COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

December 9, 2020

To: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Jeion Ward
Chairwoman, House Labor and Commerce Committee

The Honorable Richard Saslaw
Chairman, Senate Commerce and Labor Committee

The Honorable Luke Torian
Chairman, House Appropriations Committee

The Honorable Janet Howell
Chairwoman, Senate Finance Committee

RE: Virginia Market Stability Work Group Report

Dear Governor Northam, Chairwoman Ward, Chairman Saslaw, Chairwoman Howell, and Chairman Torian,

The attached report of the Virginia Market Stability and Reinsurance Work Group is submitted pursuant to Chapter 1289, Acts of Assembly, Item 291 D.

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

Sincerely,

Daniel Carey, MD, MHCM

DC/hm

Report of the Virginia Market Stability and Reinsurance Work Group

To the Governor and Chairmen of the

House Labor and Commerce

Senate Commerce and Labor

House Appropriations

and

Senate Finance and Appropriations Committees

December 9, 2020

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Executive Summary

The purpose of this report is to provide an overview of recent trends in Virginia's individual and small group markets and present findings and recommendations of the 2020 Virginia Market Stability Work Group (Work Group) to stabilize Virginia's commercial insurance markets. Building on recommendations of the 2019 Work Group, priorities included: (1) increasing the availability of quality, affordable, and comprehensive health care coverage for Virginians; (2) establishing a reinsurance program to reduce the cost of health care; and (3) ensuring policy recommendations strengthen and protect the Patient Protection and Affordable Care Act (ACA) market.

The Secretary of Health and Human Resources (HHR) established the Work Group pursuant to two directives resulting from the 2020 General Assembly Session.

1. The 2020 Appropriations Act, Item 291D, which states:

   D.1. The Secretary of Health and Human Resources shall develop a state innovation waiver under Section 1332 of the federal Patient Protection and Affordable Care Act (42 U.S.C. 18052) to implement a state reinsurance program to help stabilize the individual insurance market by reducing individual insurance premiums and out-of-pocket costs while preserving access to health insurance. The Secretary shall convene stakeholders to include representatives of health insurers, the State Corporation Commission (SCC) Bureau of Insurance (BOI), consumer advocates, and others deemed necessary to assist in developing the reinsurance program.

   2. The State Corporation Commission Bureau of Insurance shall provide technical assistance to the Secretary of Health and Human Resources as requested.

   3. The Secretary shall report on the reinsurance program to the Chairs of House Labor and Commerce and Senate Commerce and Labor Committees and the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2020. Such report shall include an analysis of the costs and assumptions of such a reinsurance program and potential options to fund the non-federal share of costs. In addition, the report shall include suggested legislation to implement the program. Implementation of the reinsurance program shall be subject to appropriation of the non-federal share of costs by the General Assembly and approval by the United States Secretary of Health and Human Services.

2. Governor Northam's veto language for 1) Senate Bill 235 and House Bill 795, which would have codified the U.S. Department of Labor federal rule that expands the availability of Association Health Plans (AHPs) beyond what is currently allowed in Virginia, and under the more lenient regulatory standards of large group employers (over 50 employees), including less consumer protection than is provided by the Affordable Care Act;, and 2) Senate Bill 861, which would have expanded Virginia's Multiple Employer Welfare Arrangements (MEWAs) to allow small employers, to join together as a single self-funded group. Although different fundamentally, the Administration believes that these bills would undermine the Commonwealth's new investments in the

Health Benefit Exchange, and pose a potential threat to destabilize the individual and small group markets. The veto language for SB 235/HB 795 and SB 861 states:

Pursuant to Article V, Section 6, of the Constitution of Virginia, I veto Senate Bill 235. This legislation allows associations with more than 50 members to offer association health plans (AHPs) to members. The legislation also expands the availability of and the rules regulating AHPs beyond what is currently allowed in Virginia.

I am concerned that Senate Bill 235 addressed the health care concerns of only a segment of Virginians, possibly at the cost of other Virginians. This bill would undermine current efforts to stabilize the Virginia health insurance marketplace. Virginians who enroll in AHPs may be disproportionately healthy when they enroll, leading to higher premiums for Virginians who do not qualify for an AHP and remain in the marketplace.

Virginia took a positive step to increase the availability of quality, affordable, and comprehensive health care coverage through Medicaid expansion. The Governor and General Assembly worked together to begin implementing a state based exchange and to lay out steps to create a reinsurance program. Our responsibility is to look at solutions like these to improve the quality and cost of health care for all Virginians, not pick winners and losers based on employment status. This is why I am directing the Secretary of Health and Human Resources to convene a workgroup in collaboration with the State Corporation Commission Bureau of Insurance to identify strategies to reduce the cost and improve the quality of health care coverage and increase the number of Virginians with comprehensive coverage. The workgroup will build off of the recommendations of the 2019 Market Stability Workgroup. We look forward to working together holistically to ensure all Virginians' have lower health care costs and ensure the overall market is at a minimum held harmless by future reforms. All Virginians have a right to quality, affordable, and comprehensive coverage.[1]

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

- Secretary of Health and Human Resources
- Commissioner of Insurance and other representatives of the BOI[2]
- Virginia Association of Health Plans
- Kaiser Permanente
- Medical Society of Virginia
- Virginia Hospital and Healthcare Association
- Virginia Chamber of Commerce
- Virginia Association of Realtors
- National Federation of Independent Business

[1] Virginia's Legislative Information System, 2020 Session, SB 235 Governor's Veto, https://lis.virginia.gov/cgi-bin/legp604.exe?201+amd+SB235AG accessed 11.12.2020.

[2] Non-voting representation, providing technical assistance only

- Virginia Poverty Law Center
- AARP Virginia
- Washington and Lee University
- Georgetown University Center on Health Insurance Reforms

Various representatives from related industries, including insurance carriers and physician member organizations, and members of the General Assembly, were also involved in the discussions.

The Work Group met seven times from August 5, 2020 to October 31, 2020. During the first four meetings, the Work Group examined Virginia's individual and small group markets, including current market trends, 2021 rate information, states' reinsurance programs through 1332 state innovation waivers, and additional approaches other states have taken to improve affordability and stabilize both the individual and small group markets. Experts from the State Corporation Commission Bureau of Insurance (BOI), National Governors Association, Georgetown University's Center on Health Insurance Reforms, and Manatt's State Health and Value Strategies, led these respective discussions. The final three meetings involved discussions of state options to stabilize Virginia's individual and small group markets, including advantages and considerations associated with each option, and how the approach could be operationalized.

From the aforementioned discussions, the Work Group viewed the following policy actions as most promising to stabilize Virginia's individual and small group markets:

Individual Market

1. Pursue a reinsurance program through a 1332 state innovation waiver (1332 waiver).
2. Direct the BOI to structure a state-based subsidies program that makes coverage more affordable.
3. Upon full transition to a state-based marketplace (SBM), the Health Benefit Exchange should establish standing extended open enrollment periods (OEPs) and special enrollment periods (SEPs) to maximize enrollment and to promote seamless coverage (e.g., to coincide with tax filing, and for emergency situations such as COVID-19).

Small Group Market

1. Pursue a reinsurance program to decrease premiums in the small group market.
2. Direct the Exchange, navigator programs, and benefit manager organizations to increase outreach and marketing to small businesses, providing education and technical assistance to small businesses regarding:
    a. Small-employer Health Options Program (SHOP) and small group opportunities, including the value of narrow networks, with employee choice.
    b. Education and technical assistance information about Health Reimbursement Accounts (HRAs) through Virginia benefit manager organizations, registered agents and brokers, and provide technical assistance to small employers and employees for using HRAs.
3. Direct the State Corporation Commission to pursue additional data collection pertaining to the small group market. Such data should include:

a. Self-funded plans, including, but not limited to obtaining: marketing and outreach strategies, the number of employers that have shifted to self-funded plans, claims profiles of self-insured small employers, relative to the fully-insured small group market.
b. Professional employer organizations (PEOs), and impacts on the small group market enrollment.

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

Introduction

In the months preceding the first year of the Patient Protection and Affordable Care Act (ACA) (2014) approximately forty-nine million U.S. citizens were uninsured, placing them at risk for poor health access and quality.

One of the primary aims of the ACA was to address significant health care coverage issues experienced by consumers in the health insurance market. To incentivize market participation and ensure a larger, more stable risk pool, the ACA featured a series of provisions to facilitate stabilization, such as temporary reinsurance and risk corridor programs, permanent risk adjustments, and financial penalties for both individuals and employers that did not participate. Four overarching goals are 1). To produce more affordable health coverage, 2) emphasize preventive care, shifting the balance of the healthcare system to health versus treatments, 3) improve health outcomes, and 4) reduce health care spending overall.

Virginia's ACA market enrollment reached its peak of 421,897 individuals in 2016[3], and the rate of uninsured had decreased by 27.9% from pre-ACA levels.[4] While the ACA achieved some of its intended policy goals, (no exclusions for pre-existing conditions, guaranteed issue, ending lifetime limits on coverage, allowing children to remain on their parent's insurance until age 26) recent federal actions have undermined key ACA provisions that protected both consumers and insurers.

Yet, since then, federal actions have aimed to dismantle the ACA. Policy changes, such as the elimination of reimbursement for ACA cost sharing reductions, the carrier risk corridor program, the individual mandate penalty, and funding for outreach and enrollment programs, provisions which made the marketplace a more attractive place for insurers to sell and more affordable for consumers to buy health insurance plans, have had a destructive effect. They have generated increased risk and lack of predictability for insurance carriers, resulting in significant volatility and destabilization of the individual and small group markets. As such, Virginia, like many states has seen large premium increases, declining insurer participation, and consequently, decreased enrollment. By 2018, costs of coverage in Virginia's individual market were 65% higher than they had been in the individual market 2014, and enrollment in the marketplace had declined by 35%.[5] Enrollment is expected to decline again in 2020, down approximately 30% since 2018. [6] In 2017, major carriers in Virginia announced they were leaving the individual market as a result of the instability caused by federal actions.[7] These factors have eroded the

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[3]University of Minnesota, The Affordable Care Act: What Are Its Goals and Do We Need It? http://www.epi.umn.edu/mch/wp-content/uploads/2013/09/ACA-Overview.pdf
http:// Health Insurance.org, Virginia health insurance marketplace: history and news of the state's exchange, 08/24/2020, https://www.healthinsurance.org/virginia-state-health-insurance-exchange/, accessed 10/02/2020

[4] United States Census Bureau, "Health Insurance Coverage in the United States: 2016", https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf, accessed 10/02/2020.

[5] Oliver Wyman Virginia-Individual Market Summary and Reinsurance Modeling Results, January 22, 2020.

[6]Oliver Wyman Virginia-Individual Market Summary and Reinsurance Modeling Results, September 28, 2020.

[7]Johnson, Carolyn, Washington Post, "Anthem to leave Virginia's Obamacare Marketplace Next Year", 8/11/2017. https://www.washingtonpost.com/news/wonk/wp/2017/08/11/anthem-to-leave-virginias-obamacare-marketplace-next-year/, accessed 10/21/2020.

positive impact that the ACA had on coverage gains and making comprehensive health insurance affordable to more Americans.

In the summer of 2018, the Secretary of Health and Human Resources convened a Market Stability Work Group to identify recommendations for Virginia to take action and begin to expand access to coverage and stabilize the individual market. Virginia then embarked on a series of reforms to begin the multi-year, multi-sector process of reducing costs, expanding access, and improving quality of coverage and healthcare for all Virginians.

Virginia's Progress in Market Stability

Virginia adopted Medicaid Expansion in 2019, and as of November 2020, has enrolled 485,599 newly eligible adults[8]. This provided life-saving health coverage to many individuals who had previously been uninsured.

In response to the instability created at the federal level, the 2020 Virginia General Assembly enacted legislation to take back control of its individual and small group marketplaces, by developing a Virginia state-based health benefit exchange (SB 732[9]). The state-based exchange will allow Virginia to own enrollment data and use demographic and enrollment information to target outreach efforts. States that have developed their own exchanges have increased and retained enrollment, and have been more successful at cost containment. The Virginia Health Benefit Exchange will also allow for unprecedented stakeholder input into the operations and direction of the Exchange, and therefore insurance market, by creating a 15 member advisory committee and requiring further consultation with stakeholder groups.

Since enactment, the SCC BOI has worked continuously to prepare the SCC and Virginia for the Exchange. In August this year, the SCC received approval from the Centers for Medicare and Medicaid Services (CMS) to move forward as a state-based marketplace operating on the federal platform (SBM-FP). They have established a Navigator Grant program and received approval from CMS on the outreach plan. Two Virginia organizations have received navigator grant funding to conduct robust outreach and enrollment activities this year in advance of open enrollment for plans effective in Plan Year 2021.

This year, the General Assembly also laid groundwork for a reinsurance program to protect insurance carriers from exorbitant claims costs and reduce premiums in the individual market. Reinsurance is successful in reducing premiums in all of the 14 states[10]that enacted programs and incentivized carrier participation in marketplaces.

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[8] Virginia Department of Medical Assistance Services, Expansion Dashboard, https://www.dmas.virginia.gov/#/dashboard. Accessed 11.12.2020.

[9] Virginia Legislative Information System, 2020 General Assembly Session Chapter 917, https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP0917, accessed 10/02/20.

[10] Giovannelli, Justin, et al. The Commonwealth Fund. "The Benefits and Limitations of State-Run Individual market Reinsurance", https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/benefits-limitations-state-run-individual-market-reinsurance, accessed 11.12.2020

Finally, the General Assembly passed (SB 404)[11], to insulate Virginia from federal rules that expand access to short-term limited duration plans (STLDs). These plans provide very limited benefits, are not considered health insurance, and are heavily marketed to younger, healthier people. They have a history of fraud and, with expanded terms, risk siphoning healthy risk outside of the individual marketplace. SB 404 places stronger regulation on STLDs, limiting them to no more than a three month period with one renewal, and bans the marketing and sale during open enrollment.

