



Rhode Island's 1332 Waiver Application

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State of Rhode Island and Providence Plantations

State House
Providence, Rhode Island 02903-1196
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Gina M. Raimondo
Governor

June 28, 2019

The Honorable Alex M. Azar II
Secretary, U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Steven Mnuchin
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

Secretary Azar and Secretary Mnuchin:

The State of Rhode Island submits for your review and consideration this application for a State Innovation Waiver under §1332 of the Affordable Care Act (ACA). Rhode Island seeks to establish a reinsurance program via the attached waiver application and appendices. We appreciate your consideration and the opportunity to protect Rhode Islanders from market instability and rate volatility.

Expanding and improving access to quality health care and achieving near universal coverage in Rhode Island was a major priority of my first term. Through the successful implementation of the ACA and our state's shared leadership across all sectors of the health care community – providers, insurers, consumer advocates, government, and the business community – more than 96% of Rhode Islanders are now insured. Our marketplace, HealthSource RI, has had some of the most affordable plans in the nation. While Rhode Island's markets have been relatively stable, the future is more precarious, particularly and most immediately for the individual and small group markets. In the last two plan years, customers who do not qualify for subsidies through HealthSource RI have seen an average premium increase of 26%. Absent the action proposed through this waiver application, this trend will continue at an unsustainable pace and middle-class families and our smallest businesses will be priced out of the market.

Approval of this waiver will help stabilize our market and protect Rhode Islanders by preserving their access to affordable health care. Based on expert analysis, as outlined in the attached application, Rhode Island's reinsurance program is projected to produce a 5.9% premium decrease in 2020, and 6.3% in 2021 compared to the baseline we would expect absent the waiver. Rhode Island's program relies on the approval of this waiver, as well as the federal pass-through savings created by reducing advanced premium tax credits as a result of the reinsurance program.

We appreciate the opportunity to propose this innovative strategy that would allow Rhode Island to take control of meeting the needs of its own unique health care system. With your partnership, we can protect Rhode Islanders from large, unsustainable premium increases, keep people covered, and preserve our nearly universal coverage levels. Thank you for your consideration of Rhode Island's application.

Sincerely,

Gina M. Raimondo
Governor

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Congress of the United States
Washington, DC 20510

June 11, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

We write to express our strong support of the Section 1332 State Relief and Empowerment Waiver Application submitted by the State of Rhode Island through its state-based official health insurance marketplace, HealthSource RI. The application request seeks to waive certain requirements of the Affordable Care Act (ACA) to develop a state-based reinsurance program.

In 2013, the state created HealthSource RI - one of only 12 state-based insurance marketplaces. Since its implementation, Rhode Island's uninsured rate has decreased by two-thirds. Today, 96 percent of Rhode Islanders have health coverage, an all-time high. Further, Rhode Island currently has the third least expensive benchmark plan in the country.

Although ACA implementation has been largely successful in Rhode Island, it has not been without challenges. Rising premiums in the individual market are expected to continue on an upward trend with projected increases of 5.9 percent in 2020 and 6.3 percent in 2021. This trend may result in young and healthy individuals opting out of health insurance coverage, potentially leading to an unbalanced risk pool and destabilization of the market.

Approval of this Section 1332 waiver would allow HealthSource RI to work on innovative strategies to stabilize market enrollment, mitigate rate increases, and maintain a market that continues to attract and retain insurance providers. Specifically, HealthSource RI would establish a reinsurance program using a combination of state and federal funding to partially reimburse carriers for certain claims for high-cost members in the individual market.

Administrator Seema Verma

June 11, 2019

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Access to high quality, affordable health insurance coverage is a necessity for the state's residents, and the creation of the proposed reinsurance program is critical to maintaining affordability and stability in Rhode Island's individual insurance market. We strongly support the State of Rhode Island's waiver request and respectfully request your consideration of this application within all applicable rules and regulations of the agency. If we can be of assistance to you in this matter, please do not hesitate to contact our offices. Thank you.

Sincerely,



Jack Reed
United States Senator



Sheldon Whitehouse
United States Senator



James R. Langevin
Member of Congress



David N. Cicilline
Member of Congress

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Executive Overview

Request

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

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

Early and Ongoing Impacts of the ACA

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

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

However, premiums in Rhode Island's individual market have been rising over the last few years and are anticipated to continue to rise in the future. Between 2017 and 2019, the average monthly premium for HealthSource RI customers not eligible for tax credits increased by 26%.³ Expert analysis of the individual market in RI projects a 9.6% increase in individual premiums from 2019-2020.⁴

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

¹ RI Health Insurance Survey, 2018.

² Kaiser Family Foundation estimates based on Census Bureau American Community Survey, 2017. www.kff.org

³ Internal HSRI analysis of unsubsidized customer premiums.

⁴ Wakely Actuarial and Economic Analysis – see Attachment 1 Table 4.

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

The individual market writ large has been, and continues to be, volatile due to factors such as the phase-out of the transitional reinsurance program and the recent repeal of the individual mandate penalty. In addition, populations newly insured under the ACA have been sicker and/or riskier than anticipated, which has led to higher premiums. The individual market also faces potential challenges of adverse selection due to the availability of alternative insurance products such as short-term limited duration (STLD) plans and Association Health Plans⁵.

Ensuring Ongoing Success in Rhode Island

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

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

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

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

The Rhode Island General Assembly passed legislation in 2018 authorizing HSRI to pursue a 1332 waiver to establish a reinsurance program to stabilize the state's individual market.

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

Additional legislation was passed in 2019 to establish a state revenue source for the reinsurance program through the implementation of an individual mandate penalty.

- The Rhode Island Market Stability and Reinsurance Act, R.I. Gen. Laws § 42-157.1, passed and was signed into law on July 2, 2018. This law authorizes the director of the state's exchange, HSRI, to establish and implement a state-based reinsurance program, to provide reinsurance to carriers that offer health insurance coverage on the state's individual market that meets the requirements of a waiver approved under 42 U.S.C. § 18052.
- H 5151Aaa, Article 11 Relating to Market Stability, was a budget article signed into law on July 5, 2019. Sections 3 – 6 of this article (see Attachment 2) authorize the state to establish a health insurance mandate by Jan 1, 2020, and to impose financial penalties on certain Rhode Islanders not meeting the statute's requirements. The legislation also authorizes the state to utilize any penalties collected under this statute as a state funding source for its individual market reinsurance program.

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

The reinsurance program will reimburse qualifying individual health insurers for a percentage of an enrollee's claims between an attachment point and a cap, the parameters of which will be set annually by the Director of HSRI. In 2020, the program is projected to reimburse fifty percent (50%) of claims between an attachment point of \$40,000 and cap of \$97,000. HSRI estimates that the reinsurance program, as part of the waiver proposal, will result in a net premium decrease of 5.9% in 2020 and 6.3% in 2021.⁶ We define net premium decrease as the difference between expected premiums with and without the reinsurance program.

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

Compliance with Section 1332

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

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

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

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

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

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

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

I. Rhode Island's 1332 Waiver Request

Like others across the country, Rhode Island's individual health insurance market has seen significant changes and challenges over the past several years. That said, it has remained relatively competitive and stable. This is largely due to the state's efforts to work collaboratively with Rhode Island's health insurance carriers to ensure a stable and adequately-priced market with multiple statewide plan options. Despite this relative success, insurance premiums in the individual market have increased significantly in the last three years and are expected to continue to increase into 2020.⁷ Higher costs will result in increased numbers of uninsured Rhode Islanders, particularly impacting middle-income individuals and families who do not receive a premium tax credit and thus pay the full cost of their health insurance premiums in the individual market.

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

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

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

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

⁷ Wakely Actuarial Analysis, see Attachment 1.

This premium reduction will reduce federal APTC cost. Table 1 shows that absent the waiver, 2020 federal APTC spending in Rhode Island will be an estimated \$118.0 million. After factoring in the waiver, total 2020 federal APTC spending is estimated to be \$110.6 million – a reduction of \$7.4 million. Similar reductions are estimated for each year of the 10-year budget window.

To establish the state’s reinsurance program, Rhode Island seeks federal pass-through funds in the amount of the federal savings for PTC, subject to the cap imposed by the statutory deficit neutrality requirement of the 1332 Waiver Program. Table 1 shows that after taking into account the waiver’s federal PTC savings and impact on federal revenues from the health insurance providers fee (HIT), Rhode Island requests pass-through funding of \$6.4 million in 2020.⁸

II. Compliance with Section 1332 Guardrails

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

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

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

As noted above, the reinsurance program will make the cost of individual coverage lower than it would be absent the waiver in each year it is in effect. Cost sharing protections against excessive out-of-pocket spending will remain the same and within federal requirements, so the waiver will not have an impact on affordability in terms of cost sharing. The waiver will not affect the premiums or cost-sharing for coverage obtained through other means, such as Medicaid, CHIP, and employer-based coverage.

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

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

The waiver will have no material effect on the comprehensiveness of coverage for Rhode Island residents. Regardless of whether the waiver is granted, all Rhode Island ACA-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits

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

provided by other types of coverage such as Medicaid, CHIP, and grandfathered plans will not be impacted. The waiver is expected to increase access to comprehensive and affordable coverage, thereby increasing the number of individuals with effective health coverage and access to high quality health care. Individuals gaining health coverage under the waiver will have coverage for more comprehensive health benefits than they would absent the waiver.

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

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

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

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

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

III. Description of the Rhode Island 1332 Waiver Proposal

A. Authorizing Legislation

Rhode Island passed legislation in 2018 and 2019 related to pursuing a 1332 waiver to establish a reinsurance program to stabilize the state’s individual market. The text of this legislation can be found in Attachment 2.

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

Legislation to authorize state funding for the reinsurance program was included in the state budget for FY 2020, which was signed into law by the Governor on July 5, 2019. H 5151Aaa, Article 11 Relating to Market Stability authorizes the state to establish a state requirement for Rhode Island residents to maintain minimum essential health coverage starting Jan 1, 2020. The legislation also includes a shared responsibility payment penalty to be imposed for Rhode Islanders not complying with a requirement to obtain qualifying health coverage. The legislation authorizes the placement of any shared responsibility payment penalties collected into a Health Insurance Market Integrity Fund, to be used as a state funding source for the individual market reinsurance program and the administration of the reinsurance program. The Health Insurance Market Integrity Fund can also be used for preventive health care programs vulnerable populations and administration of both the health coverage requirement and reinsurance program.

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

Given that the actual values of revenue, funding and claims may differ from projected values, the state has laid out the following rules for management of the reinsurance program so that program decisions will be predictable and transparent. The State will reduce or increase the coinsurance rate to the extent necessary to ensure that reinsurance payments equal to the total available funding for the benefit year. The maximum coinsurance rate under the program would be 100% of claims eligible for reinsurance.

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

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

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

upon CMS approval of the 1332 waiver request. The funding source is not contingent on waiver approval.

