
HEALTH CARE WAIVERS: 1332-STATE RELIEF AND EMPOWERMENT WAIVERS WEBINAR

MONDAY, MARCH 11, 2019

2:00 PM ET / 1:00 PM CT / NOON MT / 11:00 AM PT





Overview of 1332 guidance for State Relief and Empowerment Waivers

March 2019

1332 Initiatives

- 1332 waivers are one way CMS is providing states with flexibility to establish innovative ways to stabilize the risk pool and meet the needs of their residents in their particular states. These Section 1332 waivers are now called State Relief and Empowerment Waivers to reflect this new direction and opportunity.
- **1332 Guidance:** New guidance that provides greater flexibility for states to pursue waivers under section 1332 to waive certain PPACA requirements;
- **1332 Waiver Concepts:** To help foster discussion with states, and illustrate how states might take advantage of this new opportunity.

WHAT ARE SECTION 1332 WAIVERS?

- Under Section 1332 of the PPACA, a state can apply for a **State Relief and Empowerment Waiver**, allowing the state to implement innovative ways to provide access to quality health care so long as coverage available under the waiver is at least as comprehensive and affordable as would be available under the PPACA absent the waiver, coverage is provided to a comparable number of residents of the state as would be provided coverage absent a waiver, and the waiver does not increase the federal deficit .
- For a waiver to be approved, it has to meet the four guardrails below. This means that for each year of the waiver, the application must compare measures of **coverage, comprehensiveness, affordability** , and the impact on the **federal deficit** under the waiver to those measures absent the waiver (referred to as the baseline).
- Waivers can be granted for up to a 5 year-period.
- The U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (collectively, the Departments) are responsible for reviewing waiver applications.



What Can Be Waived?

- Part I of Subtitle D of Title I of the Patient Protection and Affordable Care Act (PPACA) (relating to establishing Qualified Health Plans (QHPs));
- Part II of Subtitle D of Title I of the PPACA (relating to consumer choices and insurance competition through health insurance Exchanges);
- Sections 36B of the Internal Revenue Code and 1402 of the PPACA (relating to premium tax credits and cost-sharing reductions for QHPs offered within the Exchanges); and
- Section 4980H of the Internal Revenue Code (relating to employer shared responsibility).

Examples of What Can be Waived

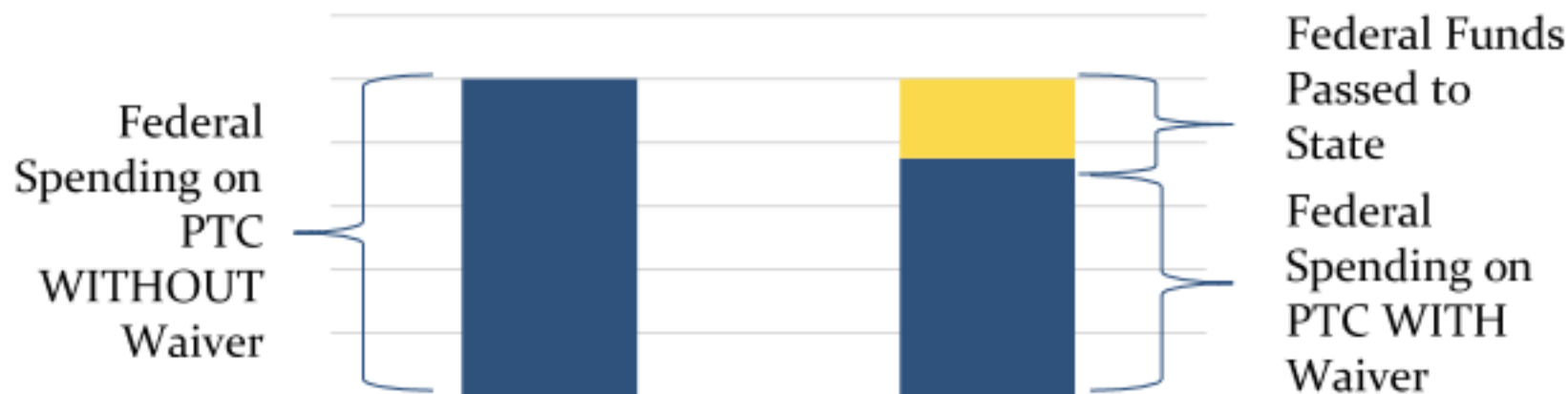
- Examples of Parts I and II of Subtitle D of the PPACA:
 - Establishment of an Exchange
 - Functions of an Exchange , including QHP Certification
 - Enrollment periods, both Open Enrollment and Special Enrollment Periods
 - Essential Health Benefits (EHB)
 - Actuarial Value (AV) metal levels
 - Single Risk Pool