The first phase of Virginia's reforms made initial structural changes that solved for access for Virginia's most vulnerable and set a foundation for future stabilization reforms and sustainability. However, affordability of coverage (including premiums, deductibles, co-insurance, and other cost sharing) continues to contribute to a high rate of uninsured individuals and coverage that is cost-prohibitive for many.

This set the stage for the 2020 Market Stability Work Group to develop a plan, funding mechanism, and legislative language for a reinsurance program for the individual market, and evaluate options to continue stabilization, including costs of coverage.

The Secretary of Health and Human Resources convened the Work Group and explained the charge and the administrations three guiding principles for market stabilization. They are to:

1. Maximize access, affordability, and quality of coverage for all Virginians,
2. Preserve Affordable Care Act consumer protections, and
3. Further stabilize the individual and small group markets.

Virginia's Individual Market Update

The 2020 Work Group began with an update to develop a common understanding of the characteristics and drivers of the individual market in 2020. While the ACA was successful in reducing the numbers of the uninsured, in 2016 this number began a precipitous decline. The BOI, reports that enrollment in the individual market is the lowest it has been in 10 years. Individual market enrollees are typically those who do not have employer-sponsored insurance, are between jobs, or are impacted by marriage status or other life circumstances. The market is susceptible to churn because its consumers tend to experience fluctuations in income more frequently. Thus, there is greater movement between Medicaid and the individual market, and those that drop coverage.

The individual market is also more susceptible to adverse selection than the employer market which also adds to the instability. The individual market has greater risk that individuals will forgo coverage and get coverage only when they are sick. This problem is compounded as individual market premiums rise due to a sicker risk pool, (where consumers with unsubsidized premiums drop coverage).

[11] Virginia Legislative Information System, 2020 General Assembly Session Chapter 1077, SB 404: https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP1077. Accessed 10/02/20.

Medicaid expansion provided quality, affordable coverage to over 485,599 of Virginia's most vulnerable residents. Other significant impacts to enrollment are attributed to the passage of SB 1475 (2019), which allowed sole proprietors to purchase coverage in the small group market, passed in response to the 2018 Charlottesville experience.

For many, insurance coverage is still cost prohibitive despite a trend of modest decline in recent years. The percent of enrollment from the 18-54 segment decreased since 2017, while the percent of enrollment over the age of 55 has increased. This suggests that younger, healthier Virginians are choosing not to enroll in coverage, while the increasing aging population, with typically greater health care needs and higher risk, are opting to purchase ACA plans.

An actuarial study commissioned by the BOI estimates that 242,000 Virginians will be enrolled in the ACA individual market in 2020. This represents an approximate 30% decrease from 2018.

According to data contained in carrier ACA rate filings, average individual market premium per member per month (PMPM) is $644.00. For 2021, the average PMPM rate in the individual market is projected to be $590.00 PMPM.[12] 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 Federal Poverty Level (FPL), as they do not receive federal subsidies. Other compounding factors are high deductibles that are difficult for many to reach and coverage is extremely limited until they can be met.

Despite high rates in Virginia, there are signs of stabilization. While rates increased by 65% from 2017 to 2018, they decreased from 2019 to 2020 by 3.7%. BOI projects an average 7% decrease in rates from 2020 to 2021. Overall, 2021 rate decreases are estimated to range from -3.4% to 13%, which may begin to encourage enrollment.[13]

Based on BOI's 2020 market carrier service area applications, approximately one in five persons in the individual market has a choice of only one carrier. About 15% of the state is served by 3-5 carriers, which is slightly better than in 2019 when 90% of the state only had 1-2 carriers. Based on 2021 rate filing data, nine carriers, including one new carrier, will participate in the individual market.

Following the group study and discussion of the individual market, experts from the National Governors Association, Manatt State Health and Value Strategies, and the Georgetown Center on Health Insurance Reforms led the group in a discussion of potential policy options to solve for instability in the individual market.

Several policy options throughout were previously documented in the 2018 Market Stability Work Group report. These options are noted with an asterisk. The discussion for each option in this report, reflects more recent trends. Greater detail for each previously considered option can be found in the 2018 report, which is included as an appendix.

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[12] State Corporation Commission Bureau of Insurance "Review of 2021 Rates for the Individual and Small Group Markets in VA", PowerPoint presentation, September 2, 2020.

[13] State Corporation Commission Bureau of Insurance "Review of 2021 Rates for the Individual and Small Group Markets in VA", PowerPoint presentation, September 2, 2020.

Policy Options for Individual Market

Section 1332 State Innovation Waiver for Reinsurance

The ACA was designed, in part, to help bring stability to the individual health insurance market. However, given the fluid federal regulatory environment, many states continue to encounter challenges including large premium increases and declining insurer participation. One solution to these challenges is a state-based reinsurance program that reimburses insurers for certain high cost claims to lower premiums. Although states have the ability to implement reinsurance programs independently, to receive federal pass-through funding, states must apply for a Section 1332 waiver.

Section 1332 allows states to waive certain provisions of the ACA to pursue alternative coverage approaches for the individual insurance market for up to five (5) years. States may receive a pass-through of federal funds that would have otherwise been applied to premium tax credits. States can waive certain provisions (e.g., individual mandate, employer mandate, qualified health plan certification, essential health benefits), but not others (e.g., dependent coverage up to age 26, annual limits).

Under federal law, all Section 1332 waivers must satisfy the following guardrails: (1) coverage must be available to a comparable number of individuals under the waiver as would be available absent the waiver; (2) coverage must be as affordable for individuals under the waiver as it would be absent the waiver; (3) coverage must be as comprehensive under the waiver as it would be absent the waiver; and (4) must be deficit neutral. In 2018, CMS and the Internal Revenue Service released guidance that added additional flexibilities in the interpretation of the guardrails.

The Section 1332 waiver approval process can take up to 9.5 months[14] from when an application is completed. Applications include several elements, including actuarial and economic analyses, a 10 year budget plan, a list of data assumptions, and state legislation. To date, fifteen states have approved 1332 waivers. All but one of these states used the waiver authority to receive federal pass-through funding to implement state run reinsurance programs that reimburse insurers for certain high cost claims in order to lower premiums. Recent 1332 reinsurance waiver requests have taken 1.5-4 months from submission to approval (e.g., North Dakota took two months, Montana took three months, and Delaware took 1.5 months). [15]

Reinsurance Programs

Reinsurance is a mechanism for spreading the costs of high-cost claims by pooling them together and paying for them through a separate financing system, which then allows insurers to offer lower premiums. Several states have initiated efforts to achieve market stability with reinsurance as a first step.

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[14] CMS.gov Regulations and Guidance,CMS-9987-F Application, Review ad Reporting Process for Waivers for State Innovation, https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf , accessed 11.12.2020.
[15] Kaiser Family Foundation, Tracking Section 1332 State Innovation Waivers, 11.01.2020, https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/, accessed 11.12.2020.

The standard process of implementing a reinsurance program begins by the state first creating a reinsurance plan and fund. Options for structuring a reinsurance program include:

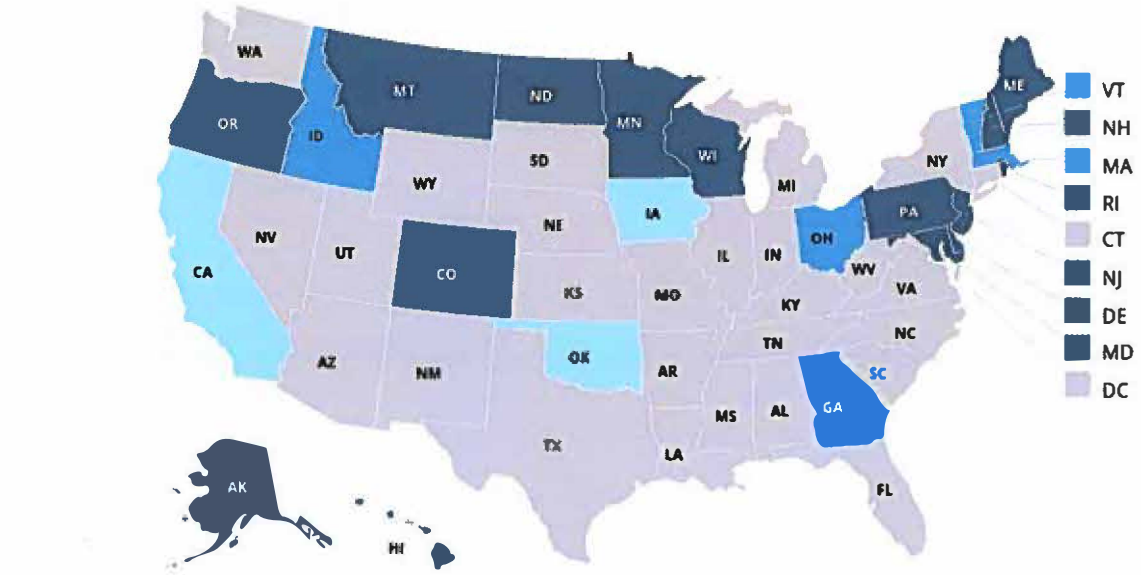
1. An Attachment point model focuses on all claims and is based on the claim's cost. This model features an attachment point, a coinsurance corridor, and a reinsurance cap. The attachment point is the cost at which reinsurance starts to pay. In the coinsurance corridor, insurers pay a specified percentage 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.

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 are passed through to the state and used to assist with the cost of funding the reinsurance program.

As illustrated in the map below, fourteen states currently have approved 1332 waivers to operate reinsurance programs (Alaska, Colorado, Delaware, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Rhode Island, Pennsylvania, and Wisconsin). Twelve of the states operate claims-based program designs. The federal government has indicated it will continue to allow states flexibility through approval of reinsurance programs.

Section 1332 State Innovation Waivers



SOURCE: Kaiser Family Foundation, kff.org

States Experiences with Reinsurance Waivers

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. A study conducted by Avalere of seven states' reinsurance programs (Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin) using 1332 waivers showed on average, premiums were reduced 19.9%. In addition, the analysis estimated that during the first year of enactment, reinsurance programs led to lower federal spending on advance premium tax credits resulting in pass through funding to reinsurance states. The average state pass through funding in the first year of enactment was $141.5 million.[16]

Additionally, rates decreased 24 percent in the individual market in 2018. The Minnesota Commerce Department has reported[17] significant rate decreases for 2019, ranging from 7.4 percent to 27 .7 percent because of its traditional attachment-point reinsurance program and

[16] Sloan, Chris, et al. "State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average", *Avalere Federal and State Policy*, Avalere, 2019.03.13 https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average.

[17] "Final 2019 health insurance rate information released for Minnesota", MN Commerce Department, October 2, 2018. https://mn.gov/commerce/media/news/?id=17-354562.

lower utilization and costs for medical services. Maryland has also reported premium decreases ranging from 7.4 percent to 17.4 percent.[18]

Insurer participation also increased under reinsurance programs, with carriers re-entering the market. 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.

One of the primary policy decisions in developing a reinsurance program, is the amount by which a state aims to reduce premiums. 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.

In Table A below, reinsurance targets have ranged from approximately 6% (RI)) to 30% (MD).

Table A: Impact of Reinsurance Programs on Premiums

Date (Date of Enactment)	Expected Premium Impact	Actual Premium Impact
Oregon (2018)	-7.5%	-6%
Minnesota (2018)	-20%	-20%
Maine (2019)	-9%	-9.4%
Maryland (2019)	-30%	-43.4%
New Jersey (2019)	-15%	-15.1%
Colorado (2019)	-16%	- 20%
Rhode Island (2019)	-5.9%	-0.4% - +1.7%
Wisconsin (2019)	-10.6%	-10.6%
Delaware (2020)	-13.7%	-19%
Montana (2020)	-8%	-13%

[18] 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/533106/.

An important consideration is that the higher the reduction sought, the greater amount of state funding is necessary to secure the reduction.

The state commits its share of the financing by identifying its reduction target and funding source though legislative action.

Virginia Impact of a 1332 Reinsurance Waiver

In order to evaluate the feasibility and impact of a Section 1332 State Innovation Reinsurance Waiver in Virginia, the BOI commissioned an actuarial analysis, completed by the consultant firm Oliver Wyman, in September 2020. The analysis provided baseline modeling of Virginia's individual market, as well as ACA market enrollment data to inform estimates on the impact of a reinsurance program in Virginia, beginning in Plan Year (PY) 2022.

The chart below demonstrates that assuming a reinsurance program in PY 2022, individual ACA enrollment would increase, and premiums would decrease, relative to having no reinsurance program.

Table B: Impact of a Virginia Reinsurance Program on Enrollment and Average Per member Per Month Premiums

	2022 Modeled Baseline	2022-10% Scenario	2022-15% Scenario	2022-20% Scenario
ACA Enrollees	240,000	245,000	249,000	255,000
Average Premium PMPM *(not including the impact of APTCS)*	$632	$569	$536	$506
Average APTC PMPM *(APTC enrollees only)*	$521	$455	$421	$386
Additional Morbidity Improvement	-	-0.1%	-0.3%	-0.6%
Average Rate Impact (incl. morbidity	-	-10.1%	-15.3%	-20.6%

	2022 Modeled Baseline	2022-10% Scenario	2022-15% Scenario	2022-20% Scenario
improvement and relative to if no reinsurance program were implemented)				

Source: Virginia—Reinsurance Modeling Results and Funding Analysis, September 28, 2020

More precisely, should Virginia adopt a reinsurance program for 2022, enrollment in the individual market could be expected to increase from approximately 240,000 to 255,000 depending upon the amount of premium reduction provided. Total premiums for individual ACA market enrollment would reduce from approximately $632month to a range of $506 to $569 depending on a 20% versus 10%, respectively, targeted premium reduction through reinsurance.

