HEALTH INSURANCE REFORM COMMISSION

EXECUTIVE SUMMARY OF 2019 INTERIM ACTIVITY AND WORK

January 2020

I. BACKGROUND

Chapter 53 (§ 30-339 et seq.) of Title 30 of the Code of Virginia charges the Health Insurance Reform Commission (HIRC) with:

- Monitoring the work of appropriate federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (the ACA), including amendments thereto and regulations promulgated thereunder;
- Assessing the implications of the ACA's implementation on residents of the Commonwealth, businesses operating within the Commonwealth, and the general fund of the Commonwealth;
- Considering the development of a comprehensive strategy for implementing health reform in Virginia;
- Recommending health benefits required to be included within the scope of the essential health benefits (EHBs) provided under health insurance products offered in the Commonwealth, including any benefits that are not required to be provided by the terms of the ACA;
- Assessing proposed mandated benefits and providers and recommending whether, on the basis of such assessments, mandated benefits and providers are providers under health care plans offered through a health benefit exchange, outside a health benefit exchange, neither, or both;
- Conducting other studies of mandated benefits and provider issues as requested by the General Assembly; and
- Developing such recommendations as may be appropriate for legislative and administrative consideration in order to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

The HIRC is chaired by Delegate Kathy Byron (the Chair). Senator Ryan McDougle serves as the HIRC's vice-chairman. The other members of the HIRC are Delegates Lee Ware, David Yancey, and Eileen Filler-Corn and Senators Rosalyn Dance, Richard Saslaw, and William Stanley. Commissioner of Insurance Scott White and Commissioner of Health and Human Resources Daniel Carey serve as ex officio nonvoting members.

The HIRC met three times during the 2019 interim, on May 6, 2019, September 17, 2019, and January 2, 2020.

This executive summary of the interim activity and work of the HIRC is submitted pursuant to § 30-345 of the Code of Virginia.

II. ISSUES ADDRESSED

A. Legislation Referred for Study

When a bill seeking to establish a new mandate for coverage of a health benefit or provider is referred to the HIRC by the chairman of the House Committee on Labor and Commerce or the Senate Committee on Commerce and Labor, the Bureau of Insurance (BOI) is directed to conduct a Step I Assessment of the measure. A Step I Assessment considers the extent to which a proposed mandated health insurance benefit is currently available from qualified health plans in Virginia and whether the proposed mandate exceeds the scope of the EHBs. The issue of whether a mandated benefit exceeds the scope of the ACA's EHBs is of critical importance because if a state enacts a new mandate that exceeds the scope of the EHBs, the ACA requires the state to reimburse the federal government for the resulting incremental increase in the cost of subsidies provided for coverage provided through the exchange.

After the Step I Assessment is presented, the HIRC determines if further assessment of a proposed mandate is warranted. If it does, the Joint Legislative Audit and Review Commission (JLARC) and the BOI perform a Step II Assessment, which requires an analysis of the proposal's impact on services, providers, and the total cost of health care in the Commonwealth.

Ten bills were referred to the HIRC during the 2019 Session of the General Assembly. The HIRC took the following actions with respect to these bills:

1. Senate Bill 1010 was introduced by Senator Richard Black. The bill would have required coverage for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment. The BOI conducted a Step I Assessment of the bill and reported that, pursuant to guidance from the federal Centers for Medicare & Medicaid Services (CMS), state mandates related to the coverage of specific drugs that goes beyond the number of drugs offered in the benchmark plan does not exceed the EHBs. As a result, enactment of this mandate would not require the Commonwealth to defray the cost.

   The HHIRC did not request the preparation of a Step II Assessment on this bill. Per Virginia Code § 30-343, the HIRC has 24 months to complete and submit its assessment legislation proposing a mandate. The HIRC took no further action with respect to Senate Bill 1010.

2. Senate Bill 1362 was introduced by former Senator Frank Wagner. The bill would have prohibited an out-of-network provider from balance billing a covered person for the costs of an ancillary service when an in-network provider referred the covered person to the out-of-network provider. Because the legislation did not seek to mandate health insurance coverage for a benefit or provider, a Step I Assessment was not conducted. The HIRC made no recommendation with respect to Senate Bill 1362, though it did receive reports regarding the issue of surprise balance billing at each of its three meetings.

