

NEVADA DEPARTMENT OF BUSINESS AND INDUSTRY
Division of Insurance

Market Options Study – Discussion Paper

Weighing Alternatives for Stabilizing the Nevada Individual Health Insurance Market



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I. BACKGROUND/OVERVIEW

The Nevada Division of Insurance (“the Division”) is concerned about the stability of the Nevada individual and small group health insurance markets that are subject to the provisions of the Patient Protection and Affordable Care Act (“ACA”). The individual market, in particular, is facing a combination of fewer issuers, rising premiums, and an increasing number of counties, particularly rural, with limited choices for consumers. For plan year 2018, four carriers initially filed health benefit plans to be sold on the Silver State Health Insurance Exchange (“the Exchange”) in only three of the State’s seventeen counties, with a proposed average rate increase of over 40 percent. Two carriers eventually pulled out of the Exchange before the end of the rate review process. For 2018, fourteen of the state’s seventeen counties will have only one carrier offering health benefit plans on the Exchange. The Division is undertaking a study aimed at exploring ways to improve the stability of the Nevada individual health insurance market.

The Division is researching potential state initiatives for the individual health insurance market that may improve market stability, reduce the number of uninsured Nevadans, improve affordability of insurance for consumers and improve access to care, particularly in Nevada’s rural areas. A stable market encourages healthy competition which increases consumer choice and tends to keep downward pressure on rates.

This document explores several potential state initiatives with the intent of determining whether any of these initiatives would be viable options for Nevada to meet the State’s goals. For the purpose of this document, unless otherwise indicated, assume that current law and federal guidance remain unchanged.

In order to prioritize the options that merit further study, the following policy goals have been identified as benchmarks against which the options should be considered:

- Stabilize the individual health insurance market
- Reduce the number of uninsured Nevadans
- Improve consumers’ access to care across the state and particularly in rural areas
- Improve affordability
- Increase competition among carriers
- Increase competition among providers

II. STATE-MANAGED PROGRAMS – HIGH-RISK POOLS / REINSURANCE PROGRAMS

The distribution of healthcare spending is skewed. Generally, fewer than 20% of individuals account for more than 80% of the cost. The premiums charged by carriers are largely driven by the cost of these

high-risk individuals. Prior to the ACA, carriers were allowed to underwrite their enrollees and vary premiums based on health status.

Under the community rating rules of the ACA, the cost of high-risk individuals are spread across a carrier's enrollees. In the ACA-compliant market, the establishment of a high-risk pool is one way to mitigate the impact of high-risk individuals.

Several states are considering the establishment of state-based reinsurance programs and/or high risk pools in order to reduce the cost of providing insurance coverage to high-cost individuals covered under ACA-compliant plans and improve the stability of the individual market. Minnesota, Oregon and Alaska all established state-based reinsurance programs. The following discussion will provide an overview and comparison of the following three approaches to mitigate the impact of high-risk individuals: a high-risk pool reimbursement program, (also referred to as a claims-based reinsurance program), a condition-based high-risk pool reimbursement program, (also referred to as an invisible high-risk pool or a condition-based reinsurance program), and a traditional high-risk pool.

a. High-Risk Pool Reimbursement (“Claims-Based Reinsurance”) Program

A high-risk pool reimbursement program is essentially a traditional claims-based reinsurance program in which a governmental agency takes on the role of the reinsurer. Examples of high-risk pool reimbursement programs in healthcare include federal programs such as the ACA's transitional reinsurance program¹, the high-risk pooling feature of the ACA risk adjustment program² and the Medicare Part D reinsurance program as well as state programs such as the reinsurance program administered by Nevada's Division of Healthcare Financing and Policy, Nevada's Medicaid agency³. Goals of these high-risk pool reimbursement programs include lowering premiums and dampening the effects of adverse selection. Minnesota and Oregon have established claims-based reinsurance programs which are expected to reduce 2018 premiums by 20% and 7%, respectively.

In March, 2017, Wakely Consulting Group, LLC (“Wakely”) issued a study,⁴ (“2017 Wakely Study”) which included an analysis of the impact of establishing a claims-based reinsurance program, for Nevada. Wakely concluded that a claims-based reinsurance program could help to stabilize the individual health insurance market and reduce premium levels if the program is funded through sources outside of the individual market.

How it would Work: The program reimburses carriers when an enrollee's claims exceed a pre-determined threshold (“attachment point”). The program pays a percentage (“coinsurance”) of claims above the point and below a maximum claim amount (“cap”). High-cost enrollees remain in the private market and therefore have the same benefit options available, pay the same premium and have access to the same subsidies as similarly situated lower cost enrollees.

¹ Section 1341 of the ACA.

² Section 1343 of the ACA

³ The State reimburses carriers for 75% of inpatient hospital costs above \$100,000 for any individual member.

⁴ “Market Analyses and the Impact of a state-based reinsurance program, March 2017”, Wakely Consulting Group, LLC

The impact on premiums of a claims-based reinsurance program depends on the source of funding. If this program is funded by simply transferring funds among the carriers benefitting from the reinsurance program, average premiums would remain unchanged but the distribution of premiums among carriers and potentially across geographic areas or other sub-sectors, such as metal tiers, would likely change. If funded externally, this approach would result in lower average premiums across the entire market. Potential sources of external funding include assessments on health insurers not directly benefitting from the program, self-insured health plans, providers, and general state or federal assessments.

Pros:

- This approach is structured as stop-loss insurance which is a common type of reinsurance arrangement used by carriers to mitigate their risk. Carriers are familiar with this approach and can easily factor the impact into their premium rates.
- This approach is easy to operationalize and requires a low to medium level of analysis to determine initial and on-going program parameters.
- A claims-based reinsurance program automatically adjusts to geographic cost differences or unanticipated changes in the incidence or severity of claims. This approach may also be modified to consider different reimbursement levels for different geographic areas, by adjusting attachment points, coinsurance and caps by region, which could result in making insurance coverage in the rural areas more affordable.
- A state claims-based reinsurance program can be designed to coordinate with the federal high-risk pool component of the risk adjustment program to provide additional risk mitigation support to carriers with high-risk individuals.
- This approach allows for continued care coordination and management of higher cost individuals.
- If funded externally, this approach would result in lower average premiums across the State, which is consistent with the goals stated in Section I above.
- This approach lowers premiums paid out-of-pocket by unsubsidized enrollees. This improves access and affordability for this segment of the population.
- This approach would allow high-cost enrollees to stay in the same risk pool with access to the same options as other enrollees. Under the ACA, the claims cost for a carrier's risk pool is spread across the entire risk pool so that a high-risk enrollee would be charged the same premium as a lower risk enrollee of the same age and geographic location. For the high-cost individual, this approach would result in lower premiums than the traditional high-risk pool approach discussed in subsection c below.
- A state establishing a claims-based reinsurance program could file for a section 1332⁵ waiver. If approved, the amount needed to be financed by a state could be reduced through federal "pass-through" funding.

⁵ Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to exempt the state from certain provisions of the ACA. See Appendix A for a summary of Section 1332 waivers. Federal regulations may be found here: <https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf>

Cons:

- If external funding cannot be secured, this approach would not reduce average premiums in the state. It may be politically difficult to obtain external funding. Legislative action may be needed to allow external funding.
- This option may require approval of a section 1332 waiver, which could be a long and expensive process for the State.
- If the parameters are too generous, this approach can cause inequities among insurers and create incentives for less efficient care management. Carriers that are able to negotiate lower provider reimbursement rates or provide tighter care management may benefit less than carriers with less effective cost controls. Similarly, carriers in low-cost areas may benefit less from this approach than carriers in high-cost areas.
- A claims-based reinsurance program may need to be coordinated with the federal risk adjustment program to avoid over-compensation for high-risk individuals. This adds administrative complexity and cost to the program.
- This approach would allow beneficiaries to stay in the same risk pool with access to the same options as other enrollees. High-cost enrollees would be charged the same premium as a lower risk enrollee of the same age and geographic location. For the low-cost individual, this approach would result in higher premiums than the traditional high-risk pool approach discussed in subsection c below.