Examples of What Can't be Waived

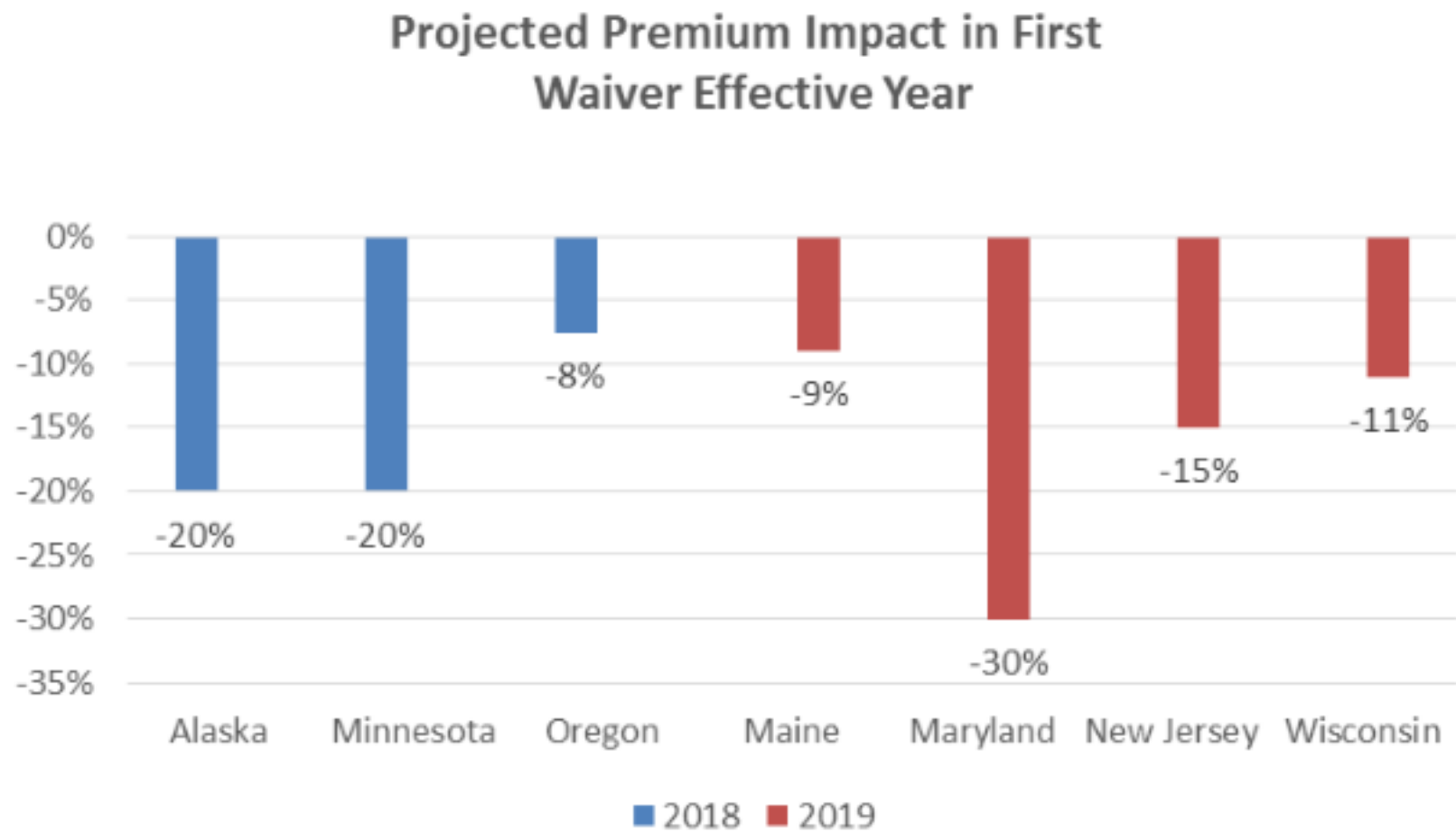
- Pre-existing condition protections
- Allowable premium rating factors, including age bands
- Guaranteed availability and renewability of health coverage
- Risk adjustment
- Eligibility determinations under section 1411 of the PPACA
 - This applies to determinations for premium tax credits (PTC), cost-sharing reductions (CSR), Medicaid, CHIP, and BHP

