 M	• **8.3% Reinsurance Program** • Cost: $21 M • State funding : $8.3 M	• **5.2% Reinsurance Program** • Cost: $13 M • State funding : $5.1 M
SRP	• **Federal Model** *Penalty: $695 flat or 2.5% of household income - whichever is higher* • $11.3 M penalty revenue	• **Exempt <138% FPL** *Penalty: $695 flat or 2.5% of household income - whichever is higher* • $9.6M penalty revenue	• **No Flat Penalty** *Penalty: 2.5% of household income* • $6.7 M penalty revenue

Please note: All options include more penalty revenue than needed for reinsurance program state funding, leaving some penalty revenue available to cover the administrative costs of implementing the reinsurance program.

DISCUSSION

ACA CONSUMER PROTECTIONS AND STATE LAW

INTRODUCTION: ACA CONSUMER PROTECTIONS IN RI

1. Workgroup Statement on Consumer Protections
2. Current Status
3. Overview
    1. Key Consumer Protections in ACA
    2. Essential Health Benefits in ACA
    3. Consumer Protections in RI law
    4. ACA Consumer Protections not in RI law

MARKET STABILITY WORKGROUP—JUNE 2018 REPORT

Future market stability actions required:

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.

TEXAS COURT DECISION RE: CONSTITUTIONALITY OF THE ACA

- On December 14, 2018, Judge Reed O'Connor in Fort Worth, Texas, concluded that:
    - Since Congress has eliminated the fine for not complying with the individual mandate, the mandate is no longer permissible under Congress's taxing power and is thus **unconstitutional**
    - Because the individual mandate is "essential" to and inseverable from the ACA the entire law is invalid
- The decision is expected to be appealed, possibly to the Supreme Court. The high court has rejected two previous efforts (2012 & 2015) to find the law unconstitutional.

CURRENT STATUS

- More than 20 million Americans who previously were uninsured gained coverage from 2010 to 2017

- RI has made great progress in achieving near universal coverage. The uninsured rate in RI has dropped from nearly 12% in 2012 to less than 4.5% today.

- If the uninsured rate goes up, we could reasonably expect to see deferred healthcare, increased emergency room utilization, increased uncompensated care costs at hospitals, and higher utilization of state human service programs

KEY CONSUMER PROTECTIONS IN THE ACA*

- 10 Essential Health Benefits (EHBs) (detailed on next slide)
- Coverage of preventive services with no cost sharing
- Allows dependents up to age 26 to stay on parent's plan
- Prohibition on pre-existing condition exclusions
- Prohibition on annual limits/lifetime dollar caps on coverage for EHBs
- Ensure that payers keep their administrative costs in check ("medical loss ratio")
- Guaranteed Issue and renewal
- Right to appeal denial of payment
- Rate review
- Actuarial value of plans
- Allowable rating factors
- Uniform explanation of benefits and coverage
- Limits on Out of Pocket Maximums

**this list is not exhaustive*

ESSENTIAL HEALTH BENEFITS (EHBs)

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

CURRENT CONSUMER PROTECTIONS IN RI LAW

- RI has been proactive in enacting legislation and adopting regulations that will mitigate some of the potential harm to consumers if the ACA is repealed or substantively replaced. Under current state law, Rhode Islanders have the following protections, among others:
  - Insurers cannot refuse to sell a health plan to RI residents and employees because of a preexisting health condition
  - Parents can keep their sons and daughters on their health plan up to age 26
  - Residents with a need for substance use and mental health treatment will continue to be covered, and such coverage must be at parity with coverage of medical and surgical treatment
  - Rate review
  - State mandates include pediatric preventive care, maternity hospitalization, emergency room services and transportation (see appendix for full list)

ACA CONSUMER PROTECTIONS NOT IN RI LAW

- Medical loss ratio requirements
- Guaranteed issue and renewal
- Out of pocket maximum limits
- Rating factors
- Preventive services with no cost sharing
- Full breadth of coverage for the Essential Health Benefits (EHBs)—particularly children's dental and vision; and habilitative services.
- In addition, there are sections of current RIGLs that contain language that will strip OHIC of enforcement authority if the ACA is declared invalid by a final judgment of the federal judicial branch or repealed by Congress, including:
  - Uniform explanation of benefits and coverage
  - Prohibition on annual and lifetime coverage limits

NEXT STEPS AND UPCOMING MEETINGS

- Next Meeting:
  - Consumer Protections (Cont'd)
  - January 22, 2019, 8:30am – 10:30am

    United Way of RI

    50 Valley Street

    Providence, RI 02905

PUBLIC COMMENT?