Additional Considerations:

In designing a state-based claims-based reinsurance program, Nevada will need to consider and prioritize the specific goals for this type of program. For example:

- Is it more important to reduce premiums or to seek equity among various subgroups, such as metal levels, geographic areas, etc.?
- If the goal is to reduce premiums, what is the target reduction level?
- Should the target premium reduction be uniform across the state or should it allow for higher reduction in rural areas in order to have more rate uniformity across the state?
- Should the program be established only for the rural areas?
- Are the parameters chosen consistent with the promotion of effective care management? A coinsurance rate higher than 60% may be inconsistent with the goal of effective care management.
- How should the program coordinate with the federal high-risk pooling component of the risk adjustment program?
- Should the program be designed to address the cost of individuals with the highest risk or medium-high risk?
- How should the program coordinate with Nevada law, which requires health maintenance organizations (“HMOs”) to have commercial reinsurance?

Table 1 below summarizes the major findings of the 2017 Wakely Study with regard to the design of a state claims-based reinsurance program. By varying the parameters (attachment point, cap and coinsurance rate) the study illustrated hypothetical scenarios that removed between 6% and 24% of claims from the individual health insurance market. The claims removed from the individual market reduce the obligation of the insurance carriers, which results in lower premiums charged to consumers. The obligation for payment of these claims would be transferred to the State’s claims-based reinsurance program.

Table 1. Summary of Claims-Based Reinsurance Program Scenarios from the 2017 Wakely Study

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Attachment Point	\$90,000	\$45,000	\$45,000	\$45,000
Reinsurance Cap	\$250,000	\$400,000	\$250,000	250,000
Coinsurance	50%	70%	100%	55%
Total Claims Removed	6%	19%	24%	13%

b. Condition-Based High-Risk Pool Reimbursement (“Condition-Based Reinsurance”) Program

A condition-based high-risk pool reimbursement program is sometimes referred to as an invisible high-risk pool because it combines the features of a traditional reinsurance program with those of a traditional high-risk pool. Alaska recently implemented an externally funded condition-based reinsurance program which reduced premiums by 20%.

How it would work: Under this approach, carriers are reimbursed by the state program for claims incurred by individuals diagnosed with certain pre-determined conditions. Generally, the program reimburses carriers for all claims incurred by eligible individuals, not just the claims related to the specific condition(s) that determined eligibility. A modification to this program would reflect reference pricing, which limits the amount that would be reimbursed for specific diagnoses based on a reference point, such as Medicare or Medicaid reimbursement levels. As in the claims-based reinsurance option (subsection a above), under this approach the high-risk individuals remain in the same risk pool as lower-risk individuals, and the net impact of the program would be reflected as a change to the index rate, which affects the final premium paid by everyone included in the risk pool.

As with the claims-based reinsurance program, the impact on premiums of a condition-based reinsurance program depends on the source of funding. If this program is funded by simply transferring funds among the carriers benefitting from the reinsurance program, average premiums would remain unchanged but the distribution of premiums among carriers and potentially across geographic areas or other sub-sectors, such as metal tiers, would likely change. If funded externally, this approach would result in lower average premiums across the entire market. Potential sources of external funding include assessments on health insurers not directly benefitting from the program, self-insured health plans, providers, and general state or federal assessments.

Pros:

- If the condition-based reimbursement approach is coupled with reference pricing, there would be incentives for medical management which would result in lower premiums.
- Since individuals eligible for this program remain in the plan selected, this approach allows for continued care coordination and management of higher cost individuals.
- If funded externally, this approach would result in lower premiums for the entire risk pool.
- This approach lowers premiums paid out-of-pocket by unsubsidized enrollees. This improves access and affordability for this segment of the population.
- This approach would allow high-cost enrollees to stay in the same risk pool with access to the same options as other enrollees. Under the ACA, the claims cost for a carrier's risk pool is spread across the entire risk pool so that a high-risk enrollee would be charged the same premium as a lower risk enrollee of the same age and geographic location. For the high-cost individual, this approach would result in lower premiums than in the traditional high-risk pool approach discussed in subsection c below.
- A state establishing a condition-based reinsurance program could file for a section 1332 waiver. If approved, the amount needed to be financed by a state could be reduced through federal "pass-through" funding.

Cons:

- This approach is operationally more complex than the claims-based reinsurance option and is dependent on the accuracy of the coding of medical conditions by providers. Determining which conditions should be reimbursed is time consuming, and requires extensive analysis for initial set-up and maintenance of the program.
- Compared to the claims-based reinsurance program discussed in subsection a above, it would be more difficult for carriers to reflect the impact of this program in their rates.
- If external funding cannot be secured, this approach would not reduce average premiums. It may be politically difficult to obtain external funding. Legislative action may be needed to allow external funding.
- This option may require approval of a section 1332 waiver, which could be a long process.
- Unless reference pricing is used with this program, this approach can incentivize less efficient care management.
- This program would need to be coordinated with the federal risk adjustment program to avoid over-compensation of specific conditions. This would increase the administrative complexity and cost of the program.
- This approach would allow beneficiaries to stay in the same risk pool with access to the same options as other enrollees. A high-cost enrollee would be charged the same premium as a lower risk enrollee of the same age and geographic location. For the low-cost individual, this approach would result in higher premiums than the traditional high-risk pool approach discussed in subsection c below.

Additional Considerations:

In designing a state condition-based reinsurance program, one of the most important decisions is developing the list of conditions that will determine eligibility for the program. Two states, Alaska and Maine have implemented different versions of this type of program so it may be beneficial to review the design, and list of conditions, used by these two states as a starting point for analyzing the impact of establishing this type of program. Appendix B includes the list of 33 conditions used in Alaska's conditions-based risk adjustment program. Appendix C provides a brief description of Maine's reinsurance program, which is a combination of a claims-based and condition-based reinsurance program.

It is also important to determine if the program will be retrospective or prospective with regard to determination of eligibility. The retrospective approach may be better aligned with the federal risk adjustment program. However, the timing of the distribution of amounts payable from the program may be delayed.

c. Traditional High-Risk Pool

Prior to the ACA, most states established high-risk pools for their residents who did not have access to employer coverage or public insurance and who, due to pre-existing conditions, were either charged much higher premiums for individual market coverage, offered coverage excluding certain conditions, or denied coverage altogether. Some states also used high-risk pools to meet the Health Insurance Portability and Accountability Act ("HIPAA") requirement that individuals losing group coverage have access to individual market coverage on a guaranteed basis. Although a few traditional high-risk pools remain, the guaranteed availability of individual market coverage at standard rates under the ACA reduced the need for traditional high-risk pools.

In addition to premiums paid by eligible individuals, high-risk pools were supported by a combination of state funds, fees assessed on private health insurance carriers, and, to a lesser extent, federal grants.

How it would Work: Under this approach, eligible enrollees are identified based on the existence of certain medical conditions. However, unlike the condition-based reinsurance option (subsection b), once identified, eligible individuals are moved out of the commercial individual market into a separate state-managed insurance pool. An example of this type of high-risk pool is the ACA's federal Pre-Existing Condition Insurance Plan ("PCIP"). By removing these high-cost individuals from the commercial risk pool, premiums in the commercial market would be lower. However, premiums in the high risk pool would be higher.

Pros

- Since the high-risk individuals are in a separate pool, the morbidity of the private individual insurance market will be lower, and enrollees in the private market would pay lower premiums than they would if either a claims-based and condition-based reinsurance options (subsections a and b) were established instead.

Cons

- Unless there is a significant amount of external funding, higher risk individuals may face much higher premiums than they would under the claims-based or condition-based reinsurance options. High premium rates may discourage coverage and may be in conflict with the State's goals.
- Since the traditional high-risk pool would be separate from the private individual market, the benefit options, provider options and choice of insurers may be different from that of the private market. This could result in discontinuity of care for members of the high-risk pool.

