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# NOVAREST REPORT TO THE MICHIGAN DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

# HEALTH INSURANCE INDIVIDUAL MARKET STUDY AND 1332 WAIVER ANALYSIS

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# I. Executive Summary

This section provides a high-level overview of the analysis performed for this report. Later sections provide additional detail on each of the summary comments here.

## *Current Market and Baseline Projections*

Although Michigan has a relatively stable individual health insurance market with numerous carriers, federal changes including the removal of the individual mandate penalty, the new rules around short term limited duration insurance (STLDI) and association health plans (AHPs), and the loss of the funding of CSRs, these market pressures continue to create uncertainty with respect to future sustainability of the ACA market, nationally as well as in Michigan. Michigan has an opportunity to consider a Section 1332 Waiver or other market reforms to ensure future stability in the individual health insurance market.

Future uncertainty may make carriers decide whether to continue with further investments.

Below are items we identified as part of our market review that reinforce the stability in Michigan's market:

- Market allowed and paid claim trends from 2014 to 2017 have been slightly negative (Tables 24 and 25).

- The average age of individual market membership over the last five years is relatively stable. We see this as a sign that younger individuals, as a percent of the covered population, are not exiting the market faster than others.

However, the following points to possibility of uncertainty in the future:

- Membership in the ACA individual market in Michigan has decreased in 2017 and through June 2018 to 74% of the 2016 membership level (Table 7). Decreasing membership creates concerns for continued stability in the ACA market.

- Premium trend from 2014 to 2018 show an annual trend of 10% (Table 23).

Based on our analysis, membership is projected to decrease by almost 19% between 2020 and 2029 under the baseline scenario (no 1332 Waiver). In addition, under conservative assumptions, the average premium rate is projected to increase from $529.96 to $815.56 between 2020 and 2029, or 54% under the baseline scenario.

## *Potential Policy Solutions*

A number of potential policy solutions were reviewed. Solutions came from Michigan stakeholders, other state initiatives, other state 1332 Waiver applications, and team suggestions.

## *Establish a High-Risk Pool Mechanism under a 1332 Waiver*

Covering high-risk individuals through a separate risk pool and plan can potentially lower premiums in the commercial insurance market.

Since individuals cannot be required to take coverage in the high-risk pool, designing a plan or plans that will entice the target population to enroll while complying with the comprehensiveness and affordability guardrails could be a challenge. One difficulty in enticing the target population is that individuals may be reluctant to disrupt the relationships they have with their current providers by moving to a high-risk pool, which may have a narrow network in order to keep costs low. By its nature, the high-risk pool would have higher claims, resulting in higher premiums if not subsidized by Michigan.

Creating and maintaining a high-risk pool would require significant administrative effort. Eligibility standards, an enrollment system, provider networks, a claims processing system, and customer service and communications systems would need to be established. Much of this could be contracted out to a carrier or an administrator, but that would add a layer of expense and would require monitoring by Michigan. The high-risk pool would receive all premium dollars and pay all claims for its members.

When an individual joins a high-risk pool, it can be disruptive to the family since now the individual may have different benefits and providers than the rest of the family. At times there can be a perceived stigma associated with being in the high-risk pool.

## *Develop a Condition-Based Reinsurance 1332 Waiver*

An example of a conditions-based reinsurance program is the Alaska Reinsurance Program (ARP), which covers all claims for members treated with one or more of 33 conditions. This program began operating under a 1332 Waiver in 2018, and it is estimated that the individual market premiums in 2018 were reduced by 20% due to the program.

Conditions-based programs can be tailored to target specific conditions and be used to support public health programs. This can create synergy with existing public policy goals and could potentially dovetail with population health management goals.

As compared to a separate high-risk pool, since this is an “invisible” reinsurance program to individuals, the members are offered the same plans as everyone else in the individual market, and Michigan does not need to set up its own high-risk plan to offer.

The conditions used for the conditions-based reinsurance program would need to be reviewed regularly to maintain the goals of premium reduction in the individual commercial market. Some conditions may be able to be removed due to developing treatments, and new ones may need to be added. In addition, if experience is used to identify conditions, since the frequency of many high cost conditions is often very low, year-to-year changes in experience could result in missed opportunities with respect to certain conditions. For example, in the ARP, paraplegia was included

in the initial list of 33 conditions, but quadriplegia was not (except for quadriplegia cerebral palsy), likely due to low levels of quadriplegia experience.[1]

If there is no aggregate max cap on reimbursement of claims, this could result in financial risk to the Michigan program. In addition, Michigan would have responsibility for administering the reinsurance program.

New high-cost technology or conditions may not be covered until they are identified by the regular review as noted above.

Since carriers would have a more difficult time predicting the number and cost of individuals with certain conditions, especially in a multi-carrier state, they may not reduce premiums as much as the projected reinsurance reimbursements would indicate. It may be possible to estimate the number of insureds in a market with a certain condition with some level of confidence, but not which carrier they would enroll with.

### *Develop a Cost-Based Reinsurance 1332 Waiver*

A cost-based reinsurance program is a more traditional reinsurance program that reinsures a portion of individual claims above a certain threshold, possibly with a cap on the reinsurance. An example of this kind of reinsurance is the temporary reinsurance program that was part of the ACA from 2014 through 2016. Wisconsin has a cost-based reinsurance program approved through a 1332 Waiver.

As compared to a separate high-risk pool, since this is an "invisible" reinsurance program to individuals, the members are offered the same plans as everyone else in the individual market, and Michigan does not need to set up its own high-risk plan to offer.

As compared to the condition-based reinsurance the savings can be projected with more accuracy and therefore the impact on premiums will be greater and the federal funding can be projected with more accuracy.

Using the data provided by the carriers NovaRest estimated the impact on the 2020 individual market. The results for a number of attachment points, coinsurance amounts, and maximum claims levels used in other states is included in Table 1. As would be expected, as the premium decrease gets larger, the federal pass-through and the amount that would be Michigan's responsibility increase. The federal funds are significantly more than the amounts that Michigan would be responsible for providing. In addition to the Michigan funds needed to fund the reinsurance, Michigan would have responsibility for administering the reinsurance. Talking to states with similar programs, it is anticipated that administering the program could be performed by one full-time equivalent employee.

[1] http://ncoil.org/wp-content/uploads/2018/03/Cecil-Bykerk-PP.pdf

| Table 1<br>Cost-Based Reinsurance Scenarios – First Year (2020)[2] | | | | | |
|---|---|---|---|---|---|
| Attachment Point | $100,000 | $200,000 | $50,000 | $50,000 | $50,000 |
| Coinsurance | 75% | 75% | 50% | 70% | 80% |
| Maximum Claim Amount | $1,000,000 | $1,000,000 | $250,000 | $250,000 | $250,000 |
| Michigan Responsibility | $150,000,000 | $71,000,000 | $129,000,000 | $180,000,000 | $206,000,000 |
| Federal Pass-Through | $228,000,000 | $107,000,000 | $195,000,000 | $274,000,000 | $313,000,000 |
| Premium Decrease | 21% | 10% | 18% | 25% | 29% |

## *Expanding the Availability of Catastrophic Level Coverage to Everyone*

The goal of expanding the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the ACA is to provide an affordable option for healthy individuals. The theory is that if more healthy individuals are covered by the single risk pool, the pool will be more stable and less expensive in total. The intent would be for healthy uninsureds to purchase the catastrophic coverage that would no longer have age and income restrictions. Having the more affordable coverage available may also be an alternative for individuals that currently have coverage but are considering dropping it because of unaffordable rate increases.

There may be an impact if this was implemented with a 1332 Waiver. If the catastrophic plan expansion was used in conjunction with a 1332 Waiver, the federal pass-through amounts may be reduced for any individuals that were eligible for tax credits and purchased the catastrophic plan with the tax credit.

Michigan would need to take on responsibilities for certification of catastrophic plan eligibility based on Michigan's criteria, unless it was available to everyone. Also, Michigan would have to provide risk adjustment for the catastrophic plans due to the expanded scope.

Please note that if changes needed to be made to the Federally Facilitated Exchange software on HealthCare.gov, Michigan would have to pay for it.

## *Change the Age Rating Curve so that Those Ages 19-26 have the Same Premium Ratios Applied to Them as an 18-Year Old*

The goal of a modified age curve is to make insurance more affordable for younger individuals and therefore have a positive impact on the total market as the younger healthier individuals purchase coverage or retain coverage that they currently have.

We modified the age curve by using the current age 18 factor for ages 18-26 and capping the factor of the older ages at three times the age 21 factor and then prorating all factors so that the age 18-26 factor is 1.0 and the age 64+ factor is 3.0. The result is a decrease in rates at ages 19-26 (0.8% to 8.8%) and 61-64+ (0.3% to 6.6%) and an increase at all other ages of about 2.3%.

[2] If Michigan pursues a cost-based reinsurance, there will be costs to Michigan to fund and administer the program in future years. This table only provides the costs for the first year.

There would be no additional impact on federal or Michigan funding if it is not implemented at the same time as a 1332 Waiver. A modification to the age curve would not require a waiver. If it were included in a 1332 Waiver or alongside a 1332 Waiver, it would decrease the cost of the second lowest silver plan at some ages and increase it at others. It may increase or decrease the pass-through funding to the extent that it impacts overall premium, but that would depend on the projected membership and the impact on APTCs.

## *Changes to Essential Health Benefits Prescription Drug Formulary to Allow Only One Drug for Each Pharmacy Therapeutic Class*

On January 24, 2019, HHS published its Proposed 2020 Payment Parameters Rule giving additional flexibility to carriers offering fully compliant ACA products. This allows mid-year changes to formularies to account for the release of new generic drugs. As part of a 13332 Waiver, if Michigan allows a formulary with only one drug for each therapeutic class, this could help reduce health care costs further.

Lowering pharmacy costs will reduce premiums in the individual market and increase affordability. This will lower premiums via reduced pharmacy costs and provide some funding for a state-based reinsurance mechanism to help keep the individual market more stabilized on an ongoing basis. The reduction in premiums based on our analysis is estimated to be between 1.3% and 1.9%.

The 1332 process requires a public comment period in Michigan. A change to the formulary included as part of a 1332 Waiver will likely attract a lot of public criticism in Michigan as it did in Alabama. This has not been done before in a 1332 Waiver and therefore will have a more detailed review by CMS to ensure that it meets all of the guardrails. In our experience this will add a level of complication and more time to the process.

## *Using Michigan-Based Adjustments to Federal Risk Adjustment Calculations*

Currently, the federal risk adjustment formula adjusts the statewide average premium by reducing it 14%. This reduction is an attempt to exclude non-claim expenses from the calculation of the statewide average premium.

Two alternatives have been suggested in Michigan. One alternative would be to add state and local taxes to the CMS retention of 14%. This would increase the 14% to 16%. This would reduce the amount of risk-adjustment transfer by 2%. Therefore, carriers receiving a transfer would get 2% less and those paying a transfer would pay 2% less.

The second alternative would be to use actual claims by using actual loss ratios rather than the 86% loss ratio implied in the CMS formula. We looked at individual market loss ratios from the NAIC Supplemental Health Care Exhibit (SHCE), the projected loss ratios in the ACA rate filings and the actual loss ratios in the ACA rate filings. The loss ratios projected in the rate filings are available in October before the rates are effective, the loss ratios in the SHCE are available April 1st of the year following the experience year and the actual loss ratio from the rate filings is available approximately a year and one-half following the experience year. It is important to note

that the loss ratios in the SHCE reflect total individual market loss ratios, including any ACA, grandfathered and transitional individual business.

Using loss ratios for each of the three retentions calculated as the compliment of the loss ratios and a three-year average of the last 3 years, the SHCE shows a 16.2% retention adjustment, the actual from the URRTs shows 14%, and the projected from the URRT shows 22.8%.

The change in the risk adjustment may impact the second lowest silver plan. If a carrier that has the second lowest silver plan in an area received a risk adjustment transfer and the risk adjustment receivable is lowered, the premium could theoretically be increased. That higher premium from the second lowest silver plan carrier would increase the advance premium tax credits. If a carrier that has the second lowest silver plan in an area had to pay in risk adjustment and the risk adjustment payable is lowered, the premium could theoretically be reduced.