3. Senate Bill 1624 was introduced by Senator George Barker and House Bill 2598 was introduced by Delegate Cliff Hayes. These identical bills would have required that if a health benefit plan that covers services that a registered surgical assistant may legally perform, equal coverage must be provided for such services when rendered by a registered surgical assistant. The BOI's Step I Assessments of these bills noted that, according to

available information from carriers surveyed by the Virginia Association of Health Plans, the services of surgical assistants are generally included in the reimbursement to the supervising physician. One carrier indicated that surgical assistants are reimbursed for covered services, and another carrier reimburses surgical assistants only for certain procedures. As the bills involve a mandated provider, a determination of whether they would create a new mandated benefit that exceeds the EHBs was not applicable. The HIRC did not request the preparation of a Step II Assessment on these bills.

4. Senate Bill 1650 was introduced by Senator Janet Howell and House Bill 2049 was introduced by Delegate Jennifer Carroll-Foy. These identical bills would have required coverage for expenses incurred in the provision of pasteurized donated human breast milk. The BOI characterized this mandate as a new benefit exceeding the EHBs and as a result the Commonwealth could be required to reimburse the federal government for associated costs. The HIRC did not request the preparation of a Step II Assessment on these bills.

5. House Bill 2177 was introduced by Delegate Kathleen Murphy. The bill would have required health benefit plans to provide coverage for medically necessary formula and enteral nutrition products. The Virginia EHB Benchmark Plan, Anthem Premier Direct Access, covers infusion services, including enteral nutrition therapy, and infusion of special medical formulas as the primary source of nutrition for persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies when prescribed by a physician. House Bill 2177 differs from the existing EHB requirement primarily in that House Bill 2177 does not limit the mandate for formula and enteral nutrition products to persons with inborn areas of metabolism. The BOI characterized this bill as an extension of an existing EHB rather than as a new benefit for which the Commonwealth would be required to defray the cost.

   At the HIRC's September 17, 2019, meeting, the members adopted a motion requesting the BOI and JLARC to conduct a Step II Assessment of House Bill 2177. Van Tompkins, Policy Advisor at the BOI, and Jeffrey Lunardi, Unit Director at JLARC, presented their reports at the January 2, 2020, meeting. The Step II Assessment revealed that:

   - An estimated 33 infants are born each year in the Commonwealth with an inherited metabolic disorder (IMD) that prevents the individual from absorbing full nutrition from normal foods.
   - Formulas and enteral nutrition are the primary treatment methods for many IMDs where the body cannot metabolize or process certain nutrients found in normal food. These products are also sometimes used to treat gastrointestinal disorders, food hypersensitivities, and the inability to consume food orally.
   - If left untreated, IMDs can cause intellectual disabilities for children and also cause seizures, metabolic crises, and possibly death throughout all stages of life, depending on the specific diagnosis.
   - At least 36 other states mandate at least some coverage some coverage of formulas or enteral nutrition. The other states' mandates specify a disease or disorder, such as an IMD or phenylketonuria (PKU), for which the product is provided.
   - If it was to be enacted, HB 2177 would be the only bill mandating coverage for formulas or enteral nutrition without specifying the covered disease or disorder.

- The cost of formulas and enteral nutrition for adults with IMDs typically ranges from a low of between $300 and $500 per month to a high of between $2,000 and $2,200 per month, depending on the amount and specific formula or enteral nutrition required.
- The cost per member per month for benefits provided by HB 2177 would be approximately 11.5 cents.

JLARC's portion of the Step II Assessment identified three policy options that the General Assembly could consider on HB 2177: Taking no action; passing the bill as is; or amending it to specify certain conditions with strong evidence of effectiveness, such as IMDs, for which the provision of formula and enteral nutrition products would be covered.

Lacking a quorum, the HIRC took no formal action on the Step II Assessment of HB 2177. However, there was a consensus among the members present that Mr. Lunardi's third option was the best of the three.

6. House Bill 2601 was introduced by Delegate Kenneth Plum. The bill would have required health benefit plans to provide coverage for the billed charges of one hearing aid per hearing-impaired ear in an amount not to exceed $3,000 per hearing aid for minors. Coverage for hearing aids is specifically excluded from the current benchmark plan. The BOI characterized this mandate as a new benefit exceeding the EHBs, and as a result the Commonwealth could be required to reimburse the federal government for associated costs.

   Ms. Tompkins also noted that the bill purports to exempt plans offered through the exchange from the coverage requirements to the extent that it would require benefits that exceed the EHBs while continuing to apply the requirements to plans offered outside the exchange. The ACA provides that state standards or requirements implementing, or related to, standards or requirements in Title I of the ACA must be applied uniformly to all health plans in each insurance market to which the standard and requirement apply. Therefore, this element of the bill appears to be inconsistent with the ACA. The HIRC did not request the preparation of a Step II Assessment of this bill.