Costs and Assumptions of a Reinsurance Program

The Oliver Wyman analysis commissioned by the BOI (completed in September 2020) demonstrates that for the state share of the reinsurance program, Virginia would be required to fund approximately 18 percent of the total cost of the reinsurance program in order to achieve a 20 percent reduction in premiums. The portion of the cost paid by the federal government, pass-through funding, is calculated by estimating the savings the federal government realizes in reduced premiums for the premium tax credits, offset by the decrease in exchange user fees the federal government realizes because of the reduced premium. Given this estimate, the federal government would fund 82 percent of the cost for a reinsurance program in the Commonwealth, in a 20 percent reduction scenario.

The actuarial study modeled for Virginia identifies three possible premium reduction targets and projects the state share of the total costs of the reinsurance program, and expected premium impact. This is shown in Table C.

Table C: The Expected Cost to the Commonwealth of a Reinsurance Program Targeting a -20% Rate Impact is approximately $65.4M under the best circumstances.

	2022 Modeled Baseline	2022-10% Scenario	2022-15% Scenario	2022-20% Scenario	
Average Rate Impact		-10.1%	-15.3%	-20.6%	
(in millions)					
Reinsurance Program Cost		$168.9	$259.4	$358.6	A

	2022 Modeled Baseline	2022-10% Scenario	2022-15% Scenario	2022-20% Scenario	
Premium Tax Credit Spending	$1, 155.1	$1, 010.	$933.2	$854.9	
Premium Tax Credit Savings		$145.1	$221.9	$300.2	B
Revenue from Exchange User Fees	$42.1	$38.4	$36.6	$35.0	
Change in Exchange User Fees		-$3.7	-$5.5	-$7.1	C
Federal Pass-Through Funding		$141.4	$216.4	$293.4	D = B + C
Pass-Through % of Total Cost		84%	83%	82%	= D / A
Expected Net Cost to the Commonwealth		$27.5	$43.0	$65.4	= A-D

Source: Virginia—Reinsurance Modeling Results and Funding Analysis, September 28, 2020

For a 20 percent premium reduction model, with the state funding 18 percent of the reinsurance program cost, the state share would be approximately $65.4 million in 2022. The state share for a 15 percent and 10 percent premium reduction model would be approximately $43 million and $27.5 million, in 2022, respectively. These are all estimates and subject to change, per annual required actuarial analyses.

Expected Operational Costs- VA Bureau of Insurance

The Bureau of Insurance estimated the total startup and operational costs for FY 2021 and FY 2022 to be $326,250. The estimated cost for FY2021 and FY2022 is preliminary.

Reinsurance Timeline for Implementation

Beginning in 2019, the BOI and HHR worked with CMS and the BOI actuarial consultant Oliver Wyman to develop a model implementation timeline for a Virginia reinsurance program. The timeline below details the tasks and milestones that will be completed in accordance with the dates indicated.

Table D. Model Timeline for a Virginia Reinsurance Timeline

Date	Milestone
October 2020	HHR finalizes 1332 reinsurance waiver report (per 2020 budget language)
February 2021	Bureau of Insurance actuary to begin rate modeling for reinsurance program.
March 2021	Governor signs budget.
March 2021	OSHHR in consultation with BOI, CMS, and stakeholders draft 1332 application.
April 2021	OSHHR finalizes draft application
	Begin 30-day public comment period, to include public hearings and tribal consultation
May 2021	OSHHR files waiver application with CMS.
	CMS deems application complete and begins 30-day federal public comment period.
	BOI begins regulation development as needed.
July 2021	Projected date for CMS approval of application
July 1, 2021	FY2022 budget year begins.
November 1- December 15, 2021	Open enrollment on the federal platform. Consumers see the initial impact of the reinsurance program through reduced premiums.
December 31, 2021	End PY 2021
January 2022	BOI regulations become effective
	Reinsurance program begins.
February 2022	CMS notifies Virginia of final 2022 pass through funding amount.
	Virginia federal pass through funding available.
	BOI submits quarterly report to the federal government.
	Virginia receives appropriation for calendar year 2022 pass through funding from the federal government.
	BOI submits quarterly report to the federal government.
May 1, 2022	State funding available for Reinsurance Program.
July 1, 2022	FY 2023 budget year begins.

Date	Milestone
October 2022	BOI submits quarterly report to the federal government.
November 1-December 15, 2022	Open enrollment for PY 2023
December 31, 2022	End PY 2022.
January 1, 2023	PY 2023 begins. State Based Exchange is operational
March 2023	BOI submits its first annual report to the federal government.
April 2023	BOI submits quarterly report to the federal government.
May 1, 2023	State funding available for Reinsurance Program.
June 2023	First reconciliation payments to carriers for PY 2022 claims. Payments annually thereafter. Funding must be available to fully fund the state plan for payment (reason for state share of funds)
July 1, 2023	FY 2024 budget year begins.
	BOI submits quarterly report to the federal government.
October 2023	BOI submits quarterly report to the federal government.
November 1-December 15, 2023	Open enrollment (Full state-based marketplace)
December 31, 2023	End PY 2023.
January 1, 2024	PY 2024 begins.
March 2024	BOI submits annual report to the federal government.

Considerations for Reinsurance Programs

It is important to note that reinsurance programs only impact premiums. There are other factors that make health care unaffordable, such as cost sharing and deductibles, which are not directly impacted by a reinsurance program. The Kaiser Family Foundation, estimated that the average deductible in Virginia for families in employer-based insurance is $3,313.00.[19] This is the amount that an enrollee must pay up front before any services are covered. Additionally, further

[19] Kaiser Family Foundation, Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance, https://www.kff.org/other/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/ , accessed 10-02-2020

segmentation of the market through the proliferation of other health insurance plans could undermine the effectiveness of the 1332 reinsurance waiver by siphoning healthier individuals away from the individual market.

Potential Options to Fund the Non-Federal Share of Costs

One of the primary considerations for a state pursuing a reinsurance program is determining how to fund the state's share of the program. As shown in Table F, the fourteen states with approved 1332 waivers fund reinsurance through a variety of means. The two main sources for reinsurance funding in these states are assessments and state general funds. Options for assessments include policy-based assessments, state premium tax, state general funds, or state provider assessments. For example, Alaska, Colorado, Minnesota, New Jersey, Rhode Island, and Wisconsin use state general funds to fund the state share of their reinsurance programs, spreading the costs of the program across all taxpayers. Colorado's general fund is enhanced by an assessment fee on hospitals and a tax on premiums while Minnesota draws funding through excess state taxes and New Jersey and Rhode Island draw funds from non-compliance with the states' individual mandates. Other states, such as Maine, use an assessment of health insurers and third-party administrators to generate revenue to cover the cost of the program.

Table E: Funding Approaches for States' Reinsurance

State	**Program Design**	**Estimated Reinsurance Funding (in millions)**	**Source of State Funds**
Alaska	*Conditions-based*	*2017: $55 in state dollars* *2018: $50.5 in federal funding* *$25 contribution from Premera*	*Premium tax on all insurers*
Colorado	Claims-based	$87 in state funding $162 in federal funding	Assessment fee on hospitals, State-level health insurance tax, & state general fund
Delaware	Claims-based	$6.9 in state funding $20 in federal funding	State-level health insurance tax
Maine	Conditions-based	$59.6 in state funding $33.4 in federal funding	Organizational & base market assessments on health insurers and third-party administrators and ceded premiums for participating enrollees
Maryland	Claims-based	$365 in state funding $373 in federal funding	State-level health insurance tax, including Medicaid plans

State	**Program Design**	**Estimated Reinsurance Funding (in millions)**	**Source of State Funds**
Alaska	*Conditions-based*	*2017: $55 in state dollars* *2018: $50.5 in federal funding* *$25 contribution from Premera*	*Premium tax on all insurers*
Minnesota	Claims-based	$271 in state funding $139 in federal funding	State general fund & Health Care Access Fund
Montana	Claims-based	$12.4 in state funding $22 in federal funding	Assessment on major medical health insurance premiums
New Hampshire	Claims-based	$13.4 in state funding $32.9 in federal funding (requested)	PMPM assessment on health insurers of the prior year's second lowest cost silver plan without-waiver rate
New Jersey	Claims-based	$105.8 in state funding $180.2 in federal funding	State individual mandate penalty & State-level health insurer assessment
North Dakota	Claims-based	$21 in state funding $21.4 in federal funding	Assessment on small and large group premiums
Oregon	Claims-based	$90 in state funding $54 in federal funding (approved)	Premium assessment on fully insured commercial major plans
Pennsylvania	Claims-based	$44.2 in state funding $95.1 in federal funding (requested)	Fee on monthly premiums for health and dental products offered on PA Health Insurance Exchange
Rhode Island	Claims-based	$8.3 in state funding $5.2 in federal funding	Penalties for non-compliance with state individual mandate & other state funds
Wisconsin	Claims-based	$34 in state funding $127 in federal funding (requested)	State general fund

State-Based Health Insurance Fees

In 2019, Congress permanently repealed the federal Health Insurers Tax, which was used to fund certain parts of the law, such as federal and state marketplace exchanges. Each year the fee, ranging from 2-3%,[20] was leveraged across all markets, including Medicaid managed care, Medicare Part D, and Medicare Advantage, and was based upon market share and dollar value of their respective business. It was structured so that carriers were not subject to the fee on the first $25 million in net premiums, imposed on 50% of net premiums above $25 million and up to $50 million. Above $50 million, the fee was imposed on 100% of premiums.

The permanent repeal (beginning in the 2021 plan year) presents an opportunity for states to replace the tax and collect additional revenue. States have flexibility to design the tax to meet specific policy objectives (e.g., for exempting nonprofit entities or other plans). In Virginia, this could mean funding additional market stabilization and affordability programs. The following chart, Table G, details how four states have enacted state-level health insurance assessments and the policy options they chose to fund to promote market stabilization activities.

[20] Cigna, Health Insurance Industry Fee Fact Sheet, Informed on Reform, 2019

Table F- State-level Health Insurance Providers Tax Structures and Uses

	Colorado	New Jersey	Delaware	Maryland
Date Enacted	2020	2020	2019	2019
Markets Taxed	- Individual plans, and fully-insured group plans (not self-insured group plans) - Hospital assessment (now lower, but previously funded reinsurance)	- Individual and large group markets	- Individual, group, and other fully insured markets. - Exclude MCOs and standalone dental/vision plans	- Individual, group, and other fully insured markets. - MCOs and standalone dental/vision
Amount Taxed	- Non-Profit Hospitals 1.015% of premiums - For-Profit Hospitals 2.1% of premiums	- 2.5% on net premiums in the individual and large group markets. - Held in Health Insurance Affordability - Fund (Treasury) - Note: HIT is in addition to 3.5% premium fee tax	2020: 1% 2020: 2.75% 2021+: 2.75%	2019: 2.75% 2020: 1% 2021: 1%
Expected Revenue	$100 million	$220 million		
Uses	- Funds existing reinsurance program for 5 more years, - Funds carrier payments to reduce premiums for APTC enrollees, - Funds state-based subsidies up to 300% for those ineligible for APTCs, including undocumented and those caught by the family glitch. - Pay administrative costs for administering the tax. (up to 3% of revenues)' - O/RE	- $70 M- reinsurance - Subsidies in individual market up to 400%, focus on reducing the racial gap in health coverage. - Bill non-specific, but recommends subsidies, reinsurance, tax policies, - O/RE	Reinsurance	Reinsurance

In 2019, Maryland established a state-based premium tax[21] to fund the state's reinsurance program. For the first year of the program revenues come from a 2.75% assessment on specified health insurance carriers to recoup an aggregate amount of health insurance provider fee that would have been assessed under the ACA. Entities subject to the tax include insurers, nonprofit health service plans, health maintenance organizations, dental plan organizations, fraternal benefit organizations, and managed care organizations. In the first year, premiums were reduced more than expected, enrollment increased, and the federal pass through funding was more than

[21] Maryland General Assembly, §6–102.1, Chapter 598 of 2019. http://mgaleg.maryland.gov/mgawebsite/laws/StatuteText?article=gin&section=6-102.1&enactments=false Accessed, 10-21-2020.

expected. Maryland reduced the assessment for 2020-2022 to 1%. Colorado[22] and New Jersey[23] passed a version of the tax in 2020.

Funding Analysis

To evaluate the potential impact for a Virginia state-level health insurance tax, an actuarial analysis was performed by Oliver Wyman.[24] The following chart demonstrates the estimated impact of funding generated by an assessment on the large group fully insured (LGFI) plans in Virginia.

Table G. Funding Analysis of Large Group Fully Insured Assessment

Estimated 2022 Funding Generated by LG FI Premium Tax in Virginia

($ millions)		Estimated Funding by Premium Tax Rate				
	Premium	Tax Rate =>	0.5%	1.0%	1.5%	2.0%
#1 Estimated 2022 LG FI Premium (assuming no change from 2019 volume)	$3,832.3		$19.2	$38.3	$57.5	$76.6
#2 Estimated 2020 LG FI Premium (assuming 4% annual trend from 2019)	$4,308.5		$21.5	$43.1	$64.6	$86.2

Source: Oliver Wyman- Virginia Reinsurance Modeling and Funding Analysis Results, September 28, 2020.