Pass-through Funding

- If a waiver saves the federal government money on PTCs, small business tax credits, or CSRs, the savings (called pass-through savings) can be passed to the state for implementation of the state's waiver plan.
 - Note: Pass-through amount will be reduced if necessary to ensure federal deficit neutrality



Projected Impact of Approved Waivers



New 2018 Guidance: Flexibility with respect to Section 1332's Guardrails

- On October 22, 2018, the Departments issued new guidance on Section 1332 waivers which replaced the previous guidance issued on December 16, 2015.
- The 2015 guidance imposed significant additional hurdles on states in meeting the guardrails. The goal of the revised guidance is to loosen excessive restrictions that limit state flexibility and consumer choice, while maintaining the requirements of the statute.
 - Comprehensiveness
 - Affordability
 - Coverage
 - Federal Deficit Neutrality
- The Secretaries retain their discretionary authority under section 1332 to deny waivers when appropriate, given consideration of the application as a whole, even if an application meets the statutory guardrails.
- Note: This guidance does not change the approval or calculation of pass-through funding for approved 1332 waivers to implement a reinsurance program.

New 2018 Guidance: Principles

- The Secretaries will favorably consider waiver applications that advance some or all of these five principles as elements of a State Relief and Empowerment Waiver application. States should explain in their waiver applications how their proposals would advance some or all of these principles:
 - Provide more affordable private market coverage
 - Encourage sustainable spending growth
 - Foster state innovation
 - Support and empower those in need
 - Promote consumer-driven healthcare

New 2018 Guidance: Flexibility with respect to Section 1332's Guardrails

- **Affordability and Comprehensiveness:** The comprehensiveness and affordability guardrails are evaluated based on whether the waiver provides *access* to coverage that is at least as comprehensive and affordable as coverage to a comparable number of people as would have access absent the waiver.
 - In contrast, the previous rule considered whether the same number of people *actually* purchase or take up coverage that is at least as comprehensive and affordable.

New 2018 Guidance: Flexibility with respect to Section 1332's Guardrails

- **Number Covered:** The state can demonstrate that a comparable number of state residents eligible for coverage under title I of PPACA will have health care coverage absent the waiver.
 - This guidance on the coverage guardrail continues to consider the number of state residents who are actually receiving coverage. As long as a comparable number of residents are projected to be covered as would have been covered absent the waiver, the coverage guardrail will be met.
 - The definition for coverage under the coverage guardrail is expanded from Minimum Essential Coverage (MEC) to MEC and the federal definition of insurance under the PPACA/Public Health Service Act. This change allows short term limited duration plans to count under the coverage definition for section 1332 waivers.

New 2018 Guidance: Examples of Approach to Guardrails

- *Example:* In the baseline without the waiver, 100 consumers have access to a plan that includes EHB and is affordable. With the waiver in effect, 100 people still have access to a plan that includes EHB and is as affordable as without the waiver but only 85 people still purchased that plan, while 15 people choose other plans that meet the coverage definition but are not QHPs and/or might not cover EHB and/or be as affordable.

Note: This is an illustrative example but the Departments would need to analyze the details of the specific waiver proposal to see if it meets the statutory guardrails.

New 2018 Guidance: Flexibility with respect to Section 1332's Guardrails

- **AggregateEffect:** Assessment of the guardrails will consider the effects of the waiver on coverage in the aggregate across allstate residents. However, an application should address how the waiverwill impact those with low incomes or high healthcare costs in alignment with the principles for eachof the guardrails.
 - For the comprehensiveness andaffordability guardrails, theDepartments will takeinto account access toaffordable, comprehensive coverage available to all state residents, regardless of the type of coverage they wouldhave had access to in the absence of the waiver.In addition to considering the number ofstate residents forwhom comprehensive coverage has become more or less affordable, the Departments will take into account the magnitude of such changes.