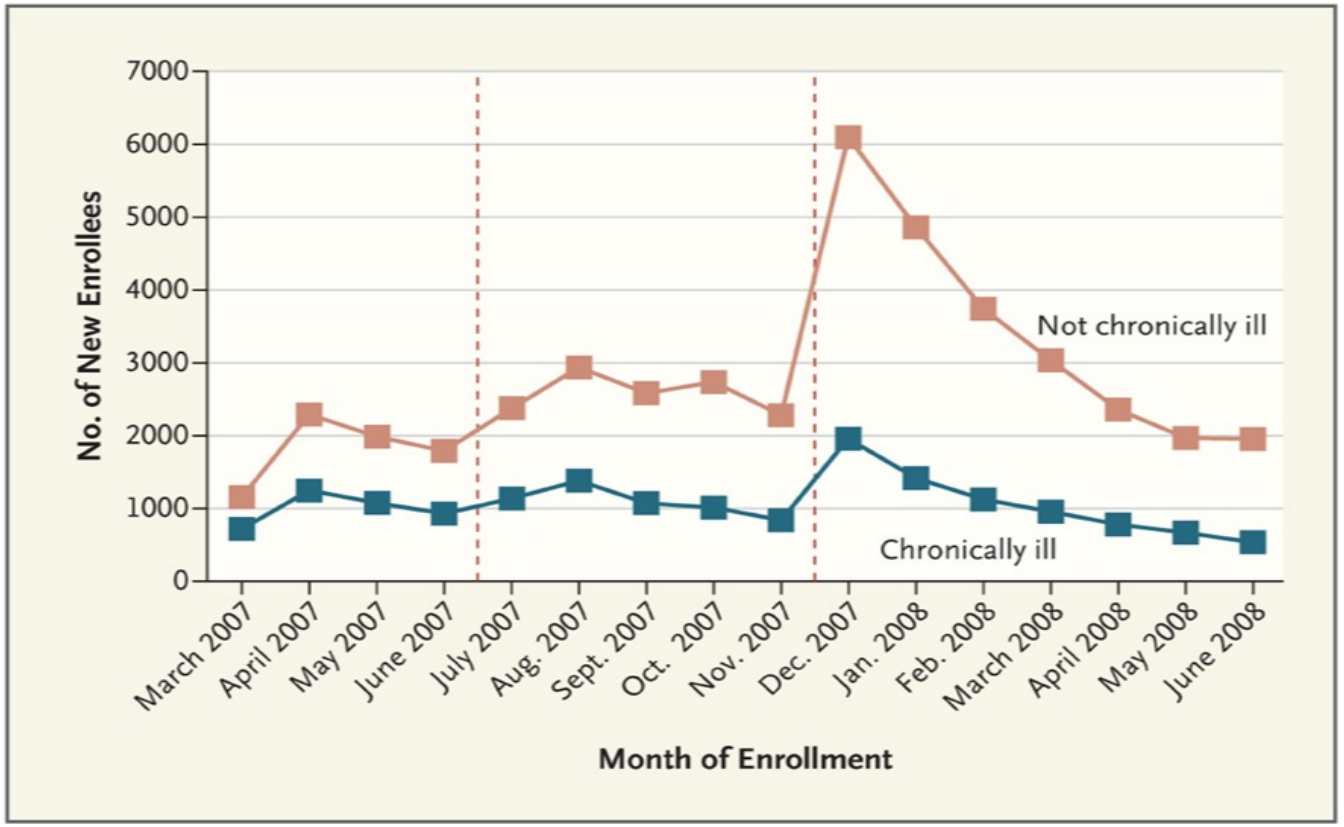
THANK YOU

HealthSourceRI
WE WORK FOR YOU

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

APPENDIX

REMINDER: WHY A REQUIREMENT TO BUY INSURANCE?



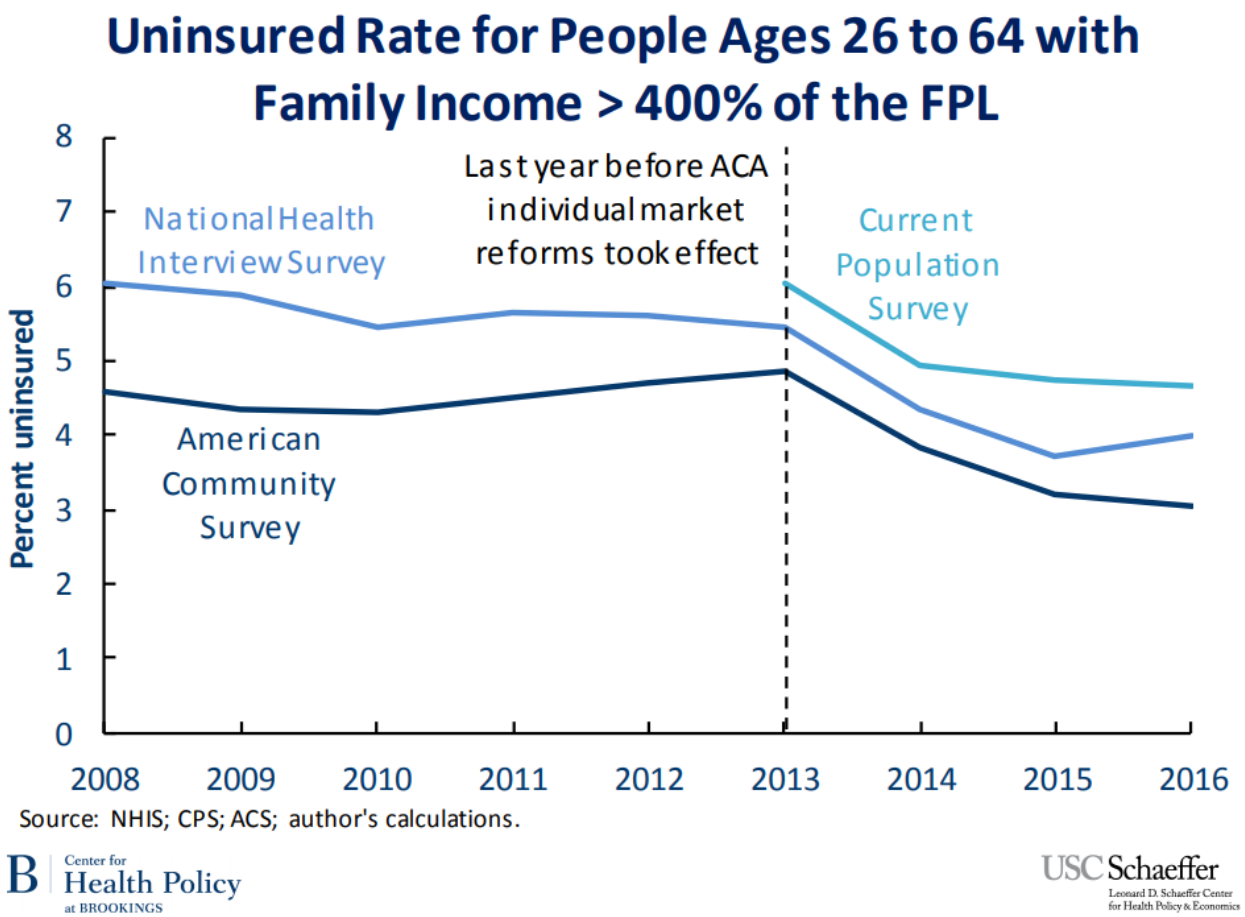
Number of New Enrollees in Commonwealth Care, According to Chronic-Illness Status.