7. House Bill 2669 was introduced by Delegate Danica Roem. The bill would have required health benefit plans to provide coverage for medically necessary prosthetic devices and their repair, fitting, replacement, and components. Because Virginia currently requires carriers to offer coverage for prosthetic devices, the BOI characterized this bill as an extension of an existing EHB rather than as a new benefit for which the Commonwealth would be required to defray the cost. The HIRC did not request the preparation of a Step II Assessment of this bill.

8. House Bill 2710 was introduced by Delegate Jeffrey Campbell. The bill would have provided for direct reimbursement by a health plan to a law-enforcement agency that provides transportation to a covered person subject to an emergency custody order or a temporary detention order, if the health plan provides coverage for such transportation. As it involves a mandated provider, a determination of whether the bill would create a new mandated benefit that exceeds the EHBs was not applicable. The BOI's Step I Assessment reported that a survey of carriers performed by the Virginia Association of Health Plans indicates that no carrier provides coverage for law-enforcement officers transporting a covered person subject to an emergency custody order or a temporary detention order.

Some carriers surveyed cover transportation in a licensed ambulance staffed by trained professionals providing clinical services primarily for emergencies. The HIRC did not request the preparation of a Step II Assessment of this bill.

B. Other Health Insurance Legislation from the 2019 Session

At the May 6, 2019, meeting, staff provided the members of the Commission with an overview of additional health insurance legislation from the 2019 Session that was not subject to a Step 1 Assessment by the Bureau of Insurance. Staff reported that the relevant stakeholders were not able to reach a consensus as to how the issue of balance billing in emergency service visits could be resolved going into Session, so numerous approaches were offered and ultimately failed. One bill addressing balance billing with regard to ancillary services, Delegate Ware's House Bill 2538, passed; it requires notice by a facility that some services may be provided by an out-of-network provider and that those services will be billed separately from the facility's charge. Additionally, seven bills relating to health insurance were vetoed by the Governor. The issues vetoed included benefits consortiums, also sometimes referred to as association health plans; short-term, limited-duration health plans; and catastrophic health plans.

C. State of the Commonwealth's Insurance Marketplace

Julie Blauvelt, Deputy Commissioner of the Life and Health Division at the BOI, provided the HIRC at its May 6 meeting with information on health care coverage in Virginia, premium rates over time in the individual and small group markets, carrier participation, and the effects of various options on the individual market. Highlights of her presentation included:

- A snapshot of Virginians' care coverage in 2018 shows that employer-sponsored plans cover more than half of Virginians, with the majority of these plans (3 million lives; 35 percent of the total) covered by self-funded, employer-sponsored coverage.
- The other major sources of health care coverage in 2018, with the corresponding percentage of covered Virginians, in declining order are large employer insurance plans (14 percent); Medicare (14 percent); Medicaid, including the Children's Health Insurance Program, and excluding those made eligible for coverage by Medicaid expansion (12 percent); other public programs (seven percent); small employer insurance plans (four percent); and individual insurance plans (four percent).
- Ten percent of Virginians were determined to be uninsured in 2018.
- Between 2008 and 2018, the percentage of Virginians with employer-sponsored coverage (ERISA plans, large employer plans, and small employer plans) declined from 59 percent to 53 percent.
- The percentage of uninsured Virginians, which ranged between 12 and 13 percent from 2008 through 2013, has hovered within a range of nine percent to 10 percent from 2014 through 2018.
- Coverage through health care policies sold in the individual market over the period that the ACA-created health benefit exchange has been operational in the Commonwealth jumped from 416,161 in 2014 to 494,086 in 2015, but since then has declined as premiums have increased, with enrollment for 2019 projected to be 293,100.

- An actuarial study estimates that between 44,300 and 70,400 individuals will move from the individual market to Medicaid over the next one to three years.
- The anticipated decline between 2015 and 2019 of over 200,000 in the number of Virginians covered through individual health plans may be attributed to the increasing cost of individual coverage on the ACA market, where the weighted average premium for such plans increased from $322 per month in 2014 to $732 in 2018.
- The number of carriers offering coverage on the exchange and outside the exchange dropped from 14 in 2017 to eight in 2018, and for 2019 that number increased by one. Another carrier is projected to start offering coverage on the exchange in 2020.
- Forty-eight percent of Virginia's localities have one carrier offering plans in the individual market; 42 percent of localities have two carriers; five percent of localities have three carriers; and five percent of localities, all of which are in or adjacent to Fairfax County, have four carriers.