Large group fully insured volumes, excluding premium amounts associated with the Federal Employee Health Benefits Program (FEHBP), were identified from the 2019 Supplemental Health Care Exhibits for carriers with reported membership in Virginia in 2019.

To evaluate the potential impact of a large group assessment, two estimates were developed: a conservative estimate that assumes total LG FI premium volumes do not change between 2019 and 2022, and another estimate that assumes that they will increase at the same annual rate (4.0%) as was observed in Virginia's LGFI market between calendar years 2016 and 2019.

Oliver Wyman found that if a 2% tax on LGFI premium were assessed on the LGFI market, it would be expected to generate between $76.6 million and $86.2 million in funding.

Turning to the table below, a tax equal to 1% of premium assessed on the 2022 individual market would be expected to generate between $16.2 million and $18.0 million in funding.

[22] Bill Track *50*, CO SB215, Health Insurance Affordability Enterprise. https://www.billtrack50.com/BillDetail/1232685 , Accessed 10/21/2020.

[23] Statain, Lilo, *"NJ Looks to Raise $200M with New Tax on Health Insurance Plans"*, New Jersey Spotlight https://www.njspotlight.com/2020/07/nj-looks-to-raise-200m-with-new-tax-on-health-insurance-plans/, Accessed 10/21/2020.

[24] Oliver Wyman- Virginia Reinsurance Modeling and Funding Analysis Results, September 28, 2020 (partially funded by the federal State Flexibility to Stabilize the Market grant program).

Table H. Funding Analysis of Individual Market Premium Tax in Virginia

Estimated 2022 Funding Generated by Individual Market Premium Tax in Virginia

($ millions)		Estimated Funding by Tax Rate Rate				
	2022 Premium Estimate	Tax Rate =>	0.5%	1.0%	1.5%	2.0%
Individual – 10% Scenario	$1,798.5		*$9.0*	*$18.0*	*$27.0*	*$36.0*
Individual – 15% Scenario	$1,710.0		*$8.6*	*$17.1*	*$25.7*	*$34.2*
Individual – 20% Scenario	$1,621.0		*$8.1*	*$16.2*	*$24.3*	*$32.4*

Source: Oliver Wyman- Virginia Reinsurance Modeling and Funding Analysis Results, September 28, 2020.

However, it should be noted that if a tax were assessed on the Individual market in 2022, the cost of the reinsurance program to Virginia would increase correspondingly, assuming that a similar net impact of the reinsurance program is desired (e.g., 10%, 15%, 20%).

With that in mind, the additional funding generated by a tax on the individual market would be expected to mostly be offset by an increase in the projected net cost of the reinsurance program.

Table I.

Estimated Net Cost of Individual Reinsurance Program to Virginia

($ millions)	Estimated Net Cost to Virginia		
	2022 – 10% Scenario	2022 – 15% Scenario	2022 – 20% Scenario
With No Individual Market Tax	$27.5	$43.0	$65.4
With 1% Individual Market Tax	$42.8	$58.5	$81.4
Difference in Net Cost	$15.3	$15.6	$16.0
Expected Funding From 1% Tax on 2022 Individual Market	$18.0	$17.1	$16.2

Source: Oliver Wyman- Virginia Reinsurance Modeling and Funding Analysis Results, September 28, 2020.

In the table above, it is assumed that the objective in both scenarios (i.e. with no assessment and with a 1% assessment) would be to produce individual rates that are 10%, 15%, or 20% lower than if there were no reinsurance program, prior to any additional rate reductions that might be expected due to anticipated morbidity improvement.

- If premium rates assuming no reinsurance program were $100 PMPM, then to produce rates that are 10% lower (i.e., $90 PMPM), the reinsurance program would need to reimburse carriers an average of $10 PMPM ($100 PMPM-$10 PMPM)
- With a 1% assessment, the reinsurance program would need to reimburse carriers an average of $11 PMPM to achieve a net premium of $90 PMPM ($100 PMPM x 1.01-$11 PMPM)

Therefore, extrapolating from the chart above, the expected net funding from a 1% individual market tax in 2022 would be in the following reinsurance program scenarios, approximately:

10% rate reduction= $2.7 million
15% rate reduction= $1.5 million
20% rate reduction= $200,000

Returning to the total cost of a 20% desired reduction in premium, it is worth noting that the cost to the Commonwealth would be approximately $65.4 million. The funding estimates from the LGFI alone are approximately $76.6 - $86.2 million.[25]

Like most states, the Commonwealth has faced unexpected and significant budget challenges with the impacts of the COVID-19 pandemic, and discretionary state dollars are scarce. Still, the pandemic has underscored the disparity in health care access and the need for all Virginians to have access to comprehensive, quality, and sustainable health insurance coverage. A health insurance provider's tax, similar to the federal health insurer provider tax that was repealed could be implemented at the state level and reinvested directly into health insurance affordability programs. This measure would provide several benefits for both insurance carriers and Virginia consumers. Reinsurance to decrease premiums will increase enrollment, diversify the risk pool, create more predictability for insurance carriers, and help protect more Virginians from the health risks and consequences associated with the pandemic and chronic illnesses.

During the Work Group discussion, some members cautioned that the tax would be transferred in premiums to consumers. However, others mentioned that economic research does not confirm that belief. Others reasoned that a 1-2% tax is lower than the health plans were paying under the federal model, and obtaining an approximate net 18% reduction would be considerably advantageous to consumers, especially combined with Virginia's other market stabilization policies (such as Medicaid Expansion, the Health Benefit Exchange, and limiting substandard plans) that are already resulting in somewhat lower costs.

Suggested Legislation to Implement the Program

The draft legislation attached in Appendix A is based upon models from a review of other states.

[25] Oliver Wyman- Virginia Reinsurance Modeling and Funding Analysis Results, September 28, 2020.

State-Based Subsidies

State-funded subsidies, or additional tax credits or cost-sharing reductions funded by state dollars, are a further option for increasing enrollment and making purchasing coverage more affordable. Individuals with incomes from 139-400% of the FPL receive APTCs and individuals with incomes up to 250% FPL receive additional assistance with cost sharing reductions. The population above 400% FPL does not currently receive any federal subsidies, and pays the full cost of health coverage, (average $650 per member per month in 2020), which can be cost prohibitive for many. An actuarial analysis commissioned by BOI showed that enrollment in Virginia's individual market declined by 30% since 2018. For the APTC population, this is mostly due to the expansion of Medicaid (up to 138% FPL) and for the non-APTC population (over 400% FPL) this is likely due to increases in premium rates by carriers with larger market share and within Rating Area 10 (Northern Virginia). [26]

There are several options for providing subsidies. State-level subsidies could be provided to individuals with incomes between 400 and 600% FPL to assist with purchasing insurance and to draw more individuals into the market. Alternatively, the state could choose to provide state-funded subsidies to individuals between 100 percent and 400 percent FPL. Individuals in these lower income brackets also have difficulty affording other cost sharing such as high deductibles and copays, and more relief is needed to further incentivize purchasing coverage. Additionally, since APTCs are income weighted, subsidies could cross between APTC and non-APTC populations, for example, 300-500% FPL. Another option is to provide subsidies to younger individuals as a method to decrease the morbidity of the risk pool, thereby decreasing rates, and incentivizing market participation.

There are several advantages to state-based subsidies. Subsidies can be targeted to populations in need, directly and efficiently. Implementing subsidies would not require a 1332 waiver application because they do not require federal authority. If a funding source is identified and available, subsidies can provide immediate relief to consumers for the next plan year. An additional benefit is that they can dissuade individuals from purchasing less robust and sustainable plans, such STLD plans and AHPs, as comprehensive coverage becomes more affordable. This prevents further segmentation of the market and maintains a larger, potentially more stable risk pool. Even with modest rate decreases in 2019 and 2020, enrollees in Virginia's individual market migrated towards gold plans (higher actuarial value) as a result of the reductions, indicating that when coverage is even slightly more affordable, Virginians have chosen more comprehensive coverage.

One of the key considerations of a state-based subsidy is a funding source. The amount of funding necessary is dependent on the size of the population targeted for subsidies as well as the size of the subsidies themselves.

As shown in Table C below, several states provide subsidies in addition to the existing ACA subsidy structure, and other states are considering introducing these programs to improve healthcare affordability. Currently, two states, Massachusetts and Vermont, offer such subsidies. Both states provide additional premium and cost sharing subsidies to people with income up to 300% of the federal poverty level. Neither state extends subsidies to those with

[26] Oliver Wyman- Virginia Reinsurance Modeling and Funding Analysis Results, September 28, 2020.

income above 400% FPL. Since 2015, Massachusetts residents under 300% FPL have been able to access ConnectorCare. ConnectorCare uses state subsidies to provide sliding scale plans that have $0 or low monthly premiums, limited co-pays, and no deductibles.

More recently, a number of states have proposed enhancing premium subsidies, particularly for individuals with income above 400% FPL who are not eligible for federal premium tax credits. California provides temporary state-funded premium subsidies to consumers with income up to 600% FPL and will further enhance subsidies for consumers with incomes from 200-400% FPL for coverage years 2020 and 2021. California will use money generated from imposing individual mandate penalties to partially finance these costs, along with general fund contributions. Colorado and New Jersey also passed subsidy legislation in 2020

Table J: State Subsidy Programs[27]

State	Subsidy Structure	Population	Program Active	How State Paid for Program
CA	State-based premium tax credit	Individuals up to 600% FPL	2020-2022	Individual mandate penalties, state general fund
CO	State-based premium tax credit	Individuals up to 300% FPL who are not otherwise eligible for tax credits (including undocumented immigrants)	Beginning in 2023	Health Insurance Affordability Fee
MA	Income level based premium structure (4 levels) with fixed premiums and lower cost-sharing	138-300% FPL	Pre-ACA-Current	Medicaid Funds (from Section 1115 waiver)

[27] National Governors Association Center for Best Practices, Memorandum to the Virginia Market Stability Workgroup, August 25th, 2020.

State	Subsidy Structure	Population	Program Active	How State Paid for Program
MN	25% premium discount	Any individuals not eligible for tax credits	2017 only	State General Fund
NJ	Tax credits	138-300% FPL	Beginning in 2021	NJ Health Insurance Assessment
VT	Tax credits (1.5% of income) and cost sharing assistance (for individuals 250-300% FPL)	138-300% FPL	2014-Current	Medicaid Funds (from Section 1115 waiver)

Several work group participants and organizations expressed strong interest in the concept of subsidies as a strategy to get immediate premium relief to individuals struggling with the cost of coverage.

Virginia is now a state-based marketplace on the federal platform and will receive more robust enrollment data from the federally facilitated marketplace. This data will be valuable to informing how this policy option might be structured. It was recommended that more in-depth information about the uninsured in Virginia could help identify which populations would most benefit from a subsidy.

There was concern that targeting the APTC population would be creating a second subsidy source, while the population over 400% FPL is receiving no assistance. Alternatively, as an adequate funding source may be difficult to find, there was interest in developing a program where small employers could contribute to a pool that could be used as a state-based subsidy for certain employees of small employers.

Expand Open and/or Special Enrollment Periods

In the initial years of the ACA (2014-2016), the minimum federal requirement for open enrollment periods (OEPs) was 12 weeks long. In the spring of 2017, the Trump Administration shortened the OEP to six weeks. Open enrollment for plan year 2021 will run from November 1 to December 15, 2020. States with state-based exchanges, however, have been able to extend their OEPs. Extending open enrollment allows more time for the outreach and enrollment of individuals which promotes increased participation in the individual market. When Virginia

fully transitions to a state-based exchange, the state will have the option to extend open enrollment beyond the 45-day federal minimum.

Studies have shown that state-based marketplaces that have extended OEPs beyond the required FFM and increased outreach and enrollment assistance successfully increased marketplace enrollment. For example, a study[28] conducted by Georgetown University Center on Health Insurance Reforms found that the 8 states that extended enrollment periods in 2019 saw a 2 percent increase in plan selection over the previous year, as compared to states with a 45 day open enrollment, which saw a 3.8 percent decrease (plan selection does not necessarily reflect complete enrollment, as individuals may select a plan, but fail to complete their first months payment and not fully enroll).

As illustrated below, to date, ten states and the District of Columbia have announced that they will extend open enrollment for 2021 beyond the FFM open enrollment dates (November 1-December 15, 2020)[29]:

Table K. State-Based Exchanges Open Enrollment Periods

State	Open Enrollment Start Date	Open Enrollment End Date
California	November 1, 2020	January 31, 2021
Colorado	November 1, 2020	January 15, 2021
Massachusetts	November 1, 2020	January 23, 2021
New York	November 1, 2020	January 31, 2021
Rhode Island	November 1, 2020	December 31, 2020
District of Columbia	November 1, 2020	January 31, 2021
Minnesota	November 1, 2020	December 22, 2021
Nevada	November 1, 2020	January 15, 2021
New Jersey	November 1, 2020	January 31, 2021
Pennsylvania	November 1, 2020	January 15, 2021
Washington	November 1, 2020	January 15, 2021

[28] The Commonwealth Fund, ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance https://www.commonwealthfund.org/blog/2019/aca-marketplace-open-enrollment-numbers-reveal-impact, accessed 10/28/2020.

[29] The Commonwealth Fund, "What Is Your State Doing to Affect Access to Adequate Health Insurance?" https://www.commonwealthfund.org/publications/maps-and-interactives/2020/oct/what-your-state-doing-affect-access-adequate-health, accessed 10/28/2020.