Additional Considerations:

The premium rates and eligibility criteria for the traditional high risk pool can have a significant impact on the premiums in the commercial individual market. The more individuals in the high risk pool, the lower the premiums in the individual market. This would improve the affordability of the individual market, but would put upward pressure on rates in the traditional high-risk pool and increase the cost of the program.

Recommendation for State High-Risk Pool / Reinsurance Programs:

The reimbursement high-risk pooling options for the claims-based and condition-based reinsurance options (subsections a and b) warrant further study.

The State needs to decide if the major goal of a high-risk pool reimbursement program would be to reduce premiums or to level out profitability across subgroups such as metal tiers or rating areas. Reducing premiums would require external funding whereas equalizing profitability could be accomplished by redistributing funds among carriers participating in the program. The following are specific recommendations for analyzing the impact of a claims-based reinsurance program.

- Update the analysis provided in the 2017 Wakely study to establish a baseline estimate of the premium reduction as well as the claims amount that would be removed from the market using the parameters for the 2015 transitional reinsurance program⁶. This would provide a baseline for developing other scenarios. The 2017 Wakely study indicated that 13% of claims (approximately \$70 million) would be removed if the 2015 transitional reinsurance parameters were used. The analysis should provide the impact on claims, premiums and profitability by county, rating area, metal level and by Exchange status (on/off Exchange).
- Produce additional scenarios which will be determined after an update of the prior study is completed. In creating the additional scenarios, consideration should be given to coordination with the State reinsurance requirement for HMOs and the federal high-risk pooling feature of

⁶ Parameters for the 2015 Transitional Reinsurance Program: \$45,000 attachment point, \$250,000 cap, 55% coinsurance rate.

the risk adjustment program as well as goals for addressing the cost of insurance in rural counties.

The following are specific recommendations for analyzing the condition-based reinsurance program:

- As a baseline, use the 33 conditions used by Alaska⁷ in their condition-based reinsurance program and estimate the funds needed to remove all paid costs (not just the costs for the identified conditions) for the individuals identified with any of the selected conditions.
- Develop a final list of conditions that would determine eligibility for the program, based on input from the Division and using Nevada data if credible. Additional data sources may be used if there are credibility concerns.
- Based on the selected list of conditions, estimate the funds needed to remove all paid costs (not just the costs for the identified conditions) for the individuals identified with any of the selected conditions and provide summaries of the impact for specific sub-segments.
- Consider the funds needed if reimbursement amounts for the specified conditions were limited to a percentage of Medicare (e.g., 120% of Medicare) or Medicaid rates. The reimbursement percentage assumed may need to vary by county and type of service.

III. STATE-MANAGED PROGRAMS - PUBLIC OPTIONS

State and federal policymakers around the country have expressed interest in exploring a public option as a way to provide access to affordable healthcare for their constituents. Some are considering offering a public option alongside private insurance and others are considering establishing a state-managed insurance program in rural counties only as a last resort solution for providing access to healthcare in underserved counties. There are primarily two types of public options currently being considered by policymakers across the country: The first is the expansion of existing government programs, such as Medicare and Medicaid (also referred to as Medicare or Medicaid buy-in). The second is the creation of a new government-run plan that could potentially compete against private insurers in the individual marketplaces.

⁷ The medical conditions used to determine eligibility for Alaska's reinsurance program are included in Appendix B. This list of conditions was extracted from Alaska's application for a section 1332 waiver which may be found here: <https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033>

a. Medicaid Buy-In

Under this option, individuals that do not meet the eligibility criteria for Medicaid would be able to purchase a Medicaid plan. There is precedent for this approach. In several states, disabled individuals who do not meet the state's Medicaid income eligibility criteria are able to purchase a Medicaid plan.

How it would Work:

The original version of the 2017 State Assembly Bill 374 ("AB 374") was an example of this option. It would have allowed non-Medicaid-eligible individuals to purchase Medicaid plans that would have been offered alongside qualified health plans ("QHPs")⁸ on the Exchange.

The State Public Option Act⁹ was recently introduced into the US House of Representatives. Under this bill, states would be able to allow individuals in their state, who are otherwise ineligible for Medicaid, to purchase a plan offered under the state Medicaid program. Non-Medicaid individuals would be charged premiums, copays and deductibles for the Medicaid plans offered, based on existing standards in the Affordable Care Act, and would be eligible for federal subsidies to help out-of-pocket expenses related to premiums, co-pays, deductibles and coinsurance. States would not be allowed to charge premiums higher than 9.5 percent of a family's income, and plans would be required to cover the essential health benefits ("EHBs") required under the ACA. In geographic areas where the public option is the only plan available, it would be considered to be the second lowest cost silver plan upon which premium subsidies would be based. Under this bill, states would also be able to apply for grant funds to cover expenses related to the implementation of a Medicaid buy-in option. Typically, the Medicaid buy-in option would be managed by the agency administering the state Medicaid program.

This is an area with significant potential for innovation. States and policy experts are exploring the feasibility of different Medicaid buy-in program options which would effectively leverage available federal, state and other resources. In the coming months, the actual design of these innovative concepts should become clearer and Nevada would have more examples of feasible Medicaid buy-in program options from which to choose.

Pros:

- A Medicaid buy-in option could offer affordable health insurance coverage and increase competition in a state.
- A Medicaid buy-in option could be a solution for underserved areas in a state.
- This option would allow for continuation of care for individuals who move between the Medicaid and commercial individual health insurance markets.

⁸ Qualified Health Plan is defined in federal regulation - 45 CFR 155.20

⁹ H.R. 4129, the State Public Option Act was introduced in the House of Representatives on October 25, 2017. The text of the bill may be accessed at this link: <https://www.congress.gov/115/bills/hr4129/BILLS-115hr4129ih.xml>

Cons:

- If provider reimbursement rates available under the Medicaid buy-in option are significantly lower than commercial reimbursement rates, providers may not want to contract with carriers that participate in the public program.
- Carriers may not want to participate in the Medicaid buy-in program. This may affect carrier participation in the Medicaid program.
- If Medicaid buy-in premiums are significantly lower than premiums in the commercial market, commercial carriers would not be able to compete and they would leave the commercial market. This would further reduce the options available to consumers who are not eligible for Medicaid. This comes at a time when Nevada is already at risk for losing carriers in the commercial individual health insurance market.

Additional Considerations:

A public option, such as a Medicaid buy-in program, is controversial and may not be politically viable. A Medicaid buy-in program would be managed by the State Medicaid agency. It would be helpful for the Division to better understand the potential impact of this program on the commercial market which it regulates.

b. Public Health Benefit Plan

There is growing support for state-run entities to offer public health benefit plans to individuals which could compete with commercial individual health insurance products. A significant number of counties in the U.S. will have just one insurer option in the ACA marketplaces in 2018. In Nevada, 14 out of the State's 17 counties will have only one carrier participating on the Exchange in 2018. The creation of a new public health benefit plan could fill the gaps in counties where insurance options are limited or nonexistent, offering consumers choice and competitive pricing.

How it would Work: There are several ways in which a public healthcare plan could work.

AB 374, which was passed by both houses of the 2017 Nevada state legislature and ultimately vetoed by the Governor, is one example of a public health benefit plan. This bill would have authorized the state's Director of Health and Human Services to enter into contracts with private insurers to create a "Nevada Care Plan," with benefits similar to Medicaid insurance. Nevada Care would have been offered alongside private insurance plans to provide consumers with additional choices.

Alternatively, the State could contract (through the State procurement process) with an existing carrier, which is currently offering QHPs or is willing to offer QHPs, to provide all plan functions on an administrative services only ("ASO") basis.