The two vertical dashed lines represent the start of the mandate phase-in period (from July through November 2007) and the start of the period when the mandate became fully operational (from December 2007 onward)

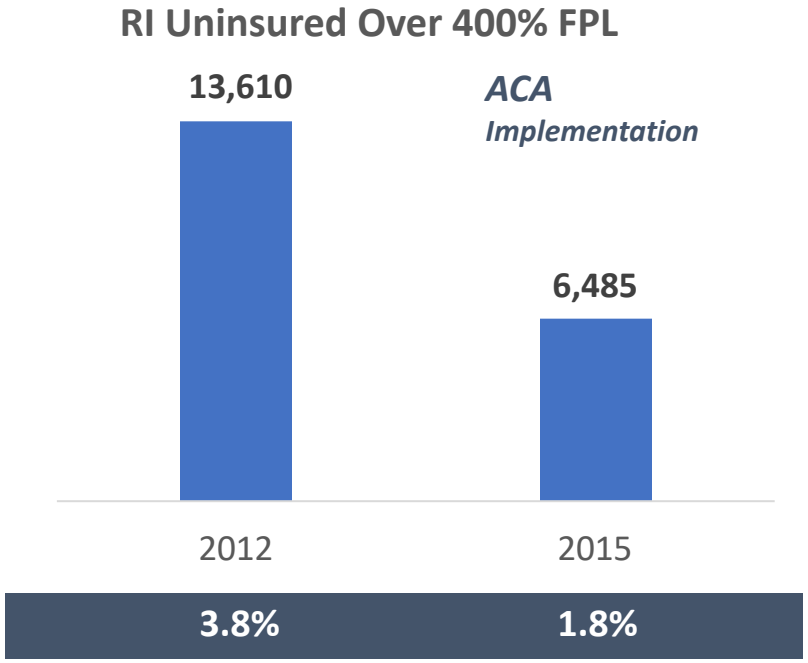
- Phased in separately from subsidies
- Increased enrollment in general
- Significant and disproportionate effect on healthy population
- MA rollout accompanied by messaging campaign

Source: https://www.nejm.org/doi/full/10.1056/NEJMp1013067

REMINDER: WHY A REQUIREMENT TO BUY INSURANCE?



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



Sources: https://www.brookings.edu/wp-content/uploads/2018/02/fiedlerslidesfor030618-for-posting.pdf; 2016 RI Health Insurance Survey (RI HIS)

Key Findings (Funding)

- Different assumptions will also impact the estimated pass-through (Federal dollars)
- The greater the pass-through, the less state funding is needed
- Estimated Federal pass-through rates and needed state funding (in millions):

Funding Level	$13 million	$21 million	$26 million
Minimal Impact	60.7%	60.7%	60.6%
KFF	60.6%	60.5%	60.5%
OACT	64.0%	64.0%	64.0%

Funding Level	$13 million	$21 million	$26 million
Minimal Impact	$5.1 million	$8.3 million	$10.2 million
KFF	$5.1 million	$8.3 million	$10.3 million
OACT	$4.7 million	$7.6 million	$9.4 million

Modeling Range and Best Estimates

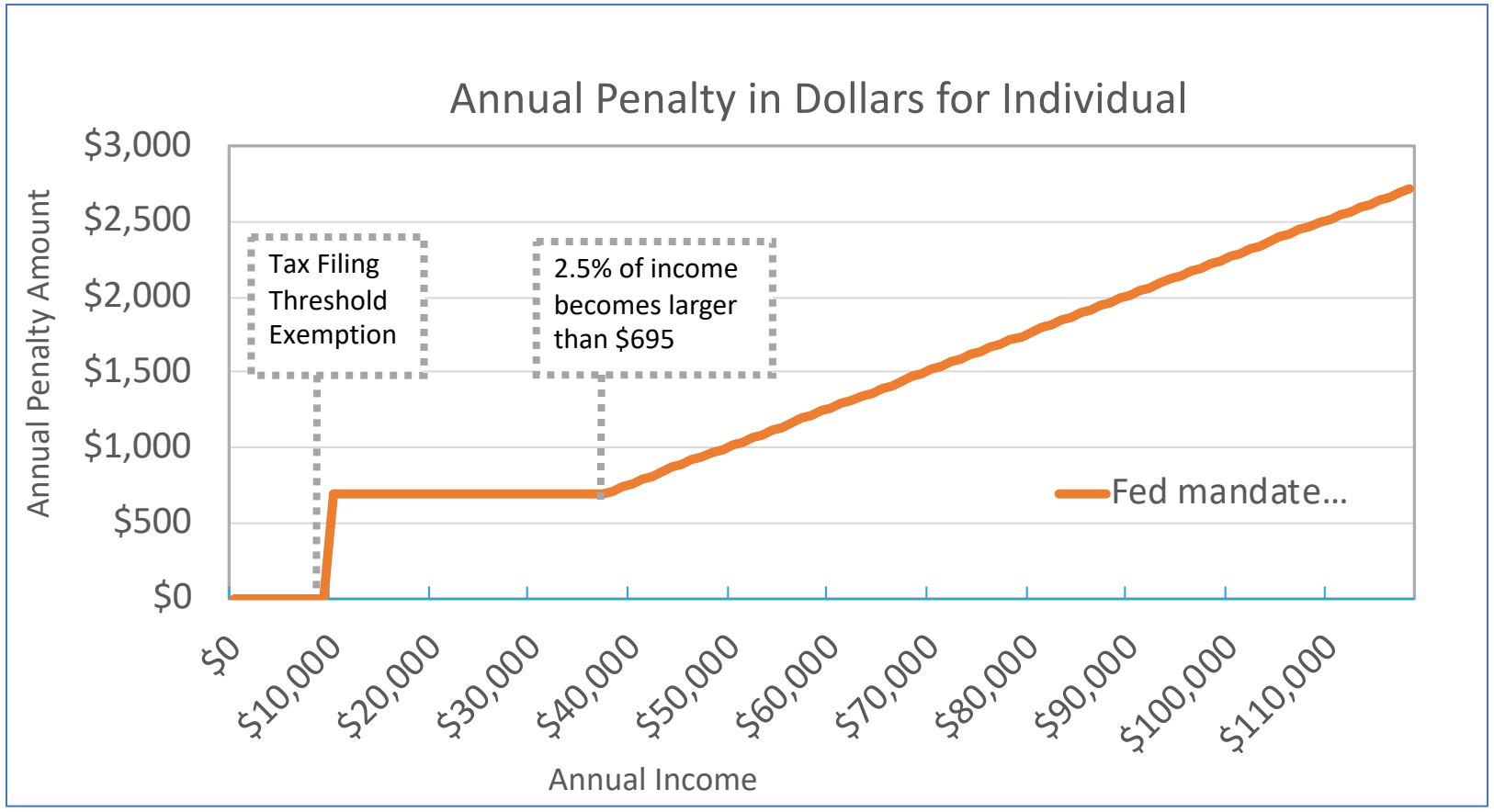
Ultimately based on 2018 experience, carrier input, and current regulatory environment (e.g., Silver loading):

- Wakely estimates a pass through range of 60% to 64% assuming moderate assumptions
- However, the pass through estimates are extremely sensitive to various levers that could change the pass through significantly (more than 20%), which could increase needed state funding

Funding Level	$13 million	$21 million	$26 million
Premium Impact	-5.2% to -5.6%	-8.3% to -9.1%	-10.3% to -11.3%
Federal Pass-through	$7.9 to $8.3 million	$12.7 to $13.4 million	$15.7 to $16.6 million
Needed State Funding	$4.7 to $5.1 million	$7.6 to $8.3 million	$9.4 to $10.3 million
Federal Pass-through %	60.6% to 64.0%	60.5% to 64.0%	60.5% to 64.0%

FEDERAL PENALTY STRUCTURE (ending 12/31/18)

Larger of 1) $695 per adult, or 2) 2.5% of income above filing threshold*



KEY EXEMPTIONS

- **Income Exemption** if income below tax filing threshold
- **Affordability Exemption** if coverage costs more than 8.13% of income
- **Hardship Exemption** in case of bankruptcy, flood/fire, death in family, etc.

