



# COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD  
Secretary of Health and Human Resources

December 11, 2018

The Honorable Ralph S. Northam  
Governor of Virginia

The Honorable S. Chris Jones  
Chairman, House Appropriations Committee

The Honorable Emmett W. Hanger, Jr.  
Co-Chair, Senate Finance Committee

The Honorable Thomas K. Norment, Jr.  
Co-Chair, Senate Finance Committee

RE: Virginia Market Stability Work Group Report

Dear Governor Northam, Chairman Jones, Chairman Hanger, and Chairman Norment,

Attached is the report of the Virginia Market Stability Work Group pursuant to Chapter 2 of the 2018 Special Session I Acts of the Assembly, and Item 281 D of the Appropriations Act.

Please feel free to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel Carey".

Daniel Carey, M.D.

DC/kb

**Report of the Virginia Market Stability  
Work Group**

**To the Governor and Chairmen of the  
House Appropriations and Senate  
Finance Committees**

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## Executive Summary

The purpose of this report is to provide an overview of recent trends in Virginia's individual market and present findings and recommendations of the Virginia Market Stability Work Group (Work Group) to stabilize that market. The Secretary of Health and Human Resources, as directed by the General Assembly established this Work Group pursuant to the 2018 Appropriations Act, Item 281 D, which states:

*The Secretary of Health and Human Resources shall convene a work group to examine recent trends in the individual insurance market and state options for stabilizing that market. The examination shall include, but not be limited to, a review of association and catastrophic health plans as well as innovative solutions that reduce individual insurance premiums and out-of-pocket costs while preserving access to comprehensive health insurance. The examination shall also consider the resources necessary to fund any proposed options. The work group shall include the Commissioner of Insurance or his designee, the Virginia Association of Health Plans, chambers of commerce, and other relevant stakeholders at the discretion of the Secretary. The Secretary shall report his findings and recommendations to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2018.*

The Work Group was composed of a diverse group of stakeholders, including members from the following state agencies, organizations, and groups:

- Office of Health and Human Resources
- Commissioner of Insurance and other representatives of the Bureau of Insurance<sup>1</sup>
- Virginia Association of Health Plans
- Medical Society of Virginia
- Virginia Hospital and Healthcare Association
- Virginia Chamber of Commerce
- National Federation of Independent Business
- Virginia Poverty Law Center
- AARP Virginia
- Washington and Lee University

As the meetings were open to the public, various representatives from related industries, including insurance carriers and physician member organizations, were also involved in the discussions.

The Work Group first met on August 13, 2018, with six meetings held between then and October 9, 2018. Deputy Secretary Figueroa at the outset of the Work Group presented a work plan to guide the Group's examination, one that was adjusted as needed to meet the dynamic nature of the Group's interests and discussions. Minutes were taken during each meeting and then provided to members before the subsequent meeting.

During the first three meetings, the Work Group examined the structure of health insurance and the insurance market under the Patient Protection and Affordable Care Act (ACA), how the federal landscape impacts market stability, and approaches other states have taken to stabilize their

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<sup>1</sup> Non-voting representation, providing technical assistance only

respective markets. Experts from the Bureau of Insurance, Virginia Association of Health Plans, University of Virginia School of Medicine, National Association for Health Underwriters, Princeton University, State Health and Value Strategies, and Manatt Health led these respective discussions. The final three meetings involved a discussion of state options to stabilize the Virginia Market, including advantages and considerations of each option and how the approach would be operationalized in the Commonwealth.

From the aforementioned discussions, the Virginia Market Stability Work Group viewed the following policy actions as most promising to stabilize Virginia's individual market:

1. Pursue a reinsurance program through a 1332 state innovation waiver (1332 waiver);
2. Develop a state-based exchange and utilize this platform for market enrollment, including outreach and application assistance; and
3. Increase transparency and develop consumer protection policies for short-term limited-duration plans and association health plans.
4. Provide a state funding source for additional outreach and enrollment assistance.

This report further details Work Group member feedback and provides considerations brought forth during discussions.

## **Introduction**

One of the primary driving forces behind passage of the Patient Protection and Affordable Care Act (ACA) was to address health care coverage issues experienced by consumers in the Individual Market (Market). The ACA contained regulatory features to address coverage concerns such as guaranteed issue, community rating, and standardized benefits. Exclusions based on pre-existing conditions were banned, as well as varying rates based on gender and health status. In addition, the rates for a 64-year-old can be no more than 3 times the rate for a 21-year-old. It eliminated cost sharing for preventive services for all and offered cost-sharing subsidies for low-income participants to increase affordability. These subsidies include cost sharing reduction payments (CSRs) for individuals between 100 percent and 250 percent of the federal poverty level (FPL) and advance premium tax credits (APTCs) for individuals between 100 percent and 400 percent FPL. The FPL for 2018 is \$12,140, for an individual or family of one (e.g. 100 percent FPL = \$12,140; 250 percent FPL = \$30,350; 400 percent FPL = \$48,560).

In order to incentivize Market participation and ensure a larger, more stable risk pool, the ACA featured stabilization features such as temporary reinsurance and risk corridor programs, permanent risk adjustments, and financial penalties for both individuals and employers that did not participate. The goal was to produce more affordable health coverage, emphasize preventive care, improve health outcomes, and reduce health care spending overall.

While the ACA achieved some of its intended policy goals – such as offering more affordable coverage for lower income, less healthy, and older populations and reducing the number of the uninsured – there are some segments of the population that have not benefited as much from the law. Generally, costs have not decreased for brackets that do not qualify for federal subsidies. Additionally, in some instances, younger and healthier individuals face higher health care costs as the system under the ACA subsidizes the older and less healthy populations.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) in their 2010 report<sup>2</sup>, forecasted that 8-9 million people would lose employer sponsored coverage, but in the 2016 revised projections less did so than expected, and as a result there are fewer individuals in the Market than anticipated.<sup>3</sup> Moreover, the market is more susceptible to churn because consumers move in and out of the individual market (e.g., income changes year over year for Medicaid eligibility, in between jobs, changes in marital status, etc.), whereas if overall individual market enrollment were larger, some level of expected churn would be easier to manage. These factors have led to disruptions in the market pools and rates, creating instability in the individual market, and frustration among market participants.

### *Recent Federal Actions Affecting the ACA*

Various Trump Administration actions have created instability in the market. In October 2017, the Trump Administration withdrew funding for CSRs, which had allowed the federal government to compensate insurers for the difference between the cost-sharing charged in a CSR plan offered to low-income enrollees versus the cost-sharing of the base silver plan. According to the Virginia Bureau of Insurance, individual market carriers assumed the change would have a 0-18.3 percent impact on 2019 rate filings in the Commonwealth.

In July of 2018, the Trump Administration announced major funding cuts for groups that assist with ACA marketing, navigation, and enrollment, from \$36 million (plan year 2018) to \$10 million (plan year 2019) for 34 states. For the 2017 plan year, \$63 million was provided. This represents a decrease of 85 percent over two years.<sup>4</sup> Moreover, in early 2018, the federal government issued regulations that provide states the authority to allow carriers to offer less comprehensive insurance products, including association health plans (AHPs) and short-term limited-duration plans (STLDs). BOI reported that changes to STLD plans and AHPs resulted in a 0-5 percent increase in carrier's 2019 rate filings.

Congressional actions have also affected the stability of the ACA and created uncertainty within the insurance markets. Throughout 2017, Congress made several efforts to repeal and replace the ACA; however, none secured the votes necessary for final passage. The Tax Cuts and Jobs Act of 2017 ("tax reform"), passed in December 2017, eliminated the financial penalty associated with the individual mandate in the ACA. Effective January 1, 2019, individuals will no longer be penalized for forgoing the purchase of approved insurance. The Congressional Budget Office has [predicted](#) that the loss of the mandate will lead to 4 million individuals deciding to forgo insurance in 2019, and 13 million people dropping coverage by 2027.<sup>5</sup> The Virginia Bureau of Insurance indicates that individual market carriers increased 2019 rates 5-10 percent as a result.

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<sup>2</sup> "Manager's Amendment to Reconciliation Proposal", Congressional Budget Office, March 2010 <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf>.

<sup>3</sup> "Manager's Amendment to Reconciliation Proposal", Congressional Budget Office, March 2010 <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf>.

<sup>4</sup> Alana Abramson. "Trump Administration Cuts \$26 Million in Funds for Organizations that Help People Sign Up For Obamacare," Time Magazine, July 11, 2018, <http://time.com/5335462/trump-administration-cuts-26-million-in-funds-for-organizations-that-help-people-sign-up-for-obamacare/>

<sup>5</sup> "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026", Congressional Budget Office, March 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-healthinsurancebaselineonecol.pdf>

The actions of both Congress and the Trump Administration have created volatility within the insurance market. These actions have reduced the positive impact that the ACA has had on coverage gains and making comprehensive health insurance affordable to more Americans. The Virginia Bureau of Insurance estimates that in 2019, the average weighted premium in the individual market is \$796.29 and, that from 2014 to 2019; the percent increase of weighted average premiums in the individual market is 147 percent.<sup>6</sup> As these impacts take hold, Virginians and people across the nation, will have increased access to less-comprehensive options, potentially leading to issues many individuals faced prior to the ACA, such as high medical debt, underinsurance, or no insurance, leading to a population of more individuals with complex conditions that are more expensive and more difficult to treat.

## **Market Stability**

*What is stability? What is instability?*

In order to understand how the aforementioned factors impact Virginia's individual market, the Work Group explored the concept of insurance market stability with the assistance of Dan Meuse, MBA from Princeton University's State Health and Value Strategies. These concepts were then applied to the Virginia context in order to develop an understanding of the dynamics influencing Virginia's individual market.

Through this process, the Work Group learned that there is no accepted definition of instability as it relates to health insurance. However, common symptoms of instability exist and include: 1.) Extreme rate increases (considered to be greater than 20 percent annually), 2.) Carriers leaving the market, and; 3.) Bare coverage areas. Various causes lead to these symptoms in the individual market, including a high risk or high utilization risk pool, a small pool of lives, payment discrepancies between carriers, population churn – both into and out of the market as well as among carriers, and external policy decisions.

*What causes instability?*

A high risk and/or high utilization risk pool is the most significant factor that leads to market instability. People in the individual market are typically those who are not eligible for employer-sponsored insurance, between jobs, or impacted by marriage status or other life circumstances. If these individuals are high health care utilizers based on health condition or other factors, then they are more expensive to insure. As such, carriers have difficulty predicting prices accurately.

Population churn throughout the commercial plans and Medicaid markets also makes it difficult for insurers to understand the risk profile of a certain pool or market. The ACA design assumed that the exchange market would be “sticky”, or that individuals would remain in a certain market for a longer period. As mentioned above, however, the individual market has been more susceptible to churn, because consumers move in and out of the market, due to changes in life circumstances, income

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<sup>6</sup> Appendix F: Increase in Average Weighted Premium- VA Bureau of Insurance

changes, Medicaid eligibility, etc. If the individual market had greater enrollment numbers, the churn would be easier to manage since the market would be understandable and costs would become more predictable. Contrary to the ACA's initial design, consumers have been more price driven than expected and churn – both into and out of the market and among carriers – has occurred with more frequency than predicted. This has created further uncertainty in market costs and the risk profile of the market itself.

Finally, external policy decisions at the federal level have further compounded the instability in the individual market. These include allowing certain plans to remain as grandfathered plans that are not subject to ACA requirements and are not part of the single risk pool, the repeal of the individual mandate penalty, uncertainty regarding and the subsequent elimination of federal CSR payments, relaxed rules related to STLD plans and AHP guidance, and reductions in marketing and outreach funding. Such policies have caused continued uncertainty for carriers, leading to higher premiums for consumers and carriers themselves deciding to pull out of certain markets.

### *What symptoms exist in Virginia?*

After exploring symptoms of market instability, the Work Group discussed observable symptoms in Virginia's market. There was general agreement that extreme rate increases greater than 20 percent and risk of bare coverage areas are the most significant instability factors present in Virginia.

When it comes to rates, rate increases from 2017 to 2018 in Virginia ranged from 24 percent to 82 percent and all carriers raised rates. From 2018 to 2019, rates are expected to increase upwards of 51 percent for some carriers, though other carriers will increase rates at a lower level or even decrease rates. The effect of increased rates has been more dramatic in specific areas of the Commonwealth. Most notably, the Charlottesville rating area had the highest individual market health insurance premiums in the country in 2018.

Virginia has been at risk of bare coverage areas due to the volatility of the individual market. In 2017, 63 counties were at risk of having no coverage options before one insurer tabled their decision to leave the exchange. Fortunately, some insurers have even begun to reenter the market in areas, including the Charlottesville rating area.

### *Who is impacted by instability in Virginia?*

Through meeting presentations and discussions, the Work Group analyzed the specific populations in the individual market and the differences between them. Increased premiums, although having an effect on both subsidized and unsubsidized individuals as well as those inside and outside of the health benefit exchange, most pointedly impacts individuals above 400 percent FPL as they do not receive federal subsidies. The Bureau of Insurances estimates this population totals 96,000 individuals.

The Work Group found it important to highlight that premium rates are only one expense that keeps health care coverage unaffordable for some. Consumers experience higher cost sharing such as deductibles, coinsurance, and copayments, or similar charges. Additionally, the Bureau of Insurance



reports that in 2017, there were 844,753 total uninsured individuals across the Commonwealth.<sup>7</sup> Any policy to affect the unsubsidized would also influence the choices of the uninsured, as well as individuals purchasing insurance in-and-out of the market. The Group nonetheless kept its focus on the population over 400 percent FPL without subsidies purchasing insurance in the market.