The purpose of a 1332 Waiver is generally to reduce the statewide average premium and therefore reduce the risk adjustment transfer amounts and to provide federal pass-through funding based on lower projected APTCs. It is not clear under this option whether the second lowest silver plan would necessarily be reduced or potentially increased, thus affecting the federal pass-through funding positively or negatively, respectively.

Additionally, CMS requires a 1332 reinsurance mechanism to coordinate with the risk adjustment. Typically, this will be done using a "muting factor" against the risk adjustment, potentially decreasing risk adjustment further. This muting factor will need to be considered as part of the waiver, and if Michigan is considering an additional adjustment to account for state and local taxes or full retention, the impact of those changes may decrease the projected pass-through funding.

## *Modify Risk Adjustment for a Michigan-Based Program*

Carriers have expressed interest in using Michigan-based adjustments to the federal risk adjustment system. This discussion considers making modifications to the current method of assigning risk points to diagnoses, which may miss the capability of each insurer to manage the cost of care through value-based benefit designs and case management. Essentially, this would require the development of a Michigan-based risk adjustment program, including revising the risk weights, potentially the methodology, and likely the transfer formula.

This alternative would require Michigan to implement its own Michigan-based exchange as well as its own risk adjustment program.

## *Michigan Funding of CSRs*

The RFP asks for an overview of waiver options not utilized in other states that may be worth consideration. One such option is Michigan funding of Cost Sharing Reductions (CSR) to replace the federal funding that was eliminated beginning in 2018. This option was suggested by Steven Chen in a 2017 Health Affairs blog,[3] but to date no state has pursued it.

[3] https://www.healthaffairs.org/do/10.1377/hblog20170815.061550/full/

At the time federal CSR funding was terminated, several analyses found that the federal government's savings in CSR payments would be less than the increase in Advance Premium Tax Credits (APTCs).[4] This is because increasing premiums on silver plans to cover CSR costs (silver loading) results in a higher premium for the Second Lowest Silver Plan (SLSP), which is the basis for APTCs.

Pass-through funding provided under the waiver may be enough to entirely fund the CSRs as well as administration of the program.

CSR funding would satisfy the four guardrails, but it is not clear whether CMS would regard it as an attempt to circumvent Congressional intent in defunding CSR. The proposed 2020 Payment Parameters on-exchange rule states the "Administration supports a legislative solution that would appropriate CSR payments and end silver loading and is seeking other ways to address Silver loading for plan year 2021 or later." If Silver loading is eventually ended, approval of a CSR 1332 Waiver and its calculation of pass-through would be re-evaluated.

## *Recommendations*

Although the Michigan individual market is currently stable with respect to carrier offerings, the ACA market in Michigan has decreased from 2016 to 2018 by 26% or 74% of membership in 2016 (Table 7) and is projected to continue to decrease such that baseline membership in 2029 is projected to be less than 81% of membership in 2020 (Table 31). As membership decreases, the single risk pool becomes more unstable, with healthier unsubsidized members projected to drop out of coverage. The baseline subsidized membership is projected to decrease slightly over this time period, but the unsubsidized and off-exchange membership is expected to drop much faster. As membership drops, carriers will need to make difficult choices of whether or not to offer coverage in a declining market.

The baseline average premium rate is projected to increase from $529.96 to $815.56 between 2020 and 2029, or 54%. This is an annualized growth rate of approximately 4.9% per year. The trend in premium used ranged from 4.5% to 5.6%. These increases are based on CMS requirements for 1332 Waiver applications and actual increases may be higher, resulting in more of a decrease in membership.

A 1332 Waiver can potentially help to keep the market stable, by decreasing premium rates and enticing more individuals to remain covered. We recommend that DIFS further explore the impact of a 1332 Waiver using a cost-based reinsurance mechanism, since that methodology has been approved in 6 of the 8 states with 1332 Waivers and seems the most likely to be approved by CMS while having the most impact on the individual market and individual market premium affordability.

[4] See for example "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments" by Larry Levitt, Cynthia Cox, and Gary Claxton of the Kaiser Family Foundation. https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/

Michigan may also want to combine a 1332 Waiver with some of the other non-waiver potential policy solutions.

# II. Introduction

## *Intent of This Report*

The NovaRest was hired by DIFS to perform a study of the Michigan individual health insurance market and to analyze Section 1332 Waiver options. The goal is to study the Michigan individual health insurance market and to analyze options to avoid the destabilization of the marketplace. This report describes the analysis performed and the conclusions drawn concerning the Michigan 1332 Waiver alternatives. All decisions in connection with this report are the sole responsibility of Michigan. No portion of this report should be considered legal advice.

This report is intended to facilitate the design of a Michigan 1332 Waiver and aid in the decision-making process around the 1332 Waiver. It may be used in part or in its entirety for the ultimate waiver application to CMS, although it is not intended to fulfill all the requirements of the waiver application. This report is for the use of Michigan to aid in its Waiver development and is not appropriate for other uses.

This report and analysis cover the components of Phase 1 of the original Statement of Work (SOW).

Market Evaluation: Perform an analysis of Michigan's individual market (on and off the Health Insurance Marketplace) from 2014 to 2019. This initial market evaluation will focus on premiums, enrollment levels, demographics (including morbidities), and insurer participation and profitability.

Baseline Market Projections from 2020 to 2029: Use trends from the initial market evaluation to predict high-level trends for the future market (if no waiver application is sought) regarding consumer premiums, enrollment levels, demographics (including morbidities), and insurer market participation and profitability. The analysis of these trends should include the impact of high-level trends on the state and federal budget. The analysis should be both qualitative (e.g., analyzing the market and potential problems facing consumer access and choice) and quantitative (e.g., Congressional Budget Office-style tables).

Provide an Overview of Potential Policy Solutions: Provide a high-level summary of potential policy solutions and data analysis capable of supporting Michigan's identification of the Waiver option best suited for Michigan. Solutions and analysis must include waiver options considered in other states that may be worth consideration in Michigan; waiver options not utilized in other states that may be worth consideration; and a summary of any non-waiver innovative approaches permitted by CMS (to be done separately or in tandem with a waiver application). Specifically, solutions and analysis included:

- Establishing a reinsurance mechanism;
- Establishing a high-risk pool mechanism;

- Expanding the availability of catastrophic level coverage to everyone (i.e., a "Copper" plan);
- Changing the age rating curve so that those ages 19-26 have the same premium ratios applied to them as an 18-year old;
- Allowing specific changes to the Essential Health Benefits prescription drug formulary to allow only one drug for each pharmacy therapeutic class or other formulary adjustments; and
- Using Michigan-based adjustments to federal risk adjustment calculations such as eliminating the percentage of premium made up of state and local taxes and fees from the calculation; limiting calculations to true medical expense only; and/or making modifications to the current method of assigning risk points to diagnoses which may miss the capability of each insurer to manage the cost of care through value-based benefit designs and case management.
- Other Options: Cost Share Reduction (CSR) Michigan funding to replace the federal funding. The analysis should include projected costs, projected impact on federal funding, examples of funding mechanisms, the likelihood of CMS approval, the projected impact on the Michigan budget, projected reductions in premiums for consumers and an analysis of how the options support the individual market.

Market Findings and Policy Solutions: Based on the findings and recommendations of this report, DIFS will choose which option to study in Phase 2.

## *NovaRest Market Migration Model*

The primary tool used for the 1332 Waiver application analysis is the NovaRest Market Migration Model (NRMM). The NRMM is an advanced actuarial tool for analyzing the impact of market migration, take-up and lapse rates resulting from proposed legislative changes. The modeling integrated into the NRMM is able to assess the impact purchasing decisions will have on the health insurance market.

The model relies on a wide range of data sources and information. This includes data submitted by the carriers via a data request, individual market ACA health insurance rate filings, the National Association of Insurance Commissioners' (NAIC) Supplemental Health Care Exhibit (SHCE) and public data. The data sources are described in detail in the report.

We have reviewed the carrier-supplied data for reasonableness and consistency, however the data has not been independently audited. The results of this report are dependent on the assumption that the data is accurate. If the data is inaccurate or incomplete, the results and conclusions will need to be revised. The projections and data are based on information provided and accessed prior to February 20, 2019.

The NRMM relies upon assumptions regarding carrier behavior, individual behavior, population factors and a number of other factors. The assumptions used are described throughout the report.

## *Distribution*

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# III. Background

## *A. Section 1332 Waivers*

Section 1332 of the Affordable Care Act (ACA) authorizes states to waive certain requirements of the ACA. The section allows states to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. States can request a waiver related to benefits, subsidies, the marketplaces, and the individual and employer mandates. In 2012, the Department of Health and Human Services (HHS) issued regulations for Section 1332 Waivers.[5] In 2015, the Department of Treasury and HHS released guidance on how they would interpret the law's guardrail requirements.[6] On October 24, 2018, the Department of Treasury and HHS released additional guidance providing more flexibility in meeting the Waiver guardrails[7] and this 2018 guidance supersedes the 2015 guidance. According to the National Conference of State Legislatures, "As of late October 2018 at least 35 states have **considered** legislation to initiate the 1332 Waiver application process."[8] As of August 2018, eight States have received approved waivers: Alaska, Hawaii, Maryland, Minnesota, New Jersey, Oregon, Wisconsin and Maine. California, Iowa and Oklahoma filed Waivers but subsequently withdrew their applications. There are a variety of waiver approaches other states have examined.

According to CMS guidelines, Michigan must demonstrate that the waiver meets the four guardrails to be approved. The four guardrails are:

Comprehensive Coverage – 1332(b)(1)(A). The proposed waiver cannot make alterations to the required scope of benefits offered in the insurance market in Michigan and cannot result in a decrease in the number of individuals with coverage that meet the ACA's Essential Health Benefits requirements.

Affordability – 1332(b)(1)(B). The proposed waiver cannot decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The waiver cannot result in any decrease in affordability for individuals.

[5] https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf
[6] https://www.govinfo.gov/content/pkg/FR-2015-12-16/pdf/2015-31563.pdf
[7] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf
[8] http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx

Scope of Coverage – 1332(b)(1)(C). The proposed will provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver in Michigan.

Federal Deficit Neutrality – 1332(b)(1)(D). The proposed waiver cannot result in increased spending, administrative, or other expenses to the federal government.

When examining the options available to prevent future destabilization of the individual health insurance market in Michigan each of these guardrails must be met.

States can receive a "pass-through" of federal funds that would have otherwise been applied to premium tax credits had the state not received the waiver. The pass-through amount will depend on the structure of the waiver.

## *B. Current Environment*

**Current State of the Affordable Care Act (ACA)**

As federal healthcare reform efforts continue to face significant challenges, changes to the ACA have put a strain on state individual health insurance markets including Michigan's. Regulations have removed the individual mandate penalty and defunded the federal cost-sharing reduction payments (CSR). Most recently, new regulations grant states the ability to expand short-term limited duration insurance (STLDI) and association health plans (AHPs)[9].

Nationally, the cost of health care is still a major barrier to obtaining coverage. Since 2014, premiums in Michigan's individual health insurance market have steadily increased. According to Kaiser Family Foundation, nationally the unsubsidized premium for the lowest-cost bronze plan increased an average of 17% between 2017 and 2018, the lowest-cost silver plan increased an average of 32%[10], and the lowest-cost gold plan increased an average of 18%.[11] For the 2018 plan year, Michigan insurers began loading on-exchange silver premium rates due to the federal government ending the CSR funding. The filed premium rate increases in 2018, which included the CSR load, ranged from 19.0% to 53.2%. The average actual premium increase from 2017 to June of 2018 for subsidized members was 11.1%, which largely represents the impact of the additional CSR load. The filed premium rate increases in Michigan in 2019 ranged from -2.5% to 11.1%. Nationally, ACA market conditions from 2014 through 2019 have resulted in carriers leaving the market or reducing the counties in which they offer plans. The DIFS wants to prevent this from happening in Michigan.

Under the ACA if a family income falls between 100% and 400% of the Federal Poverty Line (FPL), they may be eligible for cost sharing and premium subsidies.[12] Cost sharing reductions (CSR) lower the amount of cost sharing that an individual pays out of pocket. The CSR's are available to those between 100% and 250% of the FPL, with families with lower incomes paying

[9] https://www.federalregister.gov/documents/2017/10/17/2017-22677/promoting-healthcare-choice-and-competition-across-the-united-states
[10] Silver-level premium rates reflect CSR loading beginning in 2018.
[11] "How premiums are Changing in 2018." Kaiser Family Foundation. November 29, 2017. https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/
[12] "2018 Federal Poverty Level". Obamacare.net. https://obamacare.net/2018-federal-poverty-level/

less out-of-pocket. APTCs reduce the premium that a family pays based on their income level and are available up to 400% of FPL.