B. Federal Pass-Through Funding

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

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

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

IV. Draft Implementation Timeline

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

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

| | |
|---------------------|---|
| Apr - Jun 2018 | 8 public meetings of the Market Stability Workgroup are held |
| Jul 2, 2018 | Rhode Island Market Stability and Reinsurance Act is signed into law |
| Oct 2018 – Feb 2019 | 10 additional public meetings of the Market Stability Workgroup are held |
| Mar 20, 2019 | OHIC sent rate filing instructions to carriers for CY2020 rates, including final parameters of proposed reinsurance program for plan year 2020 |
| April 1, 2019 | Began outreach to Narragansett Indian Tribal Nation |
| Apr 15, 2019 | Final Actuarial and Economic Analysis delivered to the state |
| Apr 26, 2019 | Rhode Island public comment period began: Posted draft waiver for 30-day public comment period, including location, date, and time of public hearings |
| May 10, 2019 | Waiver Public Hearing #1 |
| May 20, 2019 | Waiver Public Hearing #2 |
| May 25, 2019 | Rhode Island public comment period ended. |
| May 31, 2019 | Carriers filed rates for 2020 plan year – rate filings contained 2 sets of rates in case waiver not approved. |

| | |
|-----------------|---|
| June 30, 2019 | State Legislature passed and transmitted to Governor Raimondo the FY 2020 Budget authorizing a funding source for state share of reinsurance program. |
| July 3, 2019 | Completed consultation meeting with representative of the Narragansett Indian Tribal Nation. |
| July 5, 2019 | Governor Raimondo signed the FY 2020 Budget into law. |
| July 2019 | Reinsurance program regulations drafted and posted for public comment (covering operating processes, requirements, payment parameters and procedures) |
| August 31, 2019 | Regulations finalized and promulgated |
| July 8, 2019 | 1332 application is submitted to CMS at StateInnovationWaivers@cms.hhs.gov |
| TBD | CMS deems waiver complete. |
| TBD | CMS posts waiver for 30-day public comment period |
| TBD | CMS public comment period complete. CMS begins review. |
| TBD | CMS issues decision on waiver, issues Special Terms and Conditions for RI |
| Sep 2019 | 2020 Rate filings approved by OHIC |
| Nov 2019 | CMS recommends federal pass-through funding for 2020 |
| Jan 1, 2020 | 2020 rates are in effect; reinsurance program begins |
| Jan 1, 2020 | Individual market carrier claims begin for plan year 2020 |
| Mar 2020 | HSRI sets attachment point/cap/coinsurance rate targets for 2021 |
| May 2020 | Carrier rate filings due for 2021 plan year |
| May 2020 | HSRI posts notice of Public Forum to solicit comments on the progress of a section 1332 waiver as required under 45 CFR 155.1320(c) |
| Jun 2020 | HSRI holds a public forum to solicit comments on the progress of a section 1332 waiver |
| Jun 2020 | HSRI publicly posts a summary of the forum and submits summary to CMS. |
| Aug 2020 | 2021 Rate filings approved by OHIC |
| Oct 2020 | HSRI collects preliminary Q3 claims information from carriers |
| Jan 1, 2021 | 2021 rates in effect |
| Feb 2021 | HSRI collects preliminary Q4 2020 full year claims information from carriers |
| Mar 2021 | HSRI sets attachment point/cap/coinsurance rate targets for 2022 |
| Mar 2021 | HSRI submits a quarterly report to the Secretary of HHS |
| Mar 2021 | HSRI submits a 2020 Draft Annual Report to CMS |
| Apr 2021 | HSRI posts the 2020 Draft Annual Report on its public web site |
| Apr 2021 | HSRI receives comments from CMS on draft annual report |
| Apr 2021 | HSRI collect final claims information from carriers for plan year 2020 |
| May 2021 | HSRI posts notice of Public Forum to solicit comments on the progress of a section 1332 waiver as required under 45 CFR 155.1320(c) |
| May 2021 | Carrier Issuer Rate filings due for 2022 plan year |
| Jun 2021 | HSRI collect final claims information from carriers for plan year 2020 |
| Jun 2021 | HSRI publicly posts the Final Annual Report for the waiver year 2020 |
| Jun 2021 | HSRI submits a quarterly report to the Secretary of HHS |
| Jun 2021 | HSRI holds a public forum to solicit comments on the progress of a section 1332 waiver |
| Jun 2021 | HSRI sets attachment point/cap/coinsurance rate targets for 2022 |
| Sep 2021 | HSRI submits a quarterly report to the Secretary of HHS |
| Sep 2021 | 2022 Rate filings approved by OHIC |
| Sep 2021 | Carriers Insurers submit claims for individual market for 2020 |
| Oct 2021 | HSRI collects preliminary Q3 claims information from carriers |
| Nov 2021 | 2020 state revenue collected for 2020 tax year is transferred to HSRI |
| Nov 2021 | HSRI makes 2020 reinsurance payments to the carriers |
| Dec 2021 | HSRI submits a quarterly report to the Secretary of HHS |
| Nov 2021 | CMS notifies state of 2022 pass-through funding |

V. Additional Information and Reporting

A. Administrative Burden

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. State Reporting Requirements and Targets

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

- Quarterly reports (45 CFR 155.1324(a)): To the extent required, HSRI will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.
- Annual reports (45 CFR 155.1324(b)): HSRI will submit annual reports documenting the following:
 - (1) The progress of the waiver, including how well the waiver is progressing in achieving its stated goals.
 - (2) Data, similar to that contained in Attachment 1, on compliance with Section 1332(b)(1)(B) through (D) of the ACA.
 - (3) Modifications, if any, to the essential health benefits for compliance with Section 1332(b)(1)(A) of the ACA.

- (4) The premium for the second lowest-cost silver plan under the waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
- (5) A summary of the annual post-award public forum required by 45 CFR 155.1320(c) together with a summary of action taken in response to public input.
- (6) Any additional information required by the terms of the waiver.

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

VI. Supporting Information and Miscellaneous

A. 45 CFR 155.1308(f)(4)(i) – (iii)

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

VII. Public Comment and Tribal Consultation

A. Public Comment

HSRI held a 30-day public comment period on the waiver request from April 26 through May 25, 2019. On April 26, 2019, HSRI opened public comment on this waiver request and posted notice of the opportunity to comment on the Marketplace's website: <https://healthsourceri.com/1332waiver>.

On the same date, HSRI sent notice via email to its list of interested parties and stakeholders. The list is comprised of individuals and organizations with an expressed or demonstrated interest in insurance-related matters. This list of stakeholder and community partner organizations can be found in Attachment 4. It is important to note that many of these parties and stakeholders were included in the Market Stability Workgroup which held 18 public meetings between April 2018 and February 2019. During the Workgroup, robust research and discussion informed the Workgroup's final report (found in Attachment 3). The content presented in those meetings is available at <https://healthsourceri.com/market-stability-workgroup/>. In their reports, the group unanimously recommended establishing a reinsurance program.

During the public comment period HSRI held two hearings to solicit feedback from members of the public. The agenda for these hearings was posted on the Secretary of State's website in advance of the hearings. The public notice, agenda, and presentation from both hearings can be found in Attachment 4. At the public hearings, HealthSource RI staff were on hand to present,

answer questions, and collect testimony. However, no members of the public attended either hearing.

Members of the public were also invited to submit written public comments on this waiver request. Four written public comments were received. All four were supportive of the proposed program. One comment suggested a language clarification which the State adopted. That comment also suggested an improvement in the program that is not feasible for the State for plan year 2020. The comments, in their entirety, are in Attachment 4. The public comment period closed May 25, 2019.

B. Tribal Consultation

HSRI conducted a tribal consultation with a representative of the Narragansett Indian Tribal Nation, which is the only federally-recognized tribe in Rhode Island. Rhode Island's draft application package was made available to Narragansett Indian Tribe officials electronically and in hard copy at the beginning of the State's public comment period.

On July 3, 2019, Director Zachary Sherman held a meeting via phone for tribal consultation with Autumn Leaf Spears, Director of Indian Health Services for the Narragansett Indian Tribal Nation. Details related to this conversation can be found in Attachment 5. Director Spears, on behalf of the Narragansett Tribal Nation, did not express any opposition to the proposed reinsurance program.

VIII. Alignment with Section 1332 Principles

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

- **Provide increased access to affordable private market coverage.** The reinsurance program will produce a net premium decrease exclusively for those purchasing private health insurance. Specifically, the net premium decrease for private health insurance in the individual market will be approximately 5.9 percent in the first year and at least 5.6% for each of the five years the waiver is in effect. The reinsurance program will also support competition in the health insurance market, helping to ensure access to private insurance coverage.
- **Support and empower those in need.** By producing a net premium decrease in the individual market, the waiver will target its impact at those who are not currently eligible for financial assistance and therefore generally face both the largest premiums for health insurance as well as the largest year-over-year increases in premiums. Unlike individuals eligible for APTC, who are generally insulated from the impact of premium changes, individuals ineligible for APTC are responsible for the full premium. They are also currently unprotected from annual increases in premiums. The reinsurance program will mitigate premium increases, providing support to those who currently receive no assistance.

- **Foster state innovation.** The waiver is a state-run approach to making coverage more affordable that is suited to the specific needs of Rhode Island. States across the country have pursued innovative approaches to strengthening their health care systems. A reinsurance waiver has been identified by Rhode Island as the approach that meets its needs while allowing it to take control of its own health care system.

Attachments

Attachment One: Actuarial and Economic Analysis

Attachment Two: Rhode Island's Legislation

Attachment Three: Market Stability Workgroup Report

Attachment Four: Documentation of the State's Public Comment Period

Attachment Five: Tribal Consultation

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Attachment One:
Actuarial and Economic Analysis

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State of Rhode Island

Section 1332 State Innovation Waiver Actuarial and Economic Analysis

April 22, 2019

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Introduction

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

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

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

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

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

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

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

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

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

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

Analysis Results

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

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

Table 1: 2020 High-Level Guardrail Results

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

Coverage, Affordability, and Comprehensiveness

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

Deficit Impact

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

¹ <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf>

² https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

in 2020, the waiver reduces premiums³, increases non-group enrollment, and creates millions in federal savings (which incorporates PTC savings net of other federal revenue). These results are shown in Table 2. The results are similar for years 2020 to 2029, although impacts on premium and enrollment decrease over time, as is shown in Appendix C.

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

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

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to PTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in Table 3.⁴

Table 3: 10-Year Deficit Impact of Reinsurance Program

| Category of Impact | Impact to Federal Deficit (\$ millions) ⁵ |
|---------------------------------------|--|
| Difference in PTCs⁶ | \$76.3 |
| Difference in Mandate Penalty | \$0.0 |
| Difference in User Fees | \$0.0 |
| Difference in HIT | (\$2.9) |
| Estimated Net Federal Savings | \$73.4 |

Data and Methodology

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

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

³ The premium impacts shown throughout the report represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been in 2020. They do not show 2020 premium changes relative to 2019.

⁴ Insurers that utilize the Healthcare.gov platform are assessed a fee by the Federal government. This fee is calculated as percent of Exchange premium. Since Rhode Island is a state-based Exchange, no Exchange fee offset was assumed. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. Individual mandate penalties were set to \$0 effective for the 2019 benefit year.

⁵ Numbers may not add up due to rounding.

⁶ Note PTC savings is the APTC amounts times the PTC ratio of 90.6%.