The global pandemic of COVID-19, has added another layer of complexity for small business and employees. On September 26, 2020, the Virginia Employment Commission announced that the number of initial claims filed from mid-March through September 26, 2020 totaled 1,167,032, or 28.4% of pre-pandemic payroll employment.[30]

When Virginia fully transitions to a state-based exchange, the state could prepare for the use of special enrollment periods (SEPs) to promote seamless coverage. This could be done in response to the COVID-19 pandemic. For example, in the last few months, 12 of the 13 state-based marketplaces created SEPs for individuals who were uninsured at the start of the COVID-19 pandemic. States with new SEPs saw increased enrollment during the special enrollment period, though the response varied. Washington, for example, saw a total of 22,000 new enrollments over their SEP from March 1-May 8, with increased percentages of young people, first time enrollees, and people of color.[31]

One option for Virginia would be to partner with the Virginia Employment Commission to develop policies and procedures for conducting outreach to individuals who have lost their jobs, and provide them with information about how to connect with the health benefit exchange and COVERVA to explore their options for coverage. Another option would be to codify or put into regulation a special enrollment period during tax filing periods each year, or to have one continuous 6 month enrollment period. Tax filing season is a good opportunity to capture enrollment as people have a more reliable source of information about their annual incomes for the purpose of determining eligibility.

The Work Group generally favored this policy option as a promising practice that could help Virginia maximize enrollment and capture healthy risk for the marketplace. While Virginia's exchange can expand OEPs and initiate SEPs without legislative authority, once it has transitioned to a full state-based marketplace (by 2023), codifying or setting this option in state regulation could set a public expectation, increase public awareness of the enrollment opportunities, and ensure that Virginians can benefit from a longer OEP year after year.

Standardized Plan Options

ACA exchanges were designed to encourage competition and provide an apples to apples comparison consumer shopping experience. There are federal requirements for minimum essential coverage and categories of services (Essential Health Benefits). Actuarial values (AV), correspond to metal levels, bronze, silver, gold, and platinum to denote coverage generosity. Then carriers have flexibility in varying the plan design to appeal to different consumer needs and budgeting preferences for example, a lower monthly premium, but a higher deductible, or a higher monthly premium and lower deductible to name a few. The ACA does not limit the number of plans that a carrier can sell, so shoppers can face choice overload, and are challenged

[30] Virginia's Unemployment Insurance Weekly Claims for Week Ending September 26th https://www.vec.virginia.gov/UI-press-release

[31] Supplemental Report: Uninsured Special Enrollment Period https://www.wahbexchange.org/wp-content/uploads/2020/06/Supplemental-report_uninsured-FINAL.pdf .

to make meaningful plan comparisons. In addition, as coverage costs skyrocketed, carriers have offered plans with lower premiums, but very high deductibles. A major concern for consumers is that with high deductible plans, they would have to spend thousands (the average silver plan deductible in exchanges was $4375.00 in 2019)[32] before services are covered, making coverage seem illusory, and contributing to consumer frustration.

Standardized plan designs is one approach states took to simplify the consumer shopping experience and make coverage consumers purchase more valuable.

Standardized plans promote high value care, reduce cost-sharing, improve consumer decision-making by facilitating plan comparisons (apples-to-apples comparisons across plans), and administrative simplification. In standardized plans, guidelines are laid out in terms of specific coverage details. All standardized plans must offer the same coverage for those aspects of the plan.

On the federal exchange, standardized plan options were not required of insurers, but those that did offer such plans, would be highlighted for consumers (e.g. on the exchange website) so that consumers could compare them prior to moving on to other options.

Currently eight states (CA, CT, DC, MA, NY, OR, VT, and WA) require insurers to offer some standardized plans (e.g., standardize cost sharing parameters, require more services to be covered pre-deductible). All states that require standardized plans (except California) have established requirements that allow participating individual market insurers to offer some plans with non-standardized designs. In California, all individual market plans have to be standardized. Washington's standardized plan, which will be implemented in 2021, is part of the state's broader reform efforts that are being considered, including the public option and state subsidies.

Implementing standardized plans is one approach that would not require a federal waiver or additional funding. Policy considerations for states include: (1) how to determine the right amount of consumer choice; (2) whether/how to leverage the standard design to improve consumer shopping experience; (3) state resources needed to implement, and (4) how to balance the need for affordable premiums versus the tradeoff of higher premiums with a lower deductibles/ cost-sharing

The work group did not reach agreement on whether to advance standardized plans as a recommendation. It was noted that standardized plans were an option for carriers in the federal marketplace, and it was a way to identify plans for consumers that had particular attractive features, as well as to further incentivize competition.

Concerns about plan standardization included the potential for creating richer benefits, which could increase premiums, disincentivize carrier participation, and other relaxed requirements that have resulted in the blending of actuarial value bands, making plan comparison more challenging. Some group members expressed the belief that standardized plans do not benefit

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[32] Standardizing Health Plan Benefit Design: Opportunities and Implications for States, November 18, 2019, Sabrina Corlette, SVHS
https://www.shvs.org/standardizing-health-plan-benefit-design-opportunities-and-implications-for-states/

consumers, because ACA requirements (AV, EHBs, and QHP standards) provide an appropriate balance to meet consumers' needs, while allowing carriers to develop innovative plan designs.

The group contemplated that it may be advantageous to inventory what plans currently exist in the marketplace, and if warranted, consider again when Virginia has fully transitioned to a state-based marketplace.

State-Level Individual Mandates

The federal Tax Cuts and Jobs Act of 2017 [33] eliminated the financial penalty associated with the individual mandate in the ACA, effective January 1, 2019. To reduce the number of uninsured, improve the market's risk pool, and result in lower premiums,[34] six states have chosen the option to replace the federal individual mandate policy with a state-based 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 to ensure high participation in the market.

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. Maryland considered a more enrollment oriented approach that gives the uninsured the option of applying the penalty as a down payment to help them buy health insurance.

If implemented in tandem 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, successfully lower premiums, generates more federal pass-through funding to reinvest in the reinsurance program, and increases market stability.

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 should be enough to incentivize coverage, 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 a 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).

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[33] *"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.

[34]https://www.familiesusa.org/resources/marylands-down-payment-plan-helping-people-get-health-insurance-and-lowering-families-health-costs/

- 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.

The group found that while the individual mandate could be viewed as important tool for improving the risk pool for health plans, the effectiveness of an individual mandate is limited if the plans available to purchase remain unaffordable. Of the policy options evaluated, this was not an option that was a priority for the group to pursue.

Basic Health Program

Section 1331 of the ACA gives states the option of creating a basic health program (BHP), a health benefit coverage program that covers low-income residents through state-contracted plans outside the health insurance marketplace, rather than through qualified health plans. In states with BHPs, coverage is available to consumers with incomes between 133-200% FPL who would otherwise qualify for subsidies in the marketplace. The Basic Health Plan leverages state purchasing power to make coverage more affordable for those who may still have difficulty affording coverage even with ACA financial assistance To fund the BHP, the federal government will pass through 95% of the APTCs that individuals would have received in the marketplace. States considering a BHP seek to achieve multiple goals, including providing more affordable coverage, increasing access, and reducing "churning" between Medicaid and marketplace plans. A BHP also avoids the need for consumers to reconcile APTCs on federal income tax returns. Since BHP enrollees do not receive tax credits, they would not face the risk of losing tax refunds or owing tax debts if they receive excess subsidies during the year. Under Section 1331, BHP coverage must be as affordable and as comprehensive as subsidized coverage in the marketplace. States can choose between Medicaid and an exchange administrative structure for most aspects of a BHP (ex: open enrollment or continuous eligibility).

Currently two states (Minnesota and New York) offer BHPs. In the first few years of the BHP, Minnesota's capitation rates for plans participating in Medicaid and the BHP were similar. Afterwards, by leveraging Medicaid participation, and because BHP enrollees proved healthier than the historical MinnesotaCare population, the state was able to negotiate MinnesotaCare capitation rates that were 15 percent lower than expected. In New York, the four BHP plan options had slightly different capitation rates. The rates for the two higher-income plan options were set at the Medicaid rate, while rates for the two lower-income plan options were based on previous Medicaid rates then adjusted to reflect differences between historical Medicaid and BHP utilization patterns, covered benefits, and cost-sharing rules. In both states, the state established reimbursement rates through contracts with the BHP plans and rates were lower than reimbursement rates for qualified health plans.

After discussion, the group was neutral on the potential net value of implementing a BHP in Virginia. While there was support for the goal of increasing access and sustaining coverage to individuals with lower incomes, federal pass-through funding has been reduced with the elimination of cost sharing reductions, decreasing the amount of program funding, leaving the state to find other efficiencies or a funding source for its BHP. Additionally, the BHP draws enrollment out of the individual market. In states that develop 1332 Reinsurance Waiver programs, this would result in decreased pass through funding with APTCs.

Other considerations are the potential to pull the most heavily subsidized membership out of the ACA individual market (individuals with incomes from 139-200% FPL), leaving the market less sustainable.

While BHP achieved successes in MN and NY, both states had long standing state-only funded Medicaid programs prior to passage of the ACA, which facilitated the development of their BHPs.

Virginia's Small Group Market

Prior to the ACA, the small group market comprised about one-quarter of all insurance markets. Very few were self-insured, and most were regulated under state law and the Health Insurance Portability and Accountability Act (HIPAA). There was fairly uniform regulation with states using more oversight of plan content and managed care activities.

Medical Loss Ratio (MLR) for small groups during this time was typically 70-80%. Medical underwriting occurred but was more limited than in the individual market. Regulation mitigated some medical underwriting, plans could not exclude specific conditions, but they could limit coverage for pre-existing conditions. Prices varied based upon health status and claims costs. Yet small business owners struggled to provide affordable, quality coverage to their employees.

The Small Business Health Options Program (SHOP) was created by the ACA for small employers (1-50 employees) where comprehensive, affordable coverage could be available while benefiting from a larger, and more diverse risk pool to contain the cost of coverage.

Compared to the individual market, the small group market has not been quite as volatile over the years. It is important to note that any effort to assess the small group market is hindered by a lack of publicly available data on the extent to which small employers are shifting to self-funding. Still, enrollment in SHOP has been lackluster in Virginia and in most states, especially those that are using the FFM. Contributing challenges included initial IT delays, insufficient small employer tax credits, lack of premium subsidies, and limited training available for agents and brokers to use the SHOP interface. Then in 2018, a new federal rule took effect, under which individual market insurers that offer coverage through healthcare.gov were no longer required to

offer at least one silver and one gold SHOP plan, as a condition of participation in the individual market.[35]

In Virginia, enrollment has generally decreased each year in the last 10 years. Premiums have increased more steadily, but they are inching closer to those in the individual market. Based on 2021 rate filings submitted to the BOI, the rate increase is predicted to be approximately 2.7%. With this in mind, new challenges may lie ahead for the small group market due to increasing premiums and the impacts of COVID-19 on businesses.[36]

Also, it is important to note the limitation of assessment on the small group market due to the lack of publicly available data on the numbers of and extent to which, small employers are exiting the small group market and shifting to other types of less regulated health coverage arrangements.

Some states, (CA, CT, CO, DC, ID, MD, MA, NM, NY, RI, VT) especially those with state-based marketplaces, have had robust enrollment in the SHOP. For example, Covered California's SHOP exchange had 47,000 members enrolled, and Washington DC's SHOP exchange had more than 77,000 members as of 2018. These states have SHOP platforms for small businesses. However, some have switched to a direct-to-carrier enrollment model, instead of maintaining an enrollment portal that small businesses can use.

Only three carriers participate in the Small Business Health Insurance Options Program (SHOP), primarily in northern Virginia. This is because historically, the SHOP has not received as much outreach and enrollment assistance as the individual market had in the initial years of the ACA, and the SHOP relied on group coverage to reduce rates, as APTCs were not available to SHOP enrollees.

The ACA did little to address the main challenge of the small group market, which is affordability. More than the rising cost of health care itself, factors include that while a narrow group of small businesses qualify for the small business tax credit, APTCs that make coverage affordable for many under 400% FPL in the individual market are not available to employees in the small group market. Therefore, cost mitigation in the small group relies upon enrollment numbers and the larger single risk pool.

In addition, enrollment in the small group lagged from the very beginning, as outreach and enrollment activities were more heavily targeted to the individual market (although federal funding was close to eliminated in 2016), and both businesses and employees would have benefited from education and technical assistance in offering and navigating SHOP options.

Compared to Medicare and Medicaid, the cost of private health insurance, which is what small employers buy, is rising at an unsustainable rate. Consequently, like the rest of the country, Virginia has seen a fairly steady erosion in small group offer rates (the number of employers

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[35] Health Insurance.org, SHOP exchange, https://www.healthinsurance.org/glossary/shop-exchange/, accessed, 10/2/2020.

[36] State Corporation Commission Bureau of Insurance "Review of 2021 Rates for the Individual and Small Group Markets in VA", PowerPoint presentation, September 2, 2020.

offering small group insurance to their employees) since 2000. This prevents individuals from accessing affordable, comprehensive coverage. To effectively address affordability for small employers, policy options are necessary to tackle the underlying cost drivers affecting commercial insurance. The group evaluated the following policies and programs for potential options to make coverage more affordable for small business.

Review of Policy Options for Virginia's Small Group Market

Strengthening Virginia's SHOP Market

As Virginia has transitioned to a state-based marketplace on the federal platform (SBM-FP), it will now receive additional funding for outreach and enrollment in the individual market, as well as ownership of specific demographic data pertaining to enrollment that will be used to tailor outreach programs to the needs of Virginians across the Commonwealth. The Exchange would have the power to leverage existing relationships with agencies and could be more effective than the federal government conducting outreach in 2013-2014. As such, there was some Group member interest in SHOP due to the employee choice allowed in SHOP purchasing.
It was noted that one area where the state can support small business is with marketing, outreach, and navigator functions associated with the operations of the health benefit exchange, and health literacy education to employers and employees to ensure that they understand their eligibility and how tax credits factor into their particular situation.