New 2018 Guidance: Flexibility with respect to Section 1332's Guardrails

- **Deficit Neutrality:** The projected federal spending net of federal revenues under the section 1332 waiver must be equal to or lower than projected federal spending net of federal revenues in the absence of the section 1332 waiver. The effect on federal spending includes all changes in Exchange financial assistance and any other spending that result from the section 1332 waiver.
- Waivers must not increase the federal deficit over the period of the waiver (which may not exceed 5 years unless renewed) or in total over the 10-year budget plan submitted by the state as part of the application.
 - We have revised the 2015 guidance to clarify that the ten-year budget plan should describe the changes in projected federal spending and changes in federal revenues attributed to the waiver for each of the ten years.
 - The Departments will continue to evaluate the deficit neutrality guardrail on a yearly basis. A waiver that increases the deficit in any one year is less likely to be approved.

New 2018 Guidance: Pass-through Funding

- Explicitly allows the Departments to make adjustments necessary to ensure federal deficit neutrality such as reductions in pass-through funding to account for increases in spending or decreases in revenue.
- The amount is calculated annually by the Departments and will be updated to reflect changes in federal or state law.
 - E.g. A state law that changes the structure of the waiver program, eliminates a program, makes eligibility changes in Medicaid or changes another program that impacts the size of the pass-through payment under the waiver.

Actuarial and Economic Analysis

- The actuarial and economic analyses must compare comprehensiveness, affordability, coverage, and net federal spending and revenues under the waiver to those measures absent the waiver (the baseline) for each year of the waiver including:
 - Analysis and supporting data such as enrollment, premiums, and Exchange financial assistance by age, income, and type of policies .
 - Description of the models used to produce these estimates, including data sources and quality of the data, key assumptions, and parameters for the section 1332 state plan.
 - All modeling assumptions used, sources of state-specific data, and the rationale for any deviation from federal forecasts.

New 2018 Guidance: Operational Considerations

- **Federally-Facilitated Exchange (FFE):** Allows the FFE platform to use new data-sharing functionality to share information with states, and work with private industry partners to create their own Web sites with capability that could replace the consumer-facing aspects of HealthCare.gov for their state, while allowing the state to utilize aspects of the back-end technology that supports the FFE. This could also be used to accommodate different eligibility and enrollment rules for state subsidies in different states.
 - States should engage with the Departments early in the process to determine whether federal infrastructure can accommodate technical changes that support their requested flexibilities.
 - If CMS is providing services in support of the state's section 1332 waiver plan including but not limited to eligibility determinations for participation in State waiver programs as authorized by the Intergovernmental Cooperation Act (ICA). States must reimburse CMS for all costs and those costs will not be considered as part of the deficit neutrality requirement.

New 2018 Guidance: Operational Considerations

- **Internal Revenue Service (IRS):** At this time, the IRS generally is not able to administer different sets of tax rules for different states. But IRS maybe able to accommodate small adjustments to the existing system for administering federal tax provisions. For example, a state that has not expanded its Medicaid program may wish to expand eligibility for APTC and PTC to individuals under 100 percent of the Federal Poverty Level (FPL).
 - States contemplating to waive any part of a federal tax provision should engage with the Departments early in the section 1332 application process to assess feasibility.

New 2018 Guidance: Enacted State Legislation Requirement

- The guidance clarifies that in certain circumstances, states may use existing legislation if it provides statutory authority to enforce PPACA provisions and/or the state plan, combined with a duly-enacted state regulation or executive order, may satisfy the requirement that the state enact a law.
 - States should engage with the Departments early in the process to discuss whether their state authority meets the requirement to enact a law.
 - This guidance does not eliminate the requirement for a state to enact a law, or encourage state executives to bypass their legislatures. It simply recognizes that state legislation can come in different forms.

New 2018 Guidance: Enacted State Legislation Requirement

- *E.g.* The state wants to pursue a waiver to implement a high risk pool. The state has an existing law that provides statutory authority for the DOI to implement the PPACA. The state's governor then does an executive order providing for the state DOI to pursue a waiver, and the DOI then puts out regulations to re-enact their high risk pool which already has the ability to do an assessment.
- *E.g.* The state wants to pursue a waiver to implement a reinsurance program. The state has an existing law that provides the state the authority to implement the PPACA. The DOI issues regulations to implement a reinsurance program, and the state passes new legislation to provide funding for the state share of the program which is contingent upon approval of the waiver.