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

Table 4: 2018 to 2020 Baseline Average Enrollment and Premium Data / Estimates⁷

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

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

⁷ Note total premiums and APTCs were rounded.

- a. The state average premium was based on the 2018 and February 2019 insurer information. The 2019 average premiums were increased by the average estimated 2020 rate increase, which would include increases to account for trend, market morbidity changes, higher premiums due to the reinstatement of the health insurance tax (also known as the health providers fee or the HIT), and an adjustment for historical financial performance. Further details are included in Appendix A.
- b. To estimate the average 2020 APTC amounts, Wakely used the 2018 and emerging 2019 APTC information from Rhode Island insurers including APTC amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We also used the CMS reports from 2018 and adjusted the insurer data as necessary. We then inflated net premiums for APTC enrollees by the estimated 2020 premium increase of 2% for indexing. The 2020 average gross premium is then reduced by the 2020 average net premium (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2020 APTC PMPM amounts
- c. The 2020 individual market enrollment was calculated using 2018 and emerging 2019 data from CMS and Rhode Island insurers. It was then adjusted to account for changes in enrollment due to net attrition throughout 2019, as discussed in Appendix A. Our best estimate, based on conversations with Rhode Island, assumed that because of the proposed implementation of state specific mandate and other regulatory changes, 2020 enrollment would only modestly vary from 2019. This is in part because of the introduction of a Rhode Island specific individual mandate and regulations and statutes that will limit enrollment in non-ACA individual market products such as short-term limited duration plans or association health plans. To the extent that experience deviates from this assumption, the results of this analysis will be impacted.

The estimated 2020 baseline information is shown in Table 4.

3. To estimate the effects of the reinsurance program, Wakely assumed that \$14.7 million dollars would be the total funding available to reduce premiums in 2020. None of the funds were assumed to cover administrative costs for Rhode Island to operate the program. Enrollment was re-estimated with the lower post-reinsurance premium, using an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a final individual market average enrollment per scenario. The results for the best estimate scenario are shown in Table 5.
4. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.

- a. A health reform study from Massachusetts⁸ indicated that enrollees who leave the market have costs that are approximately 73% compared to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program. Wakely further assumed that only enrollees without subsidies would enroll in the individual market as a result of lower premiums due the reinsurance program. Unsubsidized enrollees would have their premiums decreased due to reinsurance but subsidized enrollees would not. For more details, please see the Appendix.
 - b. The result is an additional 0.2% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program.
 - c. Applying the additional reduction due to morbidity improvement to the reduction in plan liability results in an overall premium reduction estimate of 5.9% under the best estimate scenario.
 - d. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of further iterations.
5. The best estimate assumptions resulted in a reduction in premiums of 5.9% due to the reinsurance program and resulting improvement in morbidity.

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

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

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

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

6. To calculate the pass-through amounts Wakely calculated the difference in APTC in the baseline scenario and waiver scenario. Wakely then multiplied the APTC savings amount by the ratio of total PTC subsidy after reconciliation to APTC based on tax data for benefit year 2016 (or 90.6%) to arrive at the PTC savings amount.⁹ This amount was then reduced by the potential HIT fee differences between baseline and waiver scenarios.
7. The following are the assumptions incorporated for the 10-year estimates:
 - a. Premiums were trended using National Health Expenditure Data from CMS.¹⁰ In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 2.0% based on 2018 rate filing information and discussions with the carriers.
 - b. The individual market enrollment was assumed to have small decreases as a function of premium increase using the Council of Economic Advisor’s (CEA) take-up function for each year.¹¹
 - c. In 2020 total reinsurance funding was set equal to \$14.7 million based on targeting state funding at \$8.3 million.
 - d. In 2021, and all future years, total reinsurance funding was solved by targeting total state funding of \$9.05 million.

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

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

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

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

Scenario Testing

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

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

Table 6: High-Level Results of Scenario Testing

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

Appendix A

Data and Methodology

2020 Baseline Enrollment and Premium Estimates

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

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

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

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

2. The relationship between February 2018 and average 2018 experience was studied to approximate average 2019 experience from February 2019 insurer data. The adjustment varied by subsidized, non-subsidized on-Exchange, and non-subsidized off-Exchange.
3. Metal level distribution was estimated using 2019 insurer submitted data while FPL distribution was estimated using 2019 data supplied by HSRI.
4. For the best estimate, overall enrollment in 2020 was estimated using a non-linear enrollment response function estimated by the CEA take-up function.¹² The function computes expected enrollment change based on premium rate increases and the portion of the market that is not receiving subsidies. This resulted in an enrollment decrease of 1.4% compared to 2019. 2020 APTC enrollment was assumed to be consistent with 2019 enrollment, as these enrollees are partly shielded from premium increases. Wakely assumed that Rhode Island's individual mandate, effective in 2020, as well as policies limiting enrollment in short-term limited duration plans would reduce the potential number of people exiting the individual market, which resulted in the low change in enrollment. The result of these three assumptions is that enrollment changes would occur among the unsubsidized portion of the non-group market. The changes in enrollment were distributed pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented.

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

5. For 2020, premiums were estimated using the 2019 insurer submitted data and data sources described previously. The average 2020 premium was increased by approximately 9.6% to account for all rating factors such as trend, financial adjustment, change in morbidity due to enrollment changes, and to account for the health insurance tax returning for the 2020 benefit year.
6. To estimate 2020 APTC PMPMs, we used emerging 2019 Rhode Island insurer data to calculate the average net premium among APTC enrollees (that is the actual amount APTC enrollees pay). We increased the 2019 required contribution (i.e., net premium) to conform with the indexing of the contribution rate. We increased it 2% from 2019. We then inflated gross premiums for APTC enrollees (the 2020 APTC amounts plus net premiums) by the 2020 estimated premium increase (9.6%). This new gross premium amount is reduced by the net premium amount (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2020 APTC PMPM amounts. These assumptions, in totality, were used to generate the baseline estimates shown in Table 4.

2020 Waiver Effects

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

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

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

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

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

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

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

¹⁴ <https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/>

¹⁵ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Treasury-Method-Calculation-1332-Pass-through-Amounts.pdf>

¹⁶ <https://www.irs.gov/statistics/soi-tax-stats-historic-table-2>

¹⁷ *ibid*

Alternative Scenarios

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

- Scenario 1 (Best Estimate): 2020 enrollment was lower than 2019 estimated enrollment, using the elasticity function to model enrollment drops due solely to premium increases. Those leaving the market were estimated to have a morbidity 27% lower than the market.¹⁸ Average baseline premium rates were estimated to be 9.6% higher than in 2019. The reinsurance program is estimated to lower market average premiums by 5.9% after morbidity impacts with the SLCSP decreasing by 4.7% (4.5% before morbidity).
- Scenario 2: In this scenario, the impact of reinsurance on the second-lowest cost silver plan premium was 1% smaller than Scenario 1, or 3.5% before the impact of morbidity. A lower impact to the SLCSP reduces APTC savings which lowers pass-through amounts compared to Scenario 1. Assuming the state funding cannot exceed \$8.3 million, the lower pass-through results in funding for reinsurance payments of \$13.3 million.
- Scenario 3: This scenario assumes that 2020 enrollment (both subsidized and unsubsidized) is 5% higher than the best estimate and gross premiums are 3% lower than the best estimate. This would mean that APTC amounts are less than Scenario 1. Finally, the impact to the SLCSP is 1% less than the best estimate. These numbers selected are reasonable discrepancies to highlight the sensitivity of the results. As a result, total funding available for reinsurance payments would be \$13.4 million.
- Scenario 4: This scenario models a larger enrollment decrease (roughly 3.5% overall including a 2.6% reduction in subsidized enrollment) compared to Scenario 1. Premiums increase more than Scenario 1 due to healthier members leaving the market. Given uncertainty in pass through calculation, Scenario 4 includes a variation in which the calculated pass-through amounts do not include offsets for lower HIT fee. Finally, the impact on the SLCSP plan is 0.5% lower than market average impact. The available funds for reinsurance payments would be \$16.1 million.
- Scenario 5 models a scenario that has different issuer assumptions and pass-through methodology assumptions. In this scenario carriers perceive the level of enrollment in Scenario 1. However, the SLCSP premium is reduced 1% less than the reduction estimated in Scenario 1. Furthermore, the premium tax ratio used to adjust APTC amounts is lower than projected (82.6% rather than 90.6%). This can happen if there were dramatic changes in tax filing behavior in 2017 relative to 2016. As a result, total premium

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

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

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

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

Table 7: Summary of Alternative Scenario Results for 2020

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

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

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

Beyond 2020

For years beyond 2020, Wakely made the following assumptions:

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

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

Table 8: Baseline Data and Detailed Results after Reinsurance, by Year²⁰

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

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

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

Appendix B

Reinsurance Parameters

Reinsurance Parameters

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

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

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

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

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

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

Appendix C

Guardrail Requirements

Scope of Coverage Requirement

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

Affordability Requirement

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

Comprehensiveness of Coverage Requirement

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

Deficit Neutrality

PTCs

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

Table 9: Detailed Results of Federal Savings, by Year

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

Offsets to PTC Savings

INDIVIDUAL RESPONSIBILITY REQUIREMENT

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

EXCHANGE USER FEE

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

HEALTH INSURANCE PROVIDERS FEE

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

OTHER FEDERAL IMPACTS

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

²¹ <http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf>

EMPLOYER MARKETS

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

DEFICIT NEUTRALITY IN ALTERNATIVE SCENARIOS

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

Table 10: Estimated 2020 Federal Savings in Alternative Scenarios

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

Appendix D

5 and 10 year Projections

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

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

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

| Rating Area | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 |
|--------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Baseline | | | | | | | | | | | |
| 1 | \$263 | \$288 | \$303 | \$317 | \$333 | \$351 | \$368 | \$386 | \$404 | \$424 | \$445 |
| After Reinsurance | | | | | | | | | | | |
| 1 | | \$274 | \$288 | \$302 | \$318 | \$335 | \$353 | \$370 | \$388 | \$408 | \$428 |

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

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

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

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

Appendix E Reliances

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

- Issuer submitted premium and enrollment information for 2017, 2018, and for January/February 2019
- Insurers submitted APTC information, including enrollment and premiums, for 2018 and January/February 2019
- Insurer submitted paid claim continuance tables for 2017 and 2018
- The 2016, 2017, and 2018 Open Enrollment Report PUF produced by HHS^{22 23 24}
- Effectuated Enrollment Reports released by CMS²⁵
- CBO Analysis on Impact of Repeal of the Mandate²⁶
- Information from the State of Rhode Island for on-Exchange demographic and FPL data

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

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

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

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

²² <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>

²³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

²⁴ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

²⁵ <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>

²⁶ <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf>

years. In particular, CSR funding or a requirement to spread the cost of CSRs across all metal levels could significantly decrease the pass-through percentage relative to what was estimated in this report. State political reactions to changes in the individual market could alter the results. Finally, the analysis was completed before the finalization of the 2020 Notice of Benefit and Payment Parameters and the HRA regulation. As a result, the impacts, particularly of the HRA regulation, were not included in the analysis.