A third option would be for the State to leverage the Public Employees Benefit Plan (PEBP) contract and use the provider network to offer health benefit plans on a fee for service basis in the rural counties. Written consent from PEBP's leadership, and potentially its Board of Directors, would be required before this option could be explored in-depth.

Pros:

- This option could be a solution for underserved areas/bare counties in a state.
- If offered alongside commercial plans, a public health benefit plan could offer affordable health insurance coverage and increase competition in a state.
- A public health benefit plan that leverages the resources available to the State Medicaid agency would allow for continuation of care for individuals who move between the Medicaid and commercial individual health insurance markets.
- A public health benefit plan could leverage the State's Medicaid or PEBP programs to negotiate more favorable provider reimbursement rates and prescription drug costs.

Cons:

- If the public health benefit plans were designed to mimic the provisions of AB 374, carriers would not be obligated to offer the public health benefit plan.
- If the public health benefit plans were designed to mimic the provisions of AB 374, it is unclear how the public health benefit plan would work in non-urban areas where the Medicaid managed care organizations ("MCOs") are not currently providing coverage. Under current contracts, MCOs are providing coverage in Washoe and Clark counties only. That would leave 15 counties not covered by the public health benefit plan.
- If provider reimbursement rates offered by the State, for the public health benefit plans, are significantly lower than commercial reimbursement rates, providers may not want to contract with carriers who participate in the public program.
- If premiums for the public health benefit plans are significantly lower than premiums in the commercial market, commercial carriers would not be able to compete and they would leave the commercial market.
- Depending on how a public health benefit plan is implemented, legislative action may be needed.

Additional Considerations:

This option may be more politically feasible, and easier to implement, than a Medicaid buy-in program. Pursuant to NRS 686B.180, the Nevada Commissioner of Insurance ("the Commissioner") may establish

a state-managed insurance program if there is no voluntary market for any type of essential insurance. Under this authority, the Commissioner could establish a public health benefit plan, as described above, to ensure that residents in counties with no commercial insurance options would have access to health insurance coverage. The Commissioner has the authority to assess all health carriers in order to fund essential insurance association program.

Recommendation for State Managed Programs – Public Option:

The Division should analyze the impact of a Medicaid buy-in option on the commercial insurance market.

In order to be prepared for the possibility of having bare counties, the Division should analyze the cost and benefits of implementing a state-run health benefit plan for under-served areas. This may include the use of networks currently used by the state (PEBP, Medicaid) with similar reimbursement rates. The analysis may include suggestions for designing the state public option to allow enrollees to have continued access to federal subsidies.

IV. STATE-MANAGED PROGRAMS - RISK ADJUSTMENT PROGRAM

In the guaranteed issue, community rating environment of the ACA, a risk adjustment program is needed to ensure that carriers are appropriately compensated for the risk that they assume. The federal ACA risk adjustment program is intended to accomplish this goal. A state risk adjustment program could complement the federal program to meet the specific policy goals of the state.

How it would Work:

Generally, carriers with healthier enrollees pay into the program and carriers with less healthy enrollees receive payments from the program. The State risk adjustment program could be designed to simplify transfer payments among carriers or, additional funding from state or federal sources may be used to supplement transfer payments from carriers. A state supplemental risk adjustment program could be designed to take into account the federal risk adjustment program as well as any state programs that change the level of compensation (such as the options discussed in Section II) and ensure that all carriers are appropriately compensated after the impact of all federal and state programs are reflected.

An effective risk adjustment program requires constant monitoring and refinement of the risk adjustment methodology to ensure that the program meets its goals.

Pros:

- A state risk adjustment program could reduce the impact of adverse selection and coordinate the net effect of the federal risk adjustment and state risk pooling arrangements to improve the overall appropriateness of compensation received by carriers.
- If funded externally, a State risk adjustment program would reduce state average premiums.

Cons:

- A state risk adjustment program could add a significant level of administrative complexity and cost to the state.
- The federal risk adjustment program is still being refined to ensure that the transfer payments between carriers better reflect the differences in the risk of enrollees of each carrier. It may be difficult to design an effective supplemental risk adjustment program until the planned modifications to the federal risk adjustment program are fully implemented. In the meantime, a well-designed high risk pooling program (Section II) could have a similar impact and is easier to implement.
- A supplemental state risk adjustment program may need to be approved by the Centers for Medicare and Medicaid Services (“CMS”). This may be a lengthy and costly endeavor.
- A supplemental state risk adjustment program does not address the underlying cost of coverage.

Additional Considerations:

A well designed risk adjustment program, with external funding, aligns well with the State’s goals of lowering premiums and stabilizing the individual health insurance market. Risk adjustment is a complex program to administer so a cost benefit analysis should be performed as part of the decision making process to ensure the cost-effectiveness of the program.

Recommendation for State-Managed Programs - Risk Adjustment

Further study of a state supplemental risk adjustment program should be delayed until the design elements of the federal risk adjustment program have stabilized. If the State decides to implement any initiative that changes the compensation of carriers, it may be prudent to consider establishing a supplemental state risk adjustment program to ensure that carriers are not paid more than once for the same risk.

V. OTHER STATE INITIATIVES

Nevada may want to consider implementing other options that are consistent with the State’s goals of improving access to and affordability of health insurance coverage available to Nevada residents. This Section discusses three such initiatives: an inter-state compact, a premium subsidy wrap program, and a cost-sharing subsidy wrap program.

a. Inter-State Compact

Section 1333 of the ACA provides the framework for the sale of health benefit plans across state lines. Under this provision, two or more states are permitted to form “health care choice inter-state compacts” to allow carriers to sell QHPs in any state participating in the compact. Under these compacts, at least one QHP may be offered, subject to the laws and regulations of the state in which the QHP was written or issued.

Nevada is in the early stages of weighing the benefits, challenges and limitations of entering into a Section 1333 compact with Utah (and potentially other states) to enhance access to affordable insurance for individuals residing in rural counties close to Nevada’s borders. Federal regulations pertaining to Section 1333 of the ACA have not yet been promulgated. The implementation of this type of arrangement will depend on final federal regulations, states’ interpretation and understanding of applicable laws if regulations are not promulgated before states are ready to enter into compact agreements, actual terms of the compact and the laws of the states that are included in the compact. Once the main elements of the compact are determined, an analysis of the impact on cost and other factors may be appropriate.

How it would Work:

Under the ACA, all products approved by a Section 1333 compact could be sold in any of the compact states. Carriers offering policies approved by the Section 1333 compact would have to:

- Remain subject to the market conduct, unfair trade practices, network adequacy, consumer protection, and dispute resolution standards of any state in which a plan issued under a compact agreement is sold,
- Be licensed in each state in which a plan issued under the compact agreement is sold, and
- Notify consumers that a plan sold under a compact agreement may not be subject to the laws of the state in which the plan was purchased.

The US Department of Health and Human Services (“HHS”) is required to approve Section 1333 compacts provided that the compact does not: reduce the comprehensiveness of coverage, reduce cost sharing and affordability protections, decrease the number of people insured, increase the federal deficit, or weaken enforcement of laws and regulations in any of the participating states.

Pros:

- A compact may allow Nevada to meet the State’s main policy goals of improving access to healthcare and / or improving affordability of healthcare. Additionally, compacts may bring more carriers into the state which should increase competition and apply downward pressure on premium rates.

Cons:

- Agreements of this nature will need legislative approval. Implementation of a compact may need to be delayed until after the 2019 legislative session.
- Entering into a compact agreement before Section 1333 regulations are promulgated may be legally risky.
- Nevada's interest in entering into a compact agreement is related to improving access to care for rural residents. The establishment of a section 1333 compact may have broader implications than intended.

Additional Considerations:

Inter-state agreements of this nature may be consistent with the State's policy goals but may be difficult to implement due to the political and cultural climate. It is expected that there would be strong opinions on every side of this issue from consumers, providers and carriers. Further legal analysis is being done in order to better understand the requirements of Section 1333 and the implications for states signing the compact. Although several states have enacted legislation to allow them to enter into compacts with other states, none have actually established compacts.