## Reinsurance

Reinsurance is a mechanism for spreading the costs of expensive claims by pooling them together and paying for them through a separate financing system, which then allows insurance carriers to offer lower premium plans. As states grapple with the impacts of the loss of federal CSR payments and other destabilizing factors, several states have begun efforts to achieve market stability with reinsurance as a first step.

The standard process of implementing a reinsurance program begins by the state first creating a reinsurance plan and fund. There are options to the structure of a reinsurance program:

1. An Attachment point model focuses on all claims and is based on the claim's cost. This model features an attachment point, a coinsurance corridor, and a cap. The attachment point is the cost at which reinsurance starts to pay. In the coinsurance corridor, insurers pay a specified percentage of the claims cost with reinsurance covering the remaining part of the cost. The cap is the amount at which the claim is no longer eligible for reinsurance, and full responsibility reverts to the insurer.
2. A Condition-based model identifies specific high-cost conditions to be included in the reinsurance program. Under this model, insurers typically cede some lives and premium to the reinsurance program. Insurers could still handle claims and patient management (e.g., preauthorization, claim payment or denial, care coordination), but might not have financial responsibility for the claims.<sup>8</sup>

In both models, as the insurer is protected against some high-risk claims, they do not need to build such claims into their premium rates. These lower rates create savings for the federal government, as it is responsible for smaller advanced premium tax credits (APTCs) than it would otherwise pay without the lowered premiums that result from the reinsurance program. The federal savings is passed-through to the state and used to assist with the cost of funding the reinsurance program.

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<sup>7</sup> See Appendix D: VA Uninsured by County and FPL-Bureau of Insurance

<sup>8</sup>“*State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States*”, Manatt Health, March 2018

[https://www.shvs.org/wpcontent/uploads/2018/03/SHVS\\_Reinsurance\\_Final.pdf](https://www.shvs.org/wpcontent/uploads/2018/03/SHVS_Reinsurance_Final.pdf)

**Table A. Overview of Three Approved 1332 Waivers<sup>9</sup>**

	Alaska	Minnesota	Oregon
Approval Date	7/11/17	9/22/17	10/19/17
Reinsurance Type	Condition Based	Attachment Based	Attachment Based
Targeted Premium Reduction	20%	20%	Approximately 7%
<b>Reinsurance Funding</b>			
2018 Total Reinsurance Program Funding <sup>1</sup>	\$60 M	\$271 M	\$90 M
Federal Pass Through Funding for 2018	\$58 M	\$131 M	\$54M
2018 State Funding Required (after pass through funding)	\$2 M	\$140 M	\$36 M
Percent of Program Covered by Federal Dollars <sup>2</sup>	97%	48%	61%
Authorizing Legislation	<u>Reinsurance Program: Health Ins. Waivers, HB 374, 29th Legis., 2nd Session</u>	<u>Minnesota Premium Security Plan, Chapter 13, HF 5, 90th Legis., Regular Session</u>	<u>Enrolled, HB 2391, 79th Leg, 2017 Regular Session</u>

States have the ability to implement a reinsurance program independently, but in order to receive pass-through funding; the state must apply for a Section 1332 waiver under the ACA. Seven states currently have approved 1332 waivers to operate reinsurance programs and the federal government has indicated it will continue to allow states flexibility through approval of reinsurance programs. In 2017, Alaska, Minnesota, and Oregon received approval to implement reinsurance programs to begin operation in 2018. Four additional waivers were approved this year for reinsurance programs to begin operation in 2019 in Maine, Maryland, New Jersey, and Wisconsin.

For Virginia to set up a reinsurance program, the Bureau of Insurance estimates that Virginia would be required to fund approximately 31 percent of the costs of a reinsurance program. The estimate is based on the assumption that 69 percent of the individual market will be receiving subsidies in 2019. Given this estimate, 69 percent of the funding for a reinsurance program would be passed through to the Commonwealth from the federal government. The Bureau has also developed projections regarding the cost of the state’s share of a reinsurance program based on various premium reduction targets. For a 5 percent premium reduction model, at 31 percent cost to the state, the state share would be approximately \$40.5 million. The state share for a 10 percent and 20 percent premium reduction model would be approximately \$81 million and \$162 million, respectively. These are all estimates and subject to change.

Reinsurance has a proven track record of reducing premiums, increasing insurer participation in the market, and reducing market volatility by limiting carriers’ exposure to high cost claims. For example, rates in Alaska were expected to increase 42 percent in 2017. Following the funding of a conditions-based reinsurance program, premium rate increases dropped to only 7.3 percent.

<sup>9</sup> *Individual Market Stability: Definitions and State Efforts*, Dan Meuse, Princeton University, State Health & Value Strategies, September 4, 2018.

Additionally, rates decreased 24 percent in the individual market in 2018. The Minnesota Commerce Department has reported <sup>10</sup> significant rate decreases for 2019, ranging from 7.4 percent to 27.7 percent because of its traditional attachment-point reinsurance program and lower utilization and costs for medical services. Maryland has also reported premium decreases ranging from 7.4 percent to 17.4 percent.<sup>11</sup>

Insurer participation has also increased under reinsurance programs, with carriers re-entering the market in Alaska following approval of their 1332 waiver. With funding available to cover the high-cost claims that would normally force insurers to price premiums higher, the market becomes more attractive to insurers.

A further advantage of reinsurance programs is that states can actuarially model the amount of funding required to achieve the desired results. The development of a reinsurance program allows the state to titrate the system in order to achieve the anticipated impact in terms of premium reductions, size of population impacted, and cost of the program. States can develop their reinsurance program based on a desired premium reduction, such as 10 percent or 20 percent, or can determine the expected premium reduction based on the amount of state funding available for the reinsurance program.

One of the primary considerations for a state interested in pursuing a reinsurance program is determining how to fund the state's share of the program. The seven states with approved 1332 waivers are funding reinsurance through a variety of means. The two main sources for reinsurance funding in these states are state general funds or an assessment. See Table B. Options for assessments include policy-based assessments, a provider or hospital assessment, a state premium tax, or a premium-license tax. Alaska and Minnesota, for example, use state general funds to fund the state share of their reinsurance programs, spreading the costs of the program across all taxpayers. Alaska's general fund is enhanced by a tax on premiums while Minnesota draws funding through excess state taxes. Other states, such as Maine, are using an assessment of health insurers and third-party administrators to generate revenue to cover the cost of the program, a hybrid model combining conditions-based and attachment point elements.

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<sup>10</sup> "Final 2019 health insurance rate information released for Minnesota", MN Commerce Department, October 2, 2018. <https://mn.gov/commerce/media/news/#/detail/appId/2/id/354562>.

<sup>11</sup> Les Masterson. "Maryland reinsurance program credited for premium decreases," Healthcare Dive, September 26, 2018, <https://www.healthcaredive.com/news/maryland-reinsurance-program-credited-for-premium-decreases/333106/>.



**Table B. Reinsurance State-share Funding Approaches<sup>12</sup>**

Source	Example
Policy Assessment	The federal reinsurance program assessed all health insurance coverage including the large and small group markets, as well as stop-loss and third party administrators (TPAs) to reach self-insured plans.
State Premium Tax	Maine assessed health insurers and TPAs to reach all forms of health insurance except self-funded and self-administered plans.
State General Funds	Alaska's program is financed by a portion of the state's premium tax that applies to all lines of insurance.
State Provider Assessments	Minnesota used general funds as one of several sources, which spreads costs across all taxpayers.
	Minnesota's funding includes a portion of the state's 2% provider tax, which applies to hospitals and other providers.

Additional considerations related to such a policy option include that a reinsurance program only affects premium cost. Other factors that continue to make health care unaffordable, such as cost sharing and deductibles, are not directly impacted by a reinsurance program. Additionally, further segmentation of the market through the proliferation of other plans could undermine the effectiveness of the 1332 reinsurance waiver by siphoning off healthier individuals away from the individual market.

During discussions, the Work Group reached the majority consensus that a reinsurance program is a vital step to stabilizing the Virginia individual market. Consensus, on the other hand, was not reached on how to fund the state's share of a reinsurance program. Discussions referenced a hospital tax; provider tax, premium license tax, third-party administrator tax, broad-based assessment, state general funds, and revenue generated from a state-level individual mandate penalty as potential funding options.

### State-Based Exchange

Under the ACA, states have the option to administer their own health insurance exchange marketplaces as state-based marketplaces (SBMs), or default to the federally run marketplace. Since passage of the ACA, there are now twelve states that have developed and sustained their own state-based exchange. These states include California, Colorado, Connecticut, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington. Five states currently operate their own state-based marketplace but rely on the federally-facilitated market's IT platform, which is referred to as a "state-based marketplace-federal platform system." Further, six other states operate a state-partnership marketplace where the state conducts plan management and administers in-person consumer assistance while the federal government performs the remaining marketplace functions.

Virginia is currently one of 28 states that participates in the federally facilitated marketplace (FFM); however, Virginia also is one of seven states that received approval from the U. S. Department of

<sup>12</sup> "State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States", Manatt Health, March 2018

[https://www.shvs.org/wpcontent/uploads/2018/03/SHVS\\_Reinsurance\\_Final.pdf](https://www.shvs.org/wpcontent/uploads/2018/03/SHVS_Reinsurance_Final.pdf)

Health and Human Services (HHS) to perform plan management activities supporting the certification of Qualified Health Plans (QHPs) for the FFM, but stopping short of final certification. Consumers still must enroll in coverage through [healthcare.gov](https://www.healthcare.gov) rather than a state-specific platform and the federal government provides all enrollment and marketing services.

In review of the symptoms of instability in Virginia, and potential policy interventions to correct the instability to create a healthy, robust market, there was increased support and interest in establishing a state-based exchange. The three main benefits of a state-based exchange are:

1. Leveraging marketing dollars to target outreach to specific Virginia populations to encourage enrollment.
2. The ability to establish other market stabilization policies beyond reinsurance.
3. Active purchasers (additional rules for QHPs)

Virginia's authority over review of rates, rate increase justifications, policy forms, benefit levels, actuarial plan values, and compliance with market reforms would remain largely unchanged, but the state would maintain full local authority for oversight and accreditation, market conduct, adequacy of plan-level rate and benefit data, and proposed changes in services/networks, ownership, mergers, or acquisitions. Virginia could establish requirements and provide oversight of local standards regarding which individuals and organizations can provide navigator/broker/assistor services and what training may be required. The state would additionally have more control over funding for outreach and enrollment by establishing the payment and financing structures through which navigators/brokers/assistors would be paid. Finally, with a 1332 waiver, the state could set policies specific to Virginia's population.

Carriers participating in the FFM in Virginia, and in turn Virginia's consumers, currently pay the federal government a fee of 3.5 percent annually to operate the FFM. The FFM does not make known the fee amounts collected, but according to an estimate provided by the Bureau of Insurance, this fee would amount to roughly \$91,000,000 for 2019, but there is little sense of what Virginia gets in return. Additionally, after switching from an FFM, both Nevada and Idaho have seen savings of \$6 million and \$22 million, respectively, thus far. The design, development, and implementation budget for Nevada's new state-based exchange was \$1 million. Nevada's exchange is funded with a 3.15 percent premium charge for carriers in order to support ongoing operation costs.

With the data available through a state-based exchange about the unenrolled and subsidy-eligible individuals, enrollment and retention efforts could improve. Currently, targeted outreach is not possible because, as an FFM state, Virginia does not have access to the eligibility and enrollment data of the exchange population. Additionally, transitioning to a state-based exchange would allow Virginia Medicaid to make its own determinations rather than full integration of determinations like on [healthcare.gov](https://www.healthcare.gov). Similar effects have led to a 2.2 percent increase in enrollment in Nevada since transitioning from a FFM.

Given the multitude of benefits surrounding a state-based exchange, Work Group discussions about this option were very positive. As discussed above and in other sections, the Work Group also recognizes the ability of a state-based exchange to simplify other stabilization efforts, such as outreach or state-funded tax credits. Along with using data to target outreach and enrollment efforts,

an exchange could use data to develop a better understanding of the population in the individual market. This information could also be used to facilitate future market stabilization policies, such as providing verification for exemptions from a state-level individual mandate.

Work Group discussions also highlighted considerations that would need to be taken into account before transitioning to a state-based exchange. Despite operating a FFM, Virginia has previously considered developing its own state-based exchange. In August of 2010, Governor Robert F. McDonnell appointed 24 political, health system, civic and business leaders to the Virginia Health Reform Initiative (VHRI) Advisory Council to develop recommendations about implementing health reform in Virginia. A resulting recommendation was for Virginia to establish a state-based health benefit exchange, which the Virginia General Assembly considered and passed, [HB 2434 Health benefits exchange; intent to develop](#). A decision was made later that year to not pursue the state-based exchange, and instead proceed with the federally facilitated marketplace. In order to move forward to development of an exchange, Virginia would again need enabling legislation from the General Assembly.

To add, as federal grants to states for the development of exchanges are no longer available, there is a need for state funds prior to collecting revenue to fund state agency staff and a startup budget. As mentioned, Nevada began its exchange with \$1 million for design, development, and implementation of the market. In addition to enabling legislation and start-up funding, Virginia would have several issues to consider, principally:

- What would the exchange structure look like? Public/private partnership? Would it be a standalone entity? A separate wing of the State Corporation Commission?
- Would the state utilize an existing platform or develop our own?
- What entity would hold accountability/oversight? An Exchange Board?
- How much funding would be needed upon startup? What would be the funding source for startup?
- How much funding would be needed to maintain operations of the exchange? What would be the funding source for maintaining operations of the exchange?
- Would the General Assembly support a state-based exchange again, eight years later?
- What messaging would be effective with the General Assembly and with stakeholders?