- **Enrollment Uncertainty.** Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also have uncertainty (for example, state mandate). All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- **Premium Uncertainty.** Given that several recent changes to statutory and regulatory rules of the individual market (e.g., mandate) have not reached steady state in their effects on the individual market, there is uncertainty in how insurers may respond in their 2020 premiums. These uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- **Pass-Through Uncertainty.** Ultimately, the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely's models, differences in the pass-through amounts are possible.
- **Reinsurance Operations.** If actual operations of the reinsurance program differ from the data configurations used in this analysis, Wakely's analysis would need to be adjusted to match actual reinsurance data requirements. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results.

Appendix F

Disclosures and Limitations

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

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

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

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

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

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2019 experiences. Change in emerging 2019 enrollment and experience could impact the results. Finally, the analyses did not include the HRA final regulation as the regulation was released after the analyses were completed. The regulation could have an impact on the estimates.

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

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

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

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Attachment Two:
Rhode Island's Legislation

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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

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A N A C T

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

Introduced By: Senator Joshua Miller

Date Introduced: May 29, 2018

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

3 CHAPTER 157.1

4 RHODE ISLAND MARKET STABILITY AND REINSURANCE ACT

5 **42-157.1-1. Short title and purpose.**

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

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

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

13 **42-157.1-2. Definitions.**

14 As used in this chapter:

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

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

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

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

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

3 (6) "Office of the health insurance commissioner" means the entity established by § 42-
4 14.5-1 within the department of business regulation.

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

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

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

8 **42-157.1-3. Establishment of the Rhode Island reinsurance program.**

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

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

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

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

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

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

19 (1) An attachment point;

20 (2) A coinsurance rate; and

21 (3) A coinsurance cap.

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

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

28 **42-157.1-4. Powers of the director.**

29 (a) The director may:

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

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

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

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

4 **42-157.1-5. Establishment of program fund.**

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

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

8 (c) The fund shall consist of:

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

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

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

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

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

18 **42-157.1-6. State innovation waiver.**

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

23 **42-157.1-7. Program contingent on federal waiver and appropriation of state**
24 **funding.**

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

27 SECTION 2. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T
RELATING TO STATE AFFAIRS AND GOVERNMENT -- HEALTH CARE--HEALTH
INSURANCE

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

6 This act would take effect upon passage.

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ARTICLE 11

RELATING TO HEALTHCARE MARKET STABILITY

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

SECTION 1 - OMITTED.

SECTION 2. Section 42-157-4 of the General Laws in Chapter 42-157 titled "Rhode Island Health Benefit Exchange" is hereby amended to read as follows:

SECTION 2 - OMITTED.

SECTION 3. Chapter 42-157 of the General Laws entitled "Rhode Island Health Benefit Exchange" is hereby amended by adding thereto the following section:

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

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

(b) Eligibility determinations. The exchange shall make determinations as to whether to

1 grant a certification described in subsection (a). The exchange shall notify the individual and the
2 tax administrator for the Rhode Island Department of Revenue of any such determination in such
3 a time and manner as the exchange, in consultation with the tax administrator, shall prescribe. In
4 notifying the tax administrator, the exchange shall adhere to the data privacy and data security
5 standards adopted in accordance with 45 C.F.R. 155.260. The exchange shall only be required to
6 notify the tax administrator to the extent that the exchange determines such disclosure is permitted
7 under 45 C.F.R. 155.260.

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

11 **42-157-12. Special enrollment period for qualified individuals assessed a shared**
12 **responsibility payment penalty.**

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

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

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

23 (c) Effective Date. The exchange must ensure that coverage is effective for a qualified
24 individual who is eligible for a special enrollment period under this section on the first day of the
25 month after the qualified individual completes enrollment in a qualified health plan through the
26 exchange.

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

31 **42-157-13. Outreach to Rhode Island residents and individuals assessed a shared**
32 **responsibility payment penalty.**

33 Outreach. The exchange, in consultation with the Office of the Health Insurance
34 Commissioner and the Division of Taxation, is authorized to engage in coordinated outreach efforts

1 to educate Rhode Island residents about the importance of health insurance coverage, their
2 responsibilities to maintain minimum essential coverage as defined in section 44-30-101 of the
3 general laws, the penalties for failure to maintain such coverage, and information on the services
4 available through the exchange.

5 **42-157-14. Regulatory authority.**

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

8 SECTION 4. Sections 42-157.1-1 and 42-157.1-5 of the General Laws in Chapter 42-157.1
9 entitled "Rhode Island Market Stability and Reinsurance Act" are hereby amended to read as
10 follows:

11 **42-157.1-1. Short title and purpose.**

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

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

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

19 (c) No general revenue funding shall be used for reinsurance payments.

20 **42-157.1-5. Establishment of program fund.**

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

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

25 (c) The fund shall consist of:

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

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

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

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

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

1 (d) No general revenue funding shall be used for reinsurance payments.

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

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

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

14 **42-157.1-7. Program contingent on federal waiver and appropriation of state funding**

15 **Program contingent on federal waiver.**

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

18 SECTION 5. Chapter 44-30 of the General Laws entitled “Personal Income Tax” is hereby
19 amended by adding thereto the following sections:

20 **44-30-101. Requirements concerning qualifying health insurance coverage.**

21 (a) Definitions. For purposes of this section:

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

23 (2) “Minimum essential coverage” has the same meaning as set forth in 26 U.S. C. §
24 5000A(f).

25 (3) “Shared Responsibility Payment Penalty” means the penalty imposed pursuant to
26 subsection (c) of this section.

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

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

31 (c) Shared Responsibility Payment Penalty imposed for failing to maintain minimum
32 essential coverage. As of January 1, 2020, every applicable individual required to file a personal
33 income tax return pursuant to section 44-30-51 of the general laws, shall indicate on the return, in
34 a manner to be prescribed by the tax administrator, whether and for what period of time during the

1 relevant tax year the individual and his or her spouse and dependents who are applicable individuals
2 were covered by minimum essential coverage. If a return submitted pursuant to this subsection
3 fails to indicate that such coverage was in force or indicates that any applicable individuals did not
4 have such coverage in force, a Shared Responsibility Payment Penalty shall hereby be assessed as
5 a tax on the return.

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

10 (e) Exceptions.

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

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

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

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

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

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

31 (g) Deficiency. If, upon examination of a taxpayer's return, the tax administrator
32 determines there is a deficiency because any refund due to the taxpayer is insufficient to satisfy the
33 Shared Responsibility Penalty or because there was no refund due, the tax administrator may notify
34 the taxpayer of such deficiency in accordance with section 44-30-81 and interest shall accrue on

1 such deficiency as set forth in section 44-30-84. All monies collected on said deficiency shall be
2 placed in the Health Insurance Market Integrity Fund created pursuant to section 42-157.1-5 of the
3 general laws.

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

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

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

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

25 **44-30-102. Reporting Requirement for Applicable Entities providing Minimum**
26 **Essential Coverage.**

27 (a) Findings.

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

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

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

34 (4) The reporting requirement provided for in this section is necessary for the successful

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

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

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

15 (7) The reporting requirement in this section has been narrowly tailored to support
16 compliance with the Shared Responsibility Payment Penalty imposed by subsection 44-30-101(c)
17 of the general laws, while imposing only an incidental burden on reporting entities. In particular,
18 the information that must be reported is limited to the information that must already be reported
19 under a similar federal reporting requirement under section 6055 of the Internal Revenue Code of
20 1986. In addition, this section provides that its reporting requirement may be satisfied by providing
21 the same information that is currently reported under such federal requirement.

22 (b) Definitions. For purposes of this section:

23 (1) “Applicable entity” means:

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

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

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

31 (2) “Minimum essential coverage” has the meaning given such term by section 44-30-
32 101(a)(2) of the general laws.

33 (c) For purposes of administering the Shared Responsibility Payment Penalty to individuals
34 who do not maintain minimum essential coverage under subsection 44-30-101(b) of the general

1 laws, every applicable entity that provides minimum essential coverage to an individual during a
2 calendar year shall, at such time as the tax administrator may prescribe, file a form in a manner
3 prescribed by the tax administrator.

4 (d) Form and manner of return.

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

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

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

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

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

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

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

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

28 (f) Reporting responsibility.

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

34 (2) Delegation. An applicable entity may contract with third-party service providers,

1 [including insurance carriers, to provide the returns and statements required by this section.](#)

2 SECTION 6. Section 2 of this article shall take effect January 1, 2020. The remainder of
3 this article shall take effect upon passage.

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Attachment Three:
Market Stability Workgroup Report

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MAINTAINING THE STABILITY OF RHODE ISLAND'S HEALTH INSURANCE MARKETS

Key findings and recommendations of the
Market Stability Workgroup

June 2018

EXECUTIVE SUMMARY & RECOMMENDATIONS

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

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

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

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

The Workgroup reviewed the progress Rhode Island has made since the ACA's implementation in 2014, including cutting the uninsured rate by almost two-thirds and keeping individual market rates among the lowest in the country. The Workgroup considered indicators of market stability, noting that Rhode Island's markets have been relatively stable while the future is more precarious, particularly and most immediately for the individual and small group markets. Recent federal actions that may undermine that stability include the repeal of the shared responsibility requirement (also known as the "individual mandate") penalty and the proposal to expand consumer access to non-ACA compliant plans. The Workgroup considered policy options aimed at protecting market stability. These options were categorized in terms of three key legs of the ACA: affordability, shared responsibility, and insurance reforms. Throughout its deliberations, the Workgroup noted that the state should consider the impacts of any recommendations on those who purchase on the individual market, including those who receive federal premium tax credits and those who do not.

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

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

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

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

In addition to the above policy recommendations, which should be addressed immediately, the Workgroup acknowledges that further work remains. The Workgroup therefore also recommends the following:

- **Future market stability actions required:** Rhode Island should focus next on how to fund a state reinsurance program and how to best design and implement a shared responsibility requirement. Additionally, further efforts must be made to address the particulars of the aforementioned affordability initiatives, including whether any further affordability initiatives are necessary. The state should also carefully consider codifying into law critical consumer protections provided through the ACA which are currently at risk and vulnerable to future federal changes. Examples of critical consumer protections include, but are not limited to, coverage of the ten Essential Health Benefits categories, no-cost preventive services and bans on annual and life-time limits. The Workgroup also notes that these recommendations are necessary, but may not fully address all potential causes of market instability, and more actions may be needed in the future.
- **Context of health care costs:** The state should address the underlying drivers of health care costs. The Workgroup noted that its specific consideration of market stability does not encompass the complex and pervasive issue of addressing the underlying costs of providing healthcare in Rhode Island. The time limitations and core charge of this group precluded a complete deliberation on this topic. Without addressing this concern, high underlying costs will remain a risk to the health and stability of the market.