**Half dollar amount for children, and max per family is equivalent of 3 adults. Overall max set at bronze plan cost*

Current Federal SRP Exemptions

Income Related Exemptions
Income is below the filing threshold
The cheapest available plan was unaffordable
Hardship Exemptions
You were homeless
You were evicted or were facing eviction or foreclosure
You received a shut-off notice from a utility company
You experienced domestic violence
You experienced the death of a family member
You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property
You filed for bankruptcy
You had medical expenses you couldn't pay that resulted in substantial debt
You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member
You claim a child as a tax dependent who's been denied coverage for Medicaid and CHIP for 2017, and another person is required by court order to give medical support to the child. In this case you don't have to pay the penalty for the child.
As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace in 2016
You had another hardship. If you experienced another hardship obtaining health insurance, describe your hardship and apply for an exemption.

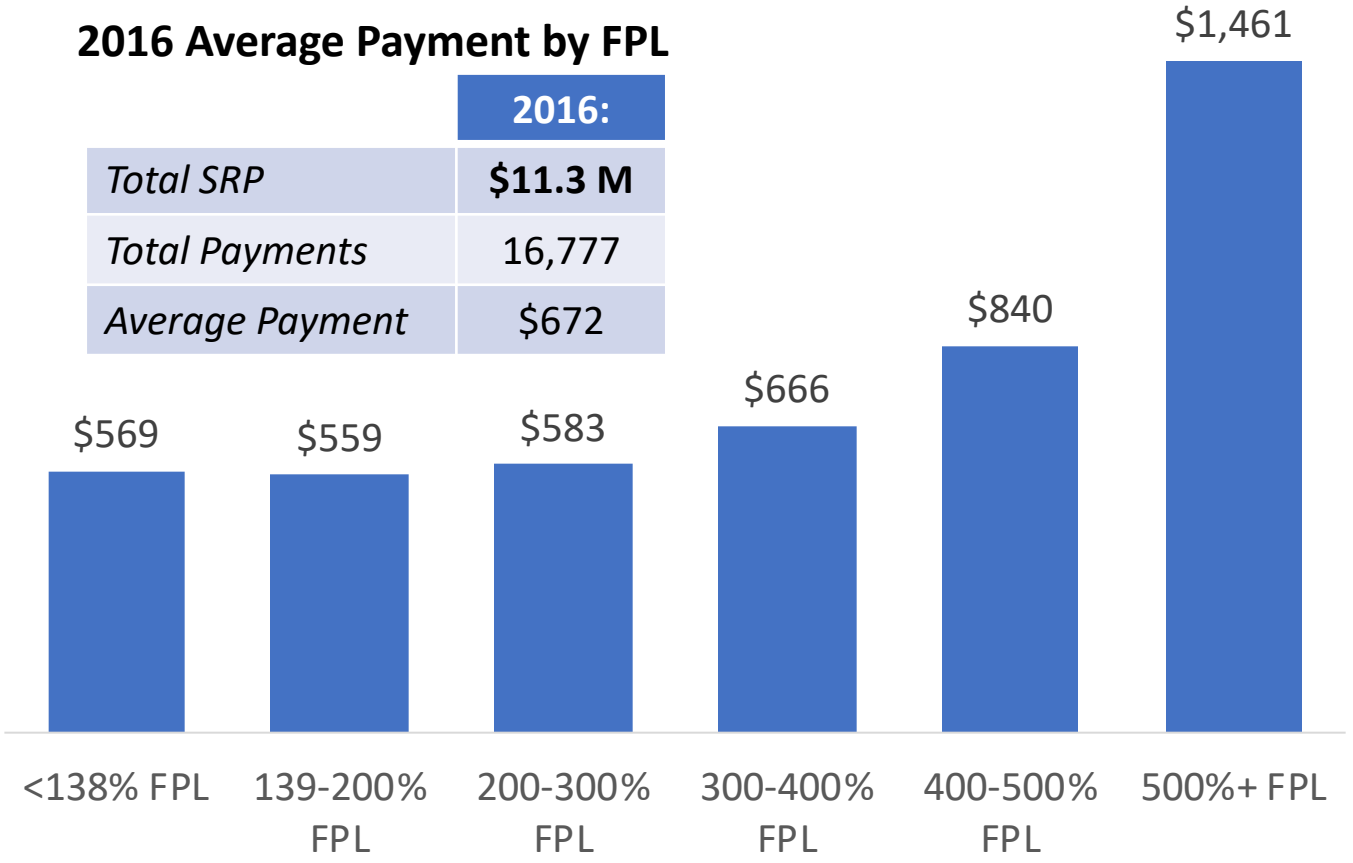
Health Coverage-Related Exemptions
You were uninsured for less than 3 consecutive months of the year.
You lived in a state that didn't expand its Medicaid program and your household income was below 138% of the federal poverty level.
Group Membership Exemptions
You're a member of a federally recognized tribe or eligible for services through an Indian Health Services provider.
You're a member of a recognized health care sharing ministry.
You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare. Application required.
Other Exemptions
You're incarcerated (serving a term in prison or jail).
You're a U.S. citizen living abroad, a certain type of non-citizen, or not lawfully present.
A member of your tax household was born or adopted during the year. This exemption applies only to the month of the event and the month before. You can claim this exemption only if you're also claiming another exemption.
A member of your tax household died during the year. This exemption applies only to the month of the death and the month before. You can claim this exemption only if you're also claiming another exemption.