Nevada's interest in establishing a compact with contiguous states is motivated by the State's goal of offering additional choices to residents of rural counties who faced the real possibility of not having any carriers offering coverage on the Exchange in 2018. This goal may be accomplished by encouraging carriers in contiguous states, to become licensed in Nevada and to provide health benefit plans in Nevada with in-network access to providers both within and outside the State borders, provided network adequacy requirements are met. This is a simpler solution which may not require additional legislation and which does not compromise State regulatory authority.

b. Premium Wrap

Some states are considering providing premium subsidies in addition to the federal subsidies available on the marketplaces. These "premium wrap" programs could be designed to target specific populations to make insurance more affordable and encourage more individuals to obtain insurance.

How it would Work:

A premium wrap program provides state subsidies to a target population in addition to any subsidies that may be available from the federal government. The actual design of this program depends on the target population.

For example, if the target population is rural Nevada, then premium subsidies would be designed to supplement the federal subsidies to residents of eligible counties. To target younger residents of the State, the subsidies could vary by age, with younger residents receiving higher subsidies and older residents receiving lower subsidies.

Pros:

- A premium wrap reduces the premiums paid by an individual and therefore makes it more affordable for the individual to purchase insurance.
- Individuals with no or low healthcare needs may be incentivized to purchase insurance. This would likely improve the morbidity of the individual health insurance pool which should ultimately result in lower rates.

Cons:

- A premium wrap program does not address the cost of coverage.
- A premium wrap program adds complexity to the calculation of net premiums payable by the individual. The current IT platform used by the Exchange, healthcare.gov, may not be able to accommodate this added complexity. Operationalizing this feature so that it is seamless to the consumer may be a challenge.

Additional Considerations:

Determining the target population for a premium wrap program may be a challenge since it would involve prioritizing the needs of different segments of the population in addition to considering the costs and benefits.

c. Cost-Sharing Subsidy Wrap

A cost-sharing subsidy wrap reduces the out-of-pocket expenses paid by the consumer and therefore makes it more affordable for the individual to purchase insurance. Therefore, more individuals may be incentivized to purchase insurance.

How it would Work

A state cost-sharing wrap would cover some of an enrollee's out of pocket expenses such as deductibles, coinsurance and copays. As with premium wraps, this program could be designed to target specific populations by age, geographic area or income level.

Pros:

- A cost sharing wrap addresses the issue of under-insurance. It increases the value of insurance to the individual by reducing out of pocket expenses, which could make insurance more affordable for the individual. More individuals may be encouraged to purchase insurance and the incentive for healthy individuals to drop coverage may be dampened.

Cons:

- A cost-sharing wrap feature adds operational complexity for the carrier and would need to be coordinated with the federal cost-sharing subsidies.

- The current IT platform used by the Exchange, healthcare.gov, may not be able to accurately reflect the net cost-sharing amounts to consumers.
- Operationalizing this feature so that it is seamless to the consumer may be a challenge.
- A cost sharing wrap does not address the cost of coverage.

d. Elimination of Grandfathered Plans

A grandfathered plan is a health insurance policy purchased on or before March 23, 2010, that has not changed significantly since that time. Many carriers across the country have stopped offering grandfathered plans and many enrollees have dropped coverage in these plans. The enrollees in these plans tend to be healthier than average and the premiums charged for grandfathered plans tend to be lower than premiums charged for non-grandfathered plans.

Pros:

- Eliminating grandfathered plans in Nevada could improve the morbidity of the individual single risk pool and reduce premiums in this market.
- For carriers with grandfathered plans, this change would likely reduce administrative expenses associated with maintaining plans under two different sets of rules.

Cons:

- This change may increase premiums for grandfathered individuals and reduce choices for these particular consumers.

Additional Considerations:

The majority of grandfathered policies in Nevada are offered by two carriers. It is our current understanding that federal laws prohibit a state from eliminating grandfathered plans. However, it may be prudent for the Division or another State agency to initiate discussions with these two carriers to determine their openness to voluntarily eliminate their grandfathered plans. Quantifying the potential impact on premiums may be helpful in starting the conversation.

Recommendation – Other State Initiatives:

An analysis of the specific impact of an inter-state compact may be delayed until federal guidance is released and the implications for states entering into these agreements are better understood as there may be additional ways to achieve the same objective.

A high level comparison of unit costs for certain counties in Nevada and contiguous states is prudent so that the impact of having expanded networks that cross state lines may be more fully understood.

Further analysis of the impact of premium wraps and cost sharing wraps is prudent, particularly if the impact on enrollment and on the morbidity of the individual risk pool could be modeled. Additionally, an analysis of the impact of these programs on the affordability of insurance to residents of rural areas

would provide important information to policymakers. Studies relating to different designs of premium wrap programs are currently being performed by health policy experts. We expect that the results of these studies will be available in May, 2018.

The Division should analyze the impact of eliminating grandfathered plans on the individual health insurance market.

VI. CHANGE IN STATE RATING RULES

Under the ACA, states can set standards with regard to the age curve and rating areas which can have a significant impact on pricing. Nevada could review its options relating to the State rating rules and determine if changes are indicated.

a. State-Specific Age Curve

Under the ACA, the premium for a 64 year old may not be more than three times the premium for a 21 year old. The age curve represents the factors by which premiums could vary at each age. States are allowed to use a state-specific age curve or use the default federal age curve. In 2014, Nevada opted to use the federal age curve, established by CMS and which remained unchanged until the 2018 plan year. Last year, Nevada contracted with Wakely to determine whether a state-specific age curve should be established for Nevada or whether the State should use the updated 2018 federal age curve for plan years 2018 and beyond. This study¹⁰ (“Age Curve Study”) concluded that a change to the age curve was not recommended because the age curve indicated by Nevada-specific data was not sufficiently different from the federal age curve. Additionally, details of planned changes to the risk adjustment program were not known at the time of the study and those changes could have a significant impact on results. The results of the Age Curve Study do not support changing the age curve used in rating ACA-compliant plans in Nevada at this time.

b. Rating Areas

The ACA requires states to establish geographic rating areas which all carriers in the state are required to use in developing premiums. Nevada established four rating areas, the maximum number of rating areas currently allowed by Federal rating rules: 1) Nye and Clark counties, 2) Washoe county, 3) Storey, Douglas, Carson City and Lyon counties and 4) all other counties. These rating areas were set for the 2014 plan year and have remained unchanged. CMS recently indicated that there may be some flexibility in the sub-regulatory guidance relating to the determination and approval of rating areas which may allow Nevada to reconfigure the established rating areas.

Pros:

¹⁰ “2018 Age Curve Analysis and Recommendations”, Wakely Consulting, LLC.

- A change in rating areas does not require a change in state law or regulation. It simply requires the state to file the new rating areas, along with actuarial support, with CMS.
- A change in rating areas does not require a 1332 waiver (see Appendix A for a brief summary of a 1332 waiver).
- A re-configuration of the rating areas could allow carriers to rate more appropriately for each rating area and encourage carriers to provide coverage in underserved counties.

Cons:

- A change in rating areas may not be feasible for the 2019 plan year. The analysis needed to support such a change may not be completed in time for carriers to incorporate the changes into the pricing of their products for 2019. Additionally, official CMS rules require states to file rating rule changes for 2019 by December 31, 2017.
- Some counties are sparsely populated so it may be difficult to obtain credible experience data. This may limit the extent to which the rating areas may be reconfigured.
- This option does not necessarily reduce average state premiums.
- This option requires CMS approval.