**Michigan Characteristics**

According to Census.gov, Michigan's total population has been fairly stable with an increase of only 0.8% from April 1, 2010 to July 1, 2017.[13] Table 2a provides a breakdown of the population demographics as of 2017.[14]

| Table 2a<br>MI Population Estimates by Age | |
|---|---|
| Under 20 | 2,444,737 |
| 20-24 | 702,296 |
| 25-29 | 675,351 |
| 30-34 | 592,100 |
| 35-39 | 591,431 |
| 40-44 | 563,193 |
| 45-49 | 641,841 |
| 50-54 | 680,194 |
| 55-59 | 725,106 |
| 60-64 | 675,096 |
| 65 years and over | 1,667,196 |

Michigan's Gross Domestic Product (GDP) was $509 billion in 2017.[15]

The median household income in Michigan for 2017 was $52,668. The median household income for the entire United States was $57,652. The income and benefits distribution for the Michigan population, in 2017 inflation adjusted dollars, is shown in Table 2b.[16]

[13] https://www.census.gov/quickfacts/mi

[14] "Vintage Population Estimates". 2017. https: // census.gov/data/datasets/2017/demo/popest/state-detail.html#par_textimage_2063038847 (no longer accessible)

[15] "Total Gross Domestic Product for Michigan.: https://fred.stlouisfed.org/series/MINGSP.

[16] "2013-2017 American Community Survey 5-Year Estimates." United States Census Bureau. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_5YR_DP03&prodType=table#none

| Table 2b<br>Population by Income & Benefits | | |
|---|---|---|
| | **Estimate** | **Percent** |
| Total households | 3,888,646 | 100% |
| Less than $10,000 | 284,882 | 7.3% |
| $10,000 to $14,999 | 193,880 | 5.0% |
| $15,000 to $24,999 | 411,782 | 10.6% |
| $25,000 to $34,999 | 403,426 | 10.4% |
| $35,000 to $49,999 | 549,638 | 14.1% |
| $50,000 to $74,999 | 720,755 | 18.5% |
| $75,000 to $99,999 | 474,850 | 12.2% |
| $100,000 to $149,999 | 500,924 | 12.9% |
| $150,000 to $199,999 | 183,124 | 4.7% |
| $200,000 or more | 165,385 | 4.3% |
| **Median household income (dollars)** | **52,668** | |
| **Mean household income (dollars)** | **72,091** | |

Per the most recent U.S. Census Bureau estimates, the number of persons in poverty in Michigan is 14.2%, which is higher than the estimated 12.3% for the entire United States.[17]

The Federal Poverty Level (FPL) is utilized to determine if a citizen is eligible for subsidies to off-set the cost of their monthly premiums. The FPL is also used to determine eligibility for Medicaid and Children's Health Insurance Program (CHIP). In 2018, 2.7 million individuals (27% of the population) were under 200% FPL in Michigan.[18]

Michigan has a state-federal partnership exchange. Michigan oversees plan management, and Healthcare.gov is used for enrollment. Michigan expanded Medicaid under the ACA, and the exchange can enroll people in Medicaid or qualified health plans (QHPs), depending on their income.[19]

A breakdown of the health insurance coverage in Michigan is shown in Chart 1.[20]

[17] "Quickfacts: Michigan." United States Census Bureau. https://www.census.gov/quickfacts/fact/table/nd,US/PST045217
[18] "Medicaid In Michigan", Kaiser Family Foundation, November 2018, http://files.kff.org/attachment/fact-sheet-medicaid-state-MI
[19] "Michigan health insurance marketplace history and news of the state's exchange." https://www.healthinsurance.org/michigan-state-health-insurance-exchange/
[20] "Health Insurance Coverage of the Total Population." Henry J Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22michigan%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7 .

Chart 1
Michigan Health Coverage, 2017

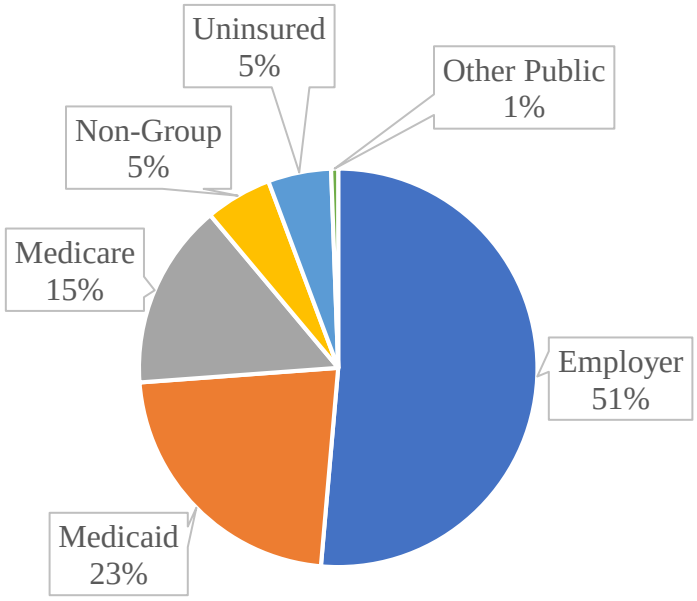


Table 3 below shows the market breakdown from 2013 to 2017.[21]

**Table 3**
**Health Insurance Coverage of the Total Population**

| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| Employer | 50% | 50% | 50% | 51% | 51% |
| Non-Group | 5% | 6% | 6% | 6% | 5% |
| Medicaid | 20% | 20% | 23% | 23% | 23% |
| Medicare | 14% | 14% | 15% | 15% | 15% |
| Other Public | 1% | 1% | 1% | 1% | 1% |
| Uninsured | 11% | 8% | 6% | 5% | 5% |

[21] "Health Insurance Coverage of the Total Population." Henry J Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22michigan%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

The approved 2018 average rate increases for the individual market, including off-exchange are included in Table 4.[22, 23] These rate increases include the one-time increase for the on-exchange Silver plans due to the federal defunding of CSRs.

**Table 4**
**Michigan 2018 Final Average Individual Market Rate Increases by Company**

| Company | 2018 Rate Increase |
|---|---|
| Alliance Health and Life Insurance Company | 19.8% |
| Blue Care Network of Michigan | 22.6% |
| Blue Cross Blue Shield of Michigan | 31.7% |
| Health Alliance Plan of Michigan | 29.6% |
| McLaren Health Plan Community | 26.6% |
| Meridian Health Plan of Michigan | 53.2% |
| Molina Healthcare of Michigan, Inc. | 42.8% |
| Physician's Health Plan | 26.0% |
| Priority Health | 19.0% |
| Total Health Care USA | 27.6% |

The approved 2019 average rate increases for the individual market, including off-exchange, are included in Table 5.[24]

**Table 5**
**Michigan 2019 Final Average Individual Market Rate Increases by Company**

| Company | 2019 Rate Increase |
|---|---|
| Alliance Health and Life Insurance Company | 0.0% |
| Blue Care Network of Michigan | 1.1% |
| Blue Cross Blue Shield of Michigan | 4.2% |
| Health Alliance Plan of Michigan | 0.0% |
| McLaren Health Plan Community | 11.1 |
| Meridian Health Plan of Michigan | 0.7% |
| Molina Healthcare of Michigan, Inc. | 2.2% |
| Oscar Insurance Company | New |
| Physician's Health Plan | 3.0% |
| Priority Health | -2.5% |
| Total Health Care USA | 7.6% |

Although Michigan has numerous carriers as noted in the table above, with the removal of the individual mandate penalty, the new rules around STLDI and AHPs, and the loss of the funding of CSRs, these pressures continue to create uncertainty with respect to future sustainability of the

[22] https://filingaccess.serff.com/sfa/home/MI
[23] In 2018, Michigan insurers began loading silver premiums for CSR's not being funded.
[24] https://filingaccess.serff.com/sfa/home/MI

ACA market, nationally as well as in Michigan. Michigan has an opportunity to consider a Section 1332 Waiver to ensure continued stability in the individual health insurance market.

# IV. Task 1: Study Michigan's Individual Market

## *A. Market Evaluation*

This section provides an overview of the initial Market Evaluation of Michigan's individual market (on and off the Health Insurance Marketplace) from 2014 to 2019. This evaluation focuses on premiums, enrollment levels, demographics, morbidity, insurance participation and profitability. This evaluation included review of experience data from carriers, publicly available data such as data in filed financial statements, and filed rate materials from carriers, such as URRT information.

This section also provides an overview of our baseline market projections from 2020 to 2029, using high-level trends for the future market assuming no 1332 Waiver is requested (baseline). Separate trends for consumer premiums, enrollment levels (membership), demographics (age), and morbidity are developed, along with estimations of insurer market participation and profitability.

These baseline projections will be used to compare to proposed policy changes under 1332 Waiver options in Phase 2.

NovaRest used the initial market evaluation data detailed below as the starting point to project baseline experience for calendar years 2020 through 2029.

**Membership, Premiums, Claims & Age**

To analyze the baseline membership, premiums, claims and age data, NovaRest completed the following steps:

1) With the assistance of DIFS, NovaRest sent a data call to Michigan carriers that DIFS selected based on market presence. The list of carriers is provided in Table 6. The table also provides a reason why a carrier was not included. The data call requested data for fully compliant individual market ACA policies in years 2014 to 2018, as well as for grandfathered and transitional plans. The data for 2018 was only for 6 months, through June 2018. We requested enrollment, premium, claims, and advanced premium tax credit (APTC) information. Since health insurance buying decisions are family based, we requested the information needed to group individuals into families. Data on membership and average premium was also provided by Cost Sharing Reduction (CSR) and metal level.

| Table 6: Carriers Data Request | | |
|---|---|---|
| **Company** | **Used in Study** | **Reason not used** |
| Aetna Life Insurance Company | Y | |
| All Savers Insurance Company | N | No Individual Business |
| Alliance Health & Life | Y | |
| Blue Care Network (BCN) | Y | |
| Blue Cross Blue Shield of Michigan (BCBSM) | Y | |
| Freedom Life Insurance Company of America | N | No Individual Business |
| Golden Rule Insurance Co | N | No Individual Business |
| Harbor Health Plan | N | Minimum membership amount |
| HAP | Y | |
| Humana Insurance Company | Y | |
| Humana Med Plan of Michigan | Y | |
| McLaren Health Plan Comm | Y | |
| Meridian Health Plan of Michigan | Y | |
| Molina Healthcare of Michigan | Y | |
| Physicians Health Plan (PHP) | Y | |
| Priority Health | Y | |
| Priority Health Insurance Company | Y | |
| Total Health Care USA | Y | |
| UnitedHealthcare Comm Plan (UHCCP) | Y | |
| UnitedHealthcare Life Insurance Company (UHCLIC) | Y | |

2) We verified the data content was in the format requested and checked for completeness. The goal of this step is to ensure the data that was provided is correct and reasonable.

3) We summarized the members, claims and premiums by year.

4) To calculate the per member per month (PMPM) amounts for premium and claims, we divide total premium and claims for each category by the number of member months.

5) For each category we calculated a trend for membership, premium, and claims by market category, and membership by age for each year. Trends were calculated for each of the years of data collected (January 2014-June 2018) and annualized over the total period.

6) For the projection period we then calculated the total market premium by multiplying the membership by the PMPM premiums to show the market as a whole.

The data and baseline projections are shown in the Analysis section below.

# *B. Analysis*

## *2014 to 2018 Membership, Premium and Claims*

Based on the data received, the individual insurance market membership, average and total premium and claims are shown in the following tables. We requested data from 2014 to 2018. Since 2018 was not yet complete, we only received 6 months of data for 2018. Since the premium is the average based on the age mix in the category, the premiums are not totally comparable, but give a sense of what individuals are paying in each market segment. Table 7 presents the members for 2014 through June 2018. These member counts reflect any member at any time who was covered during the period. It does not reflect the ending members or the average members. Table 8 presents the total premium in the market from 2014 through June 2018. Table 9 presents the member months from 2014 through June 2018. Table 10 presents the average premium rates in the market from 2014 through 2018. Tables 11 and 12 present the total allowed and paid claims, respectively for the individual market in Michigan from 2014 through 2017 (2018 claims have not yet been finalized). Tables 13 and 14 present the allowed and paid claims on a PMPM basis.