Work Group members indicated that in order to make SHOP programs successful in Virginia, substantial investments in marketing, outreach, education, and technical assistance for both employers and employees would be necessary.

Other Work Group members noted that SHOP was not a successful model in Virginia thus far. Most plans are isolated to Northern Virginia. Stakeholders have also expressed over time an interest in moving to a direct-to-carrier model for small businesses to purchase SHOP plans, as allowed by CMS.

Reference Pricing and Rate Setting

Reference pricing and rate setting are used by states to reduce costs by setting the price for services or capping reimbursement at a percentage of Medicare/Medicaid. Reference pricing has been used by the state employee health plans in Montana and Oregon, and is currently being explored in North Carolina. Reference pricing requires the plan to reimburse providers at no more than a percentage of the Medicare price for each service.

Rate setting has been implemented for years in Maryland, whereby the state sets the reimbursement rates that all payers, commercial and government, pay to providers. Average hospital cost per admission in Maryland went from 26% greater than the national average in 1976 to 2% lower in 2007. Furthermore, the system helped create a more equitable spread of the costs of uncompensated care and eliminated cost-shifting among payers. Commercial rates are lower in Maryland than in Virginia. Furthermore, implementing a Maryland-like program would need a federal waiver.

Providers will likely oppose reference pricing and rate setting because they reduce revenue from commercial payers. This could lead to network adequacy problems. There is also some evidence that under these type of programs providers will compensate by increasing the number of services performed. To combat this situation, Maryland instituted global budgeting, with a target for annual overall cost growth.

No agreement was reached among the group on the viability of this option, as there was both support and opposition across stakeholder participants.

Public Option Plan

Another option for increasing choice and reducing costs in the small group market is allowing small employers to purchase a state-sponsored public plan. Colorado is considering this policy option, although the legislature has put the discussion on hold due to COVID-19. Under the plan, the public option would be offered by a private insurer, but would be required to meet state standards for benefits and cost-sharing, and provider reimbursement would be capped at a percentage of Medicare. The advantages of a public option plan include the fact that they offer a new plan option and they offer lower rates to small businesses. Design challenges associated with the public option include: (1) deciding if the state should bear any financial risk; (2) deciding how much to delegate to a private insurer (e.g., benefit design, network development, marketing, etc.); (3) provider participation; and, (4) potential cost-shifting to the rest of the commercial market, which could impact QHPs.

The Work Group noted that the discussion of a public option plan will be driven largely by the outcome of the 2020 Presidential Election, as a public option could be considered at the federal level if a change in administration takes place. However, states like Washington and Colorado are working to advance state-level public options, so federal and state proposals are not mutually exclusive. Some work group members expressed support for increasing the number of insured Virginians, and mitigating the need for charity care, however, the population to target and provider reimbursement rates are a concern that should be addressed. Some Work Group members expressed concern that a public option for either the individual or small group sets rates at a percentage of Medicare and this would cause cost shifting to the large group market, in the form of rate increases. Other Work Group members disagreed, stating that economic literature dispels the cost shifting argument. Market consolidation by providers is the greater driver of cost increases and plans can mitigate cost shifting as part of contracting strategy.

Small Employer Buy-In to State Employee Plan or Medicaid

A buy-in program allows small employers to purchase coverage through other programs, such as the state employee health plan or Medicaid. Connecticut and Massachusetts have considered buy-in programs. In Connecticut, the buy-in program would allow small employers to buy into the state employee health program. Employers would be part of the same risk pool as state employees and have access to the same plan options. They would pay full premiums directly to the state. This buy-in proposal failed in the Connecticut legislature last year, but the state is still considering the idea. In Massachusetts, the state commissioned a feasibility study to allow small businesses to "buy in" to Medicaid or a Medicaid-like product at full cost. This program would leverage the lower cost-Medicaid structure/fee schedule.

Depending on the design, a buy-in program can lower premiums and increase choices. However, Connecticut was concerned about potential costs to the state and state employees, if small employers were part of the same risk pool. State employee premiums may have increased if adverse selection occurred whereby only an older/sicker employer group bought into the program.

Small business advocates had concerns about sustainability and cost shifting to employers and employees that would mitigate the positive effects of a buy-in option. Others expressed concerns that buy-in for small group would destabilize the small group market, because carriers would be unable to compete and would withdraw from the market and providers would receive lower rates than they are currently receiving. It was stated that reinsurance for the small group market would be more beneficial than the concept of buy-in.

Narrow Network Plans via a SHOP

Massachusetts is a unique example of a SHOP success story. Through the Massachusetts Health Connector, the state's health benefit exchange, small employers can choose to buy a group plan and determine the level of contribution they wish to make. When small employers choose benefit plans, they feel they need to meet the needs of all their employees, which drives them more towards PPO style or broad networks.

The SHOP market has narrow network plans and standard plans and employees have the flexibility to select their insurer and plan, and employees pay the difference between the premium and the employer's contribution. Massachusetts found that when small business employees purchase their own plan, employees are choosing the narrow network, less expensive plan options.[37]

The benefits of the Massachusetts' model include lower premiums and more plan choices. The approach builds from existing law and infrastructure. The plans in the Massachusetts SHOP market have Medicaid Managed Care Organization experience and have been able leverage those provider networks, creating a lower-cost option, and it is unclear whether similar favorable conditions could be replicated in other states. Massachusetts reports that small businesses are saving on average 22% on premiums compared to small employers shopping off-Exchange. Furthermore, 46% of small businesses reported that they didn't offer any insurance, before SHOP purchase.

Reinsurance for the Small Group Market

Similar to a reinsurance program in the individual market as described in the Individual Market section of this report, a state-run reinsurance program could be implemented in the small group market. It would also require a separate financing mechanism. There is a National Association of Insurance Commissioners (NAIC) model law creating a small group market reinsurance program. Several states have enacted it, but the work group is not aware of any programs currently being funded or operated.

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[37] Sabrina Corlette, Georgetown University Center on Health Insurance Reforms, Virginia Market Stability Task Force: Improving Affordability for Small Business Health Insurance, PowerPoint presentation, September 2, 2020.

Work group members noted that similar to the individual market, reinsurance is a proven strategy, the quickest way to reduce premiums for the most number of people, and is easier to implement in comparison to other policy options. Another advantage is that reinsurance programs tend to attract more insurers to the marketplace as risk is mitigated. More insurers increases competition and therefore reduces rates.

Considerations include that reinsurance is a one-time reduction unless the attachment point (as described in the individual market section) is changed. In the small group market, there would be no pass-through funding as the small group does not get APTCs. The state would need to identify a financing mechanism and structure for the pool. One option would be to assess plans that market to small businesses, but do not follow small group market rules. The risk pools would also need to be managed, along with other stabilization measures, in order to contain premium growth.

It was also noted that it is important to conduct thorough research into small group market dynamics, and consider the potential impacts, as a program may not have the same benefits in the small group as the individual market.

The group had a range of opinions about the concept of a reinsurance program for the small group markets and indicated support would depend upon the structure, and as done in tandem with other stabilization options.

Purchasing Alliance

Creating a purchasing alliance is another option to reduce costs in the small group market. A purchasing alliance is an organizing mechanism for small employers that are fully insured, to partner with the small business market and large-group purchasers to negotiate price discounts from healthcare providers. Insurers providing the benefit are required to comply with all state and federal small group rules, including participating in the single risk pool and risk adjustment programs, so they are not treated differently in state regulation.

A Colorado model has proven to be successful. The Peak Health Alliance formed last year in a rural, high cost county. This is a coalition of small and large employers that are self-funded and participating in the health benefit exchange. The Alliance uses data from the state all-payer claims database to understand the local cost drivers and negotiate discounts from providers. For 2020, they were able to negotiate a 20% reduction in rates. The price reduction stems from direct negotiation with the health system in the community, and the entities must comply with ACA rating factors, such as the 3:1 age rating.

Under the Alliance, the state provides regulation of the entity (i.e., it is not allowed to bear risk) and access to necessary data. It is not clear if the Colorado model is replicable, but the concept has been expanded to seven other rural communities in Colorado and is being explored by similar purchasing coalitions in Wyoming and Idaho.[38]

[38] Sabrina Corlette, Georgetown University Center on Health Insurance Reforms, Virginia Market Stability Task Force: Improving Affordability for Small Business Health Insurance, PowerPoint presentation, September 2, 2020.

Work Group members generally viewed this option as having value if locally driven. However, sustainability can be a concern, as the negotiation process takes extensive time and effort, as different discounts factor in to fully insured and self-insured, and further, different lines of services would need to be negotiated. Some Work Group members likened this model to a narrow network model which has limitations. Another issue raised was that they would likely be de-facto narrow networks, and the issue is broader than cost, as quality and access should also be considered.

Promote the Use of Health Reimbursement Accounts (HRAs)

HRAs can help promote premium affordability for some small employers. The employer contributes to a tax-exempt account that the employee can use to buy an individual market plan. HRAs could be attractive to some small employers because they make premium contributions more predictable for the employer, and are tax advantaged for both employers and employees. A caveat is that they are less predictable for employees, because the employer's contribution may not increase commensurately with the cost of the plans.

Starting January 1, 2020, employers were able to offer employees an Individual Coverage HRA, or Individual Coverage HRA (ICHRA) instead of a traditional job-based health plan. This type of HRA is an alternative to traditional group health coverage to reimburse medical expenses such as monthly premiums and other out of pocket costs.

Individual Health Coverage Reimbursement Arrangements (ICHRAs) and Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)

Both ICHRAs and QSEHRAs allow the business to reimburse employees for health care. The business can set a monthly allowance amount, the maximum the business will pay out for the HRA. In both models, employees purchase healthcare and submit reimbursement requests with documentation. The business reviews and approves the requests. The business reimburses the employees tax free.

Section 18001 of the 21st Century Cures Act amends the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act (PHSA) to permit an eligible employer to provide a QSEHRA to eligible employees. To offer a QSEHRA[39], a business or organization must have less than 50 full-time employees, and it cannot offer a group insurance policy (health, dental, or vision). The QSEHRA must be available for all full-time employees and their families. The employer can opt to extend eligibility to part time employees as long as the allowance offered is the same regardless of employment status. In addition, an employee can participate in the QSEHRA, even if they have individual health coverage from their spouse's employer, MediShare, or no insurance at all. Employees can retain the tax exempt status of QSEHRA, as long as they retain minimum essential coverage. Businesses cannot offer both group insurance and the QSEHRA to employees. The IRS sets annual caps for QSEHRAs: $5,250 ($439.00/month) for single employees and $10,600 ($833.33/ month) for employees with

[39] Health Reimbursement Arrangements (HRAs) for small employers https://www.healthcare.gov/small-businesses/learn-more/qsehra/, accessed 10/2/2020.

a family. QSEHRAs can roll over month to month and year to year, but the total reimbursements in a year can never exceed the annual cap. Employers can offer different alliance amounts to different employees based on age and family size.[40]

ICHRAs are more flexible in nature. Businesses can structure eligibility requirements based on a given set of employee classes, including: full-time, part-time, salaried employees, hourly employees, seasonal employees and others. For example; 10 employees for employers with fewer than 100 employees or 10 percent of the total number of employees for those that have between 100 and 200 employees. All employees must be covered by individual health insurance, or Medicare Parts A and B, or Part C. Uninsured employees or those with a healthcare sharing ministry plan, and those covered by a spouse's group health insurance cannot participate in the ICHRA. There are no annual contribution caps in ICHRAs, and employers can offer a different allowance amount to different employees based upon the specific defined classes mentioned above. Further, ICHRA allowance amounts can roll over month to month and year to year without restriction.[41] Also, if the employer contribution does not meet affordability standards, then the employee can apply for advance premium tax credits.

This is a policy option where the state does not have to provide any required intervention since employers can already provide HRAs under federal law. Some benefits of HRAs are that they promotes employer and employee choice, while offering employees more options to purchase comprehensive, sustainable coverage. HRAs are also an option that could help draw greater numbers of people and healthier risk into the individual market, without undermining the risk pool, and causing market segmentation.

Some considerations of HRAs as an affordability solution, is that they potentially shift financial risks to employees, particularly if there is a spike in individual market premiums and the employer contribution does not grow commensurately. Depending on the market, individual market plans can come with narrower provider networks and higher deductibles, so employees may see it as lower quality. Lastly, many employees will need assistance understanding their options and how to avoid tax liability. That said, they would provide an option for greater enrollment and a diverse risk pool, which contributes to cost containment. Further, narrow networks can be a reasonable option, (especially if there is greater transparency around what providers are in the network), to allow the consumer to make an informed cost/benefit analysis of the option.

Generally speaking small business stakeholders supported HRAs as a viable option for small employers to provide health insurance benefits to employees.

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[40] IRS Internal Revenue Bulletin 2017-67, https://www.irs.gov/irb/2017-47_IRB#NOT-2017-67, accessed 10/2/2020.

[41] Individual coverage Health Reimbursement Arrangements (HRAs) https://www.healthcare.gov/small-businesses/learn-more/individual-coverage-hra/, accessed 10/2/2020.