Hardship Exemptions (Not Relevant In RI)
You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid in 2017 under the Affordable Care Act
Your "grandfathered" individual insurance plan (a plan you've had since March 23, 2010 or before) was canceled because it doesn't meet the requirements of the Affordable Care Act and you believe other Marketplace plans are unaffordable

RI SHARED RESPONSIBILITY PAYMENTS: 2016

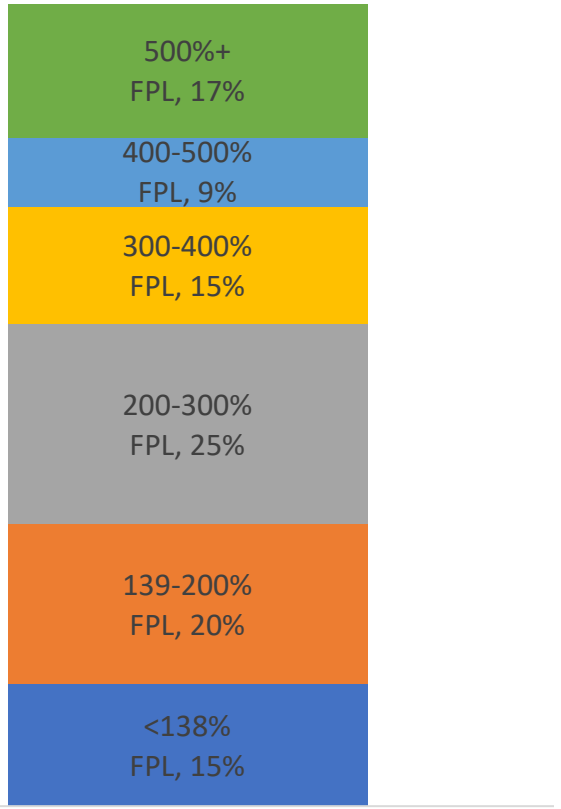
2016 Average Payment by FPL

	2016:
Total SRP	**$11.3 M**
Total Payments	16,777
Average Payment	$672

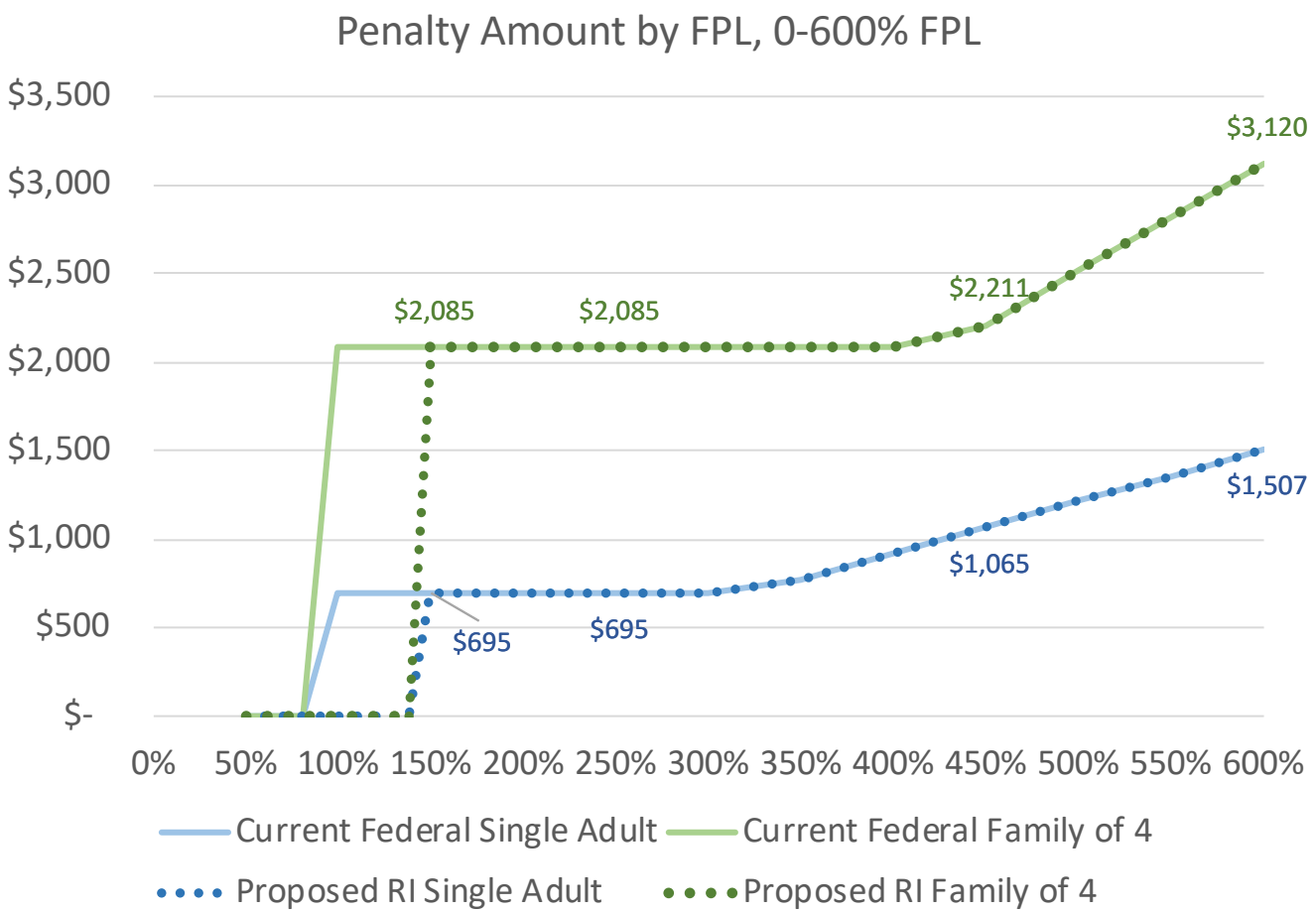


	<138% FPL	139-200% FPL	200-300% FPL	300-400% FPL	400-500% FPL	500%+ FPL
# Payments	2,993	4,027	4,840	2,467	1,177	1,274