**Table 7**
**Total Members**

| Members | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Total APTC On Exchange | 147,882 | 271,834 | 288,041 | 259,496 | 205,114 |
| Total Non-APTC (> 400%) On Exchange | 135,634 | 100,113 | 97,172 | 88,683 | 88,079 |
| **Total On Exchange** | **283,516** | **371,947** | **385,213** | **348,179** | **293,193** |
| **Off Exchange** | **75,137** | **134,909** | **147,711** | **130,154** | **98,857** |
| **Total ACA** | **358,653** | **506,856** | **532,924** | **478,333** | **392,050** |

As can be seen in Table 7, membership in the ACA individual market in Michigan has decreased in 2017 and through June 2018 to 74% of the 2016 membership level (392,050/532,924). Decreasing membership creates concerns for stability in the ACA market.

| Table 8<br>Total Premium | | | | | |
|---|---|---|---|---|---|
| **Total Premium** | **2014** | **2015** | **2016** | **2017** | **2018** |
| Total APTC On Exchange | $438,177,093 | $880,171,500 | $985,366,984 | $988,669,266 | $556,902,056 |
| Total Non-APTC (> 400%) On Exchange | $338,041,809 | $271,429,428 | $287,859,251 | $296,480,157 | $201,115,108 |
| **Total On Exchange** | **$776,218,902** | **$1,151,600,927** | **$1,273,226,235** | **$1,285,149,422** | **$758,017,165** |
| **Off Exchange** | **$212,428,006** | **$430,915,642** | **$548,919,982** | **$539,197,084** | **$257,554,472** |
| **Total ACA** | **$988,646,908** | **$1,582,516,569** | **$1,822,146,217** | **$1,824,346,506** | **$1,015,571,637** |

As can be seen in Table 8, if the 6 months 2018 premium was doubled (likely too high as members may drop off throughout the year), total estimated market premium for 2018 would be $2,031,143,274. This reflects an increase from both 2017 and 2016. If the actual is less than 2 times the 6-month level, total premium in the market would seem to be fairly flat from 2016 through 2018, even with the decrease in members, due to the large increase in premium rates in 2018, as seen in Table 4.

| Table 9<br>Member Months | | | | | |
|---|---|---|---|---|---|
| **Member Months** | **2014** | **2015** | **2016** | **2017** | **2018** |
| Total APTC On Exchange | 1,175,110 | 2,279,593 | 2,500,835 | 2,321,646 | 1,059,477 |
| Total Non-APTC (> 400%) On Exchange | 1,022,449 | 831,561 | 859,585 | 804,529 | 464,416 |
| **Total On Exchange** | **2,197,559** | **3,111,154** | **3,360,420** | **3,126,176** | **1,523,893** |
| **Off Exchange** | **603,858** | **1,217,178** | **1,470,610** | **1,309,810** | **538,586** |
| **Total ACA** | **2,801,417** | **4,328,332** | **4,831,030** | **4,435,986** | **2,062,479** |

Member months reflect the total months of coverage of members and is used to calculate per member per month (PMPM) values. If a member is covered the entire year, 12 member months are counted for that member. If a member is only covered from January to June, then only 6 months are counted for that member. As can be seen in Table 9, if the 6 months of member months in 2018 was doubled (likely a high estimate for 2018 due to continued membership dropping), estimated 2018 member months would be 4,124,958. This reflects a decrease in member months since both 2016 and 2017, down to a level below that in 2015, to approximately 85% of that seen in 2016.

| Table 10<br>Average Premium PMPM | | | | | |
|---|---|---|---|---|---|
| **Average Premium PMPM** | **2014** | **2015** | **2016** | **2017** | **2018** |
| Total APTC On Exchange | $372.88 | $386.11 | $394.02 | $425.85 | $525.64 |
| Total Non-APTC (> 400%) On Exchange | $330.62 | $326.41 | $334.88 | $368.51 | $433.05 |
| **Total On Exchange** | **$353.22** | **$370.15** | **$378.89** | **$411.09** | **$497.42** |
| **Off Exchange** | **$351.78** | **$354.03** | **$373.26** | **$411.66** | **$478.20** |
| **Total ACA** | **$352.91** | **$365.62** | **$377.18** | **$411.26** | **$492.40** |
| **Annualized ACA Increase (over prior year)** | | **3.6%** | **3.2%** | **9.0%** | **9.4%** |

As can be seen from Table 10, average premiums PMPM have increased 31% from 2016 to 2018 ($492.40/$377.18 – 1).

| Table 11<br>Total Allowed Claims | | | | |
|---|---|---|---|---|
| **Total Allowed Claims** | **2014** | **2015** | **2016** | **2017** |
| Total APTC On Exchange | $551,170,402 | $1,043,583,390 | $1,153,296,801 | $1,029,158,709 |
| Total Non-APTC (> 400%) On Exchange | $386,469,396 | $288,158,555 | $326,629,589 | $315,077,926 |
| **Total On Exchange** | **$937,639,799** | **$1,331,741,945** | **$1,479,926,391** | **$1,344,236,635** |
| **Off Exchange** | **$304,465,036** | **$511,413,490** | **$650,410,795** | **$581,271,091** |
| **Total ACA** | **$1,242,104,835** | **$1,843,155,435** | **$2,130,337,186** | **$1,925,507,726** |

Table 11 shows how the allowed claims in total dollars decreased by 10% in 2017 as compared to 2016 ($1,925,507,726/$2,130,337,186 – 1). Allowed claims reflect the total cost of healthcare services utilized by members.

| Table 12<br>Total Paid Claims | | | | |
|---|---|---|---|---|
| **Total Paid Claims** | **2014** | **2015** | **2016** | **2017** |
| Total APTC On Exchange | $463,169,106 | $881,531,722 | $969,856,610 | $854,281,701 |
| Total Non-APTC (> 400%) On Exchange | $319,758,566 | $215,888,804 | $253,854,534 | $240,047,242 |
| **Total On Exchange** | **$782,927,672** | **$1,097,420,526** | **$1,223,711,144** | **$1,094,328,943** |
| **Off Exchange** | **$233,198,564** | **$384,959,713** | **$500,987,181** | **$430,232,744** |
| **Total ACA** | **$1,016,126,236** | **$1,482,380,239** | **$1,724,698,325** | **$1,524,561,688** |

As can be seen in Table 12, paid claims in total decreased 12% in 2017 as compared to 2016 ($1,524,561,688/$1,724,698,325 -1). Paid claims reflect the total cost of healthcare services paid by carriers, excluding the amounts paid by members as cost shares.

| Table 13<br>Allowed Claims PMPM | | | | |
|---|---|---|---|---|
| **Allowed Claims PMPM** | **2014** | **2015** | **2016** | **2017** |
| Total APTC On Exchange | $469.04 | $457.79 | $461.16 | $443.29 |
| Total Non-APTC (> 400%) On Exchange | $377.98 | $346.53 | $379.99 | $391.63 |
| **Total On Exchange** | **$426.67** | **$428.05** | **$440.40** | **$429.99** |
| **Off Exchange** | **$504.20** | **$420.16** | **$442.27** | **$443.78** |
| **Total ACA** | **$443.38** | **$425.83** | **$440.97** | **$434.07** |
| **Annualized ACA Increase (over prior year)** | | **-4.0%** | **3.6%** | **-1.6%** |

As can be seen in Table 13, the trend in the allowed claims PMPM in 2017 from 2016 was a decrease of 1.6%.

| Table 14<br>Paid Claims PMPM | | | | |
|---|---|---|---|---|
| **Paid Claims PMPM** | **2014** | **2015** | **2016** | **2017** |
| Total APTC On Exchange | $394.15 | $386.71 | $387.81 | $367.96 |
| Total Non-APTC (> 400%) On Exchange | $312.74 | $259.62 | $295.32 | $298.37 |
| **Total On Exchange** | **$356.27** | **$352.74** | **$364.15** | **$350.05** |
| **Off Exchange** | **$386.18** | **$316.27** | **$340.67** | **$328.47** |
| **Total ACA** | **$362.72** | **$342.48** | **$357.00** | **$343.68** |
| **Annualized ACA Increase (over prior year)** | | **-5.6%** | **4.2%** | **-3.7%** |

As seen in Table 14, the trend in the paid claims PMPM in 2017 from 2016 was a decrease of 3.7%.

Loss ratios (the ratio of paid claims over premium) for 2016 and 2017 were 94.7% and 83.6%, respectively. This can be seen using the PMPM values from Tables 14 and 10, or the total values from Tables 12 and 8. The loss ratios from one year suggest whether that year's premium was at a reasonable level. This is at an aggregate level for the market, and results could vary by carrier.

Because ACA rates must be filed based on experience 2 years prior to the effective dates of rates being filed, that is rates are filed for calendar year 20XX in the spring of 20(XX-1) based on data

from 20(XX-2), very little is known about how the experience will ultimately develop for the calendar year 20(XX-1). Therefore, the 95% loss ratio in 2016 suggests that the aggregate premium rates for 2016 were too low for the covered population and helps to partially explain why the rate increases in 2018 were relatively high (as seen in Table 4). The 83.6% loss ratio in 2017 suggests the 2017 premium rates, in aggregate, were likely at a more reasonable level, which helps to partially explain why the rate increases in 2019 were relatively low (as seen in Table 5). Of course, another driver of premium rate increases in 2018 was the loss of the CSR funding.

As the underlying rules continue to change from year to year affecting the ACA market, and if membership continues to decrease as seen in the Michigan market, carriers need to make choices about what plans to offer based on the level of risk they project in future years. This can affect access to coverage and healthcare services for consumers.

In addition, as the premium continues to increase, affordability for covered members becomes a concern. Subsidy eligible members may, at times, be somewhat protected from the increases due to the way the subsidies are calculated as a % of their income and the second lowest silver premium; however, non-subsidized members must decide whether they can afford to pay the entire rate increase each year. Typically, as the premium rate increases to higher than what an individual expects to use for healthcare services, they may decide to go uninsured, especially with the elimination of the individual mandate penalty. As healthier individuals drop coverage, the underlying risk pool gets riskier, resulting in higher rate increases necessary to cover the cost of healthcare services. Thus, stability in a market can, to some degree, be increased if steps are taken to increase membership in the ACA risk pool by helping to keep premiums lower and to attract members who would otherwise choose to go uninsured to stay in the market.

## *2014 to 2018 Demographics*

### *Age*

Table 15 shows the membership by age band from 2014 to 2018. The average age has fluctuated between 40.93 and 42.36, but considering that each covered individual will age 1 year, the average age is relatively stable. We see this as a sign that younger individuals, as a percent of the covered population, are not exiting the market faster than others.

| Table 15<br>Summary of Member Months by Age Band | | | | | |
|---|---|---|---|---|---|
| **Ages** | **2014** | **2015** | **2016** | **2017** | **2018[25]** |
| 0-14 | 190,990 | 403,736 | 506,765 | 470,387 | 411,412 |
| 15-20 | 130,083 | 244,892 | 295,377 | 270,549 | 234,022 |
| 21-25 | 186,417 | 265,343 | 278,925 | 247,960 | 217,360 |
| 26-30 | 278,540 | 389,059 | 410,917 | 369,251 | 328,850 |
| 31-35 | 205,937 | 309,986 | 340,029 | 311,460 | 290,237 |
| 36-40 | 177,114 | 276,758 | 314,677 | 292,995 | 275,393 |
| 41-45 | 212,066 | 314,385 | 330,838 | 290,233 | 266,347 |
| 46-50 | 260,454 | 389,992 | 431,053 | 382,840 | 344,086 |
| 51-55 | 337,602 | 502,813 | 536,772 | 477,736 | 422,219 |
| 56-60 | 402,574 | 578,640 | 642,041 | 597,930 | 547,522 |
| 61-65 | 413,974 | 641,559 | 730,129 | 710,051 | 691,312 |
| 65+ | 5,666 | 11,170 | 13,505 | 14,593 | 15,909 |
| **Average** | **42.36** | **41.31** | **40.93** | **41.14** | **41.64** |

### *Morbidity*

Morbidity rate is the measure of illness that will occur in the population. The morbidity rate considers how often an illness appears in a population of people. Trend in morbidity reflects changes in the morbidity of the underlying population, as the population covered by the individual market can vary every year. Morbidity trends affect projected claims.