Association Health Plans (AHPs) and Multiple Employer Welfare Arrangements (MEWAs)

Association Health Plans (AHPs) have existed for decades, and have offered legitimate health coverage benefits to their members. AHPs are a type of Multiple Employer Welfare Arrangement (MEWA), regulated by the U.S. Department of Labor (DOL) Employee Retirement Income Security Act (ERISA), that were designed to allow small businesses and self-employed individuals to join together and purchase coverage as part of an association. They are also subject to state regulation, but regulatory gaps between the state and federal regulation have enabled AHPs to avoid regulatory requirements. Consequently, there has been a history of fraud and insolvency, as some plans have ended up unable to pay members' claims.[42] Efforts to reform AHPs with greater regulation led to near extinction.[43]

To address those issues, the ACA provided greater regulatory oversight of AHPs, clarifying that they are subject to individual and small group market rules, known as the "look through" policy, such as the requirement to offer EHBs and comply with ACA rating rules.[44] However, it did leave open an exception for small employers to be considered a single large group health plan if they could demonstrate that they were a bona fide single employer under ERISA. This means they would have to 1) demonstrate that the association is a bona fide organization with a purpose other than for providing health insurance to its members, 2) whether the employers share a commonality of interest unrelated to providing benefits, and 3) whether the employers exercise control over the program. Bona fide employer status is important, because it creates a bonding mechanism for the group other than the desire to provide health insurance.

In the post ACA landscape, AHPs can decrease costs for some businesses and employees by exempting plans from ACA rating and risk sharing rules of the small group market. This is a policy option that has generated extensive conversation in the General Assembly and in the Work Group.

In 2018, the Trump administration unveiled a cornerstone of the administration's health care policy, to expand the use of Association Health Plans as an ACA alternative[45]. The U.S. DOL issued a new rule by changing the definition of "bona fide employer", to allow sole proprietors and individuals, as well as small businesses, that would otherwise be in the individual and small group market, to circumvent the "commonality of interest" provision that required that an association be formed for a reason other than providing health insurance.

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[42] Jost, Tim The Commonwealth Fund. "The Past and Future of Association Health Plans", https://www.commonwealthfund.org/blog/2019/past-future-association-health-plans. Accessed 10/19/2020.

[43] Protect Our Care, "Reminder: Association Health Plans Have Long History of Fraud and Unpaid Claims", January 30, 2019, https://www.protectourcare.org/reminder-association-health-plans-have-long-history-of-fraud-and-unpaid-claims/ accessed 11.12.2020.

[44] U.S. Department of Health & Human Services, Center for Medicare and Medicaid Services, Insurance Standards Bulletin Series, September 1, 2011. https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf, accessed October 19, 2020.

[45] Jost, Tim The Commonwealth Fund. The Past and Future of Association Health Plans. https://www.commonwealthfund.org/blog/2019/past-future-association-health-plans. Accessed 10/19/2020.

Virginia, like other states, has sought to address premium relief. The last several years Virginia has had an ongoing discussion about the expansion of AHPs and MEWAs that can operate exempt from some of the ACA rules (e.g., rating and risk sharing rules) that govern the small group market. AHPs can offer lower premiums for many employers and self-employed individuals, largely because they have greater flexibility to adjust rates based on a greater number of factors than permitted under the ACA. However, employers with sicker, older workforces, or ones who have many women of childbearing age, could face higher premiums.

In the self-insured market, ERISA (1973) preempts state regulation with no supplanting federal regulation. Preemption includes

- Regulation of solvency to other financial matters
- Consumer protection
- Regulation of the content of health insurance. (*Note, however, that ERISA excludes MEWAs from its exemption clause, so states have full authority to regulate solvency, consumer protection, and benefits offered by self-funded MEWA's.)*

A 2018 study for the District of Columbia Health Benefit Exchange Authority, conducted by the actuarial firm Oliver Wyman, estimates that under the new DOL rule, AHPs could increase ACA individual market rates ranging from +1.1%-+10.9%, on a per member per month basis. For the small group market it estimates an increase ranging from +0.2-25.8%, depending upon assumptions.[46] Furthermore, AHPs have a history of taking employers' premium payments and declaring insolvency or committing fraud. They have been able to do this in part due to the dual way AHPs are regulated (by the federal government and by states). AHPs have become adept at taking advantage of the gaps in oversight/enforcement.

This option generated significant discussion across the group. The work group agreed on two central issues, that more Virginians should have access to health insurance and that cost is a problem for both the individual and small group markets. However they had divergent perspectives on the efficacy of AHPs in reducing costs and overall impacts on the individual and small group markets. For the purpose of analyzing the technical discussion, the perspectives are categorized by proponents and opponents.

Proponents

Proponents of AHPs (those in support of 2020 AHP legislation), expressed concern that many small business owners and sole proprietors are unable to afford coverage and would like to provide an option for their employees. They stated that under the proposed federal rules expanding the definition of bona fide employer, AHPs can create a larger single risk pool, similar to the way that large employers do today, and reduce premiums 7-10% for this group by health utilization management and rating factors such as geography. Proponents stated that they support the concept of comprehensive benefit coverage, and being subject to some specific rating rules. They argue that this was embodied in the bills passed by the General Assembly this year

[46] Oliver Wyman, Letter to DC Health Benefit Exchange Authority, February 21, 2018. https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Review%20of%20Impact%20of%20AHPs%202.21.2018.pdf Accessed November 15, 2020.

and vetoed by the Governor. They indicated that they could engage in the practice of the ACA risk adjustment program, like other carriers do, to offset the potential adverse selection that could occur, but that they considered it inappropriate citing that their plan would be for their members only, and that large group plans are not required to participate in risk adjustment under the ACA.

Opponents

Opponents of the potential expanded AHPs stated that it is only possible to get a cost reduction by creating a product that is not regulated by the BOI and does not have to comply fully with ACA standards. AHPs could be effective in cost reduction for some, because they are carving out a group from the ACA individual and small group single risk pools and applying their own rating rules. One example is that although they purport not to rate on health status specifically, there are other mechanisms that can be used to discriminate against higher risk individuals, for example, individuals that have drug usage, or are pregnant, or rate older individuals on a 5: 1 ratio versus the 3:1 ratio allowed by the ACA, or allow past claims experience to influence rates. Fundamentally, AHPs could draw healthier individuals out of the individual and small group markets into the association for lower rates but, could raise costs or ration benefits for others. This creates a system of winners and losers, instead of improving quality and affordability for all. Opponents stated that participation in the ACA risk adjustment program, single risk pool, and abiding by a 3:1 age rating would make the AHP proposals more palatable.

Opponents were sympathetic to the challenges small business owners face, and their goal is to help all individuals and small businesses afford comprehensive, sustainable coverage. The BOI and the SCC have invested months of hard work to implement the state-based exchange at the direction of the General Assembly, and have recently hired a new director. Now with the SBM-FP, the state is able to invest heavily in additional outreach and enrollment programs that target individuals without employees or employer based coverage. These activities make the market more predictable, which is attractive to carriers. In its first year as a state-based marketplace-federal platform, Virginia has seen a reduction in rates and an additional carrier has joined the marketplace. With the opportunity afforded to Virginia through its own Exchange, there are many stabilizing policy interventions supported by this group and mentioned in this report to strengthen its marketplace and drive down costs for everyone.

It was noted by the group that the difference between a large employer and an AHP is the risk pool. The large employer risk pool has individuals all employed by the same company versus an AHP where individuals are not. Fundamentally, this does not create adverse selection, and large employers are not competing for individuals or siphoning off those who would otherwise enroll in the individual or small group market. However, if a trade association wanted to require participation of all members that would make them more akin to a large group. The group also noted that for an AHP to reach a 7% rate reduction from where the premiums are today would be challenging, because that would assume that they would be able to manage costs better than insurance companies do today, because most savings are generated through the single risk pool.

Finally, the option for creating this new pathway of AHPs under federal law, is pending the outcome of the U.S. Circuit Court appeal in the *State of New York v. U.S. Department of Labor,* filed by a coalition of twelve U.S. Attorneys General (including Virginia Attorney General Mark

Herring) that challenged the DOL AHP Rule. If the Circuit Court upholds the lower court decision, that the rule is in conflict with ERISA and the Administrative Procedures Act, then the DOL rule will be vacated. If that occurs, Virginia would need to obtain an approved 1332 waiver in order to implement the AHPs that have been recently proposed in the General Assembly. However, it is not clear whether such a 1332 waiver would be approved, as the plans would still need to satisfy four guardrails in the ACA in order to obtain approval. The guardrails are:

1. Coverage must be "at least as comprehensive" as marketplace coverage.
2. Coverage and protections against excessive out-of-pocket spending under the waiver must be as affordable as marketplace coverage.
3. A comparable number of people must have coverage under the waiver as would have had coverage without the waiver.
4. The waiver cannot increase the federal deficit.

The intention of the guardrails is to ensure that the 1332 waivers do not leave state residents worse off than they would be without the waiver and that they do not benefit a single state at the expense of increased federal costs.

If the Circuit Court overturns the lower court decision, and the DOL AHP rule is validated, a 1332 waiver would not be necessary.

Another issue that should be considered is that with the outcome of the 2020 Presidential Election, under a Biden administration, the AHP rule could be rescinded entirely.

The discussion pertaining to AHPs and MEWAs was robust and spanned several meetings. However there are several questions that could inform Virginia's discussion, including, 1) What are the specific rating factors and utilization management strategies AHPs will use to decrease costs, and 2) How will AHPs and MEWAs avoid individual and small group market segmentation that studies show could undermine the state-based exchange?[47]

Increased Regulation of Level-Funded / Stop Loss Plans, and Professional Employer Organizations

Level-funded plans (LFPs) are plans and have been gaining traction with small businesses in recent years. LFPs are exempt from ACA regulations such as the EHB requirement, rating practices, and the MLR or 80/20 rule.[48]

In LFPs, employers pay a fixed amount of money to an insurance company for administrative and expected claims costs. If employer's total payments exceed the actual claims costs, there is a

[47] Keith, Katie, Health Affairs, "Reports Find Risk of Non-ACA Compliant Plans To Be Higher Than Federal Estimates", March 4, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180303.392660/full/, accessed November 15, 2020.

[48] Medical Loss Ratio (MLR), is a measurement to provide greater quality and value to enrollees. It indicates what percentage of premium dollars are required to be spent on medical claims and what percent can be spent on overhead expenses.

surplus that is refunded to the employer. However, if employee claims exceed employer contributions, then a "stop loss' insurance pays the balance.

In the small group market, businesses in a geographic region are pooled together, which spreads out risk and premiums are the same for everyone in the group. In contrast, level-funded plans are rated by individual business, so a company with healthier employees pays less than companies with employees that have greater health care needs. Further, with the MLR exemption, carriers are not held to the same claim expenses standard. Similar to AHPs and MEWAs, these plans attract businesses due to initial lower costs, but can segment the marketplace into higher and lower risk groups, and in the long run, do not meaningfully address the costs of coverage.[49]

The impact of level funded plans has gained the interest of the National Association of Insurance Commissioners (NAIC). The NAIC considered updating its model law in 2012, but efforts to update it by increasing the attachment point ($20,000 and 120% of expected claims) failed. A few states have slightly higher attachment points, running from $22,500 (MD) to $40,000 (DC and CA).

Some Work Group members state that LFPs are an attractive option for small businesses. Advantages cited are more predictable costs, the ability to compete with health benefits offered by large employers, and that while LFPs are exempt from the ACA actuarial requirements, offerings meet the minimum essential coverage (MEC) standard.[50]

Regarding further regulation, these Work Group members felt that increasing the attachment point of level-funded/stop lost plans, requires employers to take on more risk and disadvantages small employers. These members suggested that requiring EHB coverage could be considered, but that the potential impact should be studied.

Proponents of greater regulation felt strongly that level-funded or stop loss plans, as well as professional employer organizations (PEOs), have been a major reason for small groups leaving the marketplace. However, a challenge in seeking to further regulate them is that it is not known at this time how many small businesses have left the market to enroll in level funded plans, or what the details of these plans are. The proponents of further regulation recommended that Virginia conduct an environmental scan related to level-funded/stop loss plans and PEOs to identify the plan structures, financial risk exposure, and impact on the marketplace. Once data has been collected, policy interventions such as increasing the attachment point and regulating the marketing of such plans could be developed.

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[49] Shumate, Nathan. Fringe Benefit Analysts, "Fully Insured vs Self-Insured vs Level-Funded: What Does It All Mean to the Small Employer?" July 14, 2020, https://www.fbabenefits.com/fully-insured-self-insured-level-funded-mean-small-employer/accessed 10/28/2020.

[50] The Business Journals. "Is level-funded premium health insurance right for your small business?" October 25, 2019, https://www.bizjournals.com/bizjournals/news/2019/10/25/is-level-funded-premium-health-insurance-right-for.html , accessed 10/28/2020.

Merged Markets

Another policy option explored in several states is merged markets. This can take one of two forms. The first would be to merge the individual and small-group market together, like Massachusetts and Vermont. The second would be to expand the small-group market from 50 to 100 employees, similar to New York. The appeal of merged markets is in creating a bigger risk pool, which can decrease costs for some and lead to more stable premiums over time. However, studies on the impact of merging individual and small group markets suggest that small employers could see an increase in price, although those were generally in markets where the individual market rates were higher than small group rates. If small employers did see rate increases, it could potentially push more of these employers into self-funding or other unregulated arrangements.

The work group generally did not favor this option citing concerns such as: potential disincentive for carrier participation, it does not necessarily ensure cost reductions, and incentive for small employers to enter self-funded plans. Others saw this option as potentially destabilizing as more employers leave the marketplace.

Findings

The Market Stability and Reinsurance Work Group met eight times through the course of the summer and early fall of 2020. All meetings were held virtually. There was a high level of engagement from the broad cross section of stakeholder participants, and various opportunities for all participants to provide comment in the meetings and in writing. The group held substantive discussions on each topic presented.