Note. This is an illustrative example but the Departments would need to analyze the details of the specific waiver proposal to see if it meets the statutory guardrails.

New 2018 Guidance

- **Public Input Process:** Consistent with the previous guidance, states must provide for a meaningful level of public input prior to submitting an application. Including consultation with federally recognized tribes if applicable; the state and federal comment period should both be no less than 30 days.
- **Impact of Other Programs on Assessment of a Waiver Proposal:** Consistent with the previous guidance, savings accrued under either proposed or current Section 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed State Relief and Empowerment Waiver meets the deficit neutrality requirement.

1332 Model Waiver Concepts

- CMS plans to provide states with waiver concepts to help foster discussion with states and illustrate how states might take advantage of the new flexibilities described in the guidance. These waiver concepts are offered to serve as a springboard for innovative ideas that may improve the health care markets in individual states.
- States may use waiver concepts potentially alone or in combination with other waiver components or other state proposals or policy changes.
- Four waiver concepts:
 - State-Specific Premium Assistance
 - Adjusted Plan Options
 - Account Based Subsidies
 - Risk Stabilization strategies

Additional Resources

- **CCIIO website**
https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html
- **45 CFR 1300-1328**
<https://www.ecfr.gov/cgi-bin/text-idx?SID=c3aofa8ofd8oad165d9f7d9af7ecef4f&mc=true&node=sp45.1.155.n&rgn=div6>
- **Guidance - December 2015**
<https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>
- **Guidance-October 2018**
<https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>
Note: The guidance has a 60 day comment period which ends December 24, 2018.
- **Secretary Letter to States - March 2017**
https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf
- **Checklist for States on State Reinsurance Waivers - May 2017**
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf>

QUESTIONS?

- We encourage states interested in applying for Section 1332 waivers to reach out to HHS and Treasury (the Departments) as soon as possible.
- Email stateinnovationwaivers@cms.hhs.gov for assistance in formulating and enacting a plan that meets the requirements of Section 1332.

Wisconsin's Healthcare Stability Plan

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Vice President State Affairs



HORIZON
GOVERNMENT AFFAIRS



Overview

- Wisconsin's Individual Health Insurance Market
- Impact of the Affordable Care Act (ACA)
- Overview of the Wisconsin Healthcare Stability Plan



InsuranceMarket

Most people receive their health insurance coverage from their employer, Medicare, or Medicaid

- Group Health Coverage
 - Employer Sponsored Coverage
 - Large Group
 - Small Group
- Public Coverage
 - BadgerCare / Medicaid
 - Medicare

WHO BUYS INSURANCE IN THE INDIVIDUAL MARKET?

Approximately 5% of most state's population purchase coverage from the individual market

- Non-Medicare eligible retirees
- Individuals not eligible for group coverage/group coverage not offered
- Sole proprietors
- Part-time workers
- Contract employees
- Individuals in-between jobs

PURCHASING IN THE INDIVIDUAL MARKET

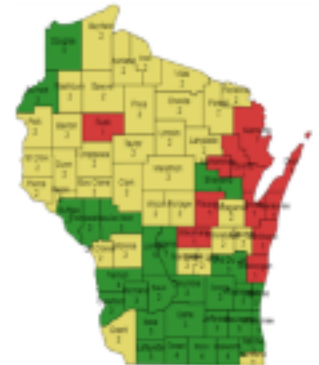
- Health Insurance Exchange
 - Advanced Premium Tax Credits : Covers individuals from 100% to 400% of the federal poverty level (FPL)
 - Cost Sharing Reduction Subsidies (CSRs): 100% to 250% FPL Receive a higher actuarial value plan if silver plan is purchased
 - Unsubsidized Over 400% FPL
- Off-Exchange - No subsidies available
 - Same plan designs, same cost

INSURERS LEFT THE MARKET

- 2017:
 - Approximately 37,000 Wisconsinites had to choose a new insurer
 - Humana and UnitedHealthcare left the individual market entirely
 - Managed Health Services, WPS Health Plan, and Physicians Plus left the Exchange
- 2018:
 - Approximately 75,000 Wisconsinites had to choose a new insurer
 - Health Tradition left the individual market
 - Anthem and Molina left the Exchange
 - Molina and Anthem offer plans off-Exchange in one county

Coverage Map 2016, 2017, 2018

- Green= 3 or more insurers
- Yellow = 2 insurers
- Red = 1 insurer
- Source: Wisconsin OCI



WHY WERE RATES INCREASING AND INSURERS LEAVING?