D. Balance Billing Issues

Ms. Blauvelt reported that on June 9, 2019, the State Corporation Commission (SCC) issued proposed rules governing balance billing for elective health care services. The requirements of the proposed regulations are intended to supplement, and not replace, the requirements of § 38.2-3445.1 of the Code of Virginia, which were enacted in the 2019 Session of the General Assembly pursuant to House Bill 2538. The proposed rules are intended to address the aspect of surprise balance billing that occurs when elective services are received from a non-participating provider at an inpatient or outpatient in-network facility without the patient's knowledge that a non-participating provider will be providing services at the in-network facility. In these situations, the health plan makes some payment for the service provided by the non-participating provider, but the patient is billed for the balance of the non-participating provider's charges, in addition to the patient's required deductible, co-payment, or other cost-sharing obligation.

The proposed rules attempt to help increase the potential that consumers are made aware of a possible surprise balance billing situation by enhancing the notice to be provided to the patient in the situation the General Assembly addressed in House Bill 2538. The SCC conducted a hearing on the proposed rules on September 12, 2019, and has received comments addressing legal issues. The proposed rules currently are under consideration by the SCC.

Ms. Blauvelt updated the HIRC at both its September 2019 and January 2020 meetings on the efforts of the balance billing work group established pursuant to Item 281 F of the 2019 Appropriations Act. The item directs the Secretary of Health and Human Resources, in collaboration with the Secretary of Administration, Secretary of Finance, and SCC, to convene a work group to evaluate options to prohibit the practice of balance billing by out-of-network health care providers for emergency services rendered, and to establish equitable and fair reimbursement for these health care providers. The work group is directed to report on the fiscal impact of each option considered and the impact on provider networks and to include recommendations for future legislation.

Ms. Blauvelt reported at the January 2, 2020, meeting that the BOI commissioned the Oliver Wyman consulting firm to produce a study focused on emergency balance billing. The study examined four proposals. The first is the current payment requirement, which requires payment to out-of-network providers of emergency services to be the greatest of three factors: the

median in-network amount statewide; the usual, customary and reasonable amount; or the Medicare payment. The second is the approach taken in House Bill 1714 (2019), which would have required fair market value and regional average for commercial payments to be added to as a fourth payment standard. The third is the approach taken in House Bill 2544 (2019), which would have revised the first factor of the existing three-factor test from a statewide median in-network standard to a regional average in-network standard. The fourth proposal is to require payments equal to 200 percent of the Medicare fee schedule amount.

The final report of the balance billing work group had not been released by the time the HIRC completed its work in the 2019 interim.

Jeanette Thornton, Senior Vice President, America's Health Insurance Plans (AHIP), reported that the prospects for the enactment of federal legislation addressing surprise balance billing are uncertain. She noted that popular support exists for such legislation, in part due to the fact that surprise balance billing affects at least one in five Americans annually. Per Ms. Thornton, surprise balance billing is a concentrated problem among certain medical specialties and in states where freestanding emergency departments and provider consolidation have become common. Ms. Thornton reported that at least 21 states have acted to reduce surprise balance billing, with varying success. She noted that state laws do not apply to the more than 100 million Americans who have health coverage through their employer's self-funded plans, which are not subject to state oversight pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA). Another issue that states are currently preempted from addressing is air ambulance services.

AHIP advocates a solution that bans balance billing in situations where patients are involuntarily treated by an out-of-network provider in emergency situations, when services are provided by an out-of-network doctor at in-network facility, and for ambulance transportation. A solution should also provide that patients are held harmless for liability in such situations. Ms. Thornton recommended that health carriers be required to reimburse non-participating providers based on local market rates negotiated by other doctors in the area. This solution, she suggested, would not raise health care costs and would maintain robust health insurance networks. She was critical of proposed solutions that would establish an arbitration process that increases costs for patients, businesses, and taxpayers. She was particularly critical of private equity firms that have established emergency room physician practices that contract to provide staffing at hospitals without participating in the hospital's health insurance networks. These firms have aired advertisements aimed at stopping a federal solution to balance billing, which, according to Ms. Thornton, have been found to be false.