Share of Total Paid Amount by FPL



VARIATION 1: EXEMPTION UNDER 138% FPL



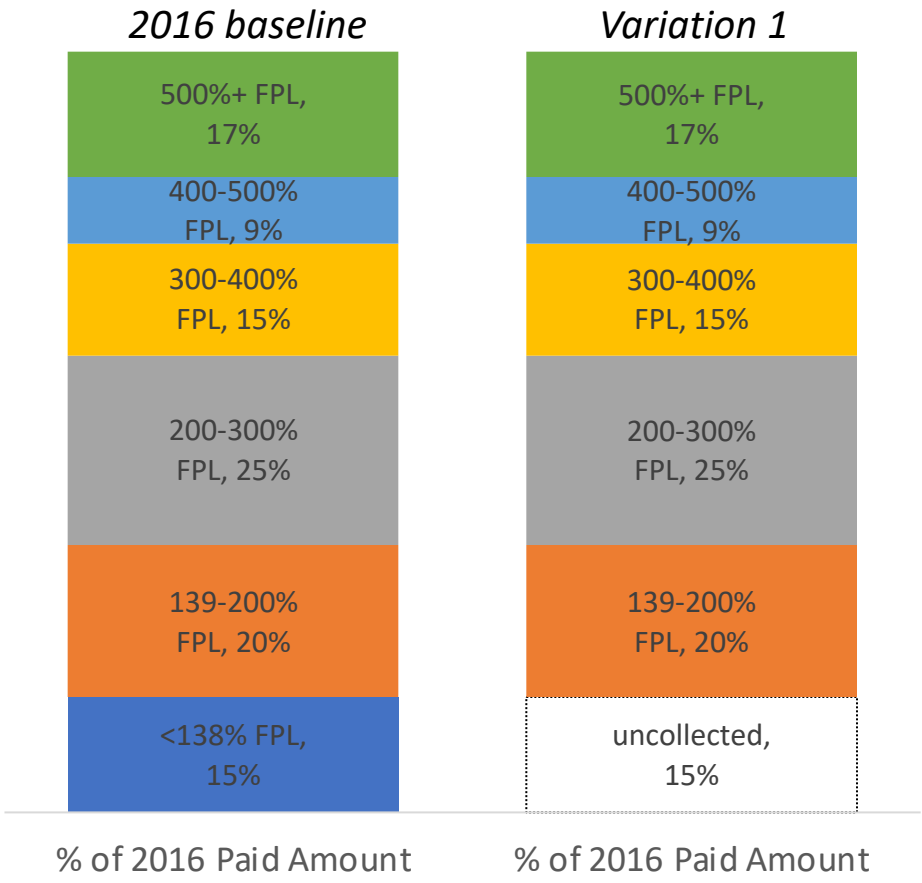
- Corresponds with Medicaid eligibility for most adults
- Many ought to be exempt via affordability exemption, but simplification may make it easier to avoid being penalized
- Estimated revenue reduction of $1.7M
- 100% reduction at lowest income ranges. No impact above that
- Could be “revenue neutral” if the percentage were also increased to 3.5%

VARIATION 1: EXEMPTION UNDER 138% FPL

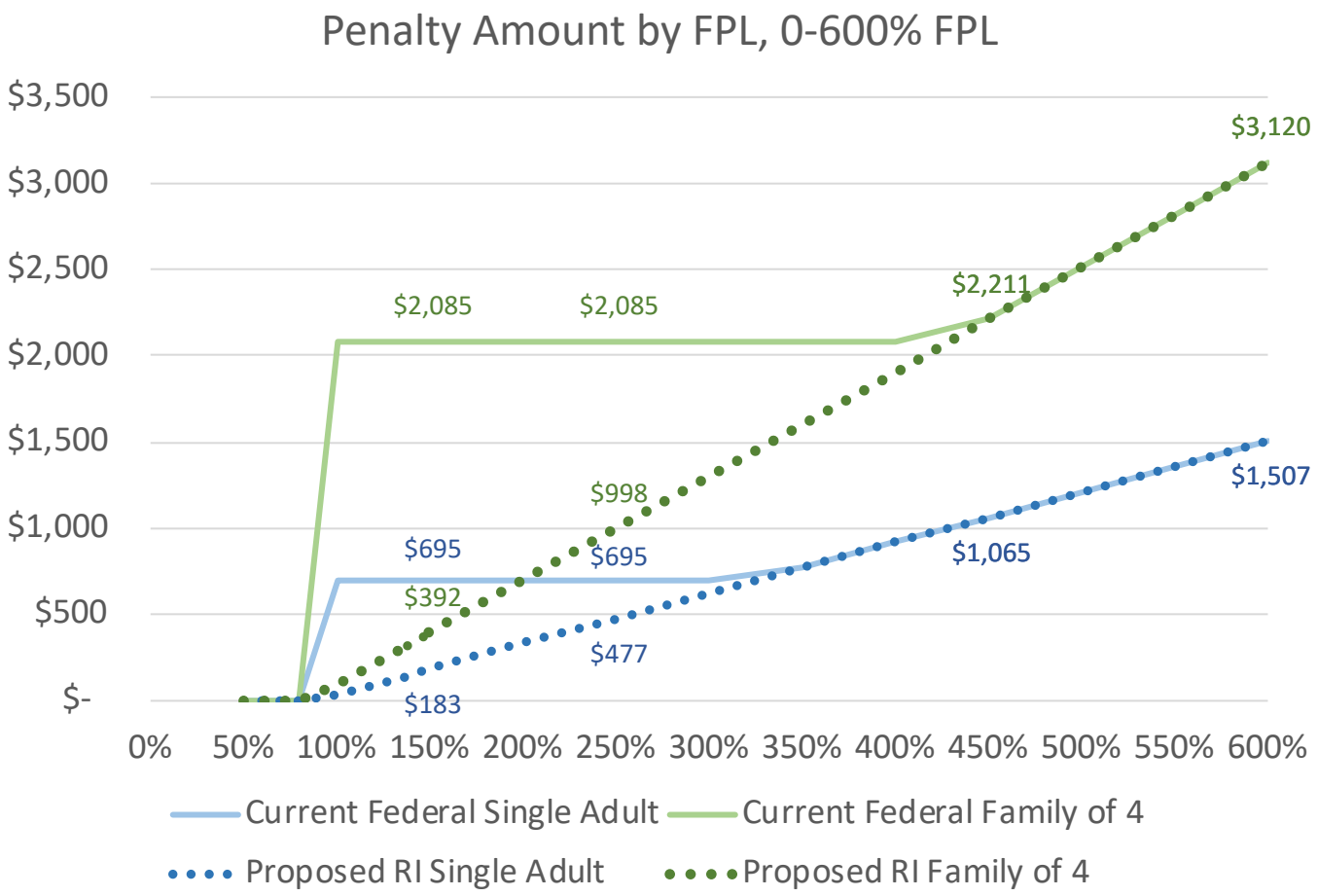
Payment by FPL: 2016 vs. Variation 1

	2016:	Variation 1:	Difference
Total SRP	$11.3 M	$9.6 M	-$1.7 M
Total Payments	16,777	13,784	-2,993
Average Payment	$672	$694	+$22