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

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

| Print Full Name | Organization | Signature |
|--------------------------|--|--------------------------|
| William K. Wray | Chair, HSRI Advisory | William K. Wray |
| Stephen C. Boyle | Assistant Chamber of Commerce | Stephen C. Boyle |
| RALPH COPPOLA | N. E. BUSINESS ASSOCIATION | Ralph Coppola |
| PETER HOLLMANN MD | RHODE ISLAND MEDICAL SOCIETY | Peter Hollmann |
| IAI Cherkovskaya | RI Business Group on Health | IAI Cherkovskaya |
| Susan A. Storti, PhD, RN | The Substance Use and Mental Health Leadership Council of RI | Susan A. Storti, PhD, RN |
| M. Teresa Pawaluch | President, Hospital Association of RI | M. Teresa Pawaluch |
| Larry O. Warner, MPH | Rhode Island Foundation | Larry O. Warner |
| Samuel Salganik | Rhode Island Parent Information Network | Samuel Salganik |
| Jane Hayward | RI Health Center Association | Jane A. Hayward |
| Kirk Myers | NEIGHBORHOOD HEALTH | Kirk Myers |
| CRISTINA ANGELO | UNITED WAY 2-1-1 IN RHODE ISLAND | Cristina Angelo |
| Kim A. Keck | Blue Cross Blue Shield RI | Kim A. Keck |
| JOSHUA MILLER | RI STATE SENATE | Joshua Miller |
| Gayle Goldin | RI State Senate | Gayle Goldin |
| Janet Raymond | Greater Providence Chamber of Commerce | Janet Raymond |

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

SUMMARY OF WORKGROUP DISCUSSIONS AND FINDINGS

Background and Key Concerns

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

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

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

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

In addition, proposed federal changes could make it easier for individuals to join association health plans² and to purchase STLD plans, neither of which are required to include some ACA defined consumer protections, such as EHBs. As with the elimination of the mandate penalty, both changes

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

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

Timeline for Action

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

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

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

Affordability

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

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

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

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

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

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

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

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

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

Insurance Reforms

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

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

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

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

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

Shared Responsibility

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

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

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

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

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

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

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

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

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

Other considerations

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

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MAINTAINING THE STABILITY OF RHODE ISLAND'S HEALTH INSURANCE MARKETS

Further action recommendations of the
Market Stability Workgroup

January 2019

BACKGROUND

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

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

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

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

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

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

FURTHER ACTION RECOMMENDATIONS

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

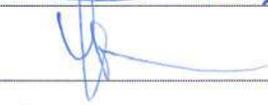
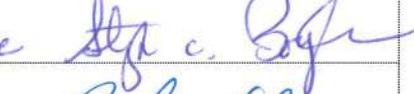
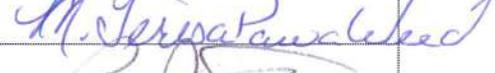
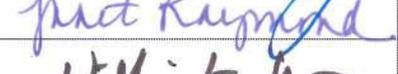
After careful consideration and determined debate, the Workgroup made the following statements in support of their original recommendations and the three Guiding Principles:

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

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

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

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

| Print Full Name | Organization | Signature |
|--------------------------|--|---|
| Monica A. Neronen | Blue Cross & Blue Shield of RI |  |
| Elizabeth McClaine | Neighborhood Health Plan of Rhode Island |  |
| Susan A. Starti, PhD, RN | The Substance Use and Mental Health Leadership Council of RI | Susan A. Starti, PhD, RN |
| CRISTINA AMEDEO | UNITED WAY 2-1-1 RI |  |
| RALPH COPPOLA | IVY WEALTH, RI BUSINESS SBA SUMMIT, COALITION |  |
| MARC BACKON | TUFTS HEALTH PLAN |  |
| PETER TOLMANN MD | RI MEDICAL SOCIETY |  |
| Sam Salganik | RI Parent Information Network |  |
| Stephen C. Boyle | Cranston Chamber of Commerce |  |
| JOSHUA MILLER | RI SENATE |  |
| Susan Pawawled | HARI |  |
| Larry Warner | Rhode Island Foundation |  |
| Al Chembanez* | RI Business Guy or Gal |  |
| Jane A. Hayward | Rhode Island Health Center Association |  |
| Janet Raymond | Greater Providence Chamber of Commerce |  |
| Willi K. Wj | Washington Trust |  |
| | | |
| | | |
| | | |

* with letter

Attachment Four:
Documentation of the State's Public
Comment Period

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The attached email announcing the State's public comment period was sent to the following on April 26, 2019:

All members of the following groups:

- HealthSource RI Advisory Board
- Broker Advisory Board
- Market Stability Workgroup
- Health Insurance Advisory Council (HIAC)

Representatives from the following organizations and groups:

- Neighborhood Health Plan of Rhode Island
- Representatives from Blue Cross & Blue Shield of Rhode Island
- United Healthcare
- Tufts Health Plan
- Rhode Island Public Expenditure Council (RIPEC)
- Rhode Island Parent Information Network (RIPIN)
- Rhode Island Medical Society
- Rhode Island Health Center Association
- United Way of Rhode Island
- National Academy for State Health Policy (NASHP)
- Mental Health Association of Rhode Island (MHARI)
- The Cranston Chamber of Commerce
- Hospital Association of Rhode Island
- Small Business Community

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Hall, Katie M (HBE)

From: Zach Sherman <1332waiverapplication@healthsourceri.com>
Sent: Friday, April 26, 2019 3:37 PM
To: Hall, Katie M (HBE)
Subject: [EXTERNAL] : Public comment period for 1332 Waiver Draft Application



Hello all,

We are excited to announce the State of Rhode Island is seeking public comment on its draft Section 1332 State Relief and Empowerment Waiver Application! The application seeks to waive certain requirements of the ACA with the goal of expanding state's flexibility to implement a reinsurance program in the individual health insurance market.

A public comment period is an important step in the waiver development process and is required to happen prior to the application's submission. The State is not obligated by this draft application or the public comment period to implement or fund a reinsurance program.

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

Public comment on the draft is open until May 25, and we welcome your input. Additionally, there will be two public hearings on May 10 and May 20.

Please visit the site below to view the draft application, and for more details about how to provide input.

[Rhode Island 1332 Waiver Draft Application \[healthsourceri.us7.list-manage.com\]](https://healthsourceri.us7.list-manage.com)

Thank you,

Zach Sherman

Director, HealthSource RI



[\[healthsourceri.us7.list-manage.com\]](https://healthsourceri.us7.list-manage.com)



[\[healthsourceri.us7.list-manage.com\]](https://healthsourceri.us7.list-manage.com)



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You are receiving this email because you've been identified as a community partner who wants to share information about HealthSource RI and the Department of Human Services.

Our mailing address is:

HealthSource RI
501 Wampanoag Trail Suite 400
East Providence, RI 02915

[Add us to your address book \[healthsourceri.us7.list-manage.com\]](https://healthsourceri.us7.list-manage.com)



Rhode Island Department of State
Nellie M. Gorbea
 Secretary of State

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| HealthSource RI (/OpenMeetingsPublic/OpenMeetingDashboard?subtopmenuId=201&EntityID=1417&MeetingID=979008) | May 20 2019, 09:00AM |
| HealthSource RI (/OpenMeetingsPublic/OpenMeetingDashboard?subtopmenuId=201&EntityID=1417&MeetingID=978384) | May 10 2019, 01:00PM |

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| July 2019 | | | | | | |
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(401) 222-3983 (<tel://1-401-222-3983>)

opengovernment@sos.ri.gov

<mailto:opengovernment@sos.ri.gov>



Rhode Island Department of State



An Official Rhode Island State Website



<https://twitter.com/riseystate> (<https://www.linkedin.com/compe>)

Public Meeting Notice



Public Hearing #1: 1332 Waiver Application

Notice Posted: May 7, 2019
Date of Meeting: May 10, 2019
Meeting Time: 1:00 pm – 3:00pm
Meeting Location: Department of Administration
Conference Room 2B, 1 Capitol Hill
Providence, RI 02908

Agenda

- I. Call to order
- II. Staff Presentation: Rhode Island's Proposed §1332 Waiver Application under the Affordable Care Act
- III. Public Comment
- IV. Additional hearing:
May 20, 2019, 9:00am – 11:00am
Department of Labor and Training,
Conference Room 73-1,
1511 Pontiac Ave., Cranston, RI 02920
- V. Adjourn

The Department of Administration 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 401-408-4199 or email her at lindsay.lang@exchange.ri.gov at least 48 business hours in advance of the meeting.

Public Meeting Notice



Public Hearing #2: 1332 Waiver Application

Notice Posted: May 16, 2019
Date of Meeting: May 20, 2019
Meeting Time: 9:00 am – 11:00am
Meeting Location: Department of Labor and Training
Conference Room 73-1,
1511 Pontiac Ave., Cranston, RI 02920

Agenda

- I. Call to order
- II. Staff Presentation: Rhode Island's Proposed §1332 Waiver Application under the Affordable Care Act
- III. Public Comment
- IV. Adjourn

The Department of Labor and Training 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 401-408-4199 or email her at lindsay.lang@exchange.ri.gov in advance of the meeting.

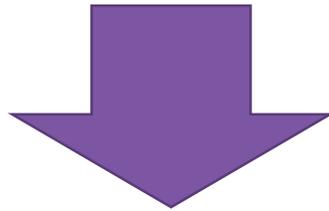


Rhode Island's Proposed Section 1332 Waiver Application

Public Hearings, May 10 & May 20, 2019

What is a Section 1332 Waiver?

- The Affordable Care Act (ACA) permits a state to apply for a State Relief and Empowerment Waiver (Section 1332 Waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health coverage.
- Rhode Island is seeking a waiver of Section 1312(c)(1) for a period of five years beginning in the 2020 plan year to develop a state-based reinsurance program.



This waiver application supports the implementation of a reinsurance program in the individual market, including the ability to use federal funding to partially fund the reinsurance program.

What is the purpose of this waiver?

The waiver is intended to stabilize individual market enrollment, to mitigate rate increases, and to maintain a market attractive to carriers.

- Four “guardrails” apply to 1332 waivers. The waiver must:
 1. Provide access to quality health care that is **at least as comprehensive** as would be provided without the waiver
 2. Provide access to quality health care that is **at least as affordable** as would be provided without the waiver
 3. Provide coverage to **at least a comparable number of residents** as would be provided without the waiver
 4. **Not increase** the federal deficit.
- To the extent the state saves federal dollars through actions it takes under its waiver, those dollars can be given to the state to fund waiver approved activities.

Draft Waiver Application – Status Update

- Governor Raimondo **included a State reinsurance program** in Article 14 of her proposed 2020 budget to help protect gains of the Affordable Care Act in Rhode Island by mitigating premium increases.
- That proposal is currently under consideration by the Rhode Island General Assembly. If approved as proposed, the **reinsurance program would first impact rates for calendar year 2020.**
- To meet Federal requirements for that timeline, the State needed to release a draft 1332 waiver application for public comment in April 2019. **This public hearing is a requirement of that comment period.**
- If the General Assembly does not approve the proposed reinsurance program as part of the FY20 budget, this waiver application will not be submitted to the Federal government.

Protecting Access to Affordable Health Care

- **The Affordable Care Act has worked in RI:**

- Prior to ACA implementation, RI's uninsured rate was 12%
- Today, 96% of Rhode Islanders are covered
- In 2019, RI has the 3rd lowest cost benchmark plan in the country

- **However, this progress is at risk...**

- Congress repealed the individual mandate penalty effective January 2019
- The federal transitional reinsurance program, which stabilized rates in the individual market, has been phased out
- Premiums are expected to rise in 2020 and future years at an increasing rate
 - Between 2017-19 the average monthly premium for unsubsidized HSRI customers jumped 26%
- Additional changes from the federal government threaten to undermine the progress that has been made in RI.