Additional Considerations:

The 2017 Wakely Study indicated that there was a significant variability in profitability of carriers by rating area on and off the Exchange. The study showed that, based on 2015 data, on the Exchange, rating area 4 was the most profitable and rating area 3 was the least profitable. Off the Exchange, the study indicated that rating area 2 was the most profitable and rating area 4 was the least profitable. These results are counter-intuitive and do not explain the reluctance of carriers to participate in rating areas 3 and 4. These results may be more reflective of the sensitivity of results to the quality of the data used and to the rating factors used by specific carriers. In addition to analyzing profitability by rating area, an analysis of normalized claims by county using updated 2016 data may provide insight into the reluctance of carriers to provide coverage in rating areas 3 and 4.

Currently, the service areas on the Exchange are aligned with the rating areas. It is important for a change in the rating areas to be coordinated with a review and potential reconfiguration of the service areas for QHPs. Otherwise, a change in the rating areas may exacerbate the “bare county” situation. While the setting of the rating areas is under the purview of the Division, the service areas for QHPs are set by the Exchange. Therefore, the Division would need to coordinate closely with the Exchange before final decisions are made with regard to changing rating areas.

Recommendation for Changes to State Rating Rules:

There is no need to re-evaluate the need for state-specific age curve at this time.

The Division should continue to explore the optimal rating area configuration by analyzing profitability as well as normalized claims cost by county. This analysis should compare unit costs across counties and consider the credibility of available data within each rating area.

VII. OTHER CHANGES TO STATE LAW

In addition to exploring the establishment of state-managed programs and changing State rating factors, Nevada may also want to consider implementing certain changes to state law which may help to achieve State goals relating to the individual health insurance market. These changes may include: 1) Establishing annual enrollment period for plans offered off the Exchange, 2) Eliminating grandfathered plans, and 3) Establishing incentives for purchasing insurance or imposing penalties for not purchasing insurance in the individual market both on and off the Exchange.

a. Annual Enrollment Period for Plans Offered Off the Exchange.

Nevada is the only state that allows for year-round enrollment off the Exchange¹¹. On the Exchange, with the exception of special enrollment periods established for individuals with qualifying life events occurring during the year, enrollment is limited to an annual open enrollment period. Carriers have indicated that, although there is a 90 day waiting period, year-round enrollment introduces additional adverse selection to the off-exchange market. The results of the 2017 Wakely study (Table 2) provide initial support for this conclusion.

Pros:

- Changing to an annual enrollment period for off-Exchange plans would ensure parity between the Exchange and off-Exchange markets.
- This change will bring Nevada law in line with the rest of the country.
- This change should improve the morbidity of the off-Exchange market and encourage carrier participation.
- For carriers with off-Exchange plans, this change would likely reduce administrative expenses associated with administering year-round enrollment.

Cons:

- This change may reduce consumer choice in the off-Exchange market.

Additional Considerations:

The information included in Table 2, below was taken from the 2017 Wakely study and demonstrates that there is a significant disparity in profitability between the off-Exchange individuals enrolled for part of the year and those enrolled for the entire year. Table 2 also shows that there was not a significant disparity in profitability for individuals enrolled on the Exchange for part of the year. The data collected for this study did not differentiate between off-Exchange enrollees who enrolled for part of the year due to a qualifying life event during the year and those who chose to be enrolled for less than the full year.

¹¹ NRS 687B.480

This law change is consistent with the State’s goals of improving the cost of insurance, improving competition among carriers and improving consumer choice statewide.

Table 2. Impact of Partial Year Enrollees on Profitability – On and Off Exchange

Enrollee Type	Relative Profitability – On Exchange	Relative Profitability – Off Exchange
Full Year Enrollees	\$1.82	\$11.29
Partial Year Enrollees	\$1.83	-\$20.54
Special Enrollment Period (“SEP”) Enrollees	-\$8.00	Included with Partial Year Enrollees

b. Incentives for Purchasing Insurance / Penalties for Not Purchasing Insurance in the Individual Market

One of Nevada’s policy goals is reducing the uninsured rate in Nevada. State initiatives aimed at increasing awareness and lowering premiums or out of pocket expenses may be helpful in achieving this goal.

Additionally, with the repeal of the federal individual mandate, this may be a good time to consider adopting state laws that encourage individuals to participate in the individual market and that decrease the attractiveness of only obtaining insurance when it is needed. This would reduce the number of uninsured and improve the morbidity of the risk pool, thereby reducing premiums.

Under federal law, the current rating rules do not allow a carrier to apply a late entrant adjustment or a longevity discount to an individual’s premiums. An adjustment of this type would need to be applied to the index rate which affects the premiums of the entire risk pool. However, penalties and/or incentives administered by the Exchange or another State agency may be an area open to exploration.

Pros:

- This type of change should improve the morbidity of the entire individual market and encourage carrier participation.

Cons:

- Given the current level of regulatory uncertainty at the federal level and the charged political environment, it may not be politically viable to make this type of a change to State law.
- The implementation of a law which effectively replaces the federal individual mandate may be operationally and legally challenging.

Additional Considerations:

This law change is consistent with the State’s goals of lowering the cost of insurance and the number of uninsured in the State. Since Nevada does not have a state income tax, simply replacing the federal

income tax penalty with a state income tax penalty is not an option so State policymakers will need to look at innovative alternatives to effectively enforcing a state mandate requiring Nevadans to purchase health insurance.

Recommendation for Other Changes to State Law:

The Division should refine the March, 2017 study to include data that distinguishes between partial year off-Exchange enrollees with and without special enrollment periods so that the reason for the disparity in experience for individuals enrolled for the entire year and those enrolled for a shorter period could be better understood. This would allow the State to develop regulatory and/or statutory changes that address the issues.

It is difficult to evaluate the impact of implementing potential incentives for purchasing insurance or imposing penalties for not purchasing insurance in the individual market until there are definitive proposals that could be evaluated. The lack of a State income tax makes the implementation of this type of law change a little more challenging. Therefore, the Division should delay analysis of this type of law change until viable options can be vetted.

VIII. CONCLUSION

Around the country, the ACA-compliant individual health insurance market shows signs of destabilization. Double-digit rate increases have become the norm and carriers are exiting the market citing profitability concerns, leaving consumers with fewer choices. States are searching for ways to address the situation before it becomes worse.

This Paper presents several potential solutions, many of which are currently being used or considered by different states to address the stabilization of the individual ACA-compliant health insurance market. Although every state is different, an in-depth study and analysis of the recommended options as potential solutions for Nevada may provide the State with further insight into the factors affecting the stability of the market as well as the potential costs and benefits of implementing one or more of the options discussed in this Paper.

Appendix A – Section 1332 Waivers – Brief Summary

What is a 1332 Waiver?

Under Section 1332 of the ACA, states may apply for State Innovation Waivers (“1332 waivers”) which allow states to modify or opt out of certain provisions of the ACA while maintaining compliance with the law. This provision affords states some flexibility to reflect the unique circumstances of the state. For example, Hawaii used a 1332 waiver to remove conflicts between the ACA and its employer mandate. The waiver has to be approved by both HHS and the US Department of the Treasury (“Treasury”). Once approved, the waiver remains in place for five years and could be renewed.

What provisions may be waived or altered under Section 1332?

The following provisions may be waived:

- Part I of Subtitle D of Title I of the Affordable Care Act (relating to establishing QHPs). Examples include provisions related to:
 - Essential health benefit requirements,
 - Limitations on cost sharing,
 - Metal tier requirements (may change or eliminate metal tiers),
 - Definitions related to markets and employer size (single risk pool)
- Part II of Subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through health insurance marketplaces). Examples include provisions relating to:
 - Manner in which individuals and/or groups enroll in coverage and receive financial assistance
 - Risk pool definitions
 - Enrollment period¹
- Sections 36B of the Internal Revenue Code and 1402 of the ACA.
 - Calculation of premium tax credits, including the benchmark (currently the second lowest cost silver plan) used for the calculation of the premium tax credits.
 - Cost-sharing reductions
- Section 4980H of the Internal Revenue Code
- Large employer coverage mandate (relating to employer shared responsibility); and
- Section 5000A of the Internal Revenue Code (relating to individual shared responsibility).
 - Individual coverage mandate

¹ CMS controls Exchange enrollment rules for states using the Federal IT platform. Nevada’s ability to alter provisions related to the enrollment period for Exchange members is limited at this time because the State Exchange is using the Federal IT platform.