E. Charity Care Data Collection Efforts

The second enactment of House Bill 2101 of the 2017 Session, which was patroned by the Chair, directs the Commissioner of Health to prepare an analysis of charity care that each medical care facility provided to indigent persons. In 2018, Erik Bodin, Director of the Certificate of Public Need program in the Virginia Department of Health (VDH), reported on the status of data collection efforts, the analysis methodologies, and the timetable for completing the report. He updated his report on the charity care data collection efforts at the HIRC's September 17, 2019, meeting. Mr. Bodin's presentation focused on the shift in the method by which the value of charity care is measured. Previously, charity care had been valued at the provider's chargemaster. Under

the new methodology, the value of charity care provided is required to be reported on the basis of Medicaid reimbursement rates.

The Virginia Health Information (VHI) is collecting the annual charity care reports under the new requirements. Facilities are required to file charity care reports with VHI within 90 days from the end of the facility's fiscal year. VHI is actively collecting reports from the facilities that have certificates of public need issued on the condition of the provision of charity care for fiscal years that ended in calendar year 2018, while the requirement for collection from facilities that do not have conditioned certificates of public need became effective on July 1, 2019. To date, 96 percent of hospitals and about 40 percent of outpatient providers have completed their reports. Conditions for the provision of indigent care on certificates of public need (COPN) are now written to reflect the new valuation of charity care based on Medicare reimbursement rates. With respect to certificates issued prior to effective date of the new requirements, certificate holders may request changes to the rate. Section 32.1-102.4 of the Code of Virginia requires a review of conditions every three years. However, new conditions may be applied subject to consent of the applicant or certificate holder.

F. Rates and Policies on the Exchange for 2020

At the September 17, 2019, meeting Toni Janoski, Policy Advisor, Policy, Compliance & Administration Division at the BOI, reported that final rates for health plans in the individual and small group markets to be offered in 2020 have been finalized. For 2020, the average per member per month rate for individual policies sold on and off the Exchange will be $743.58. While this represents a decrease of approximately $53 per month from the 2019 average of $796.29, the 2020 average rate will be the second-highest since Virginia began participating in the Exchange in 2014. The BOI projects that individual on-Exchange and off-Exchange total enrollment for 2020 will be 303,225, which is an increase of about 3,000 over the corresponding figure for 2019, but nearly 115,000 fewer than the peak reached in 2016.

Ms. Janoski reported that the number of carriers operating in the individual market in 2020 has increased, with two new carriers entering the market. Two or more carriers will be operating in 58 percent of Virginia localities in 2020. Average rates in the small group market for 2020 have increased by 2.1 percent, compared to 2019 rates, to $539.83. The change was attributed to favorable claims experience, the medical cost trend holding steady, and the movement of the "super small" groups into the small group market, which is putting upward pressure on rates due to projections of a higher morbidity rate in this population. The number of persons obtaining coverage through the small group market is more stable than the individual market, with the number for 2020 projected to be 363,516.

Senator McDougle observed that when the number of insured persons in the individual and small group markets is aggregated, the data show a drop from over 811,000 in 2015 to a projected number of over 666,000 in 2020. The drop was attributed to several factors, including increased premiums in the individual market, persons switching to Medicaid or large group coverage, and persons aging into Medicare eligibility.

G. Mandated Benefits in Virginia

Donald Beatty, Deputy Commissioner, Policy, Compliance & Administration at the BOI, reported at the September 17, 2019, meeting on health benefit mandates. One source of mandates is the federal ACA, which requires fully insured small employer group plans and individual health

plans, and to some extent self-funded and fully insured employer health plans, to provide 10 categories of EHBs. Rather than specify what specific benefits fall into the 10 EHBs, the federal government allows states to identify a benchmark plan being offered in the state that covers the 10 categories, with the specifically required benefits being those provided under that benchmark plan. Virginia chose the most popular plan offered in the small group market as its benchmark plan. By incorporating the benefits provided under an existing state-approved plan, all state-mandated benefits are included in the EHBs. Virginia's benchmark plan includes benefits that were not previously required by ERISA or state mandates.

Comparing the number of state-mandated health insurance benefits may be problematic because a state may require coverage of a benefit thorough a mechanism other than enacting legislation. Nevertheless, one study noted that, in 2009, Virginia, with 34 mandates, ranked seventh among states in number of mandates. The study found that Rhode Island had the most mandates (44) and Idaho had the fewest (six). The average number of mandates across all states was 40. Given that all states are required to ensure that health plans cover all 10 EHB categories, states are fairly aligned as to what is required of plans sold in the individual and small group markets related to EHBs. The average annual claim cost per contract of the mandated benefits was reported to be $747 for individual contracts and almost $1,238 for group contracts.