Share of 2016 Paid Amount by FPL



VARIATION 3: REMOVE FLAT PENALTY AMOUNT



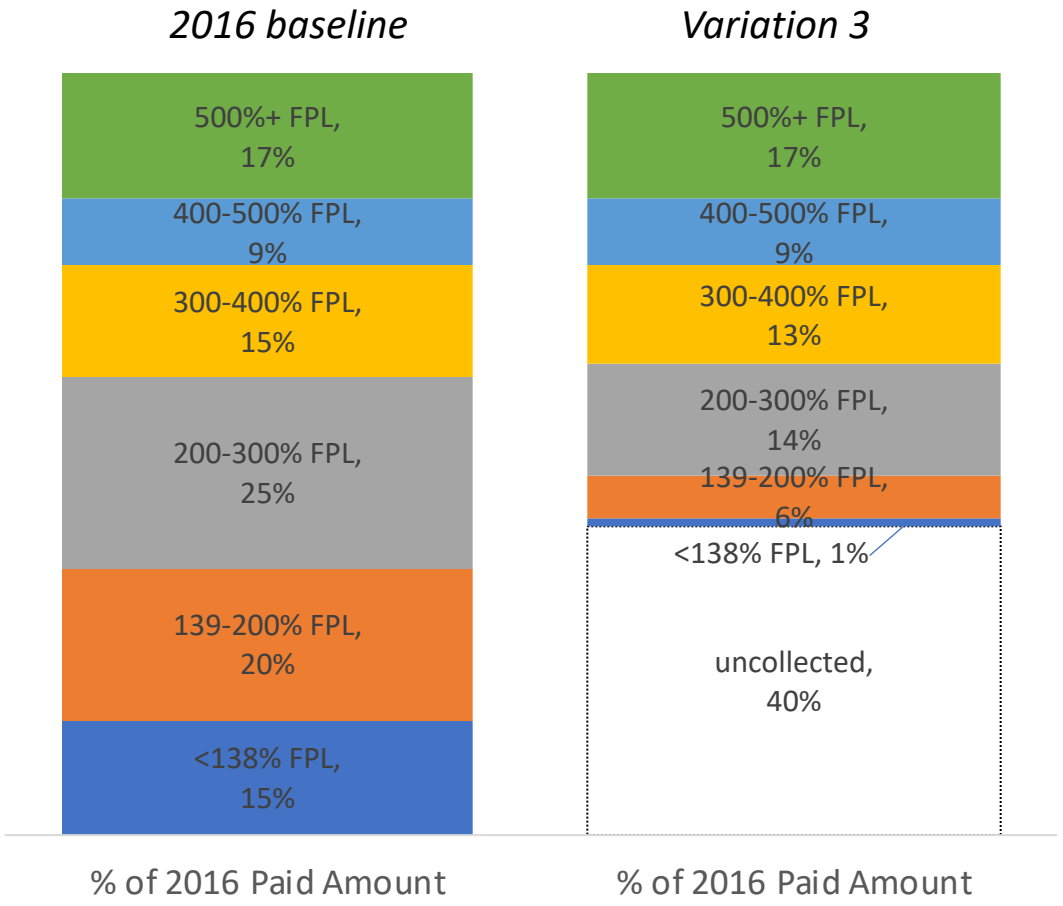
- Slightly simplifies filing process
- Estimated revenue reduction of $4.6M
- Impact largest at lowest income ranges—aggregate 80+% reduction below 150% FPL
- Modification phases out as income increases—aggregate 31-50% reduction for 200%-300% FPL
- No impact above 450% FPL
- Could be “revenue neutral” if the percentage were also increased to 4.25%