The majority of the Work Group felt that if these considerations were addressed, the benefits of a state-based exchange would make a positive impact on stabilizing the individual market and supporting Virginians with access to affordable comprehensive health coverage.

### **Regulation of Short-Term Limited-Duration Plans**

The Center for Medicare and Medicaid Services (CMS) defines short-term limited duration (STLD) insurance as “a type of health insurance coverage that is primarily designed to fill gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage, such as in between jobs.”<sup>13</sup> This type of coverage is exempt from the definition of individual health insurance coverage under the Patient Protection and Affordable Care Act (PPACA

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<sup>13</sup> “Short-Term, Limited-Duration Insurance Final Rule”, Center for Medicare and Medicaid Services, August 1, 2018, <https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-final-rule>.

or ACA), and is therefore not subject to the PPACA provisions that apply to individual health insurance coverage.

Following the Trump Administration's 2017 directive, federal regulation reversed the 2016 rule's 3-month duration limit for STLDs. This new rule returns federal policy pertaining to STLDs to the pre-ACA definition, which is a policy existing for less than 12 months. Under the new definition, STLDs are renewable for a limited duration of up to 36 months (but can be medically underwritten). Further, it revises consumer disclosure requirements to say that coverage is not required to comply with the ACA and there is no eligibility for special enrollment periods. The effective date for new STLDs is October 2, 2018. This short-term, limited-duration insurance is generally exempt from the federal market requirements applicable to individual health insurance coverage. For example, short-term, limited-duration insurance is not subject to the requirement to provide essential health benefits and it is not subject to the prohibitions on pre-existing condition exclusions, or lifetime and annual dollar limits. It is also not subject to requirements regarding guaranteed availability and guaranteed renewability.<sup>14</sup>

STLD insurance products could impact consumers by further segmenting the individual market. Younger, healthier individuals could be attracted to purchase these plans drawing such individuals out of the individual market single risk pool. This would result in a smaller individual market with an older, less healthy population. As a result, premiums will increase for individuals remaining in the market.

The change in federal policy to expand options for STLDs is expected to result in a decrease in enrollment in ACA coverage in the individual market. The U.S. Department of Health and Human Services estimates that 100,000-200,000 fewer individuals will enroll nationwide.

The Agency acknowledges in the federal guidance that:

"Depending on the plan design, consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions could face financial hardship as a result, until they are able to enroll in PPACA-compliant plans that would provide for such conditions."<sup>15</sup>

Additionally, with a smaller, sicker risk pool:

"Individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market. Although choices of plans available in the individual market have already been reduced to plans

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<sup>14</sup> "Short Term, Limited Duration Insurance", Federal Register The Daily Journal of the United States Government, August 3, 2018, <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance/>

<sup>15</sup> "Short Term, Limited Duration Insurance", Federal Register The Daily Journal of the United States Government, August 3, 2018, <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance/>



from a single insurer in roughly half of all counties, the proposed rule may further reduce choices for individuals remaining in those individual market single risk pools."<sup>16</sup>

Such market segmentation will be even further compounded by the zeroing out of the individual mandate penalty. In issuing federal guidance, the Agency states:

"Short-term, limited-duration insurance policies would be unlikely to include all the elements of PPACA-compliant plans, such as the pre-existing condition exclusion prohibition, coverage of essential health benefits without annual or lifetime dollar limits, preventive care, maternity and prescription drug coverage, rating restrictions, and guaranteed renewability."<sup>17</sup>

### *STLDs in Virginia: Current Landscape*

During the last decade, the Bureau of Insurance has received approximately 30 STLD insurance filings that have been filed or filed and approved in Virginia. During this time, all but one carrier filed to issue these policies on a group basis through an association. Prior to the ACA and new federal rules in 2016, 26 carriers had filed to offer STLD insurance coverage in Virginia: 20 filed as out-of-state associations, five carriers filed as in-state associations, and one was approved to offer individual policies. Since the ACA and new federal rules, two carriers have been approved to offer this coverage to Virginia residents through out-of-state associations. The Bureau has received numerous questions from carriers since the new aforementioned federal regulations. STLD insurance coverage is offered in the following three ways: (i) by a carrier to individuals in the individual market, (ii) by a carrier to an out-of-state association or trust that offers certificates to individuals in the individual market, and (iii) by a carrier to an in-state association or trust that offers certificates to an individual in the individual market.<sup>18</sup>

### *Virginia STLD Coverage Requirements*

STLD insurance coverage that either exceeds six months in duration or is any duration but is renewable is required to comply with the mandated benefit requirements contained in Article 2 of Chapter 34 of Title 38.2 of the Code. However, if the coverage is written through an out-of-state association, the policy is not required to meet Virginia's mandated benefits provisions. It is worth noting that the mandated benefits provisions of the Virginia Code do not require STLD coverage to provide prescription drugs, maternity, or mental health and substance use disorder benefits that are required to be covered as essential health benefits for individual and small group health insurance under the ACA. Pursuant to Section 38.2-3412.1 of the Code, all individual and group health insurance coverage must include benefits for mental health and substance use disorder; however, STLD insurance coverage is not required to provide these benefits. No individual STLD insurance coverage is required to provide essential health benefits.<sup>19</sup>

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<sup>16</sup> "Short Term, Limited Duration Insurance", Federal Register The Daily Journal of the United States Government, August 3, 2018, <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance/>

<sup>17</sup> "Short Term, Limited Duration Insurance", Federal Register The Daily Journal of the United States Government, August 3, 2018, <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance/>

<sup>18</sup> See Appendix C: STLD and AHP FAQs- Virginia Bureau of Insurance

<sup>19</sup> See Appendix C: STLD and AHP FAQs- Virginia Bureau of Insurance

## *STLD Regulation in Virginia*

Forms associated with STLD insurance coverage are filed with, and approved by, the Bureau of Insurance. As indicated earlier, the current landscape for this coverage in Virginia is through an out-of-state association. These forms are required to be filed in Virginia but are not required to be approved. However, such forms must certify compliance with similar laws in the state of issuance, providing a basic level of consumer protection, but does not ensure compliance with all Virginia mandates.

The rates associated with individual STLD insurance coverage are also approved by the Bureau of Insurance, including rates for coverage issued in Virginia to an association, group trust, purchasing cooperative or other group that is not an employer plan operating inside or outside of Virginia. Any individual STLD insurance coverage issued in Virginia that is underwritten or that exceeds six months in duration must be renewable up to 36 months in total, must credit previous continuous coverage held 30 days prior to the new coverage, and must comply with other pre-existing conditions requirements under Virginia state law. Such regulations could allow individuals to use short-term policies as long-term policies (up to 3 years), facilitating the perception that STLDs offer comprehensive insurance coverage.<sup>20</sup>

## *State Options to Protect Markets and Consumers*

The current Virginia regulations surrounding STLDs could be adjusted in a variety of ways. In general, improving oversight would create more consumer protections and prevent further segmentation of the individual market.

Some Work Group participants felt strongly that STLDs are an important tool for some individuals to be able to purchase at least some level of coverage. Other participants felt strongly that STLDs should be strictly constrained and that the new federal requirements are not restrictive enough. In particular, some members were concerned that short-term policies could be marketed as comprehensive coverage, although they often contain extensive limitations and exclusions that consumers may find difficult to navigate.

While the Group did not agree about the potential market impacts of these plans, there was a consensus for strengthening consumer protections. For example, Virginia could require that individual market consumer protections, including essential health benefits, apply to all fully insured health plans sold to individuals, including STLDs. Virginia could also require clear consumer disclosures pertaining to coverage limitations on all marketing materials and broker websites, and require increased oversight, monitoring, and response to deceptive plan marketing. Alaska, Indiana, Iowa, and Wyoming have implemented such consumer fraud alerts as well as secret shopper arrangements. The state could also ban STLDs outright by requiring compliance with all individual market rules, like New York and New Jersey have done. Another approach to consider is requiring compliance with selected individual market rules, such as benefit mandates and underwriting limits. Arizona has taken this approach to regulate STLD coverage. STLD insurers could also be prohibited

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<sup>20</sup> See Appendix C: STLD and AHP FAQs- Virginia Bureau of Insurance

from rescinding coverage absent fraud or intentional misrepresentation, and STLD enrollees given the right to appeal rescissions to the BOI.

Additionally, Virginia could use the same approach used in Colorado, Indiana, Maryland, Oregon, and Washington and limit the duration and renewability of STLDs. Further, the state could require contributions from STLD carriers to reinsurance, ban telemarketing advertising, and/or ban the sale of STLDs during open enrollment. These approaches would prevent consumer confusion regarding the type of product STLDs are and avoid the perception that they are a comprehensive insurance product. Another approach is to return to the pre-October 2018 rules, which allowed for true short-term plans (the status quo).

While the Work Group generally favored stronger state oversight over STLDs rather than banning STLDs outright, it was noted that expanding the availability of plans could promote further market segmentation. With STLDs as a coverage option, individuals are able to leave the individual market and purchase such plans. This would leave less healthy people in the ACA-compliant market and lead to rate increases. Individuals who are less healthy and above 400 percent FPL, will be unable to purchase in the STLD market, and premiums in the ACA market may be cost prohibitive.

### **Regulation of Association Health Plans**

The U.S. Department of Labor describes Association Health Plans (AHPs) as health insurance plans that work by allowing small businesses, including self-employed workers, to band together by geography or industry to obtain healthcare coverage as if they were a single, large employer. AHPs allow small employers to band together to purchase the types of coverage that are available to large employers, through strengthened negotiating power, which can be less expensive and better tailored to the needs of their employees. An AHP can offer coverage to some or all employers in a state, city, county, or a multi-state metro area, or it could offer coverage to businesses in a trade or industry group nationwide.<sup>21</sup>

A new [federal rule](#)<sup>22</sup> from the Trump Administration allows associations to aggregate small businesses and individual working owners and sell them coverage subject only to large group rules rather than individual or small group rules. Thus, they do not have to provide essential health benefits or participate in the risk adjustment program. The provisions allow “working owners” to purchase association coverage, where Employee Retirement Income Security Act (ERISA) had previously been interpreted to only apply to plans with at least one active common law employee. The new rule loosens the commonality of interest test by making either industry or geography sufficient to demonstrate commonality of interest. Previously, both industry and geography were generally necessary, but neither was sufficient to establish commonality on their own.<sup>23</sup>

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<sup>21</sup> “About Association Health Plans”, U.S. Department of Labor, June 19, 2018, <https://www.dol.gov/general/topic/association-health-plans>.

<sup>22</sup> “Definition of ‘Employer’ Under Section 3(5) of ERISA-Association Health Plans”, Federal Register The Daily Journal of the United States Government, <https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans>.

<sup>23</sup> Fritz Busch. Jason Karcher. “Association health plans after the final rule”, Milliman, <http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/>

If participation and formation enables it to be viewed as a large group, a health carrier issuing coverage to the AHP may offer coverage as it would to a large group; that is, it is not required to cover or be subject to ACA individual or small group rating restrictions. Carriers are able to vary rates based on gender, occupation, and other social factors at the employer level.

### *AHPs in Virginia: Current Landscape*

There are currently 123 fully insured multiple employer welfare arrangements (MEWAs) registered with the Bureau of Insurance. AHPs are a means for employers to band together to offer health insurance coverage in the small and large group markets.

The new federal rule relaxed the “commonality of interest” test used to establish an AHP by providing that AHPs can meet the requirement on the basis of geography or industry. The new rule also permitted working owners without employees to qualify as employers and added new nondiscrimination provisions. The new rule conflicts with Virginia law in its definition of “employers” and “bona fide associations,” which place additional restrictions on the formation of AHPs. However, the Bureau has determined that the new federal rules will allow the newly permitted AHPs to operate in Virginia provided the AHP is properly registered in Virginia, and the carrier uses filed or filed and approved forms and rates, as applicable.<sup>24</sup>

### *Virginia AHP Coverage Requirements*

AHPs offer insurance coverage in the small and large group markets depending on their formation and membership. Coverage in the small group market must comply with the essential health benefit requirements of the ACA. Coverage in the large group market must comply with the applicable mandated benefits, but does not need to comply with essential health benefit requirements. The mandated benefits provisions of the Virginia Code do not require coverage for prescription drugs or maternity, but do require coverage for mental health and substance use disorder benefits. The mandated benefits requirements do not cover all of the essential health benefits that are required under the ACA.<sup>25</sup>

### *AHP Regulation in Virginia*

Forms for insurance coverage that are issued, or issued for delivery in Virginia by AHPs are filed with and approved by the Bureau of Insurance. Rates for such coverage issued in the small group market are also filed with and approved by the Bureau; however, rates for coverage issued in the large group market are filed for information only, with no rating restrictions other than a prohibition of rates based on health status. The Bureau will enforce any new legislative revisions that may become necessary to ensure the market is in order and to protect consumers.