Mr. Beatty reported that federal law establishes a procedure by which a state may revise its EHB benchmark upon obtaining a waiver under § 1332 of the ACA. A proposed new EHB benchmark is required to (i) be an EHB benchmark used by another state, (ii) replace a category of EHBs from the state's existing benchmark with a category used by another state's benchmark, or (iii) choose its own set of EHBs within parameters that include providing a scope of benefits at least as great as a typical employer plan.

H. Recommend Health Insurance Reforms

James C. Sherlock, Captain, U.S. Navy (Ret.), closed the September 17, 2019, meeting with a presentation of his recommendations to reform the health insurance system. Four of the recommendations address the system for issuance of COPN. First, he recommended exempting physician-owned surgical centers (POSCs) from the COPN process, as has been done in Maryland. Second, he suggested Virginia follow Maryland in exempting rural hospitals from COPN requirements when converting existing inpatient facilities to ambulatory and emergency facilities. Third, he said to follow Maryland's lead and establish health enterprise zones (HEZs) in the state's poorest regions. In these HEZs, ambulatory surgical centers, imagery centers, and equipment purchases for health care delivery facilities would be exempt from COPN requirements.

Captain Sherlock's fourth COPN recommendation, for which Maryland has not established a precedent, is to move COPN administration from VDH to the SCC. This move would, it was argued, unite oversight of health insurance and the business of health care. In addition, he suggested that the SCC is more capable of overseeing the business of health care than VDH. Captain Sherlock also recommended banning provider systems from ownership or control of HMOs and health insurers. He also cited the woeful financial condition of many rural hospitals and asserted that the general hospital business model is unsustainable in rural locations.

I. Effects of Proposed Reinsurance Program and State Exchange on Virginia's Insurance Market

Mr. Beatty of the BOI and Doug Gray of the Virginia Association of Health Plans provided testimony at the January 2, 2020, meeting on two proposals that have been identified as possible

gubernatorial initiatives for the 2020 Session: a reinsurance program for policies sold on the health marketplace and the establishment of a state-run health marketplace.

Currently, Virginia participates in the federal marketplace through the HealthCare.gov website. Mr. Beatty noted that Governor Ralph Northam's proposed budget for the 2020-2022 biennium at Item 487 provides $13.5 million in the first year and $41.5 million in the second year for the creation of a state health benefit exchange within the SCC. The Commonwealth would be required to obtain approval from CMS prior to enrolling persons through the state exchange. Advocates of a state-run exchange anticipate that it could be run at a lower cost than is currently charged by the federal government for state participation in the federal exchange while giving the Commonwealth more flexibility in the exchange's operations.

Currently Virginia's health carriers pay to the federal government an assessment of three percent of premiums earned for participation the federal exchange. The assessments for the individual and small group markets were estimated to be $130 million in 2022. For the individual market only, the 2022 revenue estimate would be $54 million.

Mr. Gray cited the experience of Nevada as a recent case where a state has moved from the federal exchange to a state-run exchange. Rather than setting up the exchange from scratch, contractors are offering states the option of purchasing their services as a package. He observed that increases in premiums in the individual market in recent years have resulted in a situation where most people buying individual policies on the exchange are either receiving federal subsidies or have such serious medical conditions that the high costs of coverage are not a deterrent. Mr. Gray proposed that if Virginia creates a state-run exchange that it adopt a competitive and open exchange model where carriers are able to participate, and that it adopt minimum plan standards with benefit design flexibility. The steps, he asserted, would increase plan participation and provide more choices. He favored the location of a state-run exchange within the SCC and recommended that the Commissioner of Insurance be given final regulatory authority. Savings from a state-run exchange could be used to establish a reinsurance program, create a state-funded premium discount program for persons buying coverage on the individual market without a federal subsidy, and increase enrollment outreach and support efforts.

The establishment of a reinsurance program, which would require CMS approval of a waiver under § 1332 of the ACA, posits that a reinsurance program would reduce the cost of premiums on policies sold on the exchange. This, in turn, would save the federal government money by reducing the cost it pays for premiums to subsidize premiums on the exchange. If a § 1332 waiver was granted, the federal government would return these savings to the Commonwealth to be used to fund a portion of the cost of the reinsurance program.

III. CONCLUSION

The HIRC appreciates the efforts of everyone who contributed to its work in 2019 and looks forward to working with interested persons as it continues to examine issues concerning the Commonwealth's health insurance market.

Materials provided by speakers at the HIRC's meetings in 2019 may be found on the HIRC's website at http://dls.virginia.gov/commissions/hir.htm?x=mtg.