The group built off of the recommendations of the 2018 Work Group, which set in motion the first phase of Virginia's market stability efforts, including the impact of Medicaid Expansion, and the development of the Virginia Health Benefit Exchange. The Work Group found the policy options below to be the most promising to build on Virginia's foundational work to provide access to coverage for as many Virginians as possible, improve affordability of coverage, preserve ACA protections, and to stabilize and sustain the individual and small group marketplaces.

While there are various operational details that would need to be addressed, the work group had general agreement about the following options for both the individual and small group markets.

Individual Market

1. Pursue a reinsurance program through a 1332 state innovation waiver (1332 waiver).
2. Direct the Bureau of Insurance to structure a state-based subsidies program that makes coverage more affordable.
3. Upon full transition to a state-based marketplace, the Health Benefit Exchange shall establish standing extended open enrollment periods and special enrollment periods to maximize enrollment and to promote seamless coverage (e.g., to coincide with tax filing, and for emergency situations such as COVID-19).

Small Group Market

1. Pursue a reinsurance program to decrease premiums in the small group market.
2. Direct the Exchange, navigator programs, and benefit manager organizations to increase outreach and marketing to small businesses, providing education and technical assistance to small businesses regarding:
    a. Small Business Health Options Program and small group opportunities, including the value of narrow networks, with employee choice.
    b. Educate and provide technical assistance information about Health Reimbursement Accounts (HRAs) through Virginia benefit manager organizations, registered agents and brokers, and provide technical assistance to small employers and employees for using HRAs.
3. Direct the State Corporation Commission to pursue additional data collection pertaining to the small group market. Such data should include:
    c. Self-funded plans, including, but not limited to obtaining: marketing and outreach strategies, the number of employers that have shifted to self-funded plans, claims profiles of self-insured small employers, relative to the fully-insured small group market.
    d. Professional employer organizations, and impacts on the small group market enrollment.

Limitations and Other Considerations

One of the key issues pertaining to affordability is the cost of healthcare services in the Commonwealth, and across the nation. The Work Group through both 2018 and 2020 meetings recommended important, strategic reforms that would improve Virginia's health coverage infrastructure. However, the Commonwealth has not yet undertaken a study that would address the cost drivers of health insurance in Virginia. This is partly due to insufficient data and resources to provide such comprehensive data analysis. With the reforms presently underway, and should the recommendations of the 2020 Work Group be implemented, Virginia will have made significant strides in improving its health care access infrastructure, and its health care markets and systems will be well-positioned to maximize the opportunities from decreasing the actual costs of healthcare.

New York v. the U.S. Department of Labor

In July 2018, Virginia Attorney General Mark Herring joined a coalition of twelve Attorneys General challenging the Department of Labor's Association Health Plan (AHP) rule. The lawsuit alleges that the rule violates both the Administrative Procedures Act and the Employment Retirement Income Security Act (ERISA), unlawfully reversing decades of agency and judicial interpretation of ERISA's key terms, especially the definition of bona fide employer. The lawsuit claims the primary purpose of the Rule is to undermine the ACA and fails to mitigate the increased risk of fraud and harm to consumers, based on an ample historical pattern

of AHPs. The Attorneys General are urging that the AHP Rule be vacated.[51] In March 2019, the Court struck down parts of the rule and a decision by the federal circuit court in *New York v. the US Department of Labor* is anticipated in late 2020. This decision, along with the outcome of the Presidential election will determine whether Association Health Plans can be expanded under federal law. It is possible that the future of the Department of Labor Rule will be known after this report is submitted but prior to 2021 General Assembly session.

Conclusion

In 2018, the Commonwealth expanded Medicaid, providing critical, lifesaving insurance coverage to 485,599 newly eligible, low-income Virginians. In 2020, the General Assembly, the Northam administration, and the State Corporation Commission worked together to enact, and implement the Virginia Health Benefit Exchange. The General Assembly also limited the sale of substandard health plans, to protect consumers from the serious financial risk that can arise with inadequate health coverage.

With these policy actions, Virginia is stabilizing the market, by adopting policies that align with the ACA at the state level. These actions have started to produce positive results. Rates decreased two years in a row, and another carrier entered the marketplace for 2021. Virginia invested a significant amount in outreach and enrollment for the next plan year. The state is committed to outreach to groups that typically do not have employer sponsored insurance and to marginalized communities. The State Corporation Commission hired a Director for the Virginia Health Benefit Exchange and a foundation for a reinsurance program has been established. There is much opportunity and work to be done prior to Virginia's transition to a full state-based exchange in 2023. With the policy priorities and principles espoused by the Market Stability and Reinsurance Work Group, Virginia is positioned to build upon previous efforts to make quality, affordable coverage more accessible.

[51] Attorney General Herring Joins Coalition of 12 States Attorneys General to File Suit to Block Trump Administration's Attempt to Undermine the Affordable Care Act. July 26, 2018, https://www.oag.state.va.us/media-center/news-releases/1239-july-26-2018-ag-herring-joins-coalition-of-12-state-ags-to-file-suit-to-block-trump-administration-s-attempt-to-undermine-affordable-care-act , Accessed 10/21/2020.

Appendix A – Model Virginia Health Insurance Affordability Act

Note: The draft legislation presented is based upon models from a review of other states.

Title 38.2

Reinsurance Program

Definition

- "Attachment point" is the threshold amount for claims costs incurred by an eligible insurer related to an enrolled individual's covered benefits in a calendar year, above which the claims costs for benefits are eligible for reinsurance payments under this part.

- "Affordable Care Act" is the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152, 124 Stat. 1029).

- "Coinsurance" is the percentage of claims to be reimbursed by reinsurance payments under this part that are above the attachment point but below the reinsurance cap.

- "Commission" is the State Corporation Commission.

- "Eligible insurer" is an insurer offering reinsurance-eligible health care plans to consumers in this Commonwealth.

- "Entity subject to this act" or "entity" means an entity that is subject to section 9010 of the Affordable Care Act and that may be subject to an assessment by the Commonwealth, including an insurer licensed to sell accident and sickness insurance, a health services plan, an health maintenance organization, a dental or optometric services plan, or a dental plan organization, authorized to deliver or issue for delivery health benefits, vision benefits, dental benefits plans in this Commonwealth. "Entity" shall include a non-fully insured multiple employer welfare arrangement that may at some point be registered pursuant to 14VAC5-410 or its successor.

- "Exchange" has the same meaning as set forth in § 38.2-6500.

- "Health benefits plan" means a benefits plan, that pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this Commonwealth by or through an entity subject to this act, including a vision or dental plan. For the purposes of this act, "health benefits plan" shall not include the following plans, policies or contracts: Medicaid, Medicare, Medicare Advantage, Medicare Supplement, accident only, credit, disability, long-term care, plans sold in the small group market as defined in §38.2-3431, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment

insurance, personal injury protection insurance issued pursuant to XXX, and hospital confinement indemnity coverage.

- "Health Insurance Affordability Assessment" is an assessment on an entity's net written premium.

- "Health Insurance Affordability Fund" means a special fund established within the state Treasury for the purpose of depositing Federal money and all other money received pursuant to and disbursements permitted by this chapter

- "Net written premiums." Premiums earned on health benefit plans delivered or issued for delivery in this State, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net written premium shall include the aggregate premiums earned on the entity's insured large group and individual business related to health benefit plans.

- "Plan year" means the calendar year for which insurance coverage is effective.

- "Reinsurance cap." The upper limit amount for claims costs incurred by an eligible insurer for an enrolled individual's covered benefits in a benefit year, over which the claims costs for benefits are no longer eligible for reinsurance payments under the reinsurance program.

- "Reinsurance-eligible enrollee" is an enrollee who is insured in a reinsurance-eligible health care plan under this part.

- "Reinsurance-eligible health care plan" means individual health insurance coverage, as defined in 38.2-3431, excluding grandfathered health plans.

- "Reinsurance program" means the Commonwealth Health Insurance Reinsurance Program.

- "Section 1332 State Innovation Waiver" or "waiver" means a waiver granted under the authority given by section 1332 of the Patient Protection and Affordable Care Act (PPACA) and its implementing regulations for the United States Secretary of Health and Human Services and the United States Secretary of the Treasury (collectively, the Secretaries) approving a state's proposal to waive specific provisions of the PPACA (also referred to as a State Relief and Empowerment Waiver), if the plan meets certain requirements.

- "Small group market" means the same as it is defined in § 38.2-3431.

Application

(a) Public review. The Secretary of Health and Human Resources shall make a draft application for a Section 1332 State Innovation Waiver available for public comment within 60 days of

the signing of this act and may submit the application on or before 120 days after the signing of this act.

(b) Amendment. The Secretary may amend the waiver application as necessary to carry out the provisions of this chapter.

(c) Notification. The Secretary of Health and Human Resources shall promptly notify the Senate Finance Committee, House Appropriations Committee, Senate Labor and Commerce Committee, and House of Delegates Labor and Commerce Committee, Senate Education and Health, and House Education and Health of any Federal actions regarding the waiver application and of any amendment to the waiver application.

Establishment of reinsurance program and operation of reinsurance program

(a) Upon approval of the Secretary's application for a Section 1332 State Innovation Waiver by appropriate or applicable federal agencies, the Commission shall implement a reinsurance program, known as the Commonwealth Health Insurance Reinsurance Program. The purpose of the program is to stabilize the premiums for health insurance policies in the individual market.

(b) The Commission, through the Bureau of Insurance, shall administer the program.

Reinsurance parameters

(a) The Commission shall, not less than 20 days before initial rates and not less than 60 days before final rates for health insurance policies are required to be submitted each year, determine and publish the attachment point, coinsurance and reinsurance cap applicable to the reinsurance program for the plan year applicable to the filed rates.

(b) In determining the attachment point, coinsurance rate, and reinsurance cap applicable to the reinsurance program, the Commission shall manage the program within the amount of total program funding available to the Commission through the Health Insurance Affordability Fund.

Funding

(a) Health Insurance Affordability Fund; The reinsurance program, including related administrative costs, shall be funded by the Health Insurance Affordability Fund, which includes assessment revenue from (b), such funds as the General Assembly may from time to time appropriate and any funds received from the Federal Government, or a combination of the three. The Commission shall have the authority to maintain a reasonable margin in the nature of a reserve in the Health Insurance Affordability Fund State Corporation Commission for the expenses of the reinsurance program.

(b) The Commission shall impose and collect an annual health insurance affordability assessment on entities actively issuing or administering health benefit plans in the Commonwealth during the plan year on which assessment is based. All such funds received under this section and paid into the state treasury shall be deposited to a special

fund designated "Health Insurance Affordability Fund," hereafter referred to as the "Fund." Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Nothing in this section shall prevent money in the Fund from being used as a revolving fund to cover necessary administrative and other expenditures of the assessment, reinsurance program and state subsidy programs if Federal money is requested and committed but not yet received or if other money is committed but not yet received.

(c) As directed by the Commission and pursuant to the uses specified for the Fund in **§ 38.2-XXXX** the monies in the fund shall be used exclusively for the purposes of increasing affordability in the individual market through a reinsurance program intended to decrease premiums by up to 20%, depending upon available revenue.

(d) The Commission shall not use any special fund revenues dedicated to its other functions and duties, including revenues from utility consumer taxes or fees from licensees regulated by the Commission, or fees paid to the office of the clerk of the Commission, to fund any of the activities or operating expenses of the Reinsurance program.

Assessment.

(a) The assessment imposed and collected by the Commission shall be 2.00% of an entity's net written premiums, as defined in this act, for the preceding plan year.

(b) The Commission shall calculate the assessment without regard to:

1) The threshold limits established in section 9010(b)(2)(A) of the Affordable Care Act; or

2) The partial exclusion of net written premiums provided for in section 9010(b)(2)(B) of the Affordable Care Act.

(c) No later than May 1 of each year, beginning with May 1, 2022, an entity shall:

1) Pay the health insurance affordability assessment pursuant to this section; and

2) Submit the entity's calculation of net written premiums to the Commission, as the Commission prescribes.

Annual audit

(a) The Commission's internal auditor shall:

1) Assess compliance with the requirements of this chapter, and
2) Document any material or significant deficiencies.

Annual report of operations

a) By October 15 of each year, in consultation with the Secretary of Health and Human Resources, the Commission shall report to Senate Finance, House Appropriations and the Governor. The report must include, at a minimum, the following information for the plan year that is the subject of the report:
    1) Amounts deposited into the Health Insurance Affordability Fund.
    2) Requests for reinsurance payments received from eligible insurers.
    3) Reinsurance payments made to eligible insurers.
    4) Administrative and operational expenses incurred for the reinsurance program.
    5) Quantifiable impact of the reinsurance program on individual health insurance coverage rates for the applicable plan year.

Emergency Enactment Clause

1. Upon approval of the Secretary's application for a Section 1332 State Innovation Waiver by appropriate or applicable federal agencies, the Commission shall implement a reinsurance program, known as the Commonwealth Health Insurance Reinsurance Program.

2. The Secretary of Health and Human Resources shall convene a Work Group that includes representatives from the State Corporation Commission Bureau of Insurance and Virginia Health Benefit Exchange Division, the Department of Tax, health plans, agents and brokers, navigators, other consumer assisters, consumer advocates, and other relevant stakeholders to develop recommendations for developing a state-based subsidy program to increase affordability of health plans to individuals and to increase enrollment in the state-based Exchange. The Work Group shall make use of available data pertaining to Exchange enrollment and uninsured individuals, to identify recommended options for providing subsidies. In doing so, the Work Group shall consider implications of a subsidy program on Exchange enrollment, the Reinsurance program, possible tax consequences for individuals, and a feasible timeframe for timeframe for implementing a subsidy program. The Secretary shall report the Work Group's recommendations for legislative consideration, to the Governor, the Health Benefit Exchange Advisory Committee, and the General Assembly, by September 15, 2021.