AHPs are subject to provisions applicable to the small and large group markets, including guaranteed renewability, pre-existing condition exclusion prohibitions, and prohibitions on discrimination based on health status. Virginia treats the registration of out-of-state AHPs the same as it does those domiciled in Virginia. However, similar to other group plans issued outside Virginia that cover

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<sup>24</sup> See Appendix C: STLD and AHP FAQs- Virginia Bureau of Insurance

<sup>25</sup> See Appendix C: STLD and AHP FAQs- Virginia Bureau of Insurance



residents of Virginia, the Bureau does not have the authority to regulate the forms issued, nor the benefits provided. Fully-insured AHPs must register with the Bureau of Insurance and self-insured AHPs must become a licensed insurance company.<sup>26</sup>

### *State Options to Protect Markets and Consumers*

The current Virginia regulations surrounding AHPs could be adjusted in a variety of ways. In general, tightening of regulations would create more consumer protections and prevent further segmentation of the individual market. Maintaining or loosening the current regulations would allow for more consumer choice when purchasing plans.

In order to mitigate or prevent segmentation of the individual market, which would likely raise premiums, states can take action to create stricter rules or limit expansion of AHPs. Possible state approaches to protect market stability (similar to those affecting STLD policies) include banning AHPs outright, requiring compliance with all individual market rules, and limiting the duration of coverage. States also have several options to protect markets and consumers from the impacts of AHPs. Key consumer protection options include setting minimum coverage requirements, setting governance requirements, requiring AHPs to contribute to state guaranty funds, requiring state review of marketing materials, requiring clear consumer disclosures pertaining to coverage requirements and limitations, and establishing limits on out-of-state plans.

Regulating AHPs would have similar impacts as regulating STLDs on the individual market. Stronger state regulations could help to stabilize the individual market by reducing market segmentation and improve transparency so that consumers are better equipped to make better informed decisions pertaining to their health coverage. Defining the AHP product more clearly improves quality and accountability, protecting consumers from unfulfilled benefits and solvency issues.

While there was general agreement about the need for more state oversight over AHPs, the Work Group identified several considerations regarding AHP regulation. Some members expressed the opinion that AHPs segment the individual market and remove healthy individuals from the risk pool. This creates a higher risk market and leads to increasing prices. Other members thought that AHPs provide a more affordable coverage option to individuals. These members felt that too much regulation could result in loss of carrier offerings and a lack of affordable options for consumers. The Group generally favored consumer protections surrounding AHPs rather than banning them outright in Virginia.

### **Outreach**

Outreach efforts in Virginia are primarily administered through Enroll Virginia and its various navigator partners. Enroll Virginia is a network of community-based organizations that provide free, unbiased assistance regarding health insurance options through navigators and enrollment experts. This navigator project is coordinated by the Virginia Poverty Law Center and is financially supported by federal grants. Navigators work year-round, providing the majority of assistance during the open enrollment period but also support and assist Virginians during special enrollment periods, which are

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<sup>26</sup> See Appendix C: STLD and AHP FAQs- Virginia Bureau of Insurance

available for life-changing circumstances. These include marriage, loss of employment, and changes in Medicaid or market eligibility. Navigators are located in 19 offices throughout the Commonwealth and provide services throughout the state.

Navigator funding has historically been offered under the ACA, however recent cuts have reduced funding available at the federal level. At its peak in 2014 and 2015, Virginia's navigator programs received \$2.5 million for full-time staff. Due to both state and federal funding cuts, Enroll Virginia's navigator team has been reduced from 70 year-round navigators in 2014 and 2015 to 12 full-time and 4 part-time navigators for the rest of 2018. While funding for the part-time staff is available until August 31, 2019, funding for the full-time navigators will expire on January 1, 2019. Enroll Virginia currently receives \$400,000 in federal grants. The only other navigator program in the state, Boat People SOS, received \$125,000 this year. This program is based in Falls Church and primarily serves the Vietnamese and Asian populations in Northern Virginia.

Enroll Virginia and its partner navigators' efforts help increase or maintain enrollment in the individual market. Funding reductions have resulted in declines in enrollment, with enrollment decreasing correspondingly with funding decreases. Declines in enrollment have been most severe in the population between 100-200 percent FPL. This population needs significant assistance with enrollment and is generally unattractive to insurance brokers. There are 403,776 Virginians over 139 percent FPL who are uninsured. Many Virginians rely on navigators for help understanding premium tax credits and other federal subsidies, differences in health plans, and the nuances of eligibility based on their income level. Evidence suggests that these individuals forgo insurance and do not participate in the market without the help of navigators as they are unable to complete enrollment themselves.

With significant and continued cuts to navigator funding at the federal level, many states that utilize a state-based exchange have taken on their own outreach and enrollment efforts. Some states may be able to retain or request to retain some of the 2 percent (3 percent in 2019) user fee required to be paid to the federal exchange by expanding their own outreach and advertisement.

California, for instance, invested \$100 million in outreach and enrollment efforts and the state has not seen the enrollment declines that most other states have, even in the 100-200 percent FPL population. With data from their state-based exchange, these states have also been able to target outreach efforts directly to the individuals they know are eligible but have not enrolled in the market, increasing the size of the risk pool, thus creating a more stable market for all populations.

Work Group discussions regarding outreach were very positive. The majority of Work Group members recognized the need for increased outreach efforts and agreed that they are most effective when a state operates a state-based exchange. There were also remarks on how relatively little funding is needed for successful outreach relative to other stabilization options. Discussions also highlighted the acute need for navigators in the coming months as Medicaid expansion begins to unfold.

### **Extend Open Enrollment Periods**

In the initial years of the ACA, open enrollment periods (OEPs) for states utilizing the FFM were 12 weeks long. In the spring of 2017, the Trump Administration shortened the OEP to six weeks. Open enrollment for plan year 2019 will run from November 1 to December 15, 2018. States with state-based exchanges, however, have been able to extend their OEPs. For example, California enacted legislation that permanently establishes different enrollment dates for both on and off the exchange.

Enrollment will begin on October 15 and end on January 15. Colorado has initiated rulemaking to permanently extend open enrollment by including a special enrollment period from December 16, 2018 to January 15, 2019 every year. Minnesota's enrollment extension will run from November 1, 2018 through January 13, 2019. Extending open enrollment allows more time for the outreach and enrollment of individuals, and will promote higher participation in the individual market. There was support in the Work Group for extending open enrollment; however, Virginia would need to develop a state-based exchange to have the authority to pursue this policy option.

### **State-Level Individual Mandate**

The federal Tax Cuts and Jobs Act of 2017<sup>27</sup> eliminated the financial penalty associated with the individual mandate in the ACA, effective January 1, 2019. This penalty was the greatest of \$695 per adult or 2.5 percent of household income for individuals without approved health insurance. Because of this action, CBO estimates that premiums in the individual market will increase by 10 percent and more than 13 million people will become uninsured, nationally. States have the option to replace the federal individual mandate policy with a state-based mandate in order to keep individuals in the market. A state-based penalty can be implemented in a variety of ways in terms of its structure and amount. With the goal of comprehensively stabilizing their individual markets, some states have considered using the revenue generated from an individual mandate penalty to offset some of the costs of other stabilization options, such as a reinsurance program.

An individual mandate is an effective strategy for market stabilization as it draws participants into the market. This creates a larger, more stable risk pool and may result in lower premiums for all individuals in the market. If implemented in concert with a reinsurance program, a state-level individual mandate ensures that the state sees the full benefits of the reinsurance program. The increased market participation driven by the individual mandate allows reinsurance to successfully lower premiums and increase market stability.

Following the change in federal policy, the District of Columbia, New Jersey, and Vermont have passed state-based individual mandate legislation thus far. Massachusetts continues to have a state-based individual mandate that was implemented prior to the ACA's federal mandate. States have considerable flexibility in the design and implementation of a state-level mandate. This freedom allows for policy innovation to directly target the needs of the state's market. For example, the size of the penalty can be adjusted to fit the funding needs of the state or the penalty exemptions can be tightened in order to ensure high participation in the market, below are some examples of how states have approached the mandate.

- **Maryland.** Legislation regarding an individual mandate in Maryland failed in 2018; however, the state has created a study commission to study an individual mandate option. Maryland has considered a structure where the state would collect fees for those who opt to go without health coverage, but when individuals pay the penalty, they would have the option to use the penalty money as a down payment to purchase a health plan.

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<sup>27</sup> "H.R.1 - An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018", CONGRESS.GOV, October 18, 2018, <https://www.congress.gov/bill/115th-congress/house-bill/1>.

- Vermont. Passed legislation to impose an individual mandate to have state-approved health insurance, the bill was passed with open statutory construct in terms of the operationalization of the policy. A working group is currently convening to develop recommendations for the structure and penalties associated with the mandate. This policy will go into effect in 2020.
- New Jersey. The structure and amount of the New Jersey mandate is modeled on the federal penalty. Proceeds of the penalty will go to a trust fund to offset the state's share of reinsurance costs. This mandate will go into effect January 1, 2019.
- The District of Columbia. The mandate requires that all individuals have minimum essential coverage and the maximum financial penalty is tied to the cost of an average ACA bronze plan. Further, every person who is required to pay the penalty will receive direct outreach informing them of options to purchase coverage.

A state-level individual mandate could also be designed as a tool to limit substandard health insurance plans as the state can set requirements for minimum essential coverage in which individuals must enroll in order to avoid the tax penalty. These innovative models have been seen in the various states that have begun to implement their own individual mandates.

- Elements to facilitate a successful individual mandate include:
  - The penalty exceeds the cost of coverage both initially and over time. At a minimum, it should be equal to or greater than the ACA federal penalty, and needs to be assessable even in cases where taxpayer is not otherwise receiving a tax refund;
  - Penalty revenue should be dedicated to market stabilization and reinsurance.
  - Minimal exemptions (i.e., reasonable affordability exemptions and very limited hardship exemptions (because affordability should capture most of the hardship));
  - Minimal administrative burden for all stakeholders (consumers, employers, insurers, and state).
  - Existing processes should be leveraged to verify enrollment in minimum essential coverage, collect insurance coverage reports from employers, and assessing any penalties on consumers;
  - Minimum essential coverage (MEC) should be based upon the federal definition;
  - Authorizing legislation with conditions that issuers are not required to consider the mandate in establishing rates until the mandate has demonstrated effectiveness at the state level.
  - Continual analyses of state level tax data once implemented to better understand the demographics of the uninsured and to further tailor outreach and communications to the uninsured.

That said, the effectiveness of an individual mandate is limited if the plans available to purchase remain unaffordable. As Virginia does not operate a state-based exchange and has limited access to information on individual market enrollees, it is expected that it would be difficult to determine which individuals are exempt from paying the penalty. New Jersey also utilizes a federally facilitated marketplace rather than a state-based exchange and is currently determining how best to approach this issue.

Work Group discussions highlighted that the structure of an individual mandate is critical to ensuring its success at stabilizing the market and is paramount to consider during the design of such a policy.

This includes protecting consumers that already face unaffordable health care costs and targeting ways to effectively increase participation in the market. The group also recognized that it would likely be difficult politically to adopt a mandate in Virginia.

### **Medicaid Buy-In**

One of the recurring themes of the Work Group was Virginia's need to stabilize the insurance market for individuals between 139-200 percent FPL, who are eligible for federal subsidies, but for whom other out-of-pocket costs such as deductibles and coinsurance make coverage unaffordable. For context, the annual income of a family of three at 138 percent FPL is \$28,676 and \$41,650 at 200 percent FPL. Although the Work Group did not reach a consensus on an option directed for relieving this population, it was a topic of discussion as the Group worked to identify the target population for this study.

Some states, such as Delaware, offer Medicaid buy-in programs to individuals outside of Medicaid. These programs are only available to specific groups of health care consumers, such as working adults with disabilities. Although no state currently offers a broader Medicaid buy-in option, several states have begun exploring the concept to help solve for the low-income population. A Medicaid buy-in program would also further stabilize an individual market that lacks adequate competition by offering a more affordable insurance product and increase enrollment at the lower end of the income spectrum. Competition within the market and increased enrollment both decrease premiums as market forces and a larger risk pool take effect. Further, the Delaware legislature [passed a resolution](#)<sup>28</sup> that created a commission to study a Medicaid buy-in option for market customers.

In 2017, the Nevada legislature adopted a Medicaid buy-in plan that was vetoed by the governor. Minnesota reintroduced legislation in April 2018 to allow individuals with incomes above 133 percent and below 200 percent FPL to purchase a MinnesotaCare-like product on the market. MinnesotaCare is a Basic Health Program funded by a broad based assessment on providers and enrollees, and is available to Minnesotans who earn too much money to qualify for Medicaid, but do not have enough income to purchase insurance in the individual market, even with a subsidy.<sup>29</sup>

Work Group stakeholders noted that a Medicaid buy-in option is a viable idea to address the potential for bare counties across the Commonwealth. This option would also make coverage more affordable for low-income individuals. One of the concerns with a buy-in proposal is aversion to the Medicaid fee schedule, which are lower than commercial rates, even if rates were 125 percent of Medicaid or higher. As a result, provider network adequacy issues could result.

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<sup>28</sup> "Delaware could become first state with a "public option" in health care", WDMT, June 15, 2018, <https://www.wmdt.com/2018/06/delaware-could-become-first-state-with-a-public-option-in-health-care/753691844/>

<sup>29</sup> "MinnesotaCare", Minnesota Department of Human Services, October 18, 2018, <https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/minnesotacare.jsp>



## **Market Tying Rule**

In order to promote competition in the individual market, Virginia could require that any health insurer contracting with the State also offer coverage in the individual market, provided the insurer is state licensed to offer commercial insurance and offers insurance in a given rating area.