We looked at morbidity from two perspectives. First, we looked at historic morbidity adjustments in the rate filing information since 2014. Secondly, we looked at the percent of claims over $100,000 as a percent of total claims for 2014 to 2018 in order to get a sense of the increase in large claims, which provides a sense of underlying morbidity change.

1) We used the morbidity in the rate filings weighted by membership to get a weighted average morbidity adjustment for each year (see Table 16).

2) We used the historic data on claims distributions between 2014 and 2017 from Michigan ACA fully compliant business to develop historic morbidity levels on allowed claims (see Table 17).

Looking at the projected morbidity included in the carrier URRTs weighted by experience membership from 2014 to 2019 in Table 16 we see that morbidity projections were high in the early years, but then were reduced to between 4% and 9% for 2016 through 2019[26].

[25] In this table the 2018 member months assume that members active as of June of 2018 will continue to be active for the remainder of the year to provide more accurate trends. Member month trends as of June (which is when data was provided through) would reflect a significant decrease because it would only represent a half year.

[26] https://filingaccess.serff.com/sfa/home/MI

| Table 16<br>Weighted Average Carrier Morbidity Factor by Year | | | | | |
|---|---|---|---|---|---|
| **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| 1.185 | 1.192 | 1.039 | 1.060 | 1.087 | 1.073 |

Looking at the historic percentage of allowed claims over $100,000 in Table 17 we see that it has fluctuated between 20.6% and 24.5%. Some of this change from year to year can be attributed to health care cost increases, but the remainder is due to increases in morbidity.

| Table 17<br>Michigan Fully Compliant ACA Individual Market Morbidity<br>By Annual Claim Level<br>Percent of Allowed Claims Over $100,000 | | | | |
|---|---|---|---|---|
| | 2014 | 2015 | 2016 | 2017 |
| $100,000 to $199,999 | 11.2% | 11.6% | 12.1% | 12.2% |
| $200,000 to $499,999 | 6.7% | 7.6% | 8.9% | 8.6% |
| $500,000 to $749,999 | 1.7% | 1.7% | 1.7% | 1.4% |
| $750,000 to $999,999 | 0.3% | 0.5% | 0.8% | 0.8% |
| $1,000,000 to $1,249,999 | 0.2% | 0.1% | 0.4% | 0.1% |
| $1,250,000 to $1,499,999 | 0.0% | 0.1% | 0.0% | 0.2% |
| Over $1,500,000 | 0.6% | 0.7% | 0.6% | 0.6% |
| Total Over $100,000 | 20.6% | 22.3% | 24.5% | 23.9% |

We would expect the impact of morbidity on claims to decrease in 2020 as CMS has currently not extended transitional policies beyond 2019 and these possibly healthier individuals buy into the ACA individual market. Currently there is not a lot of take-up of STLD plans or AHPs in Michigan, but if that would change it would most likely increase morbidity in the ACA market. See Table 18 for information on transitional, grandfathered, STLD and AHP membership from 2014 to 2018 from the carriers offering ACA plans.

| Table 18<br>Non-ACA Total Insured Members by Year | | | | | |
|---|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** | **2018**[27] |
| Transitional | 138,698 | 43,270 | 33,788 | 28,261 | 24,907 |
| Grandfathered | 15,170 | 8,723 | 6,990 | 5,295 | 4,644 |
| Short-Term Limited Duration | 3,637 | 4,310 | 5,125 | 4,267 | 3,199 |
| Association Health Plan | 0 | 0 | 0 | 0 | 0 |

[27] We assumed membership as of June 2018 continues for the remainder of 2018.

## *2014 to 2019 Insurer Participation*

We gathered information from the rate tables filed by carriers on how many carriers were offering coverage in each area and how many plans were offered in each metal level for each year 2014-2019. We observed a number of changes over the 5-year period.

Table 19 shows how many carriers offer coverage in each area. Tables in Appendix D break down the available carriers by metal level by area. Except for Platinum plans, there is at least one carrier offering a metal level in each area. The number of carriers offering coverage has been dropping from 2014 to 2019. Only area 16 has 2 carriers, whereas all other areas have more than 2 carriers offering plans.

**Table 19**
**Count of Carriers by Area, All Metal Levels**

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| Area 1 | 17 | 21 | 19 | 12 | 9 | 10 |
| Area 2 | 17 | 20 | 20 | 12 | 9 | 10 |
| Area 3 | 12 | 16 | 13 | 8 | 7 | 6 |
| Area 4 | 12 | 16 | 13 | 10 | 8 | 9 |
| Area 5 | 17 | 18 | 17 | 12 | 9 | 9 |
| Area 6 | 12 | 16 | 13 | 10 | 7 | 7 |
| Area 7 | 14 | 13 | 12 | 10 | 8 | 8 |
| Area 8 | 14 | 16 | 13 | 9 | 8 | 7 |
| Area 9 | 10 | 12 | 11 | 7 | 6 | 5 |
| Area 10 | 10 | 12 | 12 | 8 | 5 | 5 |
| Area 11 | 10 | 11 | 10 | 6 | 5 | 5 |
| Area 12 | 12 | 14 | 12 | 9 | 7 | 7 |
| Area 13 | 13 | 14 | 12 | 7 | 5 | 5 |
| Area 14 | 9 | 12 | 10 | 6 | 4 | 4 |
| Area 15 | 11 | 15 | 12 | 8 | 7 | 7 |
| Area 16 | 9 | 9 | 7 | 4 | 2 | 2 |

Oscar came into the market in 2019[28]. We assumed the same carriers would participate in the individual market in 2020 as in 2019. Based on DIFS information and a carrier questionnaire it does not appear that insurers in Michigan plan to enter or leave the individual market at this time. However, this could change in the future depending on the stability of the ACA market. If carriers decide to drop out of the market, this could create access to coverage issues for individuals.

## *2014 to 2019 Profitability*

Utilizing the NAIC Supplemental Health Care Exhibit (SHCE) for years 2014 through 2017 (2018 is not yet available), we calculated the profit for the individual market in total. The SHCEs only

[28] https://www.healthaffairs.org/do/10.1377/hblog20180730.31405/full/

provide information for the entire individual market by carrier, including any grandfathered and transitional business each carrier has. However, the grandfathered and transitional business, as closed blocks of business, have been decreasing, so we believe using this data is a reasonable starting place. We then calculated the trend in profit for each year and for the four years on an annual basis for each carrier and the individual market in total.

**Table 20**
**Underwriting Gain/(Loss) Total Dollars and as a % of Revenue, Michigan Individual Market**

| | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Annual ($) | $(69,184,944) | $(4,069,852) | $(109,831,603) | $19,935,698 |
| Annual (%) | -4.70% | -0.22% | -5.65% | 1.09% |
| Cumulative, From 2014 ($) | $(69,184,944) | $(73,254,796) | $(183,086,399) | $(163,150,702) |
| Cumulative, From 2014 (%) | -4.70% | -2.22% | -3.49% | -2.31% |

As seen in Table 20, total individual market underwriting losses have varied from year to year, with a gain of approximately 1% in 2017. This is one measure of the instability of the individual market in Michigan. The cumulative losses since 2014 through 2017 total approximately 2.3% of revenue, and at $163,150,000 million dollars of losses, reflect the investments made by carriers in this market. If the market is not stable, the effect of uncertainty may make carriers decide whether to continue with further investments.

In addition, we reviewed the rate filings of carriers from 2014 through 2019. The table below demonstrates the projected profit by year from the URRT weighted by actual member months and projected member months for 2019.

**Table 21**
**Profit by Year[29]**

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| PMPM | $5.11 | $5.24 | $5.86 | $5.46 | $9.31 | $8.09 |
| % of Prem | 1.80% | 1.53% | 1.68% | 1.32% | 2.07% | 1.64% |

After reviewing historic profits and filed projected profits, we anticipate that the individual market profit margins for the baseline projection for 2020 to 2029 will range between 1% and 2%, because carriers cannot continue to experience losses, but rather will position themselves for at least a minimum profit in the individual market.

## *2014 to 2018 Trends*

### *Membership Trend*

Membership trends vary significantly from year to year and by population. The last two years membership has dropped significantly as premium rates have risen and several carriers have left

[29] Weighted by Projected Membership.

the market. Table 22a presents the annual membership trends. These can be calculated from Table 7. Although we used June 2018 membership from Table 7 for 2018, we did not adjust the trends to an annualized basis. The member months trends in table 22b, however, are calculated from Table 9 with 2018 adjusted to be on an annualized basis. We suspect the trends calculated for 2018 are higher (lower decreases) than will ultimately result when considering December ending 2018 membership.

**Table 22a**
**Annual Membership Trends**

| Members Trend | 2014-2015 | 2015-2016 | 2016-2017 | 2017-June 2018 | 2014 - June 2018 |
|---|---|---|---|---|---|
| Total APTC On Exchange | 83.8% | 6.0% | -9.9% | -21.0% | 8.5% |
| Total Non-APTC (> 400%) On Exchange | -26.2% | -2.9% | -8.7% | -0.7% | -10.2% |
| **Total On Exchange** | **31.2%** | **3.6%** | **-9.6%** | **-15.8%** | **0.8%** |
| **Off Exchange** | **79.6%** | **9.5%** | **-11.9%** | **-24.0%** | **7.1%** |
| **Total ACA** | **41.3%** | **5.1%** | **-10.2%** | **-18.0%** | **2.3%** |

As seen in Table 22a, the membership dropped by 18% for 2018 from 2017. This might be interpreted as a reaction to the relatively high rate increases in 2018, making coverage less affordable for many individuals.

**Table 22b**
**Annual Membership Trends (Member Months)**

| Member Months Trend | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 | 2014 - 2018[30] |
|---|---|---|---|---|---|
| Total APTC On Exchange | 94.0% | 9.7% | -7.2% | -10.2% | 15.4% |
| Total Non-APTC (> 400%) On Exchange | -18.7% | 3.4% | -6.4% | 14.3% | -2.6% |
| **Total On Exchange** | **41.6%** | **8.0%** | **-7.0%** | **-3.9%** | **8.1%** |
| **Off Exchange** | **101.6%** | **20.8%** | **-10.9%** | **-19.0%** | **15.1%** |
| **Total ACA** | **54.5%** | **11.6%** | **-8.2%** | **-8.4%** | **9.7%** |

Table 22b, shows the annual trend in membership using adjusted member months. Because 2018 data was only provided through June 2018, annual member months for 2018 were calculated assuming all members active as of June 2018 would continue to be active for the remainder of 2018. The member months trend also shows a large membership drop from 2017 to 2018, but it is more modest than the total member trend, which reflects the member weighting based on number of active months.

[30] In this table the 2018 adjusted member months assume that members active as of June of 2018 will continue to be active for the remainder of the year to provide more accurate trends. Member month trends as of June (which is when data was provided through) would reflect a significant decrease because it would only represent a half year.

### *Premium Trend*

The trends in Table 23 show the average premium PMPM trends for years 2015 through June 2018. The trends vary significantly from year to year and by population. In total, aggregate premiums PMPM have increased every year. These can be calculated from Table 10.

**Table 23**
**Annual Premium Trends**

| Premium Trend | 2014-2015 | 2015-2016 | 2016-2017 | 2017-June 2018 | 2014 - June 2018 |
|---|---|---|---|---|---|
| Total APTC On Exchange | 3.5% | 2.0% | 8.1% | 11.1% | 10.3% |
| Total Non-APTC (> 400%) On Exchange | -1.3% | 2.6% | 10.0% | 8.4% | 8.0% |
| **Total On Exchange** | **4.8%** | **2.4%** | **8.5%** | **10.0%** | **10.3%** |
| **Off Exchange** | **0.6%** | **5.4%** | **10.3%** | **7.8%** | **9.2%** |
| **Total ACA** | **3.6%** | **3.2%** | **9.0%** | **9.4%** | **10.0%** |

As can be seen in Table 23, the average premium increased by almost 10% in 2018.