- Worsening risk pool
 - Higher percentage (34%) of older residents (55-64) and lower percentage (16%) of younger residents (26-34) than the national average
- High Medical Loss Ratios (MLR) - percentage of premiums paid for direct medical care
 - ACA contemplated an 80% MLR
 - 2014 insurers had a 91% MLR
 - 2015 insurers had a 101% MLR
 - 2016 insurers had a 94% MLR
- The net result was insurer losses in the individual market of more than \$500 million in the first four years



Finding a Solution

- Since the OCI did not have actuarial staff, we hired a consultant to work through the 1332 process.
 - Many firms partner with actuarial firms
 - Assistance with plan development
 - Using an economic model saved on actuarial expenses, and provided the state with options
 - Needed to gather significant information from insurers through OCI

WISCONSIN HEALTHCARE STABILITY PLAN

- The Plan had three main goals:
 1. Keep or expand consumer choice
 2. Lower the impact of premium increases
 3. Stabilize the individual market
- Announced by Governor Walker on January 24, 2018 at the 2018 State of the State Address
- Signed by Governor Walker on February 27, 2018
 - Enrolled as 2017 Wisconsin Act 138

HEALTHCARE STABILITY PLAN

- 2017 Wisconsin Act 138 allows OCI to administer a \$200 million reinsurance program
 - The final pass through report estimates the state will receive approximately 64% of the cost paid through pass-through dollars
 - The federal government will fund approximately \$128 million of the cost (pass through funds)
 - The state will be required to fund approximately \$72 million plus administrative costs
 - Insurers were required to file rates that reflect their premiums with and without the program

HEALTHCARE STABILITY PLAN

- The program reduced average Wisconsin consumer premiums by approximately 11%.
- This reflects a more than 4% average decrease in rates from 2018.
- The state had several insurers inquire about expanding coverage.
 - Ultimately, Molina re-entered the market
 - Several insurers expanded service areas ensuring more competition in the state.



Experience

- Despite our quick turnaround, the 1332 process takes some time to complete
 - Involve CCIIO early in the process
 - Insurers are already deep into the process of developing 2020 rates
 - Requires significant outreach, actuarial analysis
- Estimates on pass through funding should be conservative
 - Wisconsin was surprised by the final amount though it was reflected in our consultant's numbers
 - Recently released guidance should help accuracy
- The new rules add flexibility to the process
- Reinsurance will not solve all of the problems and other options may be available
- Provide as much background as possible to legislature



Thank You!

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Information on Wisconsin's 1332 Process:

<https://oci.wi.gov/Pages/Consumers/HealthcareStabilityPlan.aspx>

The Maryland 1332 Experience

Presentedby:

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Maryland Health Benefit Exchange

- ✕ Individual Market Performance in Maryland
- ✕ Legislative History
- ✕ Decision Point: Funding Source
- ✕ Decision Point: Reinsurance Impact
- ✕ Maryland State Reinsurance Program Waiver
- ✕ State Innovation Waiver Timeline
- ✕ State Reinsurance Program Impact

Individual Market Performance in Maryland - Marketplace Metrics

Table 1. Maryland Health Connection Marketplace Metrics 2014 – Present.

Benefit Year	Participating Issuers (#)	QHPs Offered (#)	Enrollment	Subsidized/ Unsubsidized (%)	Premium Change (%)	Rate Justification
2014	4	45	81,553	80/20	-	-
2015	5	53	131,974	70/30	10.24%	Sicker/Older Pool MHIP Migration Increased unit cost of care Increased utilization Health Insurer Fee
2016	5	53	162,652	70/30	17.93%	Actual claims experience higher than 2015 rates Pent-up demand from formerly uninsured entrants Risk Adjustment payments Increased cost and utilization trends Reduction in reinsurance payments
2017	3	23	157,637	78/22	21.24%	Increased unit cost of care, claims, morbidity of pool Cessation of the reinsurance program
2018	2	21	153,571	79/21	50.32%	New members entering risk pool Current members terminating coverage Increased churn and trend Loss of CSR Individual mandate enforcement not included in rate

Sources: MHBE Annual Reports, MHBE Plan Management, MIA Rate Decisions, Issuer Rate Justifications.