## **State-Funded Tax Credits**

State-funded tax credits are a further option for increasing market stability as they make purchasing coverage more affordable. The state could provide premium tax credits to subsidize the cost of health insurance coverage in order to provide relief to individuals and increase participation in the market. These tax credits could be directed to specific subsets of the population in order to make comprehensive health coverage more affordable. As the population above 400 percent is not currently receiving any federal subsidies, tax credits could be provided to individuals between 400 and 600 percent FPL in order to assist with purchasing insurance and to draw more individuals into the market. Alternatively, the state could also choose to provide state-funded subsidies to individuals between 100 percent and 400 percent FPL. Although this population is receiving support in the form of federal APTCs and CSRs (between 100 percent and 250 percent FPL), individuals in lower income brackets also have difficulty affording other cost sharing such as high deductibles and co-pays, and more relief is needed in order to further incentivize purchasing coverage. Further, tax credits could be provided to younger individuals as a method to incentivize market participation.

State-funded tax credits target the population in need of relief in a direct and efficient way that reinsurance does not. Tax credits would not require application of a 1332 waiver as they do not require federal authority. An additional benefit of providing tax credits is that it can dissuade individuals from purchasing skimpier plans, such as STLDs and AHPs, as comprehensive coverage becomes more affordable. This prevents further segmentation of the market and maintains a larger, potentially more stable risk pool.

The primary consideration for this option is determining the funding pool for tax credits. The amount of funding necessary is dependent on the size of the population that would receive these subsidies as well as the size of the tax credits themselves. A further consideration is tied to the fact that Virginia does not operate a state-based exchange. As such, the mechanism to implement the premium tax credits could not be based in the exchange and the funding would not be advanceable. This could reduce the impact of the tax credits as consumers would not see the impact of lower premiums on the front end when purchasing insurance. Although they would retroactively receive tax credits that make premiums cheaper, the value would not be assessed when purchasing is taking place.

Work Group discussions regarding state-funded tax credits reflected that other options, such as a reinsurance program or state-based exchange, are more effective uses of state spending. Minnesota temporarily used state-funded tax credits to alleviate costs for individuals over 400 percent FPL while awaiting approval of their reinsurance program, however since that program ended, no states are providing such tax credits. There is more evidence surrounding the effectiveness of these options at stabilizing the market and providing the state more control as they have been widely implemented. Although a 1332 waiver would not necessarily be required for this option, federal pass-through funding would only be available to supplement funding these tax credits if the policy was approved through a 1332 waiver. Further, given the operational challenges associated with providing these tax

credits in a federally facilitated marketplace rather than a state-based exchange, the Work Group felt that a reinsurance program was a more worthwhile use of a 1332 waiver application.

### **Expanding Access and Types of Catastrophic Health Plans**

Catastrophic health plans are available in the market and carry the ACA ten essential health benefits. They have very low premiums and very high deductibles, and premium tax credits cannot be used to purchase them. Catastrophic plans cover certain preventive services at no cost, and 3 primary care visits per year, prior to the deductible being met.

An alternative to the traditional ACA metal plans, they are designed for individuals who are healthy and do not anticipate needing health insurance, and to those who are unable to afford exchange plans even with premium subsidies. Such plans are intended for individuals who are healthy and do not plan on needing a lot of health care.<sup>30</sup> With effective coverage so limited, only certain groups of people are eligible to purchase a catastrophic plan. These are individuals under the age of 30 and people of any age with a hardship or affordability exemption<sup>31</sup> (examples include but are not limited to homelessness, eviction or foreclosure, bankruptcy, death in the family, etc.)

One option could be to increase access to catastrophic plans, as these plans could be appealing to young adults and healthy people across the lifespan. Such plans could feature lower actuarial values and accept premium tax credits to make them more affordable. The benefits of making them more accessible include that more people would officially have coverage, and it could draw more people into the individual market.

However, there are several key considerations. The price is lower today primarily because of the limited enrollment geared toward a younger population, who tend to be healthier and have less claims than an older population. If the plan is made available to everyone, rates would be adjusted to reflect the new average age and health of those expected to enroll, which most likely would result in higher premiums and take away a lower cost option currently available to those under 30. In the existing market nationwide, less than 1 percent of individuals who have purchased insurance in the individual market have selected catastrophic plans. The plans could draw less healthy individuals, and have the opposite impact. In addition, higher enrollment in catastrophic plans does not impact premiums for metal level plans as they are separate from the risk adjustment program.<sup>32</sup> In some ways, catastrophic plans could be considered an illusory benefit, as deductibles are extremely high, so most medical expenses are borne by the consumer. This exposes people to considerable financial risk, should they have unexpected medical costs.

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<sup>30</sup> "How to Choose Market insurance, Catastrophic health plans", HealthCare.gov, accessed October 30, 2018 <https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/>.

<sup>31</sup> "Hardship exemptions, forms & how to apply", HealthCare.gov, accessed October 30, 2018, <https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/>.

<sup>32</sup> <sup>32</sup> "An Evaluation of the Individual Health Insurance market and Implications of Potential Changes", p. 25-26, American Academy of Actuaries Individual and Small Group Markets Committee, January 2017, [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf)

## Findings

Throughout the six meetings of the Virginia Market Stability Work Group, there was a high level of engagement, participation, and sharing of resources among the group that led to robust, dynamic discussion and consideration of many policy opportunities to address instability in Virginia's individual market. While the Work Group was not able to reach consensus on exactly *how* to implement various policy options, they were able to reach agreement upon two general approaches that are necessary in order to stabilize Virginia's individual market:

1. Enhance state control over the individual market; and
2. Increase the number of people enrolled in the market.

As a result, the Virginia Market Stability Work Group viewed the following policy options as most promising to stabilize Virginia's individual market:

1. Pursue a reinsurance program through a 1332 state innovation waiver (1332 waiver);
2. Develop a state-based exchange and utilize this platform for market enrollment, including outreach and application assistance; and
3. Increase transparency and develop consumer protection policies for short-term limited-duration plans and association health plans.
4. Provide a state-funding source for additional outreach and enrollment assistance.

These options will improve stability in the individual market, begin to protect Virginians from unaffordable rate increases, and will lay the foundation for further stabilization efforts in the future. A reinsurance program will allow insurance carriers to offer lower premiums for the unsubsidized population in the individual market, leading to stabilization of the market itself.

Although reinsurance is a vital step to making health care coverage more affordable for Virginians, further efforts are recommended to comprehensively stabilize the market. Transitioning to a state-based exchange from the federally facilitated marketplace will allow Virginia to have more control over the operations of the individual market, enabling further stabilizing policy in the future. Additionally, the regulation of STLDs and AHPs will help prevent further degradation of the risk pool and therefore the market itself.

The aforementioned recommendations had the highest support from the Work Group following continued discussion of the benefits and considerations of each option. A majority consensus was reached regarding the need for Virginia to pursue a reinsurance program, however there was not consensus on how Virginia should fund the State's share of the program. Further, consensus was not reached how exactly to regulate STLDs and AHPs and to increase transparency of these plans for consumers.

## Limitations and Other Considerations

On October 22, 2018, the U.S. Departments of Health and Human Services and the Treasury issued new guidance effective also, October 22, 2018. The guidance allows states to propose ways for other



forms of coverage not as comprehensive as traditional ACA coverage, but more affordable, such as Short Term Limited Duration Plans and Association Health Plans to be included in a waiver plan, as long as there is an ACA plan that is *available* to a comparable number of residents. This is in contrast to the previous ACA guardrail requirement that ACA-like coverage would be *issued* to the same number of residents. States have been asked to examine the new guidance and provide comments to the federal government by December 23, 2018.<sup>33</sup> The guidance could add further confusion to the market as to the level of coverage and benefits, and increase the number of individuals who are underinsured, underscoring the need for measures that would provide greater state oversight over the individual market, such as the options that have presented in this report.

The Work Group aimed its efforts at addressing the specific charge directed by the General Assembly, however, members agreed that the market is a hydraulic system. As policy levers are implemented, multiple parts of the market intentionally or unintentionally impact others. Comprehensive health care reform will require a multi-pronged approach over time in order to solve for other issues, including cost containment, market competition, and access.

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<sup>33</sup> “*State Relief and Empowerment Waivers: A Rule by the Treasury Department and the Health and Human Services Department*”, Federal Register: The Daily Journal of the United States Government, October 24, 2018, <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>

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**2019 ACA Rate Filing Data (As of August 22, 2018)**

Company Name	BOI (SERFF) Tracking #	Rating Areas**	Average Rate Change - 2019 over 2018	Maximum Rate Change - 2019 over 2018	Minimum Rate Change - 2019 over 2018	2019 Average Per Member Per Month Rate	2019 Projected Covered Lives*****
<b>INDIVIDUAL MARKET</b>							
<b>ON and OFF Health Insurance Marketplace (HIX)***</b>							
CareFirst BlueChoice, Inc.	CFAP-131483887	10	14.50%	17.90%	8.90%	\$ 809.21	6,803
Cigna Health and Life Insurance Company	CCGH-131466701	7, 10	11.00%	19.00%	-30.60%	\$ 584.00	81,682
Group Hospitalization and Medical Services, Inc.	CFAP-131483672	10	45.10%	51.80%	30.50%	\$ 1,389.34	4,161
HealthKeepers, Inc.	AWLP-131468781	All	2.50%	8.00%	-28.30%	\$ 730.73	94,000
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	KPMA-131448325	7, 10, 12	32.10%	39.90%	20.80%	\$ 488.97	78,687
Optima Health Plan	OPHL-131486283	2, 4, 7, 9, 12	-7.20%	4.80%	-43.90%	\$ 761.06	59,525
Piedmont Community HealthCare HMO, Inc.	PDHP-131463453	2, 3, 6, 7, 12	11.94%	16.20%	-12.80%	\$ 858.80	17,786
Virginia Premier Health Plan, Inc.	VPHP-131470719	7	New****	New****	New****	\$ 575.92	3,506
<b>OFF HIX</b>							
Optima Health Insurance Company	OPHL-131486205	9	-4.90%	-4.90%	-4.90%	\$ 816.07	1
<b>SMALL GROUP MARKET</b>							
<b>ON and OFF Small Business Health Options Program (SHOP)***</b>							
CareFirst BlueChoice, Inc.	CFAP-131469872	10	-1.25%	4.74%	-7.94%	\$ 457.56	35,565
Group Hospitalization and Medical Services, Inc.	CFAP-131469902	10	8.14%	15.76%	4.57%	\$ 610.58	13,486
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	KPMA-131448361	7, 10, 12	0.00%	5.20%	-3.30%	\$ 296.60	14,728
<b>OFF SHOP</b>							
Aetna Health, Inc. *	AETN-131483416	All	15.54%	24.96%	3.67%	\$ 584.06	3,508
Aetna Life Insurance Company *	AETN-131482967	All	14.40%	25.36%	4.00%	\$ 637.95	2,920
Anthem Health Plans of Virginia, Inc.	AWLP-131465657	All	8.30%	13.60%	1.80%	\$ 580.16	85,000
HealthKeepers, Inc.	AWLP-131465637	All	5.30%	13.00%	-4.10%	\$ 500.42	70,000
Innovation Health Insurance Company *	AETN-131485602	10, 11, 12	10.92%	24.10%	6.63%	\$ 576.78	5,951
Innovation Health Plan *	AETN-131485601	10, 11, 12	16.55%	16.55%	16.55%	\$ 542.44	5,605
Optima Health Insurance Company	OPHL-131482876	All	1.90%	80.30%	-21.40%	\$ 661.05	1,774
Optima Health Plan	OPHL-131483360	All	4.70%	85.70%	-26.80%	\$ 494.49	39,893
Optimum Choice, Inc. *	UHLC-131460651	All	6.60%	21.70%	4.00%	\$ 495.00	6,861
Piedmont Community HealthCare HMO, Inc.	PDHP-131463458	2, 3, 6, 7, 12	-12.49%	-8.40%	-19.70%	\$ 462.73	2,850
UnitedHealthcare Insurance Company *	UHLC-131460646	All	6.60%	20.60%	2.80%	\$ 502.09	65,952
UnitedHealthcare of the Mid-Atlantic, Inc. *	UHLC-131460666	All	6.60%	20.80%	2.30%	\$ 424.34	1,994
UnitedHealthcare of the River Valley, Inc. *	UHLC-131475269	All	16.30%	25.50%	7.90%	\$ 528.71	1,740

Except as noted below (\*), the information above is representative of rates approved by the Virginia Bureau of Insurance (BOI). Each filing is available for public view on the Bureau of Insurance's website through the following link: <https://www.scc.virginia.gov/boi/SERFFInquiry/default.aspx>.

\* Rates, together with their supporting documentation and the various assumptions used in computing the rates submitted by carriers that did not file any On HIX or SHOP plans, continue to be under review by the BOI with final action due October 15, 2018.

\*\* A carrier's participation in an MSA does not indicate the carrier participates in the entire MSA.

\*\*\* Plans offered On HIX or SHOP are also required to be made available Off HIX or SHOP.

\*\*\*\* The notation of "new" indicates the carrier is new to this market for 2019.

\*\*\*\*\* Covered lives information represents the carrier's projections.