### *Claim Trends*

The trends in Table 24 show the allowed claim PMPM trends for years 2014 to 2017, as claims information for 2018 was not yet complete. These can be calculated from Table 13. The trends vary significantly from year to year and by population. As can be seen in Table 24, total allowed claims PMPM have decreased slightly at approximately 0.7% per year from 2014 to 2017.

**Table 24**
**Allowed Claims PMPM Trends**

| Allowed Claims PMPM Trends | 2014-2015 | 2015-2016 | 2016-2017 | 2014-2017 |
|---|---|---|---|---|
| Total APTC On Exchange | -2.4% | 0.7% | -3.9% | -1.9% |
| Total Non-APTC (> 400%) On Exchange | -8.3% | 9.7% | 3.1% | 1.2% |
| **Total On Exchange** | **0.3%** | **2.9%** | **-2.4%** | **0.3%** |
| **Off Exchange** | **-16.7%** | **5.3%** | **0.3%** | **-4.2%** |
| **Total ACA** | **-4.0%** | **3.6%** | **-1.6%** | **-0.7%** |

The trends in Table 25 show the paid claim trends for years 2014 to 2017. The trends vary significantly from year to year and by population. These can be calculated from Table 14. In Table 25, notice total paid claims PMPM have decreased at an average 1.8% per year from 2014 to 2017.

| Table 25<br>Paid Claims PMPM Trends | | | | |
|---|---|---|---|---|
| **Paid Claims PMPM Trend** | **2014-2015** | **2015-2016** | **2016-2017** | **2014-2017** |
| Total APTC On Exchange | -1.9% | 0.3% | -5.1% | -2.3% |
| Total Non-APTC (> 400%) On Exchange | -17.0% | 13.8% | 1.0% | -1.6% |
| **Total On Exchange** | -1.0% | **3.2%** | **-3.9%** | **-0.6%** |
| **Off Exchange** | **-18.1%** | **7.7%** | **-3.6%** | **-5.3%** |
| **Total ACA** | **-5.6%** | **4.2%** | **-3.7%** | **-1.8%** |

### *Demographic Trends*

#### Age Trend

We calculated the change in population by age groups as described below. This projection is used to distribute the membership by age band and is not used to project expected membership.

1) The detail growth in membership by age band included in the historic data are provided in Table 15. NovaRest analyzed the trends in membership by age band and determined the three-year annualized trend, as shown in Table 26a, was a reasonable trend for each age band. As can be seen in Table 26a, the annualized trend from 2014 to 2018 shows variability by age band but does not suggest that younger individuals are leaving the market at a much faster rate than others. However, due to the relatively large rate increases in 2018, it does look like the rate of leaving might have been slightly higher for younger ages (up to age 30). This may not be repeated in 2019 as rates increased at a much lower level than in 2018.

| Table 26a<br>Annual Age Trends | | | | | |
|---|---|---|---|---|---|
| **Ages** | **2014 - 2015** | **2015-2016** | **2016-2017** | **2017-2018** | **2015-2018**[31] |
| 0-14 | 111.4% | 25.5% | -7.2% | -12.5% | 0.6% |
| 15-20 | 88.3% | 20.6% | -8.4% | -13.5% | -1.5% |
| 21-25 | 42.3% | 5.1% | -11.1% | -12.3% | -6.4% |
| 26-30 | 39.7% | 5.6% | -10.1% | -10.9% | -5.5% |
| 31-35 | 50.5% | 9.7% | -8.4% | -6.8% | -2.2% |
| 36-40 | 56.3% | 13.7% | -6.9% | -6.0% | -0.2% |
| 41-45 | 48.2% | 5.2% | -12.3% | -8.2% | -5.4% |
| 46-50 | 49.7% | 10.5% | -11.2% | -10.1% | -4.1% |
| 51-55 | 48.9% | 6.8% | -11.0% | -11.6% | -5.7% |
| 56-60 | 43.7% | 11.0% | -6.9% | -8.4% | -1.8% |
| 61-65 | 55.0% | 13.8% | -2.7% | -2.6% | 2.5% |
| 65+ | 97.2% | 20.9% | 8.1% | 9.0% | 12.5% |
| **Total** | **54.5%** | **11.6%** | **-8.2%** | **-8.8%** | **0.3%** |

2) We trended each age category using the three-year annualized trend. This provided us with a distribution of the population by age, which we used along with the projected membership to project future membership by age for 2019 to 2029 for the baseline.

| Table 26b<br>Baseline Projected Member Months by Age Band | | | | | | |
|---|---|---|---|---|---|---|
| **Ages** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| 0-14 | 33,721 | 41,438 | 40,242 | 39,251 | 38,313 | 37,425 |
| 15-20 | 18,775 | 22,583 | 21,466 | 20,494 | 19,581 | 18,722 |
| 21-25 | 16,566 | 18,928 | 17,091 | 15,500 | 14,068 | 12,778 |
| 26-30 | 25,326 | 29,241 | 26,681 | 24,451 | 22,425 | 20,582 |
| 31-35 | 23,127 | 27,629 | 26,085 | 24,734 | 23,471 | 22,289 |
| 36-40 | 22,394 | 27,302 | 26,304 | 25,454 | 24,649 | 23,888 |
| 41-45 | 20,528 | 23,720 | 21,660 | 19,865 | 18,233 | 16,747 |
| 46-50 | 26,881 | 31,483 | 29,141 | 27,090 | 25,203 | 23,465 |
| 51-55 | 32,445 | 37,379 | 34,032 | 31,120 | 28,479 | 26,081 |
| 56-60 | 43,782 | 52,489 | 49,730 | 47,321 | 45,063 | 42,945 |
| 61-65 | 57,728 | 72,272 | 71,504 | 71,054 | 70,659 | 70,319 |
| 65+ | 1,458 | 2,003 | 2,175 | 2,372 | 2,588 | 2,827 |

[31] In this table the 2018 adjusted member months assume that members active as of June of 2018 will continue to be active for the remainder of the year to provide more accurate trends. Member month trends as of June (which is when data was provided through) would reflect a significant decrease because it would only represent a half year.

| Table 26b (cont.)<br>Projected Member Months by Age Band | | | | | |
|---|---|---|---|---|---|
| **Ages** | **2025** | **2026** | **2027** | **2028** | **2029** |
| 0-14 | 36,561 | 35,701 | 34,973 | 34,282 | 33,626 |
| 15-20 | 17,902 | 17,111 | 16,406 | 15,742 | 15,114 |
| 21-25 | 11,607 | 10,538 | 9,599 | 8,749 | 7,979 |
| 26-30 | 18,892 | 17,333 | 15,953 | 14,693 | 13,542 |
| 31-35 | 21,169 | 20,096 | 19,138 | 18,238 | 17,391 |
| 36-40 | 23,153 | 22,430 | 21,798 | 21,199 | 20,630 |
| 41-45 | 15,384 | 14,126 | 13,011 | 11,993 | 11,061 |
| 46-50 | 21,848 | 20,334 | 18,985 | 17,737 | 16,582 |
| 51-55 | 23,887 | 21,868 | 20,084 | 18,457 | 16,973 |
| 56-60 | 40,930 | 38,992 | 37,264 | 35,637 | 34,102 |
| 61-65 | 69,988 | 69,625 | 69,486 | 69,393 | 69,346 |
| 65+ | 3,088 | 3,371 | 3,692 | 4,047 | 4,438 |

# *2019-2029 Baseline Projections*

## *2018 and 2019 Baseline Membership and Premium Projections*

In order to project baseline membership for calendar year 2019 and then to calendar years 2020 through 2029 due to various assumption changes, we used an elasticity of demand assumption in the NRMM migration model, as follows:

1) We assumed elasticity based on metal level. Elasticity was adjusted downward for those with high claims costs, larger families and older individuals, meaning these kinds of members were assumed to stay covered more often than others.

2) We assumed that individuals eligible for the higher CSR categories would remain in the market.

3) We also increased membership in 2020 for the termination of the transitional insurance program. We reviewed the current average transitional premium for each carrier compared to an average Bronze premium and estimated the number of individuals currently in transitional products entering the ACA market in 2020. We used the bronze elasticity and average premium for a 36-year-old to move the transitional people into bronze off-exchange plans.

We used the model to estimate 2019 membership, starting with 2018 actual mid-year membership. We assumed members active as of 2018 mid-year would be the same as at year end, which may be slightly too high. Then, accounting for the model elasticity assumptions and actual carrier rate increases for 2019, we projected a slight decrease in membership for 2019, overall. These results are presented in Table 27.

The NRMM uses only active members as of June 2018 as the basis of the 2019 projections. Therefore, if a member dropped coverage during the first half of 2018 their claims and membership will not be represented in the tables below for later years. The NRMM aggregates individuals into families. Utilizing elasticity assumptions, it performs an analysis of the likelihood of the individual and families staying with their current plan, shopping for a less expensive option or becoming uninsured, based on the projected premium rate changes. The NRMM projects the 2019 membership and increases in the uninsured.

The migration model provides the 2019 APTC membership and non-APTC membership on and off the exchange. The model uses different elasticity assumptions for those who receive APTC subsidies and those who do not. Using the projected 2019 membership and the rates filed by the carriers for 2019, NovaRest calculated the average premium for APTC and Non-APTC without the waiver. The 2018 and 2019 Membership, average premiums, and total premiums are shown in Tables 27, 28 and 29, respectively, for the baseline. It is important to note that the 2019 membership projection from 2018 in this table is based on mid-year 2018 membership. The NRMM assumes members active as of June 2018 will stay in their plan for the remainder of 2018 and uses this information to project forward. That is, members that dropped coverage during the first half of 2018 are not counted in 2019. In addition, we assumed that all non-subsidized individuals in silver plans would not purchase silver plans on-exchange due to the loading and therefore would purchase off-exchange silver plans.

## *2018 and 2019 Membership*

**Table 27**
**2018 Average and 2019 Projection, Total Members**

| **Membership** | **Without Waiver** | |
|---|---|---|
| | **Average 2018** | **2019** |
| Total APTC On Exchange | 173,692 | 170,172 |
| Total Non-APTC (> 400%) On Exchange | 76,637 | 53,999 |
| **Total On Exchange** | **250,329** | **224,171** |
| **Off Exchange** | **88,363** | **105,275** |
| **Total ACA** | **338,692** | **329,446** |

The average 2018 members shown in Table 27 are calculated by using the actual 2018 member months through June of 2018 (from Table 9) and then assuming the mid-year membership continues for the remainder of 2018. The average members in 2019 is expected to decrease slightly, at approximately -2.7% (329,446/338,692 -1) from average 2018 membership. We have assumed for 2019 through 2029 that the baseline projected membership is an average membership count for each year.

## *2018 and 2019 Premium*

| Table 28<br>2018 and 2019 Projection, Average Premium PMPM | | |
|---|---|---|
| **Average Premium PMPM** | **Without Waiver** | |
| | **2018** | **2019** |
| Total APTC Aggregate Premium Rate | $524.30 | $536.48 |
| Total APTC Maximum Premium Paid | $136.33 | $152.49 |
| **Total APTC** | **$387.98** | **$383.99** |
| **Total Non- APTC (> 400%)** | **$431.71** | **$437.26** |
| **Total On Exchange** | **$495.96** | **$512.58** |
| **Total Off Exchange** | **$476.96** | **$518.74** |
| **Total ACA** | **$491.00** | **$514.55** |

As can be seen in Table 28, the average premium rate increase for 2019 is estimated to be 4.8% ($514.55/$491.00-1), reflecting the lower rate increase filings in 2019 from Table 5.

| Table 29<br>2018 Projected and 2019 Projection, Total Premium | | |
|---|---|---|
| **Total Premium** | **Without Waiver** | |
| | **2018** | **2019** |
| Total APTC Aggregate Premium | $1,092,805,808 | $1,095,529,170 |
| Total APTC Maximum Premium Paid | $284,148,787 | $311,396,274 |
| **Total APTC** | **$808,657,022** | **$784,132,896** |
| **Total Non-APTC** | **$397,021,429** | **$283,335,382** |
| **Total On Exchange** | **$1,489,827,237** | **$1,378,864,552** |
| **Total Off Exchange** | **$505,750,751** | **$655,322,826** |
| **Total ACA** | **$1,995,577,988** | **$2,034,187,378** |

As can be seen in Table 29, with lower membership but higher premiums, total premium for the ACA individual market is projected to show approximately a 2% increase overall.