2018 Legislative Session: HB – 1795 & SB 387

- ✕ Two bills from the 2018 Maryland Legislative Session impact the State Reinsurance Program House Bill 1795 – Establishment of a Reinsurance Program & Senate Bill 387 Maryland Health Care Access Act of 2018.
- ✕ Signed by Governor Larry Hogan on April 5 and April 10. These bills are a bipartisan short-term solution to address premium affordability and market stabilization in Maryland's individual health insurance marketplace.
- ✕ HB 1795, establishes a claims-based State Reinsurance Program to offset the impact of high cost enrollees in the individual marketplace. MHBE is required to apply for a State Innovation Waiver under section 1332 of the Affordable Care Act
- ✕ SB 387 places a 2.75% assessment on carriers to recoup the aggregate amount of the health insurance provider fees that was previously assessed under Section 9010 of the ACA. The Tax Cuts and Jobs Act of 2017 waived this fee for 2018. This funding source provides an estimated \$365 million (MIA/OCA) for the State Reinsurance Program.

State-based Health Insurance Premium Assessment

- ✕ The 2.75% premium assessment is broad-based and is applicable to all premiums that would have been subject to the federal assessment under Section 9010 of the ACA and where the state has the statutory authority to do so.
- ✕ Premiums for health benefits subject to ERISA and Federal programs (ex. Medicare, FEHBs, etc.) are exempt from the state assessment.
- ✕ 2.75% is the rate that results in the aggregate amount that would have been assessed under the federal HIT. Each issuer is assessed a different rate at the federal level based on the issuer's situation.
- ✕ The assessment will impact issuers differentially depending on their treatment under the federal assessment.

State-based Health Insurance Premium Assessment

- ✕ The broad-based nature of the assessment allows the state to assess Medicaid Managed Care Organizations under taxation rules, and increase federal contribution to the SRP.
- ✕ The state assessment is federally tax-deductible (important for determining aggregate percentage).
- ✕ Of the \$365 million (FY 2019) projected for collection under the assessment:
 - \$196.5 million from Commercial Carriers
 - \$168.4 million from Medicaid MCOs (62% of that amount is federal share)

Decision Point: Reinsurance Impact

“Front loading” Federal Pass-through funds

- ✕ The State Reinsurance Program was envisioned as a bridge program to:
 - Support market stability in the short-term
 - Provide the legislature with time to develop a long-term solution
- ✕ State-based HI Assessment for the SRP would only be collected once (FY 2019).
- ✕ Funding allocation (and thereby federal pass-through dollars) over the five-year waiver resulted in different market impacts.
 - Federal pass-through may be “additive” and not “supplementary.”
 - Pass-through funding may *increase* the size of the reinsurance program, state funding allocation is not a *cap* on program impact.

Maryland State Reinsurance Program Waiver



Application to Establish the State Reinsurance Program

- ✕ **Waived Provision:** Maryland waived Section 1312(c)(1) of the Affordable Care Act – determination of the market index rate. This allows Maryland carriers to include expected State Reinsurance Program payments when determining their market index rate.
- ✕ **Affordability:** Federal pass-through funding, through net premium tax credits savings, will fund a reinsurance program that targets a 30% premium reduction offset for 2019 and 2020. Total program costs for 2019 are approximately \$462 million.
- ✕ **Coverage:** Maryland estimates that the premium impact will result in a 5.8% increase in individual market enrollment in 2019.
- ✕ **Federal Deficit:** The decreased premiums will decrease federal spending on tax credits. Actuarial analysis estimates that federal savings will be \$280 million, \$293 million, and \$32 million in 2019, 2020, and 2021, respectively.
- ✕ **Implementation:** Maryland requested that the Department assist the state in implementation of the waiver through modification through the EDGE server infrastructure.