VARIATION 3: REMOVE FLAT PENALTY AMOUNT

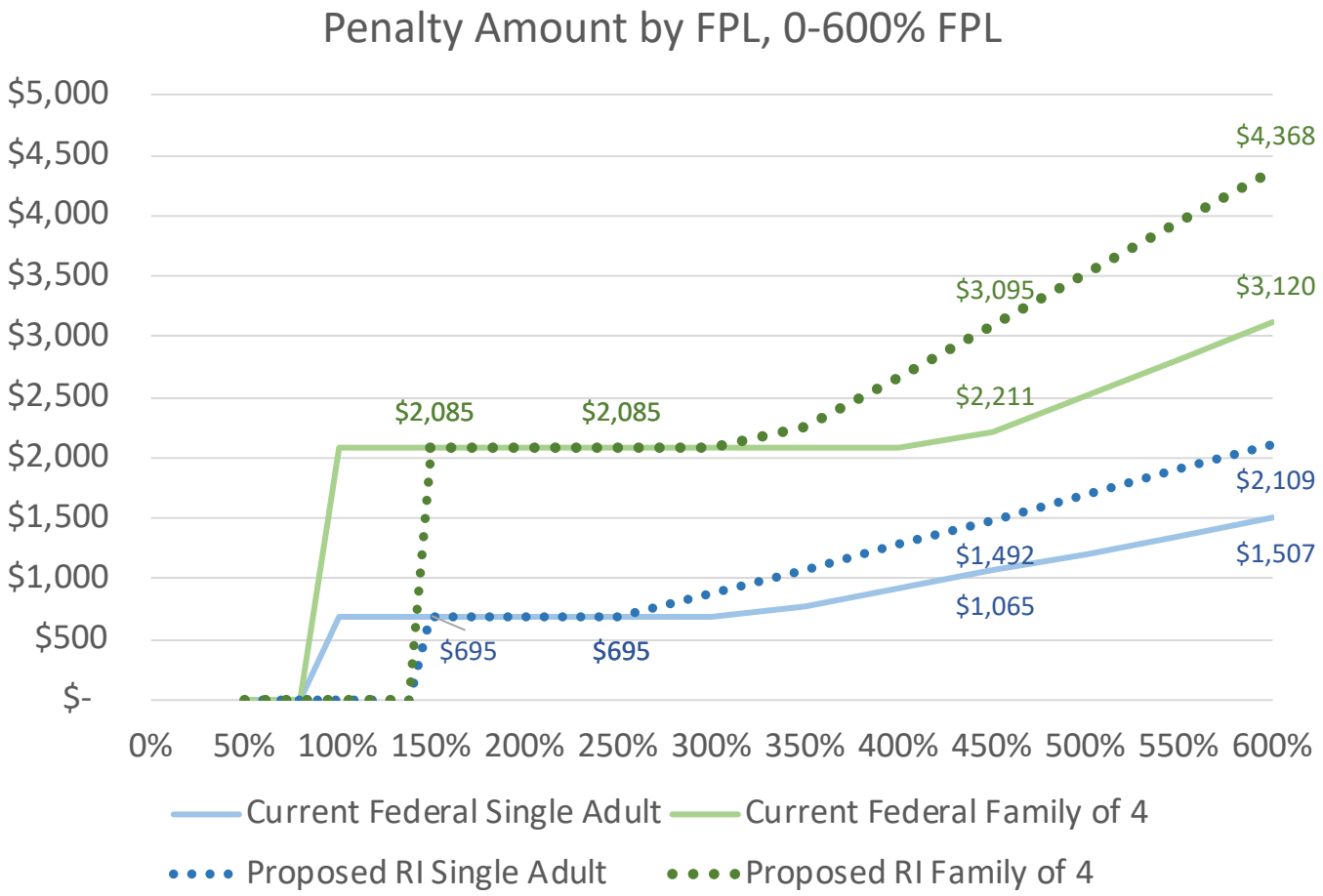
Payment by FPL: 2016 vs. Variation 3

	2016:	Variation 3:	Difference
Total SRP	$11.3 M	$6.7 M	-$4.6 M
Total Payments	16,777	16,777	-
Average Payment	$672	$400	-$272

Share of 2016 Paid Amount by FPL



VARIATION 4: EXEMPTION UNDER 138% FPL COMBINED WITH INCREASED INCOME PERCENTAGE TO 3.5%



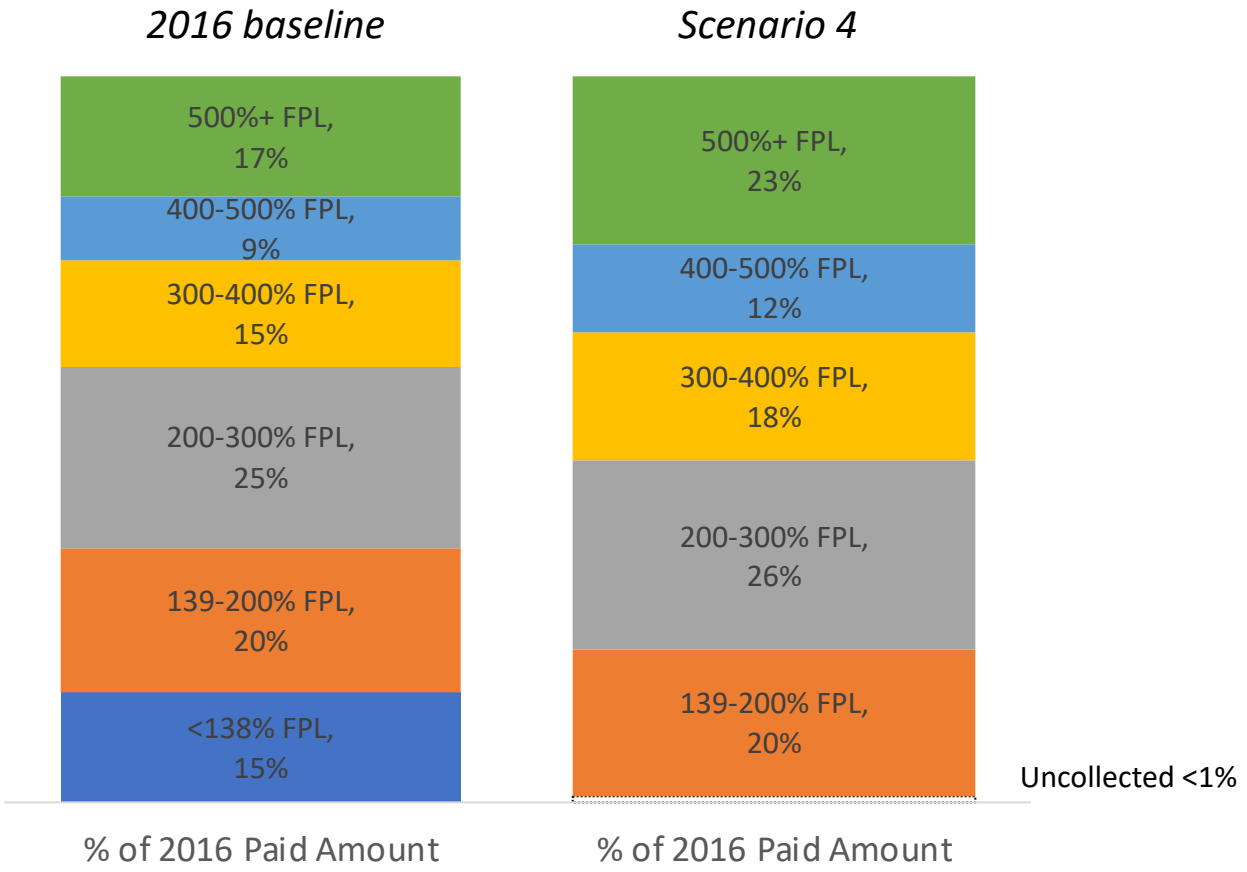
- Estimated revenue reduction of $0.1M
- Exemption matches Medicaid eligibility for most adults
- 100% reduction at lowest income ranges
- Increased penalty begins at 300% FPL and phases in fully by 450% FPL
- Penalty 40% higher for those above 450% FPL

VARIATION 4: EXEMPTION UNDER 138% FPL COMBINED WITH INCREASED INCOME PERCENTAGE TO 3.5%

Average Payment by FPL: 2016 vs. Scenario 4

	2016:	Scenario 4:	Difference
Total SRP	$11.3 M	$11.2 M	-$0.1 M
Total Payments	16,777	13,784	-2,993
Avg Payment	$672	$813	+$142

Share of 2016 Paid Amount by FPL



SUMMARY OF VARIATIONS + DISCUSSION

Variation	Revenue Change from $11.3M	Description
Use federal model	N/A	• No change
1. <138% Exemption	-$1.7M	• 100% reduction at lowest incomes (Medicaid level) • No impact above 138%
2. Half Flat Amount	-$3.3M	• Phased impact • 50+% reduction below 200% FPL • No impact above 450%
3. No Flat Amount	-$4.5M	• Phased impact • 80+% reduction below 150% FPL • No impact above 450%
4. <138% Exemption + increase to 3.5%	-$0.1	• 100% reduction at lowest incomes (Medicaid level) • Higher payments above 300% FPL

- Which options, if any, seem attractive to you?
- How do the options, including revenue impacts, fit in with other priorities for market stability?
  - reinsurance program funding and/or
  - additional affordability programs

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