## *Baseline Projections for 2020 through 2029*

Tables 31 through 33 presents the membership, average premium, and total premiums projected for calendar years 2020 through 2029 in our baseline projections without a 1332 Waiver.

For membership, we took into account future premium rate increases, which due to elasticity result in a decreasing number of covered ACA members. In general, this resulted in decreases to the covered membership each year through 2029, as can be seen in Table 31.

For premium, we used CMS guidance reflecting what CMS requires for trend rather than using historic experience.

CMS in its October 24, 2018 1332 Waiver guidance requires usage of National Health Expenditure (NHE) data for 1332 Waiver application trends and states that: "…to project the initial state variables through the 10-year Budget plan window. However, in limited circumstances where it is expected that a state will experience substantially different trends than the nation as a whole in the absence of a waiver, the Secretaries may determine that state-specific assumptions will be used." We interpret this to mean that CMS requires significant justification to use trends other than the National Health Expenditure trends. Appendix C provides additional discussion regarding the trends. We have reviewed the National Health Expenditures[32] projections and the Michigan specific trends and changes in morbidity. We will work with CMS to determine a final agreed upon trend if it is decided to go forward with the 1332 Waiver application. Our baseline projections use the National Health Expenditure trend data as shown in Table 30.

The allowed and paid claim trends using Michigan specific data were shown previously in Tables 24 and 25.

**Table 30**

**National Health Expenditure Trends (NHE Table 17 Health Spending by Source of Insurance Coverage Spending Direct Purchase)**

| Year | Annual Growth Rate |
|---|---|
| 2020 | 3.2% |
| 2021 | 5.2% |
| 2022 | 4.7% |
| 2023 | 4.7% |
| 2024 | 4.7% |
| 2025 | 4.8% |
| 2026 | 5.0% |
| 2027+ | 4.6% |

Using the National Health Expenditure trends shown in Table 30, we trended 2019 baseline premium PMPMs to 2020 and through 2029. We then used the projected membership to calculate a baseline total individual market premium for each year. We used the Direct Purchase source of insurance coverage, since that reflects the individual market purchasers.

[32] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

The FPL has an annual income amount for the first family member and another annual income amount for each additional family member. We reviewed the historic change in the increase in FPL, which can be different for the first family member and subsequent family members. Based on our analysis we used 3% for the FPL trend for the baseline projection of the APTCs.

## *2020-2029 Membership*

Note in Table 31 projected baseline membership in 2020 includes 13,000 additional members which reflects the elimination of the availability of transition plans after 2019. Although 2018 transitional membership shows almost 25,000 members in transitional plans in 2018 (see Table 18), due to the much lower premium rates for transitional plans compared to ACA plans, we expect only a small portion of these transitional members to choose coverage under an ACA plan. For example, the average premium PMPM for transitional plans in 2018 was $242, whereas the average premium PMPM for an off-exchange bronze plan was $430, or a rate increase of 78%. The NRMM uses elasticities to project the transitional members who will continue until the end of 2019 and then transitional members who join the ACA market, which resulted in a projection of approximately 52% of these 2018 transitional members remaining in the 2020 market. Should the rules change yet again to extend transition plans beyond 2019, these projections would need to be redone.

**Table 31**
**2020 to 2029 Baseline Projections, Total Members**

| | Without Waiver | | | | |
|---|---|---|---|---|---|
| **Membership** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Total APTC On Exchange | 169,139 | 168,149 | 167,201 | 166,292 | 165,422 |
| Total Non-APTC (> 400%) | 52,640 | 49,852 | 47,582 | 45,430 | 43,388 |
| **Total On Exchange** | **221,779** | **218,001** | **214,783** | **211,722** | **208,811** |
| **Off Exchange** | **115,392** | **109,858** | **105,122** | **100,607** | **96,301** |
| **Total ACA** | **337,171** | **327,859** | **319,904** | **312,329** | **305,112** |

**Table 31 (cont.)**
**2020 to 2029 Baseline Projections, Total Members**

| | Without Waiver | | | | |
|---|---|---|---|---|---|
| **Membership** | **2025** | **2026** | **2027** | **2028** | **2029** |
| Total APTC On Exchange | 164,589 | 163,790 | 163,025 | 162,292 | 161,590 |
| Total Non-APTC (> 400%) | 41,391 | 39,384 | 37,701 | 36,095 | 34,563 |
| **Total On Exchange** | **205,979** | **203,174** | **200,726** | **198,387** | **196,153** |
| **Off Exchange** | **92,103** | **87,931** | **84,273** | **80,773** | **77,422** |
| **Total ACA** | **298,083** | **291,105** | **284,999** | **279,160** | **273,575** |

As can be seen in Table 31, the baseline number of total average members is projected to decrease by 2029 to approximately 81% of membership in 2020 (273,575/337,171). However, the decrease varies by population, with the APTC On Exchange membership dropping only to 96% from 2020 to 2029, and the Non-APTC membership dropping to 66% from 2020 to 2029, and the Off-Exchange membership dropping to 67% from 2020 to 2029. This shows the sensitivity assumed on coverage decision making related to premium rate increases for non-subsidized members is higher than for subsidized members. Thus, access to affordable coverage may be more difficult for the non-subsidized members into the future in our baseline projections.

## *2020-2029 Premium*

**Table 32**
**2020 to 2029 Baseline Projections, Average Premium**

| | Without Waiver | | | | |
|---|---|---|---|---|---|
| **Average Premium** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Total APTC Agg Prem Rate | $553.57 | $582.27 | $609.56 | $638.13 | $668.03 |
| Total APTC Max Prem Paid | $157.19 | $162.03 | $167.01 | $172.14 | $177.43 |
| **Total APTC** | **$396.38** | **$420.25** | **$442.55** | **$465.98** | **$490.61** |
| **Total Non- APTC (> 400%)** | **$451.81** | **$476.36** | **$499.62** | **$523.93** | **$549.35** |
| **Total On Exchange** | **$529.42** | **$558.05** | **$585.20** | **$613.62** | **$643.37** |
| **Total Off Exchange** | **$531.01** | **$559.78** | **$587.04** | **$615.52** | **$645.28** |
| **Total ACA** | **$529.96** | **$558.63** | **$585.81** | **$614.23** | **$643.97** |

**Table 32 (cont.)**
**2020 to 2029 Baseline Projections, Average Premium**

| | Without Waiver | | | | |
|---|---|---|---|---|---|
| **Average Premium** | **2025** | **2026** | **2027** | **2028** | **2029** |
| Total APTC Agg Prem Rate | $700.01 | $734.93 | $768.65 | $803.92 | $840.81 |
| Total APTC Max Prem Paid | $182.87 | $188.48 | $194.26 | $200.20 | $206.33 |
| **Total APTC** | **$517.14** | **$546.45** | **$574.39** | **$603.71** | **$634.48** |
| **Total Non- APTC (> 400%)** | **$576.50** | **$606.13** | **$634.68** | **$664.51** | **$695.68** |
| **Total On Exchange** | **$675.20** | **$709.96** | **$743.49** | **$778.55** | **$815.24** |
| **Total Off Exchange** | **$677.04** | **$711.66** | **$745.04** | **$779.92** | **$816.36** |
| **Total ACA** | **$675.77** | **$710.47** | **$743.95** | **$778.95** | **$815.56** |

| Table 33<br>2020 to 2029 Baseline Projections, Total Premium | | | | | |
|---|---|---|---|---|---|
| | Without Waiver | | | | |
| **Total Premium** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Total APTC Agg Prem Rate | $1,123,560,678 | $1,174,905,918 | $1,223,025,579 | $1,273,385,801 | $1,326,091,827 |
| Total APTC Max Prem Paid | $319,040,026 | $326,935,708 | $335,090,577 | $343,512,109 | $352,208,013 |
| **Total APTC** | **$804,520,651** | **$847,970,209** | **$887,935,002** | **$929,873,692** | **$973,883,814** |
| **Total Non- APTC (> 400%)** | **$285,400,065** | **$284,969,345** | **$285,273,387** | **$285,626,812** | **$286,025,546** |
| **Total On Exchange** | **$1,408,960,742** | **$1,459,875,262** | **$1,508,298,966** | **$1,559,012,613** | **$1,612,117,373** |
| **Total Off Exchange** | **$735,282,512** | **$737,950,048** | **$740,527,597** | **$743,110,151** | **$745,691,782** |
| **Total ACA** | **$2,144,243,254** | **$2,197,825,311** | **$2,248,826,563** | **$2,302,122,763** | **$2,357,809,155** |

| Table 33 (cont.)<br>2020 to 2029 Baseline Projections, Total Premium | | | | | |
|---|---|---|---|---|---|
| | Without Waiver | | | | |
| **Total Premium** | **2025** | **2026** | **2027** | **2028** | **2029** |
| Total APTC Agg Prem Rate | $1,382,573,097 | $1,444,488,734 | $1,503,707,711 | $1,565,636,245 | $1,630,398,948 |
| Total APTC Max Prem Paid | $361,186,231 | $370,454,945 | $380,022,589 | $389,897,853 | $400,089,692 |
| **Total APTC** | **$1,021,386,867** | **$1,074,033,789** | **$1,123,685,122** | **$1,175,738,392** | **$1,230,309,256** |
| **Total Non- APTC (> 400%)** | **$286,343,802** | **$286,464,273** | **$287,132,977** | **$287,824,718** | **$288,537,437** |
| **Total On Exchange** | **$1,668,916,900** | **$1,730,953,007** | **$1,790,840,688** | **$1,853,460,964** | **$1,918,936,385** |
| **Total Off Exchange** | **$748,290,625** | **$750,920,268** | **$753,447,023** | **$755,958,171** | **$758,451,686** |
| **Total ACA** | **$2,417,207,525** | **$2,481,873,275** | **$2,544,287,711** | **$2,609,419,134** | **$2,677,388,071** |

As can be seen in Table 31, baseline membership is projected to decrease by almost 19% between 2020 and 2029. In addition, the baseline average premium rate seen in Table 32 is projected to increase from $529.96 to $815.56 between 2020 and 2029, or 54%. This is an annualized growth rate of approximately 4.9% per year. The trend in premium used ranged from 3.2% to 5.2% (see Table 30). These increases are based on CMS requirements for 1332 Waiver applications and actual increases could be higher, resulting in a larger decrease in membership than projected here. As can be seen in Table 33, the combined effect of projected decreasing membership and increasing premiums leads to projected total premium in the individual market to have slight increases each year from 2020 to 2029.

## *Baseline Michigan Budget Impact*

Michigan's budget will be impacted by the change in premiums. The current premium tax in Michigan is 1%. As baseline total projected premium increases, total dollars available from the premium tax will increase.

Based on the growth in premiums presented in Table 33, Table 34 presents the baseline projected premium tax revenue for each year at 1% of premium.

| Table 34<br>Projected Baseline Premium Tax by Year | | | | | |
|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Total ACA Premium | 2,144,243,254 | 2,197,825,311 | 2,248,826,563 | 2,302,122,763 | 2,357,809,155 |
| Premium Tax (1%) | 21,442,433 | 21,978,253 | 22,488,266 | 23,021,228 | 23,578,092 |

| Table 34 (cont.)<br>Projected Baseline Premium Tax by Year | | | | | |
|---|---|---|---|---|---|
| | **2025** | **2026** | **2027** | **2028** | **2029** |
| Total ACA Premium | 2,417,207,525 | 2,481,873,275 | 2,544,287,711 | 2,609,419,134 | 2,677,388,071 |
| Premium Tax (1%) | 24,172,075 | 24,818,733 | 25,442,877 | 26,094,191 | 26,773,881 |

However, Michigan's budget impact is not otherwise expected to change in the baseline projection. There will be more of an impact on Michigan's budget with the impact of a 1332 Waiver, which is part of Phase 2 of the SOW.

## *Baseline Federal Budget Impact*

1) Health insurance issuers who offer qualified health plans in the marketplace are responsible for paying a User Fee of 2.5% of premium as proposed in the 2020 Notice of Benefit and Payment Parameters.

2) The ACA requires health insurance issuers and self-funded plans to pay a 40 percent tax on annual premiums that exceed defined thresholds for single and family coverage. The tax will generate revenue to finance health reform. However, since it is unlikely to affect the results of either the baseline projection or projections with a 1332 Waiver, NovaRest did not include an adjustment for the Cadillac tax.