What provisions CANNOT be waived or altered under Section 1332?

1. Guaranteed issue of coverage requirements
2. Prohibition on pre-existing condition exclusions
3. Prohibition on annual and lifetime caps on benefits
4. 3:1 requirement for age rating
5. Provisions related to the Medicaid programs. However, application for a waiver of certain Medicaid provisions (“1115 waiver”) may be coordinated with a section 1332 waiver.
6. Coverage of preventive services at 100% at no cost to the consumer.
7. Medical loss ratio (“MLR”) requirements.

What is the Basis for Approval of a 1332 Waiver?

In order for a 1332 waiver to be approved, the State must demonstrate that the waiver complies with the following four “guard rails”:

1. Scope of Coverage. The waiver cannot reduce the number of individuals with minimum essential coverage.
2. Affordability. The waiver must not increase out of pocket spending for consumers, including premiums and cost sharing. The impact on affordability for all residents of the state is taken into consideration.
3. Comprehensiveness of Coverage. The waiver cannot provide for less comprehensive coverage. The value of EHBs cannot be reduced.
4. Deficit neutrality. The waiver cannot increase the federal deficit over a ten year projection period.

What are the Major Steps a State Must Take to Obtain Approval of a 1332 Waiver?

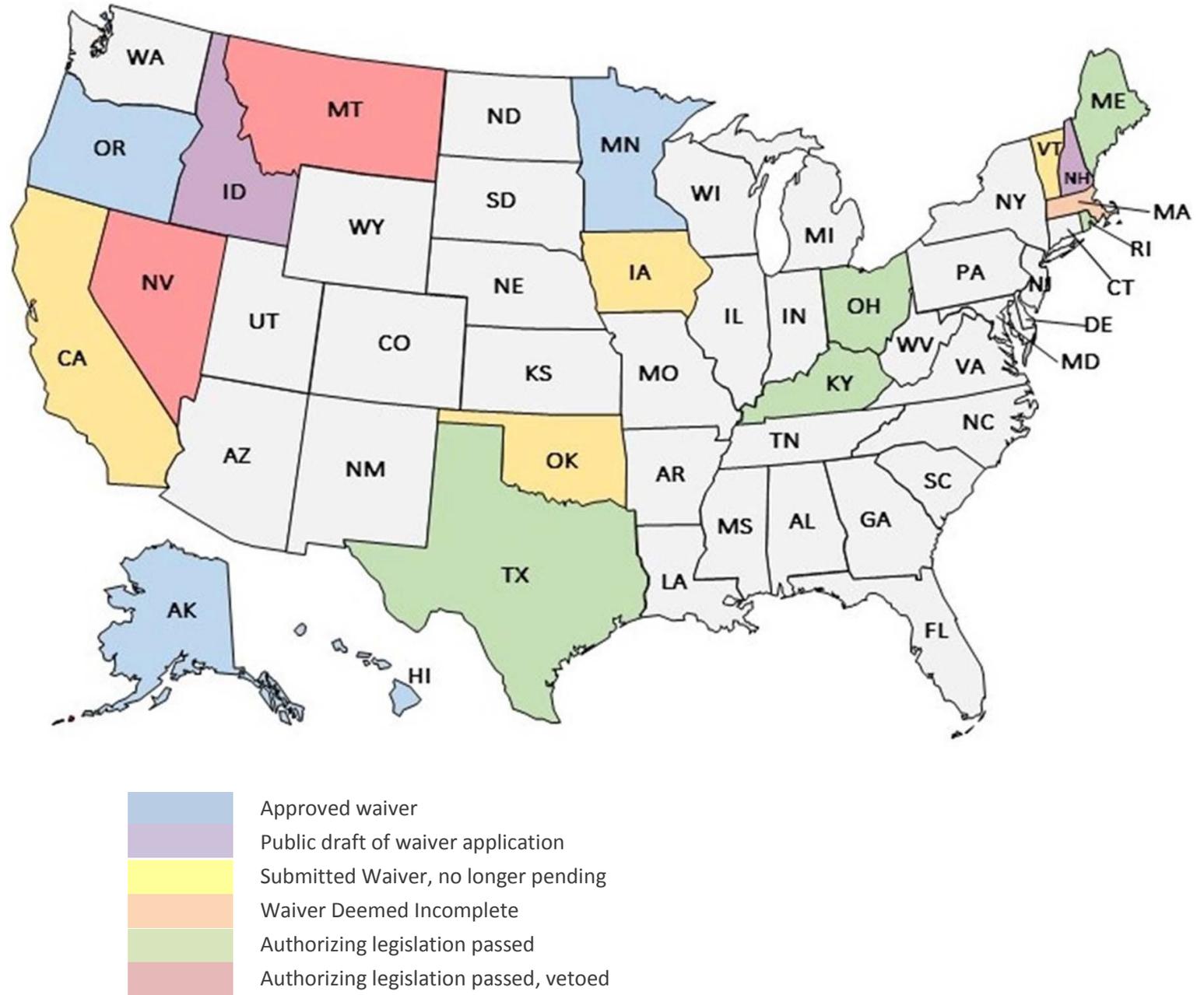
1. Enact legislation authorizing the state to apply for a waiver must be enacted
2. Hold public hearings, accept comments, and consult with tribes prior to submitting the application.
3. The state must apply for a State Innovation Waiver. Critical elements of that application include, but are not limited to:
 - a. The list of provisions the state seeks to waive, including the rationale for the specific requests;
 - b. Data, assumptions, targets, and other information sufficient to determine that the proposed waiver will provide coverage that is at least as comprehensive as would be provided absent the waiver, will provide coverage and cost sharing protections that keep care at least as affordable as would be provided absent the waiver, will provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver, and will not increase the Federal deficit;

- c. Actuarial analyses and actuarial certifications to support state estimates that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement;
 - d. A detailed 10-year budget plan that is deficit neutral to the Federal government. The budget plan may reflect any “pass-through” funding they expect to receive from the federal government over the projection period. These amounts reflect the federal funds that would be saved under the waiver and that could be passed on to the states to finance state programs.
 - a. A detailed analysis of the impact of the waiver on health insurance coverage in the state;
 - b. A description and copy of the enacted state legislation providing the state authority to implement the proposed waiver; and,
 - c. A detailed plan for implementing the waiver, including a timeline.
4. Once the waiver is approved, a state must provide annual updates to premium and membership projections with and without the waiver.

Additional Considerations for 1332 Applications

1. The impact of the waiver to vulnerable populations is considered in assessing whether a waiver meets the guardrails.
2. Coverage and affordability is measured annually as well as over the life of the waiver.
3. Comprehensiveness of coverage would be evaluated under all ten EHB categories and under each category individually
4. States cannot use savings from a 1115 waiver to offset spending under a 1332 waiver
5. The assessment of whether the waiver meets the Annual reporting requirements during the period of the waiver
6. Guardrails will take into account broader effects on the state’s health care system
7. Federal review by HHS and Treasury can be lengthy process
 - a. A preliminary review for completeness must occur within 45 days but it can take up to 180 days for a final decision

The Status of Section 1332 Waivers across the United States²



² Source: <http://www.statenetwork.org/more-states-looking-to-section-1332-waivers/>