***Metropolitan Statistical Area (Rating Area) Key
1 Blacksburg
2 Charlottesville
3 Danville
4 Harrisonburg
5 Bristol
6 Lynchburg
7 Richmond
8 Roanoke
9 VA Beach - Norfolk
10 Washington/Arlington/Alexandria
11 Winchester
12 Non-MSA

**2018 ACA Rate Filing Data (As of 09/20/2017)**

Company Name	BOI (SERFF) Tracking #	Rating Areas*	Average Rate Change - 2018 over 2017	Maximum Rate Change 2018 over 2017	Minimum Rate Change 2018 over 2017	2018 Average Per Member Per Month Rate	2018 Projected Covered Lives***
<b>INDIVIDUAL MARKET</b>							
<b>ON and OFF Health Insurance Marketplace (HIX)**</b>							
CareFirst BlueChoice, Inc.	CFAP-131008466	10	54.500%	162.500%	27.300%	\$763.65	9,712
Cigna Health and Life Insurance Company	CCGH-130904859	7, 10	51.100%	168.600%	23.900%	\$502.00	20,209
Group Hospitalization and Medical Services, Inc.	CFAP-131008507	10	67.400%	213.200%	44.900%	\$1031.14	6,916
HealthKeepers, Inc.	AWLP-131192016	1,5,7,8,10,11.	54.600%	64.100%	42.500%	\$662.71	61,000
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	KPMA-130932763	7, 10, 12	24.200%	104.800%	6.300%	\$502.25	64,105
Optima Health Plan	OPHL-131018427	2,4,7,9,12	81.800%	265.500%	39.200%	\$889.78	24,481
Piedmont Community HealthCare HMO, Inc.	PDHP-130999363	2, 3, 6, 7, 12	53.400%	161.700%	43.500%	\$668.64	15,381
<b>OFF HIX</b>							
Optima Health Insurance Company	OPHL-131018450	9	72.900%	154.300%	66.500%	\$857.46	1
<b>SMALL GROUP MARKET</b>							
<b>ON and OFF Small Business Health Options Program (SHOP)**</b>							
CareFirst BlueChoice, Inc.	CFAP-131015795	10	4.268%	9.087%	0.263%	\$477.82	34,480
Group Hospitalization and Medical Services, Inc.	CFAP-131015748	10	1.133%	3.576%	-1.284%	\$574.57	13,430
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	KPMA-131019168	7, 10, 12	4.400%	90.100%	-6.600%	\$414.69	9,424
<b>OFF SHOP</b>							
Aetna Health, Inc.	AETN-131001828	All	1.890%	116.270%	-20.249%	\$513.41	17,415
Aetna Life Insurance Company	AETN-131001849	All	-2.83%	117.88%	-21.396%	\$558.26	8,883
Anthem Health Plans of Virginia, Inc.	AWLP-130988864	All	9.000%	14.000%	7.300%	\$557.67	102,000
HealthKeepers, Inc.	AWLP-130988867	All	10.500%	16.100%	8.000%	\$503.34	56,600
Innovation Health Insurance Company	AETN-131001832	10, 11, 12	11.87%	111.740%	-0.191%	\$514.80	9,966
Innovation Health Plan, Inc.	AETN-131001833	10, 11, 12	4.36%	140.09%	-0.925%	\$437.52	12,178
Optima Health Insurance Company	OPHL-131018184	All	9.40%	20.50%	4.40%	\$652.69	1,985
Optima Health Plan	OPHL-131018137	All	9.50%	58.50%	3.40%	\$505.41	33,888
Optimum Choice, Inc.	UHLC-131008582	All	12.90%	19.500%	-1.100%	\$491.27	3,979
Piedmont Community HealthCare HMO, Inc.	PDHP-130999410	2, 3, 6, 7, 12	11.54%	76.30%	-5.70%	\$486.92	642
UnitedHealthcare Insurance Company	UHLC-131008653	All	12.90%	20.800%	-10.400%	\$500.83	42,698
UnitedHealthcare of the Mid-Atlantic, Inc.	UHLC-131008581	All	12.90%	16.600%	2.200%	\$355.66	264
UnitedHealthcare Plan of the River Valley, Inc.	UHLC-131022875	All	-0.66%	13.22%	-13.93%	\$460.85	607

**Metropolitan Statistical Area (Rating Area) Key**

- 1 Blacksburg
- 2 Charlottesville
- 3 Danville
- 4 Harrisonburg
- 5 Bristol
- 6 Lynchburg
- 7 Richmond
- 8 Roanoke
- 9 VA Beach - Norfolk
- 10 Washington/Arlington/Alexandria
- 11 Winchester
- 12 Non-MSA

The information above is representative of the rates approved by the Virginia Bureau of Insurance (BOI) as of September 20, 2017. Each filing is available for public view on the Bureau of Insurance's website through the following link: <http://www.scc.virginia.gov/boi/SERFFInquiry/default.aspx>.

\*A carrier's participation in an MSA does not indicate the carrier participates in the entire MSA.

\*\* Plans offered On HIX or SHOP are also required to be made available Off HIX or SHOP.

\*\*\*Covered lives information represents the carrier's projections.

## Short-term Limited-duration Insurance Coverage

### **Q1: What is the current landscape for short-term limited-duration (STLD) insurance coverage in Virginia?**

A1: During the last decade, the Bureau of Insurance has received approximately 11 STLD insurance filings that have been filed for use or filed and approved in Virginia. Approximately half of these filings appear to be out-of-state. We have not received any new filings since the new final rules but have received numerous questions from carriers. It appears to us that STLD insurance coverage is offered in the following three ways: (i) by a carrier to individuals in the individual market, (ii) by a carrier to an out-of-state association or trust that offers certificates to individuals in the individual market, and (iii) by a carrier to an in-state association or trust that offers certificates to an individual in the individual market.

### **Q2: What are the coverage requirements for STLD insurance coverage in Virginia?**

A2: STLD insurance coverage that exceeds six months in duration or STLD insurance coverage of any duration that is renewable shall comply with the mandated benefits requirements contained in Article 2 of Chapter 334 of Title 38.2 of the Code.

It is worth noting that the mandated benefits provisions of the Virginia Code do not require coverage for prescription drugs, maternity, or mental health and substance use disorder benefits, that are required to be covered as essential health benefits for individual and small group health insurance under the ACA. Pursuant to Section 38.2-3412.1 of the Code, all individual and group health insurance coverage must include benefits for mental health and substance use disorder; however, STLD insurance coverage is not required to provide these benefits. No individual STLD insurance coverage is required to provide essential health benefits.

### **Q3: With respect to forms and rates, how is STLD insurance coverage regulated in Virginia?**

A3: Forms associated with STLD insurance coverage that are issued or issued for delivery in Virginia shall be filed with and approved by the Bureau pursuant to Section 38.2-316 of the Code. If the coverage will be issued outside of Virginia to a group defined in Section 38.2-3521.1 of the Code, the form shall be file-and-use; however, such forms must certify compliance with similar laws in the state of issuance. This provides a basic level of protection, but does not ensure compliance with all Virginia mandates.

The rates associated with individual STLD insurance coverage shall be approved by the Bureau in accordance with Section 38.2-316.1 of the Code, including rates for coverage issued in Virginia to an association, group trust, purchasing cooperative or other group that is not an employer plan operating inside or outside of Virginia. STLD insurance coverage shall be subject to a 60/65% loss ratio standard pursuant to 14 VAC 5-130-10 *et seq.*

### **Q4: Is STLD insurance coverage subject to the renewability and preexisting conditions requirements contained in Sections 38.2-3514.2 and 38.2-3514.1, respectively?**

A4: Any STLD insurance coverage that is underwritten must be renewable up to 36 months in total pursuant to Section 38.2-3514.2 of the Code. Please note that any renewable policy must comply with all state mandated benefits subject to the applicable market, as discussed in A2 above.

Any STLD insurance coverage that is underwritten must credit previous continuous coverage held 30 days prior to the new coverage and comply with other preexisting conditions requirements contained in Section 38.2-3514.1 of the Code.

Policies that are not underwritten, that are no more than six months in duration, and nonrenewable are exempt from the requirements of Sections 38.2-3514.2 and 38.2-3514.1 of the Code.

### **Q5: Can STLD insurance coverage be underwritten either for purchase or for rating purposes?**

A5: Yes.



## Association Health Plan Insurance Coverage

### **Q1: What is the current landscape for association health plan (AHP) coverage in Virginia?**

A1: There are currently 123 fully insured MEWAs registered with the Bureau of Insurance. AHPs are a means for employers to band together to offer health insurance coverage in the small and large group markets depending on the size of their membership.

### **Q2: What is the recent federal rule change on AHPs?**

A2: The new rule relaxed the “commonality of interest” test used to establish an AHP by providing that AHPs can meet the requirement on the basis of geography or industry. The new rule also permitted working owners without employees to qualify as employers and added new nondiscrimination provisions.

The new rule likely conflicts with Virginia law in its definition of “employers” and “bona fide associations,” which place additional restrictions on the formation of AHPs. The Bureau of Insurance is currently evaluating potential preemption issues by consulting with other states who have similar laws related to employer size, AHP size, required time of AHP existence, and purpose of formation.

### **Q3: With respect to forms and rates, how is AHP insurance coverage regulated in Virginia?**

A3: Forms for insurance coverage that are issued or issued for delivery in Virginia by AHPs shall be filed with and approved by the Bureau pursuant to Section 38.2-316 of the Code. Rates for such coverage issued in the small group market shall also be filed with and approved by the Bureau under Section 38.2-316.1, but rates for coverage issued in the large group market shall be file-and-use under Section 38.2-316. If the coverage is issued outside of Virginia, forms shall be file-and-use in the small and large group markets and there is no filing requirement for rates in either market.

### **Q4: What are the coverage requirements for AHP insurance coverage in Virginia?**

A4: AHPs offer insurance coverage in the small and large group markets depending on their formation and membership. Coverage in the small group market must comply with the essential health benefit requirements of the ACA. Coverage in the large group market must comply with the applicable mandated benefits, but do not need to comply with essential health benefit requirements. The mandated benefits provisions of the Virginia Code do not require coverage for prescription drugs or maternity, but do require coverage for mental health and substance use disorder benefits. The mandated benefits requirements do not cover all of the essential health benefits that are required under the ACA.

### **Q5: Are AHPs subject to renewability, preexisting condition exclusions, and prohibitions on underwriting based on health status?**

A5: AHPs are subject to provisions applicable to the small and large group markets, including guaranteed renewability pursuant to Section 38.2-3432.1 of the Code, preexisting condition exclusion prohibitions pursuant to Section 38.2-3444, and prohibitions on discrimination based on health status pursuant to Section 38.2-3449.

### **Q6: How does Virginia regulate out-of-state AHPs?**

A6: Virginia treats out-of-state AHPs the same as it does those domiciled in Virginia. Fully insured AHPs must register with the Bureau of Insurance and self-insured AHPs must become a licensed insurance company.

The information stated here contains some generalized statements to be used for informational purposes only. It is not intended to be an opinion, legal or otherwise, of the State Corporation Commission Bureau of Insurance, nor should it be construed as an endorsement of any product, service, person or organization. Please note that responses may be different depending on specific circumstances. Please direct inquiries to the Bureau of Insurance to determine the requirements applicable to specific circumstances.

Counties	Uninsured Total by County Grouping	Uninsured 139 to 400% FPL	Uninsured above 400% FPL	Uninsured population over 138% FPL
Arlington County	15,880	7,781	1,588	9,369
Alexandria city	14,466	6,886	1,794	8,680
Fairfax County (part)	19,415	8,251	2,679	10,931
Fairfax County (part)	14,329	6,821	1,863	8,683
Fairfax County (part)	16,381	7,404	2,899	10,304
Fairfax County (part)	13,685	7,664	2,135	9,798
Fairfax County (part)	13,859	4,657	3,285	7,941
Frederick County, Shenandoah County, Winchester city	16,867	6,949	1,501	8,450
Prince William County (part)	20,465	10,376	1,494	11,870
Prince William County (part)	23,572	12,045	4,219	16,265
Loudoun County, Fauquier County, Warren County, Clarke County	32,832	14,315	4,071	18,386
Rockingham County, Harrisonburg city, Orange County, Louisa County, Page County, Madison County, Rappahannock County	35,752	15,910	2,681	18,591
Stafford County, King George County	11,665	4,094	2,088	6,182
Spotsylvania County, Culpeper County, Fredericksburg city	22,962	11,412	1,263	12,675
Albemarle County, Charlottesville city, Fluvanna County, Greene County	16,512	6,291	1,337	7,629
Augusta County, Staunton city, Rockbridge County, Waynesboro city, Nelson County, Alleghany County, Lexington city, Buena Vista city, Covington city, Craig County, Bath County, Clifton Forge city, Highland County	30,116	11,685	1,777	13,462
Richmond city	26,174	9,004	1,911	10,915
Henrico County	27,759	12,075	1,194	13,269
Chesterfield County	26,685	11,902	2,615	14,517
Hanover County, Powhatan County, Goochland County	10,628	3,135	659	3,794
Roanoke city, Salem city	14,684	4,435	338	4,772
Roanoke County, Botetourt County	6,418	2,939	205	3,145
Lynchburg city, Bedford County, Campbell County, Amherst County, Bedford city	30,978	9,108	2,726	11,834
Accomack County, Caroline County, Westmoreland County, King William County, Northampton County, Northumberland County, Lancaster County, Essex County, Middlesex County, Richmond County, King and Queen County	25,440	8,014	2,519	10,532
Newport News city	25,974	10,961	1,506	12,468
Hampton city	14,843	6,115	549	6,665
York County, James City County, Gloucester County, Williamsburg city, Poquoson city, Mathews County	12,484	4,294	2,422	6,716
Petersburg city, Prince George County, Dinwiddie County, Hopewell city, Colonial Heights city, New Kent County, Charles City County	23,867	9,165	1,026	10,191
Montgomery County, Pulaski County, Giles County, Radford city, Floyd County	17,249	5,744	293	6,037
Wise County, Russell County, Lee County, Dickenson County, Norton city	17,654	3,690	530	4,219
Washington County, Smyth County, Scott County, Bristol city	20,358	7,410	1,384	8,795
Tazewell County, Carroll County, Wythe County, Buchanan County, Grayson County, Bland County, Galax city	23,013	7,893	898	8,791
Virginia Beach city (part)	10,684	5,556	951	6,507
Virginia Beach city (part)	15,742	5,557	1,086	6,643
Virginia Beach city (part)	16,525	6,990	1,686	8,676
Norfolk city	38,808	14,747	2,328	17,076
Chesapeake city	22,449	9,810	1,459	11,269
Portsmouth city, Suffolk city, Isle of Wight County	26,427	11,760	1,136	12,896
Mecklenburg County, Brunswick County, Southampton County, Lunenburg County, Sussex County, Greensville County, Franklin city, Surry County, Emporia city	16,309	3,914	310	4,224
Henry County, Franklin County, Patrick County, Martinsville city	17,873	6,827	465	7,292
Halifax County, Prince Edward County, Nottoway County, Buckingham County, Appomattox County, Charlotte County, Amelia County, Cumberland County	21,470	6,742	1,524	8,266
Pittsylvania County, Danville city	15,500	4,046	1,008	5,053
<b>Total</b>	<b>844,753</b>	<b>334,373</b>	<b>69,403</b>	<b>403,776</b>
Source: CMS Data Files. 2017.				0.477981438

## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
<b>Increase enrollment:</b>							
<b>State requirement of individual mandate penalty/automatic enrollment</b>	MA	Penalty amounts under Massachusetts' individual mandate are based on residents' income and the cost of various plans in the exchange. And unlike the ACA penalty, the Massachusetts penalty only applies to adults.	Passed	Yes	State	Health Plans- facilitates predicatbility, promotes healthy risk, improves rates	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
	NJ	Requires most individuals, other than those who qualify for certain exemptions, to obtain health insurance or pay a penalty. Penalty equal to previous federal but pegged to NJ specific bronze plan. Penalty funds used for state-operated reinsurance program. Bills:	Passed	Yes	Federal		<a href="http://www.commonwealthfund.org">www.commonwealthfund.org</a>
	VT	Working group considering size of penalty and mechanism by next legislative session. Use of penalty not yet specified. HB696.	Passed	Yes	State		<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
	DC	Bill (part of Bill 22-753) requiring DC residents have minimal essential coverage or pay a penalty that is placed in a special fund to be used for outreach, education, and increasing availability or affordability of insurance.	Passed	Yes	State		<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
	MD	MD's proposal sought to increase enrollment by using a penalty payment as a "down payment" on coverage. Taxpayers opting in would be automatically enrolled in Medicaid or a marketplace plan if the penalty covered the full premium, or the penalty payment could be used to enroll in coverage during the next open-enrollment period.	Did not pass	Yes	State		<a href="http://www.commonwealthfund.org">www.commonwealthfund.org</a>
	HI	SB2924	Did not pass	Yes	Federal		<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
	CT	One approach Connecticut considered would have increased the penalty paid by some uninsured residents in an effort to have a larger financial incentive to purchase coverage, although a different bill proposed by the governor included a lower penalty across the board. Neither bill moved out of committee, but state lawmakers have indicated that they will likely revisit the issue. Another approach looked at by CT would have allowed uninsured consumers to invest their penalty payment in a savings account to pay for out-of-pocket health care expenses. This proposal was intended to ensure some access to care for residents unable to afford insurance.	Did not pass	Yes	State		<a href="http://www.commonwealthfund.org">www.commonwealthfund.org</a>
	NM	Senate Memorial 7 (SM7) directs the task force to consider alternatives to the ACA's individual mandate, including the possibility of auto-enrolling subsidy-eligible uninsured residents into zero-cost or low-cost plans. Also, Brookings Institutue Report notes "automatically enroll otherwise-uninsured people who are eligible for substantial subsidies... is feasible, however, only when the subscriber owes no premium, but fortunately the way most insurers handled Silver-loading for cancelled cost-sharing payments has produced "zero dollar" Bronze plans in a good number of markets around the country. Therefore, this idea has renewed promise, although logistically it would appear to be tricky to identify eligible people who have not	Health Insurance Market Stability Task Force report due by November 1, 2018.	Yes	Federal		<a href="https://www.healthinsurance.org/new-mexico-state-health-insurance-exchange/#enrollment">https://www.healthinsurance.org/new-mexico-state-health-insurance-exchange/#enrollment</a> and, Stabilizing the Market - Brookings - July 2018;

## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
Legislation proposed to require hospital employees to assist uninsured patients with creating account to apply for insurance coverage through the FFM.	NJ	A377 - designated employee would be required to provide information concerning the Federally-Facilitated Marketplace and, if authorized to do so, may also assist the patient with obtaining health insurance through the Federally-Facilitated Marketplace.	In Committee	Yes	Federal	Hospital staffing, training, Adds access points and facilitates access for patients	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
Extend open enrollment periods	CO, MN	Two state-based exchanges that operate their own enrollment platforms (CO and MN) also attributed their relative success to their ability to extend open enrollment for several weeks beyond the federal window, which was only half the length of the previous year.		Yes	State	For beneficiaries- provides more opportunity for enrollment May require increased staffing, Promotes coverage for healthy individuals, and healthier risk pools	Stabilizing the Market - Brookings - July 2018
Redraw rating areas		States may draw their own rating areas within limits. Virginia uses the default drawn by MSAs plus all non-MSAs.	Risk could be spread across a greater area or a more limited area				
Investing funding in enrollment assistance and outreach		Could strengthen the markets by increasing the number of healthy enrollees who join the insurance market and the number of people who choose to maintain their current coverage.				Increases the number of healthy people who enroll in the market and those who maintain coverage. Would require state general fund dollars or other funding.	Robert Wood Johnson Foundation. Sept 17.
	FL	Florida has seen a substantial increase in enrollment. Subjects there attribute this success in part to strong networks of nonprofit navigators and enrollment assisters that rely on local funding		No	Federal		Stabilizing the Market - Brookings - July 2018
	CO, NV	Colorado and Nevada attributed much of their success in "insulating" the market from recent federal policies to their ability to commit substantial funds to marketing and outreach, in order to offset the "drastic" cuts that "slashed" and "gutted" federal funds for these		Yes	State		Stabilizing the Market - Brookings - July 2018
	CA	California analysis estimates that increased marketing in other states could lower premiums nationally by 2 to 3 percent each of the next two years.		Yes	State		Stabilizing the Market - Brookings - July 2018
Enhanced Direct Enrollment	IL, PA	State Bureau of Insurance created their own page to supplement the federal website, and include information on Bureau of Insurance. Use Direct Enrollment Partner such as Go Health, as an alternative enrollment path. 50 different EDE partners. Consumer can fully enroll through EDE website - doesn't need to access Healthcare.gov. States may be able to retain part of 3.5% user fee if they take on tasks of the exchange.		Yes	Federal	Improves consumer access to on-line enrollment. Saves the state money in reduced healthcare.gov user fee of 3.5%	A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018, Novartis
Bureau of Insurance to work with Navigators and Community Groups to help consumers get enrolled into appropriate plans	WV			Yes	Federal	Requires investment from the BUI. Improves enrollment numbers of healthier individuals, promoting healthier risk pools. Improves and promotes ease of access for indigent and disenfranchised populations.	West Virginia Commissioner

## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
Redesign Age Rate Curve to attract younger/healthier individuals		States must keep a 3:1 or less age ratio, but can redesign the curve to benefit younger enrollees and/or to lower rates for older enrollees	Requires actuarial analysis to ensure changes would not violate guardrails for older enrollees.			Encourages participation by younger, healthier individuals	A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018,
<b>Increase competition:</b>							
Increase competition. Avoid bare counties. Require individual market insurers to offer plans on statewide basis.	NM	Four insurers are offering individual market plans - direct result of New Mexico's decision to require participating insurers to offer at least one plan statewide at each metal level where the insurer wants to offer plans (silver and gold plans are required by the ACA; insurers can choose to offer more metal levels than that if they wish, but in New Mexico, insurers must ensure that there's at least one statewide plan at each metal level).	For 2019, five insurers have filed rates and plans for exchange participation	Yes	Federal	Enhance consumer access and choice.	<a href="https://www.healthinsurance.org/new-mexico-state-health-insurance-exchange/#enrollment">https://www.healthinsurance.org/new-mexico-state-health-insurance-exchange/#enrollment</a>
Relax network adequacy rules in less populous counties, or where insurers were having difficulty securing network contracts.						May improve consumer access to coverage and improve competition. May limit access to needed services.	Stabilizing the Market - Brookings - July 2018
Capping enrollment for carrier in underserved areas	MN	Minnesota looked at capping enrollment by insurers willing to remain or expand into an underserved area, in order to limit potential downside exposure.		Yes	State	May limit carrier risk exposure. May provide some access to some individuals. Limits access to coverage for others.	Stabilizing the Market - Brookings - July 2018
Encourage participation in the individual market by tying participation to eligibility to bid for state contracts.	NV	Some states may encourage participation for eligibility to bid for state contracts. Other states have required Medicaid contractors to participate on the exchange. Nevada had this requirement for a time.	Cited as the likely reason United Healthcare remained in the Nevada exchange despite withdrawing from exchanges elsewhere.	Yes	State	Increases competition. Increases access to coverage. Increases consumer choice.	Stabilizing the Market - Brookings - July 2018
	NY	Governor banned insurers who withdraw from the state exchange from future participation that interacts with the state exchange, such as Medicaid, and from contracting with the state for the state health plan.		Yes	State		<a href="https://www.governor.ny.gov/news/governor-cuomo-announces-aggressive-actions-protect-access">https://www.governor.ny.gov/news/governor-cuomo-announces-aggressive-actions-protect-access</a>
	NJ	The bill provides that a carrier that withdraws from offering individual health benefit plans in the New Jersey Individual Health Coverage Program or withdraws from offering small employer health benefits plans in the New Jersey Small Employer Health Benefits Program shall be ineligible to enter into a contract with the Department of Human Services to provide health benefits for eligible persons under the Medicaid program or the NJ FamilyCare program.	In committee	Yes	Federal		<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>



## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
Offer incentives to carriers: (i) to participate in rural areas (ii) statewide (iii) to provide higher quality care		Tie participation in one area of the state to a requirement to participate statewide; require carriers that participate in a well-served area to participate in a nearby underserved area, i.e., require participation in a full rating area. Tie requirement to participate to Medicaid contract.	This could present issues of network adequacy and decrease competition in some currently well-served areas.			Increases competition. May distribute risk. Increases access to coverage. Increases consumer choice.	A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018, Novartis
		Offer incentives to carriers to participate in underserved areas or statewide using state funds	Would require state funding				A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018, Novartis
		States could incentivize carriers based on Quality Rating Standards.	Would require state funding				A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018, Novartis
Waived seasoning requirement for new companies	TN	No requirement that company needs to be profitable for 3 immediately preceding years before applying to insure individuals	2 new carriers entered the market	No	Federal	Increases consumer choice. May increase liability if solvency issues occur.	Tennessee Commissioner
Allow carriers to re-enter market prior to 5 year ban	TN	Currently federal law requires a 5-year lockout period for a carrier to re-enter a market once they discontinue all policies in a market.	2 carriers re-entered market	No	Federal	May increase choice. May encourage more market fluctuation with participation.	Tennessee Commissioner
<b>Health Care Cost Control:</b>							
Opioid Reduction	WV	Lower ER claims and cut down Hep C claims which eventually should cut health care costs and help lower premiums.		Yes	Federal		West Virginia Commissioner
	DE	Legislation to enhance coverage for medically necessary inpatient treatment of alcohol and drug dependencies to address growing opioid epidemic. Legislation enhancing abilities of a RX monitoring program for opioids. SB 41 and HB 91.	Passed	Yes	Federal	May limit risk pools for carriers as beneficiaries and others receive treatment. Provides more access to appropriate SUD services for individuals with SUDs.	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
Cigarette tax increased - funds used to fund programs that help lower healthcare costs	CA		Passed	Yes	State	May over time also limit risk exposure to insurers. May improve health of population.	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
Cigarette tax to fund Cancer Research	FL	S2514 - Legislation introduced requiring that a specified percentage of the cigarette tax, up to a specified amount, be paid annually to the Florida Consortium of National Cancer Institute Centers Program.	Passed	No	Federal	May over time also limit risk exposure to insurers. May improve health of population.	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
Task Force created to reduce health care spending growth	DE	SCR36 - Senate resolution to create the Health Care Spending Task Force to produce comprehensive solutions for reducing the cost growth trend in the state health care spending.	Advanced	Yes	Federal		<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>

## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
Reduction of prescription drug costs	CT	Legislation requiring PBMs disclose info regarding the maximum allowable cost (MAC) of prescription drugs and establish procedures for MAC lists. Legislation to impose additional disclosure and reporting requirements on PBMs, health carriers, Rx manufacturers, concerning prescription rebates and the cost of prescriptions. HB07124 and HB05384	Passed	Yes	State	May assist with cost of plans. May make plans more affordable. May provide more cost transparency, and thus reduce costs.	
Creation of a Mental Health Specialty Court	AK	HB1663 Provides an avenue for need assessment, risk assessment, and placement into facilities. Access to continuum of treatment and rehabilitation services for program participants. Programs for alcohol and substance abuse.	Passed	Yes	Federal	May provide better access to critical services for those with mental health conditions. May improve risk pools. May promote use of institutionalization.	Arkansas Legislative website
<b>Public Option:</b>							
Legislation introduced to create a public health option	NJ	SS61 and A.1343 - would create a publicly-funded public health insurance option in New Jersey, which would compete with the private market options.	In committee	Yes	Federal	Would increase competition. Would promote healthier risk pool in the individual market. Would provide greater access to	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
Medicaid buy-in as a "public option"	IA, ME, MN, NV	"...allow people to buy into the state's Medicaid program, in order to obtain more favorable pricing by providers, and to reduce overhead costs incurred by insurers. We heard that this "public option" possibility has been proposed or discussed (at least to some extent) in Iowa, Maine, Minnesota, and Nevada."	Proposed	Yes	State (IA, MN, NV) Federal (ME)	Would increase competition. Would promote healthier risk pool in the individual market. Would provide greater access to individuals for whom plans are unaffordable.	Stabilizing the Market - Brookings - July 2018
Basic Health Plan Program	NY, MN	BHP is an option for individuals who do not qualify for Medicaid or CHIP but who have income between 133 and 200% FPL. EHB benefits. Monthly premium and cost sharing can be no more than a QHP with CSRs and tax credits. State who operate a BHP receives federal funding of 95% of the amount of premium tax credit and CSR individual would have been provided on the Marketplace. The state handles enrollment and eligibility.	Covers churn population, Requires submission of Blueprint.	Yes	Yes	Would increase competition. Would promote healthier risk pool in the individual market. Would provide greater access to individuals for whom plans are unaffordable.	<a href="https://www.medicaid.gov/basic-health-program/downloads/bhp-final-rule-fact-sheet.pdf">https://www.medicaid.gov/basic-health-program/downloads/bhp-final-rule-fact-sheet.pdf</a>
<b>State-funded options:</b>							
State funding of tax credits for catastrophic plan		Tax credits are not available for a catastrophic plan, available to individuals under age 30. States could provide a tax credit.				Could promote healthier risk pool by encouraging younger, healthier individuals to purchase in the marketplace.	A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018, Novartis
Premium subsidy to unsubsidized consumers	MN	Funded a 25% premium subsidy to unsubsidized consumers	Would require state funding	Yes	State	Could promote healthier risk pool by encouraging more and diverse individuals to purchase in the marketplace. Encourage carrier participation, increased competition	A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018,

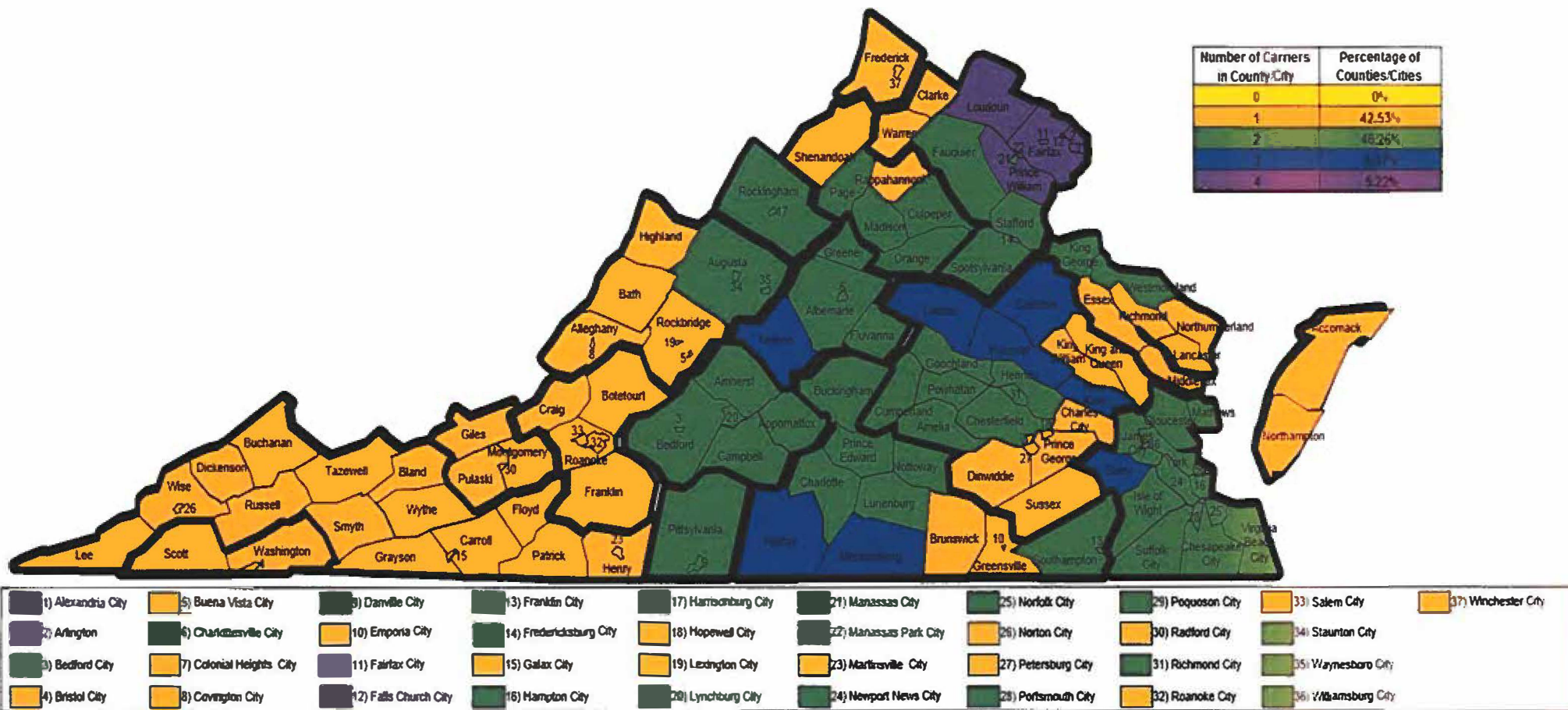
## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
		Provide a subsidy under federal parameters, but to a higher FPL. Provide a subsidy to a higher FPL population, and at a higher % of income related to premium cost (i.e., 11% instead of 9.69%)	Would require state funding				A State-Based Approach for Stabilizing the Individual Insurance Marketplace, 2nd Edition, June 2018, Novartis
Legislation introduced to assist those not qualifying for subsidies by providing state-based premium assistance	CO	Introduced in 2017. HB 1235	Did not pass	Yes	State	Could promote healthier risk pool by encouraging more and diverse individuals to purchase in the	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
Legislation introduced to authorize Insurance Commission to develop a high-risk health care coverage program for persons with high-cost medical conditions to reduce health care premiums.	CO	SB300	Passed	Yes	State	Could divert risk from individual market, provide better coverage for individuals with chronic, expensive conditions.	<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
<b>Plan Design Flexibility:</b>							
Lower premiums through credits for healthy behavior or other health-related factors	ND	Considering a state-based plan initiative that would allow insurance carriers to offer plans, outside of the existing ACA exchange, that would be more flexible in how those plans are underwritten and designed that would potentially allow for credits for healthy behavior or other health-related factors. Plan to analyze Idaho's state-based plan initiative to see how a similar state-based plan allowance could operate in North Dakota. State's insurance department to study options for market stabilization with a report due state legislature by September 1.		Yes	Federal	Could promote healthier risk pool by encouraging more and diverse individuals to purchase in the marketplace.	<a href="https://www.healthinsurance.org/north-dakota-state-health-insurance-exchange/">https://www.healthinsurance.org/north-dakota-state-health-insurance-exchange/</a>
Introduced bill implementing recommendations from the House Rural Development Council relating to health care issues.	GA	HB221 - includes provisions to revise provisions relative to pharmacy practices; to provide for and revise definitions; to revise provisions relative to credentialing and billing; to provide for the establishment of the Rural Center for Health Care Innovation and Sustainability; to revise provisions relative to certificate of need; to provide for the establishment of micro-hospitals; to provide for a grant program for insurance premium assistance for physicians practicing in medically underserved rural areas of the state.	Passed	No	Federal		<a href="https://www.healthinsurance.org/">https://www.healthinsurance.org/</a>
EHB Benchmark Revisions	IL	Revised EHB benchmark to help address the opioid crisis and improve access to mental health and substance abuse resources for plan year 2020 by including required medications in the drug formulary and adding a telepsychiatry benefit.	Approved	Yes	Federal	Could promote healthier risk pool by treating substance use disorders effectively.	<a href="https://www.cms.gov/ccio/resources/data-resources/ehb.html">https://www.cms.gov/ccio/resources/data-resources/ehb.html</a>
<b>Increased Rate Accountability:</b>							
Rate Review Enhancement: Carriers must demonstrate improvements to affordability, quality of care and access	RI	Regulations prescribe that insurers must increase primary care investments (without increasing premiums); carriers prohibited from granting hospitals an annual contractual price increase that exceeds a cap and must tie half the rate increase to quality performance.		Yes	State	Could advance the quality of care and promote better care for higher value. Could	RWJF "Pushing the Envelope: State Insurance Regulator Authority to Address Healthcare Affordability
<b>Short-Term Limited Duration Plan Options:</b>							

## Individual Market Stabilization Efforts

Effort	State	Details	Status/Results (if available)/ Comments	Expanded Medicaid	Federal or State Based Exchange	IMPACT	Source
Limit short-term, limited-duration plans to 3 months, prohibit renewals, require enhanced disclosure	WA	Limit STLD coverage to 3 months during any 12-month period. Must ask consumers whether they can buy Marketplace coverage. Limits must be no less than \$1m. Pre-ex lookback cannot exceed 2 years. Coinsurance cannot exceed 50%. Carriers offering the plans must offer at least one plan with a max \$2,000 deductible.		Yes	State		Best's news service 8/28/18
Statewide ban on short-term limited-duration plans	CA			Yes	State		Best's news service 8/22/18
Legislation to limit STLD plans to 6 months	IL	Includes a 60-day period between policy expiration and the next policy.	Governor vetoed	Yes	Federal		Best's news service 8/22/18
Encourage STLD plans as an option for consumers to consider	AL	Providing consumer information and meeting with agent associations		No	Federal		Alabama Commissioner
Require short-term policies to meet a minimum medical loss ratio.		Current minimum loss ratio for these plans in VA is based upon their renewability provisions and is basically around 60%. The minimum loss ratio of individual coverage is 75%, suggesting the short term line is more profitable than the individual market. Imposing a higher medical loss ratio for short-term coverage could help level the playing field, increase the value of these policies for consumers, and decrease the incentive to sell.					Georgetown University Health Policy Institute Center on Health Insurance Reforms. Dec 17.
Assess insurers that offer short-term coverage and reinvest the funds in a reinsurance program for the individual market		Assessment could apply to insurers that offer short-term coverage and be reinvested in the individual market for reinsurance.					Georgetown University Health Policy Institute Center on Health Insurance Reforms. Dec 17.
Require completion of an ACA marketplace eligibility determination before allowing enrollment in short-term coverage.		The consumer would attest that they received a marketplace eligibility determination and do not qualify for subsidies or Medicaid. This requirement could help ensure that consumers better understand their coverage options and the availability of subsidies for ACA-compliant coverage.					Georgetown University Health Policy Institute Center on Health Insurance Reforms.
Track enrollment in short-term policy coverage.		This could help ensure that these policies meet applicable state requirements and provide information to regulators on what is being marketed in their state.					Georgetown University Health Policy Institute Center on Health Insurance Reforms. Dec 17.
<b>Potential Individual Market Destabilizers:</b>		Association Health Plans; Short-term limited duration plans; transitional policies (grandmothered plans); Health Care Sharing Ministries; Discount Cards; Primary Care Agreements/Concierge Agreements; Bundled non-ACA coverage					
<b>Provisions the Secretary may waive:</b>		<ul style="list-style-type: none"> <li>Definition of qualified health plan</li> <li>Essential health benefits requirement</li> <li>Annual limitation on cost-sharing</li> <li>Levels of coverage (e.g., silver, bronze)</li> <li>Abortion coverage limitations</li> <li>Open enrollment periods</li> <li>Single risk pools</li> <li>Federal regulations pertaining to enrollment by agents or brokers</li> <li>Exclusion from exchanges of incarcerated persons and those not lawfully present in the United States</li> </ul>					

# 2019 Individual Market – Number of Carriers by County or Independent City



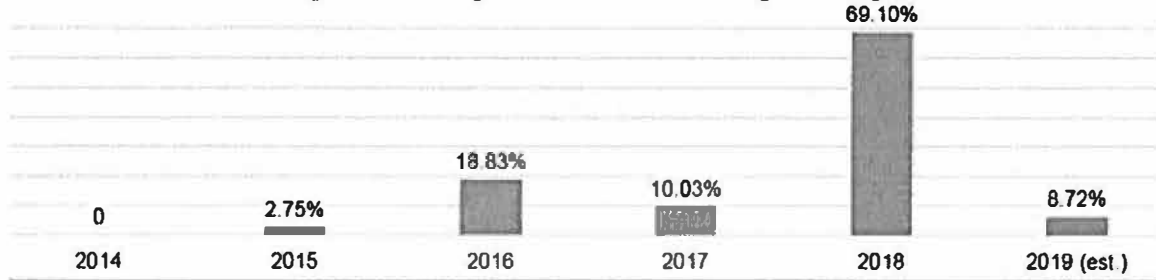
This map depicts the number of carriers operating in any part of a county. Some carriers operate in portions of certain counties. Therefore, not all individuals will be eligible to obtain coverage from the number of carriers shown in every county. However, individual health insurance coverage is available in all areas of Virginia.



### Individual Market – Total Weighted Average Premium



### Total Weighted Average Premium Percentage Change Over Prior Year



Percentage Increase of weighted average premium – Individual market from 2014 to 2019: 147%.