Key Market Stability Concerns



Loss of Coverage – RI's high insurance levels will decline as young and healthy populations drop coverage



Unbalanced Risk Pool – The remaining populations will be older and sicker, creating a smaller and more volatile risk pool



Premium Increases – A riskier pool will lead to premium increases for the remaining insured, starting with individuals and the smallest businesses

What is Rhode Island doing?

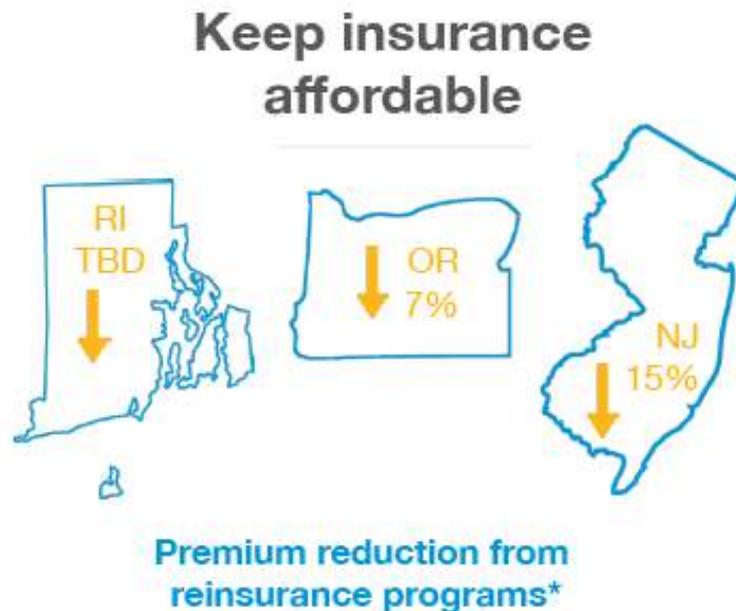
- In 2018 HSRI and OHIC convened a group of RI stakeholders to form a **Market Stability Workgroup**
- The Workgroup **developed recommendations** for protecting access and affordability at the state level
- Acting on their recommendations, Governor Raimondo included the **following initiatives** in her Proposed FY 2020 budget:
 - A **reinsurance program** to reduce premium increases in the individual market
 - A **state-based penalty** for not having insurance
 - **Regulatory authority** over short-term limited duration plans

Related Legislative Activity

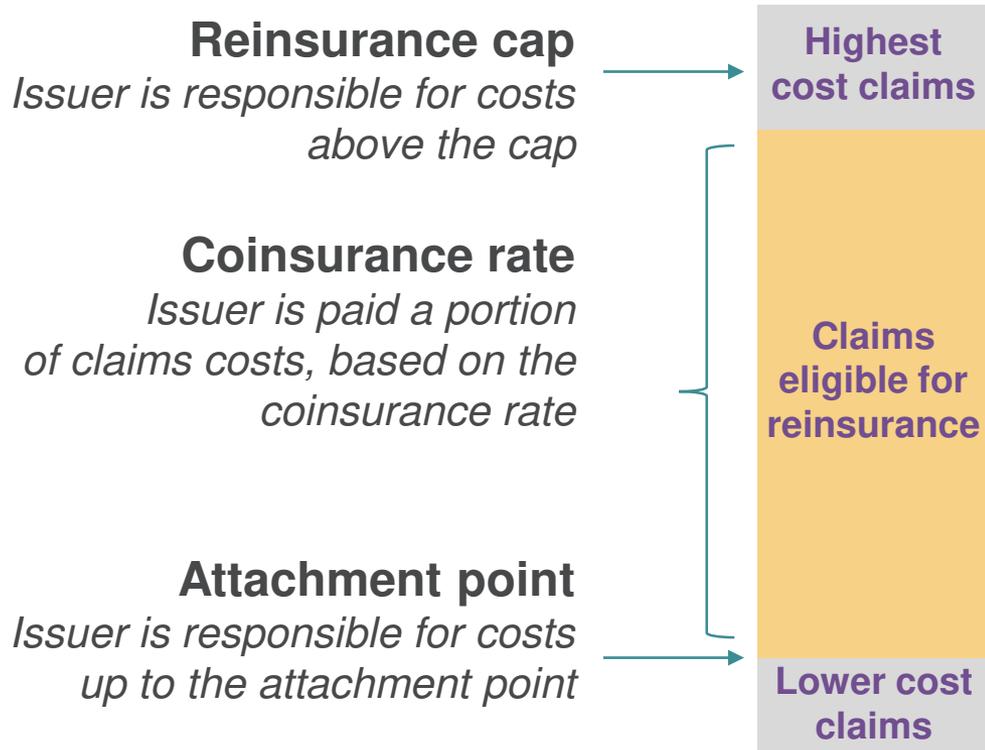
- **Rhode Island Market Stability and Reinsurance Act, R.I. Gen. Laws § 42-157.1**
 - Passed and signed into law on July 2, 2018.
 - Authorizes HSRI to pursue a 1332 waiver to establish a reinsurance program to stabilize the state's individual market
 - Authorizes HSRI to establish and implement a state-based reinsurance program and provide reinsurance to carriers that offer health insurance coverage on the state's individual market
- **Proposed Budget Article 14, Relating to Market Stability**
 - Has been proposed by Governor Gina Raimondo and is currently under review by the legislature.
 - If passed by the legislature in its current form:
 - Would authorize the state to establish a state individual mandate penalty, effective January 1, 2020.
 - Would authorize the state to utilize any penalties collected under this new statute as a state funding source for its individual market reinsurance program.

What will a reinsurance program do?

- Offset costs associated with sicker, riskier customers by paying for a portion of high-cost claims
- Provide relief to families and small businesses who don't receive financial assistance
- Allow the state to secure federal funding to support reinsurance through a 1332 waiver



How would a reinsurance program work?



- 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 to match available funding

How will the reinsurance program be funded?

If passed by the General Assembly and approved by the federal government...

- The **projected size of the reinsurance program** in Plan Year 2020 is \$14.7 million.
 - This represents the projected reinsurance claims payments made to carriers.
 - Payments expected to be made in 2021.
- The **funding for this reinsurance program** will come from a combination of state and federal funds.
 - The state projects the **1332 waiver to generate \$6.4 million in federal pass-through funds** to fund reinsurance payments.
 - The **remaining \$8.3 million** will be funded by state revenue from the assessment of individual mandate penalties.

How will this impact Rhode Islanders?

If passed by the General Assembly and approved by the federal government...

- In 2020, the program is projected to reimburse 50% of claims between an attachment point of \$40,000 and cap of \$97,000.
- HSRI estimates that the reinsurance program, as part of the waiver proposal, will result in an **average net premium decrease of 5.9% in 2020** and 6.3% in 2021.

Net premium decrease is defined as the difference between expected premiums with and without the reinsurance program.

- For customers **without any financial assistance** (who are most vulnerable to rate increases) the reinsurance proposal's estimated **average net premium decrease is 7.0% in 2020**.

Waiver Application Timeline

- To implement the proposed reinsurance program for plan year 2020, the application must be submitted to the federal government by mid-summer 2019.
- To meet Federal requirements for that timeline, the State needed to release a draft waiver application for public comment in April 2019.
- **If the General Assembly does not approve the proposed reinsurance program as part of the FY20 budget, this waiver application will not be submitted.**

| | |
|-----------------------------|---|
| Apr 26 – May 25, 2019 | 30-day public comment period, including 2 public hearings |
| Current legislative session | General Assembly considering the reinsurance program and funding source of state share of reinsurance program. |
| Mid-summer 2019 | If the General Assembly approves the reinsurance program in its current form, 1332 application is submitted to CMS |
| 2 months of review | CMS requires approximately two months for review and final approval of a waiver, including a federal 30-day comment period. |
| Fall 2019 | 2020 Rate filings approved by OHIC, Open Enrollment for 2020 Plan Year begins |
| Jan 1, 2020 | 2020 rates are in effect; reinsurance program begins |

30-Day Public Comment Period and Hearings

- HSRI is hosting 2 public hearings to gather public input:
 - May 10, 2019 at the Dept of Administration, Providence
 - May 20, 2019 at the Dept of Labor and Training, Cranston
- We will be accepting public comments on its 1332 Waiver Application beginning April 26, 2019, through May 25, 2019.
 - Comments may be sent via electronic mail to:
1332waiverapplication@healthsourceri.com
 - Or by postal mail to: State of Rhode Island 1332 Waiver Application
HealthSource RI 501 Wampanoag Trail, Suite 400, Riverside, RI 02915
- For additional information and updates, go to the following website:
<https://healthsourceri.com/1332waiver/>

PUBLIC COMMENT

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Rhode Island Proposal for ACA Section 1332 State Relief and Empowerment Waiver

Background/Introduction

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

Specifically, the State of Rhode Island is seeking public comment on its draft Section 1332 State Relief and Empowerment Waiver Application and supporting appendices. The application seeks to waive certain requirements of the ACA with the goal of expanding state's flexibility. A public comment period is an important step in the waiver development process and is required to happen prior to the application's submission to the

Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS), and the Department of the Treasury. The State is not obligated by this draft application or the public comment period to implement or fund a reinsurance program.

Rhode Island Proposal for Section 1332 Waiver

Rhode Island's Section 1332 Waiver Application Draft can be found here:

[1332 Waiver Application Draft](#)

Public Comments

The State of Rhode Island will be accepting public comments on Rhode Island's 1332 Waiver Draft Application beginning April 26, 2019, through May 25, 2019.

Comments may be sent via electronic mail to:

1332waiverapplication@healthsourceri.com

or by postal mail to:

State of Rhode Island 1332 Waiver Application
HealthSource RI
501 Wampanoag Trail, Suite 400
Riverside, RI 02915

Public Hearings

In compliance with Federal regulations, the State of Rhode Island will hold two public hearing on Rhode Island's proposed 1332 Waiver Application.

- The first public hearing will be held May 10, 2019 from 1:00pm – 3:00pm at the following location:

Department of Administration
Conference Room B, 1 Capitol Hill
Providence, RI 02908

For directions to the Department of Administration and information on parking and public transportation information, please visit the following website: <http://www.admin.ri.gov/directions/index.php>

- The second public hearing will be held May 20, 2019 from 9:00am – 11:00am at the following location:

Department of Labor and Training
Conference Room, 1511 Pontiac Ave.
Cranston, RI 02920

For directions to the Department of Labor and Training and information on parking and public transportation information, please visit the following website: <http://www.dlt.ri.gov/directions.htm>

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20 Newman Ave, Suite 1000
Rumford, RI 02916
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May 24, 2019

HealthSource RI

By Email To: 1332waiverapplication@healthsourceri.com

Re: Comments to 1332 Draft Application

To Whom It May Concern:

Thank you for the opportunity to submit these comments in support of HealthSource RI's (HSRI's) draft waiver application under section 1332 of the Affordable Care Act (ACA). The Rhode Island Parent Information Network (RIPIN) is a peer-driven agency that helps Rhode Islanders achieve their education and healthcare goals. We have had a front-row seat to the many successes of the ACA in Rhode Island. We operate a health insurance consumer assistance program that helps any Rhode Islander access coverage and care, and that in 2018 saved consumers \$2.25 million in healthcare costs. We also serve as a Navigator agency. Our mission has long included helping disabled and vulnerable Rhode Islanders access the care they need, and the ACA has brought incredible advances in that respect, drastically lowering the uninsured rate and improving access to coverage and care. HealthSource RI (HSRI) has also been a success, bringing more competition to the market, and offering rates that are among the lowest in the country and that have remained stable (often even decreasing).