Summary of Section 1332 Waiver Applications

State	Description	Status of Application
Alaska	Allow federal pass through funding to partially finance the state's \$60M condition-based reinsurance program. Premiums are projected to be reduced by 20%. Waiver is effective for 2018 through 2022.	Submitted on 12/29/2017; approved on 7/17/2017.
California	Allow undocumented immigrants to purchase individual coverage through the state's Exchange, without premium subsidies.	Submitted on 12/19/16;; withdrawn on 1/18/2017
Hawaii	Retain the employer coverage provisions currently in place through the state's Prepaid Health Care Act, (state employer mandate) which are more generous coverage than is required under the ACA. The state also waived the requirement that the small business tax credits would only be available through the SHOP. The waiver is effective for 2017 through 2021.	Submitted on 8/10/2016; approved 12/30/16
Iowa	A stop-gap plan for 2018 that included: a single standard silver plan to be offered on the Exchange, replace the advance premium tax credits ("APTC") with flat premium subsidies based on age and income, eliminate cost sharing subsidies for those over 200% FPL, and establish a claims-based reinsurance program. The waiver requested federal pass through funding to fully cover the cost of the reinsurance program and new premium subsidies.	Submitted 8/21/2017; withdrawn 10/23/2017
Massachusetts	Submitted a waiver requesting the redirection of federal CSR payments to fund a state-based premium stabilization fund ("PSF") which would directly reimburse issuers.	Submitted on 9/28/2017; determined incomplete on 10/23/2017 because it was submitted too close to the 1/1/2018 effective date.
Minnesota	Create a new state reinsurance program to be funded with a combination of federal pass through funds and state appropriations. The waiver requests that funds the federal government would have paid in premium tax credits and cost sharing reductions to eligible marketplace enrollees had the reinsurance program not been in place be provided directly to the state to be used to finance the program. The waiver is effective for 1/1/2018 through 12/31/2022.	Submitted 5/30/2017; approved on 9/22/2017. However, the request for BHP savings to be passed through to the state was denied.
Oklahoma	Request pass-through funding for a \$325M claims-based reinsurance program (80% of claims between \$15K and \$400K) for 2018. Would have reduced premiums by 34%.	Application submitted on 8/16/2017; withdrawn on 9/29 because not timely approved (by 9/25/2017).
Oregon	Established a claims-based reinsurance program (50% of claims between some attachment point and \$1M). 0.3% premium assessment on major medical policies. Premiums would be reduced by 7%. The waiver is effective for 1/1/2018 through 12/31/2022.	Submitted on 8/31/2017; approved on 10/24/2017
Vermont	Continue to allow small employers to enroll directly with health insurance carriers rather than through an online SHOP web portal. The state had adopted the direct enrollment approach for small businesses after the SHOP portal developed by the state failed to launch in 2014. Recent guidance from CMS delaying the required implementation of the SHOP portal until 2019 puts off for now the need for Vermont's waiver.	Submitted on 4/25/2016; notice of incompleteness on 6/9/2016

REFERENCES:

Final 1332 Waiver regulations: <https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf>

December 16, 2015 HHS and Treasury Guidance on Guardrails for State Innovation:
<https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>

May 11, 2017 Checklist for Section 1332 Applications: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf>

CMS website on formal state applications and approvals with guidance and regulations:
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-waivers/Section-1332-State-Innovation-Waivers-.html>

Congressional Research Service report with FAQs on State Innovation Waivers:
<https://fas.org/sgp/crs/misc/R44760.pdf>

Appendix B - Eligible Conditions for Alaska's Condition-Based Reinsurance Program

The following is the list of the 33 conditions covered under Alaska's condition-based reinsurance program:

- (1) Human immunodeficiency virus or acquired immune deficiency syndrome ("HIV/AIDS");
- (2) Septicemia sepsis, systemic inflammatory response syndrome/shock;
- (3) Metastatic cancer;
- (4) Lung, brain, and other severe cancers, including pediatric acute lymphoid leukemia;
- (5) Non-hodgkin's lymphomas and other cancers and tumors;
- (6) Mucopolysaccharidosis;
- (7) Lipidoses and glycogenosis;
- (8) Amyloidosis, porphyria, and other metabolic disorders;
- (9) End-stage liver disease;
- (10) Chronic hepatitis;
- (11) Acute liver failure or disease, including neonatal hepatitis;
- (12) Intestinal obstruction;
- (13) Chronic pancreatitis;
- (14) Inflammatory bowel disease;
- (15) Rheumatoid arthritis and specified autoimmune disorders;
- (16) Hemophilia;
- (17) Acquired hemolytic anemia, including hemolytic disease of newborn;
- (18) Sickle cell anemia (hb-ss);
- (19) Thalassemia major;
- (20) Coagulation defects and other specified hematological disorders;
- (21) Anorexia/bulimia nervosa;
- (22) Paraplegia;
- (23) Amyotrophic lateral sclerosis and other anterior horn cell disease;
- (24) Quadriplegic cerebral palsy;
- (25) Cerebral palsy, except quadriplegic;
- (26) Myasthenia gravis/myoneural disorders and guillain-barre syndrome/inflammatory and toxic neuropathy;
- (27) Multiple sclerosis;
- (28) Parkinson's, Huntington's and spinocerebellar disease, and other neurodegenerative disorders;
- (29) Cystic fibrosis;
- (30) End stage renal disease;
- (31) Premature newborns, including birthweight 2000 – 2499 grams;
- (32) Stem cell, including bone marrow, transplant status/complications;
- (33) Amputation status, lower limb/amputation

Appendix C - Maine Guaranteed Access Reinsurance Association (“Maine’s Reinsurance Program”)

What is it?

Maine’s reinsurance program began active operations on July 1, 2012 and continued to provide reinsurance through December 31, 2013. Its operations were suspended starting on January 1, 2014 because the federally administered transitional reinsurance program, which operated from 2014 to 2016, provided similar benefits to the individual carriers and Maine’s program would have duplicated some of the coverage. Maine is interested in reviving this dormant program using federal funds transferred under a 1332 waiver. Initial reactions from federal regulators have been positive.

How did it Work?

Maine’s reinsurance program operated as a prospective reinsurance pool with features similar to a claims-based reinsurance program and a condition-based reinsurance program. Specific individuals with a high risk of incurring large health claims were identified by the health carriers, some based on a standard list of conditions (see the list below), and others by carrier discretion. The program reinsured coverage for these high-risk enrollees on a calendar-year basis, and reinsurance was effective only if the carrier paid the applicable reinsurance premium when due and designated the individual for reinsurance in advance of the coverage year (except for new enrollees, who could be designated up to 60 days after their insurance policies took effect). If those specific individuals then incurred claims in excess of the attachment point of the reinsurance coverage, the carrier would be eligible for reimbursement from the program.

What Conditions determined Automatic Eligibility for the program?

The following is the list of the eight conditions used to determine automatic eligibility:

- (1) Cancer – Corus Uterus (Endometrial Carcinoma)
- (2) Cancer – Metastatic
- (3) Cancer – Prostate Gland
- (4) Chronic obstructive pulmonary disease (“COPD”)
- (5) Congestive heart failure
- (6) Human immunodeficiency virus or acquired immune deficiency syndrome (“HIV/AIDS”)
- (7) Renal failure
- (8) Rheumatoid arthritis;

How was it funded?

The program was funded by a combination of reinsurance premiums paid by health insurers ceding coverage, and an assessment of \$4 per covered person per month (\$48 per year) levied against coverage provided in the individual, small group and large group markets, as well as against third party

administrators of self-funded health plans. Maine's ability to include self-administered, self-funded plans in the assessment base was and is preempted by federal law.

Benefits Paid under the Program

Maine's reinsurance program provided for payment of 90% of claims between \$7,500 and \$32,500 and 100% of claims over \$32,500 for an eligible individual in a given year.

Impact of the Program

Maine's reinsurance program collected approximately \$26.3 million in premium from health carriers in the individual market during its 18 months of active operations in 2012 and 2013. Total assessments, including a special organizational assessment, were approximately \$41.2 million. It paid approximately \$66 million in reinsurance claims to individual health insurance market carriers. Based on rate filing information submitted by carriers in Maine's individual market, the program resulted in about a 20% reduction in requested rates.