Maryland State Reinsurance Program Waiver



Estimated Maryland/Federal Funding

Waiver Year	SRP Amount	Estimated Federal Funding	% Federal	Estimated State Funding	% State
2019	\$462,000,000	\$303,534,000	65.70%	\$158,466,000	34.30%
2020	\$451,000,000	\$315,700,000	70.80%	\$135,300,000	29.20%
2021	\$287,000,000	\$212,380,000	74.00%	\$74,620,000	26.00%
<i>Total</i>	\$1,200,000,000	\$831,614,000	69.30%	\$368,386,000	30.70%
		<i>Medicaid MCO Revenues: \$168,400,000</i>			
		<i>Federal Share (62%): \$104,408,000</i>			
<i>Adjusted Total</i>	\$1,200,000,000	\$936,022,000	78.00%	\$263,978,000	22.00%

State Application Drafting & Public Comment Period

- ✕ **Early March**, MHBE begins work with Wakely Consulting Group to begin data gathering & analysis for the draft waiver application for public comment.
- ✕ **April 10**, Governor Larry Hogan signs bills authorizing the Maryland Health Benefit Exchange to submit a 1332 waiver for a State Reinsurance Program
- ✕ **April 20**, the Maryland Health Benefit Exchange (MHBE) released a draft application for a State Innovation Waiver, starting the 30-day state public comment period.
- ✕ **April 26 – May 10**, MHBE held four public hearings across Maryland to present the application to the public.

Summary of Public Comment

✕ **Coordination with the Federal Risk Adjustment Program**

- Many stakeholders have expressed concern over potential issuer payments under the SRP and the federal Risk Adjustment program that would be duplicative of the same risk.
- Both carriers request that WAKELY conduct a study to determine the degree of overlap between the two programs, if any.

✕ **Establishing a State Reinsurance Program That Will Attract New Entrants**

- Many stakeholders expressed that the SRP could be leveraged to create a market environment that is favorable for new entrants. They caution, however, that the program should not be constructed in a manner that would support certain care delivery models over others.

✕ **Incentives for Utilization/Care Management and Quality Improvement**

- Stakeholders expressed that the SRP should be explored as a tool to increase quality and reward effective utilization/care management.
- Respondents suggest that the SRP could be used to further the goals of other state initiatives, such as the All-Payer Model and the Medicare Waiver.

Final Application Submission, Amendment, and Federal Public Comment Period

- ✕ **May 31**, the Maryland Health Benefit Exchange (MHBE) submitted a final application to the U.S. Departments of Health and Human Services and the Treasury.
- ✕ **July 5**, MHBE receives notice from waiver application reviewers that the waiver was deemed complete, starting the 30-day federal public comment period.
- ✕ **August 15**, MHBE submits an amendment to the State Innovation Waiver Application to include state response to stakeholder concern on the interaction between Federal Risk Adjustment and the SRP.
- ✕ **August 22**, MHBE receives notice that the State Innovation Waiver to Establish a State Reinsurance Program has been approved.
- ✕ **August 24**, MHBE Board of Trustees resolves to account for program interaction between Federal Risk Adjustment and the SRP through equalizing profitability between sick and health members.

Rate Impact of the SRP by Issuer. ¹

Carrier (Network)	Enrollment ² (on/off MHC)	2019 Rates (w/o Reinsurance)	2019 Rates (w/ Reinsurance)
CareFirst (HMO)	109,368	18.5%	-17%
CareFirst (PPO)	13,074	91.4%	-11.1%
Kaiser Permanente (HMO)	69,837	37.4%	-7.4%
Total	192,279	30.2%	-13.2%

¹As of October 1, 2018, 18,009 enrollees do not receive APTCon Maryland Health Connection.

²Enrollment as of June 30, 2018.

Premiums after Reinsurance and Silver-loading

- ✕ Consumers will receive less APTC but still more than otherwise due to “silver-loading.” Example:
 - The SRP reduced premiums for silver plans from -7.2% to -14.5%.
 - Silver plan premiums on Maryland HealthConnection are 11% to 28% higher than off-Exchange premiums.
- ✕ Consumers will pay less if their base premium decrease was greater than their APTC decrease and vice versa. Example:
 - The SRP reduced premiums differently depending on metal level and carrier
 - q Bronze plans -4.4% to -19.1%
 - q Silver plans -7.2% to -14.5%
 - q Gold plans -9.3% to -15.3%
- ✕ Reinsurance programs and “silver-loading” narrow the gap between gold and silver plans, i.e. lowers the barriers to “buying-up.”



Questions?

For more information contact John-Pierre Cardenas, jcardenas@maryland.gov