Thank you also for the opportunity to participate as members of both rounds of the Market Stability Working Group where this initiative was publicly vetted. The process was exemplary in its inclusiveness, transparency, and professionalism.

We write in support of this waiver proposal, which we believe will help to strengthen the ACA in Rhode Island, particularly the commercial individual market. While the individual market overall is strong, the positions of the two participating carriers are not identical. Looking merely at market average rates can obscure differences between carriers that genuinely impact the market. As HSRI moves forward with this application and later refinements to the reinsurance parameters, we urge the agency to look carefully at the differing impacts on individual carriers and plans, and how that will impact affordability for low income applicants.

In this market, one carrier has historically carried a sicker risk pool (as evidenced by risk adjustment transfers), and that carrier (which does not offer the benchmark plan) has seen its premiums grow faster. That carrier is also the only carrier that offers provider networks that include Boston-based centers of excellence. Access to this coverage is important to some patients, and it is becoming less and less affordable under current market dynamics, particularly for low-income advance premium tax credit recipients. We support this waiver proposal to the extent that it helps keep this type of coverage available and affordable to those who need it. As the process pushes forward and attachment points and coinsurance rates are set (and reset), it is important for HSRI to monitor the differing impacts on participating carriers, and to keep that

goal in mind. Reductions in the benchmark plan rate, while they lower federal outlays and increase the federal reinsurance participation rate, do not help low income people access coverage.

We offer two specific comments:

1. Clarify single-risk pool language

While the application asks to waive the ACA's single risk pool requirements (section 1312(c)(1)), it should be made very clear that the core protections of those requirements will still apply. Prior to the ACA, in many states, carriers could price a plan based on the likely risk profile attracted by that individual plan. These pricing strategies tend to drive down costs in lower-benefit plans attractive to younger and healthier enrollees, and drive up costs in more robust plans attractive to those with higher healthcare needs. These pricing strategies could also potentially allow carriers to offer differently-priced products on and off the exchange. The single risk pool requirement prevents these practices, and therefore supports a healthy market and protects patients with higher healthcare needs (e.g. pre-existing conditions).

The application already requests this waiver only "to the extent it would otherwise require excluding state reinsurance payments when establishing the market-wide index rate." We recommend adding an additional sentence immediately thereafter reading: "*To clarify, the single risk pool requirement will remain in effect to the extent that this reinsurance program can be implemented in accordance therewith, and the State will make all efforts to support the policy purpose of that requirement.*"

2. Use excess funds (if any) to create a reserve for future years

The structure of the reinsurance program and funding mechanism means that it is possible that there will either be too much or too little money in the fund to make reinsurance payments at the levels described. The application provides that, in these circumstances, the coinsurance rate will be adjusted upwards or downwards. Adjusting the coinsurance rate downwards in case of a shortfall is understandable; there is no obvious source for additional funding. If there are excess funds, however, we recommend that they be used to create a reserve. This reserve could be used to cushion shortfalls in future years.

The principal stated goal of this initiative is market "stability." As currently described, with the coinsurance rate potentially (even likely) fluctuating from year-to-year, the program may in fact lead to rate instability. Using excess funds (if any) to build a reserve instead would promote stability by adding the carriers' certainty about the availability of funding in future years.

Conclusion

Thank you again for the opportunity to submit these comments. Should you have any further questions, please do not hesitate to contact me.

Sincerely,

/s/

Sam Salganik
Executive Director
401-270-0101, ext. 101
Salganik@ripin.org

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May 25, 2019

State of Rhode Island
1332 Waiver Application
Health Source RI
501 Wampanoag Trail, Suite 400
Riverside, RI 02915

Emailed to: 1332waiverapplication@healthsourceri.com

Re: Rhode Island Section 1332 State Innovation Waiver

Dear Director Sherman & Commissioner Ganim,

The New England Hemophilia Association (NEHA), and the New England Bleeding Disorders Advocacy Coalition (NEBDAC) appreciates this opportunity to submit comments on Rhode Island's Section 1332 State Innovation Waiver. Since 1957, NEHA has served individuals and families with inherited bleeding disorders, who need information, education and support for their condition. NEBDAC was formed in 2016, as a volunteer advocacy coalition under NEHA. Both NEBDAC and NEHA provide advocacy and education about bleeding disorders in all 6 New England States.

NEHA and NEBDAC believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people in the bleeding disorder community to access the coverage that they need, and our organizations support Rhode Island's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.



Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D.

Rhode Island's proposal will create a reinsurance program starting for the 2020 plan year and continuing for 5 years. This program is projected to reduce premiums by 5.9 percent and increase the number of individuals obtaining health insurance through the individual market by .9 percent. This would help patients with pre-existing conditions, including patients with bleeding disorders, obtain affordable, comprehensive coverage.

As always, we thank you for your willingness and openness to feedback on these important questions of access to healthcare. Again, NEHA and NEBDAC believe your 1332 State Innovation Waiver will help stabilize the individual market and increase access to care. We are happy to respond to any additional questions, comments or concerns that you may have.

Handwritten signature of Richard Pezzillo in black ink.

Richard Pezzillo
Executive Director
NEHA

Handwritten signature of Joseph Zamboni in black ink.

Joseph Zamboni
Advocacy Coordinator
NEBDAC



**National
Multiple Sclerosis
Society**

May 22, 2019

State of Rhode Island 1332 Waiver Application
HealthSource RI
501 Wampanoag Trail
Suite 400
Riverside, RI 02915

Re: Rhode Island Section 1332 State Innovation Waiver

Dear Director Sherman and Commissioner Ganim,

The National Multiple Sclerosis Society appreciates the opportunity to submit comments on Rhode Island's Section 1332 State Innovation Waiver.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain and between the brain and the body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The National MS Society believes that everyone should have access to quality, affordable healthcare. Since 2014, the Affordable Care Act (ACA) health insurance marketplace has been an extremely important avenue to affordable, quality coverage for people living with MS. A strong, robust marketplace is essential for people living with multiple sclerosis to access the coverage and care that they need.

However, insurance premiums are rising and will soon price people out of the healthcare system. The Society is committed to ensuring that people living with MS have reliable access to comprehensive health insurance plans with affordable premiums, deductibles, and out-of-pocket costs. Without market stabilization measures like reinsurance, Rhode Islanders who are currently relying on the marketplace for their health insurance could lose their only affordable coverage option. The Society supports Rhode Island's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets by covering a percentage of the claims of very high cost enrollees; it allows health insurers to remain in the health insurance market when their costs would typically be too high to continue to operate. This will help make premiums more affordable for all individuals who buy insurance on the individual market. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Rhode Island's proposal will



**National
Multiple Sclerosis
Society**

create a reinsurance program starting for the 2020 plan year and continuing for five years. This program is projected to reduce net premiums by 5.9-6.3% and increase the number of individuals obtaining health insurance through the individual market by 0.9% percent. This program will undoubtedly help people who live with MS, an expensive pre-existing condition, to obtain and retain affordable, comprehensive coverage.

The Rhode Island 1332 State Innovation Waiver also implements an individual mandate and penalty, the latter of which would further fund the state's reinsurance program. The Society supports individual mandate legislation and regulations that would require all qualified people to enroll in health insurance or face a penalty if they remain uninsured. Since the repeal of the federal mandate, known as the Shared Responsibility Payment, that was put in place by the ACA was repealed, several states are working to codify mandate language into law. By requiring health insurance coverage, a state-level individual mandate would potentially lower the average premium for plans sold in Rhode Island in addition to the expected lowering by the reinsurance program. People living with MS may potentially have more affordable options for coverage as a result. By requiring that more people are enrolled in an insurance plan, the risk pool would be increased leading to cost savings to the state.

The Society would like to make one other note on the insurance market in Rhode Island. Currently, the state of Rhode Island requires all insurance plans – even short term, limited duration (STLD) plans – sold in the state to follow various regulations, including the coverage of all essential health benefits. We appreciate Rhode Island being a leader on this issue and would hope to see it continue, as many STLDs in other states fail to meet these requirements. Should less regulated STLDs be allowed in the state and be made applicable to the reinsurance program, they would put at risk the plan's goal of providing greater financial certainty to consumers of health insurance in the state.

The National MS Society believes the 1332 State Innovation Waiver will help stabilize the individual market in Rhode Island and protect patients and consumers. Thank you for the opportunity to provide comments. Should you have any questions, please do not hesitate to contact Laura Hoch at laura.hoch@nmss.org or (860) 913-2550 X52521.

Sincerely,

Laura Hoch
Manager, Advocacy
National Multiple Sclerosis Society

????????????????

May 23, 2019

Zachary W. Sherman
Director, HealthSource RI
501 Wampanoag Trail, Suite 400
Riverside, RI 02915

Re: Rhode Island 1332 Draft Waiver Application

Dear Director Sherman:

The American Lung Association in Rhode Island appreciates the opportunity to submit comments on Rhode Island's draft 1332 Waiver Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 35 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 168,000 Rhode Island residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association in Rhode Island believes everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with lung disease to access the coverage that they need. The Lung Association supports Rhode Island's efforts to strengthen its marketplace by submitting this 1332 Waiver Application to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by

Advocacy Office:

1331 Pennsylvania Avenue NW, Suite 1425 North
Washington, DC 20004-1710
Ph: 202-785-3355 F: 202-452-1805

Corporate Office:

55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

an estimated 10 to 14 percent in its first year.¹ A recent analysis by Avalere of the seven states that have already created their own reinsurance programs through Section 1332 waivers found that these states reduced individual market premiums by an average of 19.9 percent in their first year.²

Rhode Island's proposal will create a reinsurance program starting for the 2020 plan year and continuing for five years. Based on the initial analysis commissioned by the state, this program is projected to reduce premiums by 5.9 percent in 2020 and increase the number of individuals obtaining health insurance through the individual market by nearly one percent. This would help patients with pre-existing conditions, including patients with lung disease, obtain affordable, comprehensive coverage.

The American Lung Association believes this 1332 Waiver will help stabilize the individual market in Rhode Island and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,



Jennifer Wall
Advocacy Director, RI
American Lung Association

¹ American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

² Avalere. *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average*. March 2019. Retrieved from <https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average>.



Attachment Five:
Tribal Consultation

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July 5, 2019

Tribal Consultation Summary

On July 3, 2019 HealthSource RI (HSRI) held a Tribal Consultation on Rhode Island's 1332 Draft Waiver Application and reinsurance program via conference call. HSRI Director Zachary Sherman met with Director Autumn leaf Spears, of the Narragansett Indian Health Center, to discuss the proposed waiver and reinsurance program. Director Spears attended on behalf of the Narragansett Indian Tribal Nation, which is the only federally recognized tribe in Rhode Island. The draft waiver application and accompanying public hearing presentation were made available to the Narragansett Tribe by postal mail and email at the beginning of the State's public comment period.

During the Tribal Consultation, Director Sherman presented information related to the proposed reinsurance program, waiver application process, projected impact of a successful reinsurance program in Rhode Island, and the timeline for the State's reinsurance program implementation. Director Spears and Director Sherman discussed the proposal and the reinsurance program as well as another element of the Governor's FY 2020 budget proposal. Director Spears expressed appreciation for the opportunity to weigh in and be consulted regarding reinsurance and the waiver application and did not suggest any changes to the waiver proposal or to the reinsurance program.

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Hall, Katie M (HBE)

From: Hall, Katie M (HBE)
Sent: Monday, April 1, 2019 10:59 AM
To: Autumn Spears; autumnleafspears@gmail.com
Cc: Jo-Ann Benson
Subject: Requesting a Meeting to Discuss Upcoming Federal Waiver
Attachments: NarragansettLetter.pdf

Importance: High

Good morning Ms. Spears,

Your contact information was shared with me by a colleague from RI Medicaid. I am a policy analyst for the Rhode Island's State Health Exchange, HealthSource RI (HSRI). At HSRI, we are currently preparing an application to the US Department of Health and Human Services and Department of Treasury to waive a provision of the Affordable Care Act. This application requires a meeting with representative(s) of the Narragansett Indian Tribal Nation regarding the application and proposal.

Please see the attached letter requesting a meeting at your earliest convenience. I greatly appreciated your participation and look forward to speaking with you soon.

Thank you,

Katie

Katie McCarten Hall, JD
HealthSource RI
Senior Policy Analyst
Katie.M.Hall@exchange.ri.gov

April 1, 2019

Autumn Leaf Spears
Narragansett Indian Health Center
Health and Human Services Department
Charlestown, RI 02813

Dear Ms. Spears:

I am writing regarding an application the State of Rhode Island is preparing to submit in the coming months to U.S. Department of Health and Human Services and Department of Treasury. The State is preparing to apply for a §1332 waiver under the Affordable Care Act, to establish a state-based reinsurance program.

This waiver application requires that we have a meaningful consultation with the Narragansett Indian Tribal Nation. At your earliest convenience, please let me know what would work best for a meeting – I am available to meet in-person or over the phone, whichever you prefer. I can be reached at 401-338-9564, or at katie.m.hall@exchange.ri.gov.

Thank you and I look forward to working with you.

Sincerely,

Katie Hall
Senior Policy Analyst
HealthSource RI
501 Wampanoag Trail
East Providence, RI

Threats to Health Care Access and Affordability

Federal changes and legal challenges threaten the ACA's progress:

- **Regulatory and administrative changes**
 - Shorter open enrollment periods
 - Defunding of cost sharing subsidies, outreach and marketing
 - Expanded availability of short-term limited-duration plans (may not cover all benefits or protect people with pre-existing conditions)
- **Legislative changes**
 - Congress repealed the individual mandate penalty effective January 2019
- **Legal challenges**
 - Texas v. Azar lawsuit argues that ACA without the individual mandate should be struck down entirely

Key Market Stability Concerns



Loss of Coverage – RI's high insurance levels will decline as young and healthy populations drop coverage



Unbalanced Risk Pool – The remaining populations will be older and sicker, creating a smaller and more volatile risk pool



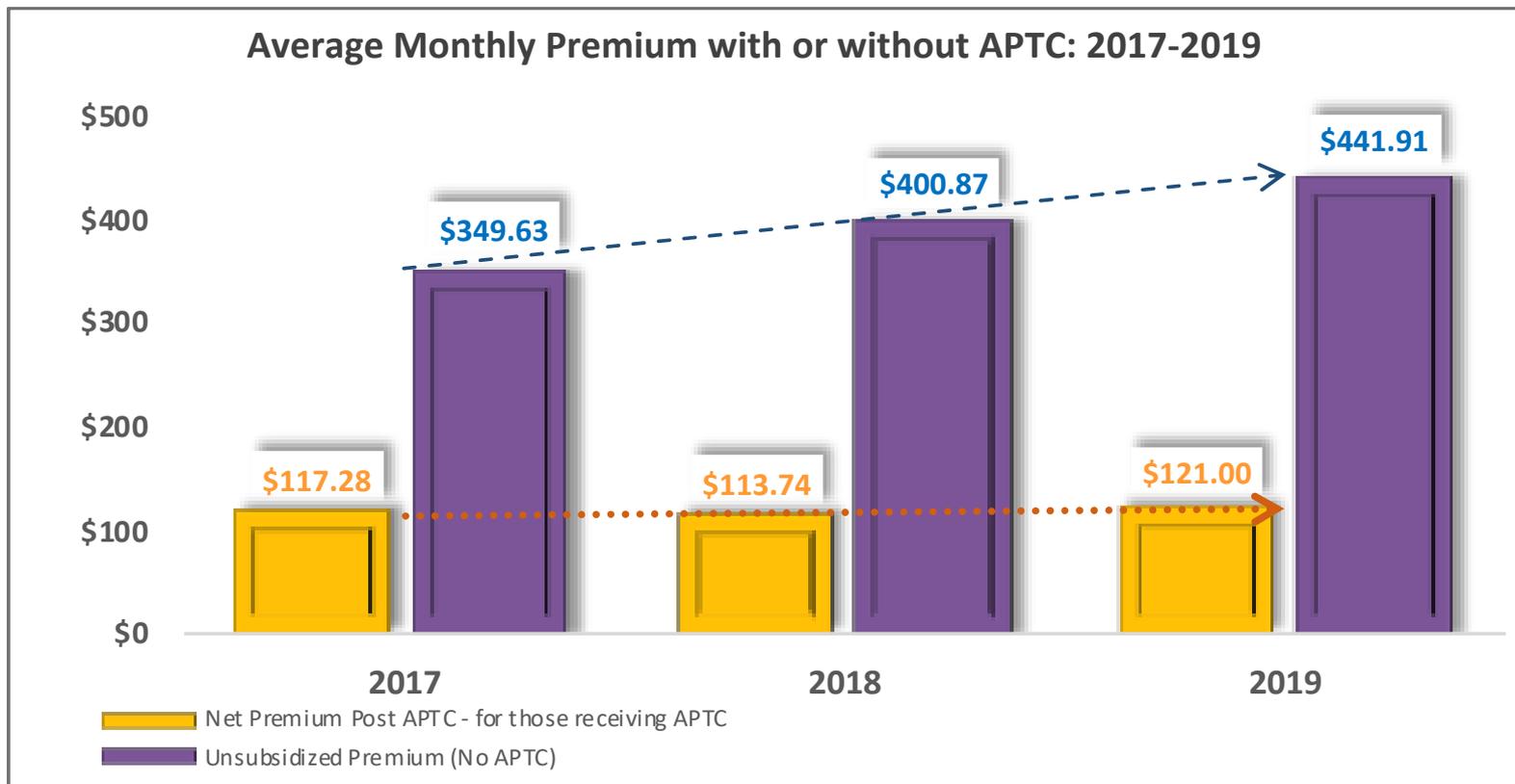
Premium Increases – A riskier pool will lead to premium increases for the remaining insured, starting with individuals and the smallest businesses



Erosion of Key Consumer Protections – Expanded availability of short-term limited-duration plans will attract healthier populations to plans that are limited on benefits and protections

Who is most at risk?

Middle class families and the smallest businesses (not eligible for tax credits) who pay the full cost of health insurance in the individual market saw their premiums increase by 26% from 2017 to 2019

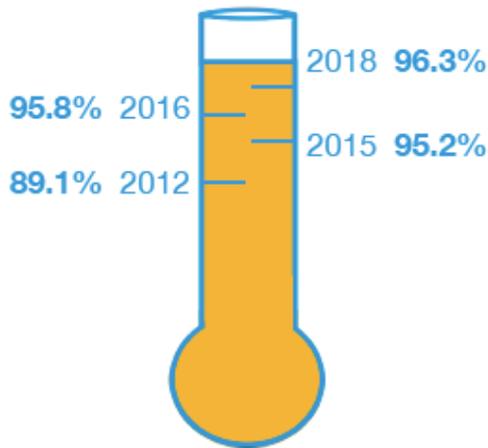


What is Rhode Island doing?

- In 2018, the Market Stability Workgroup developed recommendations for protecting access and affordability at the state level
- Acting on their recommendations, Governor Raimondo included the following initiatives in her FY 2020 budget:
 - A state-based penalty for not having insurance
 - A reinsurance program to reduce premium increases in the individual market
 - Funded with penalty revenue and federal funds secured through a 1332 waiver
 - Regulatory authority over short-term plans

State-based health insurance penalty

RI Insured Rate 2012-2018

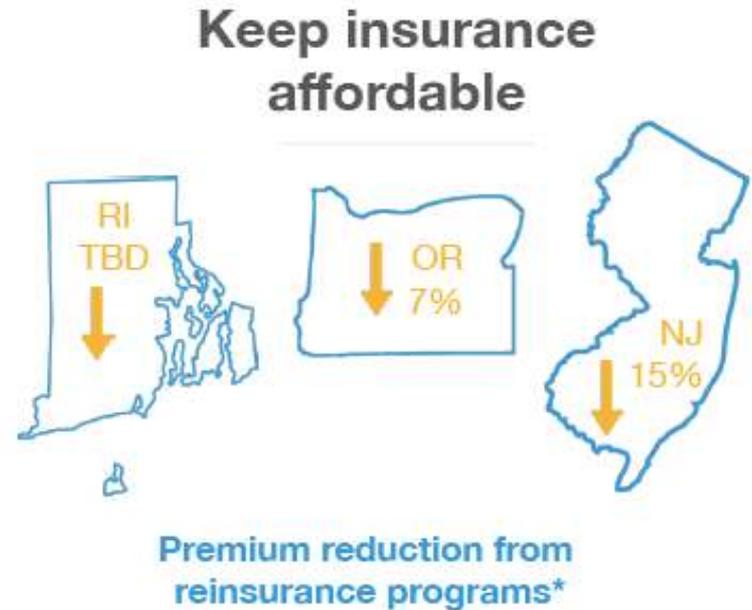


**Protect access and
keep Rlrs insured**

- Requires Rhode Islanders to have health insurance starting in 2020
- Like car insurance, this results in a larger pool and lower premiums
- Mirrors the penalty in the ACA
- Enables the state to conduct outreach to the remaining uninsured (MA example)
- Prevents increases in uncompensated care for hospitals

Reinsurance Program

- Offsets costs associated with sicker, riskier customers by paying for a portion of high-cost claims
- Provides relief to families and small businesses who don't receive financial assistance
- Allows the state to secure federal funding through a 1332 waiver



Reinsurance Fundamentals

How It Works

Reinsurance cap

Insurer is responsible for costs above the cap

Coinsurance rate

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

Attachment point

Insurer 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