3) Citizens not eligible for Medicaid or affordable employer-sponsored health insurance may qualify for help paying their health insurance premiums via Advance Premium Tax Credits (APTC), provided their incomes were from 100% to 400% federal poverty level (FPL). The APTC is the differential between the second lowest silver premium in an area and the maximum premium based on family size and family income. Since premiums are increasing faster than the FPL the APTC will increase every year.

However, the Federal Budget impact is not otherwise expected to change in the baseline projection as compared to projections with a 1332 Waiver. The Waiver option(s) pursued by Michigan will determine the impact on the federal budget. Typically, the reduced APTC saves the federal government money. To offset this savings are some potential losses to income for the federal government. This impact is included in Phase 2 of the SOW.

For the baseline period projections, we considered the following federal budget items.

The shared responsibility or individual mandate penalty would be reduced if individuals remain insured under a 1332 Waiver rather than becoming uninsured and subject to the penalty. However, in December 2017, Republican lawmakers passed H.R.1, the Tax Cuts and Jobs Act, which repealed the individual mandate penalty.[33] The repeal is effective for the 2019 plan year. Therefore, for the baseline projection or the Task 2 Waiver projections years 2020 through 2029, we did not assume any impact on the federal deficit for individuals remaining insured or choosing to remain uninsured.

The Patient-Centered Outcomes Research Institute (PCORI) fee payable to the federal government is based on enrollment. This fee is only applicable for plan years ending between October 1, 2012 and October 1, 2019.[34] Since the fee is not applicable in 2020, it will not impact the federal budget for either the baseline projections or the Task 2 Waiver projections.

The Health Insurance Providers Fee (HIF) has a moratorium in 2019. For 2020 and beyond, the applicable amount in the preceding fee year is increased by the rate of premium growth of covered entities, within the meaning of section 36B(b)(3)(A)(ii).

A covered entity is generally any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under subchapter L, Part I or II, or that would be subject to tax under subchapter L, Part I or II, but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).[35]

The fee is assessed as a percentage of net premium. For entities with less than $25,000,000 no fee will be assessed.[36] For entities with between $25,000,000 and $49,999,999, 50% of the net premiums will be taken into account and for entities with over $50,000,000 in net premium, the total net premium will be taken into account.[37] If the waiver reduces premiums sufficient enough to impact the national premium growth, the HIF collected by the federal government would be reduced. Otherwise since the HIF is a national budgeted amount, the waiver will not impact the HIF. In addition, we did not assume any change in this component of the federal budget for the baseline projection.

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[33] Norris, Louise. "With the GOP tax bill and the president's 2017 executive order, will the IRS still enforce the individual mandate penalty?" HealthInsurance.org. January 22, 2018. https://www.healthinsurance.org/faqs/does-the-presidents-executive-order-mean-the-irs-wont-enforce-the-individual-mandate-penalty/

[34] "Patient-Centered Outcomes Research Institute Fee." Internal Revenue Service. June 6, 2018. https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee

[35] Ibid.

[36] Ibid.

[37] Ibid.

The Exchange User Fee is a federally mandated fee used to fund the federal and state exchanges. Although the fee is calculated on on-exchange business, it is included in the premium for all non-grandfathered on-and-off exchange ACA business. The current fee rate in the individual market is 3.5%.[38] However, the 2020 proposed Notice of Benefit and Payment Parameters have proposed to change this to 3% for state-based exchanges and 2.5% for federal based exchanges. In the baseline projection, we did not assume this fee rate would change again in future years.

Based on the growth in premiums presented in Table 33, Table 35 presents the baseline projected Exchange User Fee federal revenue for each year at 2.5% of premium. When a 1332 Waiver option is considered that decreases projected premium levels, the Exchange User Fee revenue would then also decrease. Therefore, a 1332 Waiver must consider this lost revenue to the federal government when determining the federal pass-through amount under a Waiver option.

**Table 35**
**Baseline Projected Exchange User Fee by Year**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Total On Exchange ACA Premium | $1,408,960,742 | $1,459,875,262 | $1,508,298,966 | $1,559,012,613 | $1,612,117,373 |
| Exchange User Fee (2.5%) | $35,224,019 | $36,496,882 | $37,707,474 | $38,975,315 | $40,302,934 |

**Table 35 (cont.)**
**Baseline Projected Exchange User Fee by Year**

| | 2025 | 2026 | 2027 | 2028 | 2029 |
|---|---|---|---|---|---|
| Total On Exchange ACA Premium | $1,668,916,900 | $1,730,953,007 | $1,790,840,688 | $1,853,460,964 | $1,918,936,385 |
| Exchange User Fee (2.5%) | $41,722,922 | $43,273,825 | $44,771,017 | $46,336,524 | $47,973,410 |

[38] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

# V. Task 2: Provide an Overview of Potential Policy Solutions

This section provides an overview of potential policy solutions for a 1332 Waiver application.

## *A. Establishing a High-Risk Pool Mechanism*

Prior to the ACA, several states operated high-risk pools to provide health insurance to those rejected by insurance carriers due to medical conditions. This resulted in the high-risk pool of individuals being separate from the individual market. Beginning in 2014, there was no longer a need for this type of mechanism due to the guaranteed issue requirements of the ACA, although at least two States (New Mexico and North Dakota) are still operating pre-ACA high-risk pools. During the transition period between enactment of the ACA and implementation of the single risk pool in 2014, the ACA established a Pre-existing Condition Insurance Plan (PCIP) program, which provided $5 billion to create high-risk pools in each state. The PCIP program provided coverage to those individuals uninsured for at least 6 months prior to enrollment with a pre-existing condition or who had been denied coverage. States could either create a new program or build on an existing program. If the state did neither, the federal government operated the PCIP program directly.

In the context of 1332 Waivers, the term high-risk pool has been used to refer to a reinsurance mechanism under which applicants and/or renewing members identified as high risks have the same coverage and the same premiums as other members, but the carrier is reimbursed for all or a portion of the claims. This type of reinsurance mechanism has been referred to as an "invisible high-risk pool" because the reinsured members are treated the same as other members and do not know that they have been identified as high-risk. However, a discussion paper issued by CMS on November 29, 2018[39] refers to this type of reinsurance program as a prospective reinsurance model and uses the term "high-risk pool" to mean a traditional high-risk pool, where the state operates a separate plan or plans for high-risk individuals that is a separate risk pool from the rest of the market. The paper includes both high-risk pools and reinsurance mechanisms under the category "Risk Stabilization Programs." We will use this same terminology going forward.

Because guaranteed issue would still apply in the commercial individual health insurance market, a high-risk pool created under a 1332 Waiver would need to offer coverage that would entice the target population to enroll in the high-risk pool rather than in a commercial plan. The CMS discussion paper suggests as an example that the high-risk pool could offer an attractive plan with robust provider networks or benefits for a certain condition. To date, no states have applied for a 1332 Waiver using a high-risk pool approach.

39 https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

**Advantages of High-Risk Pools**

- Covering high-risk individuals through a separate risk pool can potentially lower premiums in the commercial insurance market. However, the program would need to be designed in a way that meets the comprehensiveness and affordability guardrails established in Section 1332.
- Conditions-based programs can be tailored to target specific conditions and be used to support public health programs. This can create synergy with existing public policy goals and could potentially dovetail with population health management goals.
- Since individuals with specific conditions are covered by the high-risk pool, the high-risk pool can contract with a narrow network and centers of excellence as well as require effective care management protocols, case management and value-based reimbursement aimed at the conditions covered.

**Disadvantages of High-Risk Pools**

- Since individuals cannot be required to take coverage in the high-risk pool, designing a plan or plans that will entice the target population to enroll while complying with the comprehensiveness and affordability guardrails would be a challenge. One difficulty in enticing the target population is that individuals may be reluctant to disrupt the relationships they have with their current providers by moving to a high-risk pool, which may have a narrow network in order to keep costs low. By its nature, the high-risk pool would have higher claims, resulting in higher premiums if not subsidized by Michigan.
- Creating and maintaining a high-risk pool would require significant administrative effort. Eligibility standards, an enrollment system, provider networks, a claims processing system, and customer service and communications systems would need to be established. Much of this could be contracted out to a carrier or an administrator, but that would add a layer of expense and would require monitoring by Michigan. The high-risk pool would receive all premium dollars and pay all claims for its members.
- The conditions that would indicate target membership in the high-risk pool would have to be reviewed regularly to maintain the goals of premium reduction in the individual commercial market. Some conditions may be able to be removed due to developing treatments, and new ones may need to be added.
- New high-cost technology or conditions will not be covered until they are identified by the high-risk pool administration.
- A high-risk pool would also require ongoing work to update premium, benefits, and provider networks.
- When an individual joins a high-risk pool, it can be disruptive to the family since now the individual will have different benefits and providers than the rest of the family.
- At times there can be a perceived stigma associated with being in the high-risk pool.

**Other Considerations**

In its Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper, CMS indicates that administrative cost for a high-risk pool would be more than for a retrospective reinsurance program.

**Federal Funding**
The impact on federal funding would be determined by the amount of premium reduction generated by the high-risk pool. When premiums are reduced the federal cost of the APTCs is reduced, but also the income from the exchange user fees is also reduced.

**Funding Mechanisms**
Premiums for high-risk pool coverage would not be self-supporting, so additional funding would be needed beyond what federal pass-through funds would be needed. In general, funding options are state funds or assessments. Assessments are often used against group insurance, either as a percentage of premium or a per member per month fee. Assessments can also be used against TPA (self-insured and other products administered by TPAs) premium equivalents or member months. An assessment could also take the form of an increased premium tax on all lines of business or a provider tax on health care providers. This will be discussed more thoroughly under the reinsurance topic once the carrier data is received.

**Likelihood of CMS Approval**
We would need to prove how all four guardrails would be met. This was an option discussed in the CMS Waiver concept paper,[40] and we believe that CMS favors this concept along with the reinsurance option more than some of the other concepts. However, no other state has yet been approved for this type of waiver.

**Impact on Michigan Budget**
Michigan would need to take on responsibilities for:

- Development of Michigan's criteria on who would be eligible to purchase the high-risk pool plan
- Certification of high-risk pool eligibility based on Michigan's criteria;
- Providing administrative services for the high-risk pool;
- Developing a methodology for coordinating the high-risk pool with the federal risk adjustment; and
- Paying for high-risk pool costs that would not be covered by the federal pass-through funding. The amount needed will be very hard to predict from year to year since it is difficult to predict the number of individuals that will have specific conditions or whether those individuals would choose the high-risk pool plan.

We would identify the high-cost conditions and target the level of coverage based on past history of condition prevalence and cost, but the estimates will have a wide confidence interval due to the variability or standard deviation of these assumptions.

**Impact on Premiums**
The high-risk pool will reduce premiums for other plans and, therefore the premium tax credit. The reduction on the premium tax credit will be the main element used for federal pass-through funding.

[40] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

Once we determine the conditions and the historical cost we can estimate the premium impact, but the estimates will have a wide confidence interval due to the variability or standard deviation of these assumptions.

**Impact on Individual Market**

The claimants and their claims covered by the high-risk pool will reduce premiums in the individual market and increase affordability. Every year the experience of the pool will need to be reviewed and adjustments made to react to that year's current market conditions. Doing so will provide a mechanism to keep the individual market stabilized on an ongoing basis.

## B. Establishing a Conditions-Based Reinsurance Mechanism

In the context of 1332 Waivers, a conditions-based reinsurance program refers to a reinsurance mechanism under which applicants and/or renewing members identified as having certain pre-defined conditions have the same coverage and the same premiums as other members, but the carrier is reimbursed for all or a portion of the claims. This type of reinsurance mechanism has been referred to as an "invisible high-risk pool" because the reinsured members are treated the same as other members and do not know that they have been identified as high-risk. A discussion paper issued by CMS on November 29, 2018[41] refers to this type of risk stabilization program as a conditions-based reinsurance model. Typically, this is a retrospective reinsurance model, reinsuring all claims for members identified as being treated for one or more of the pre-defined conditions, even if the condition is identified partway through the year.

An example of a conditions-based reinsurance program is the Alaska Reinsurance Program (ARP), which covers all claims for members treated with one or more of 33 conditions. This program began operating under a 1332 Waiver in 2018, and it is estimated that the individual market premiums in 2018 were reduced by 20% due to the program. In this program, all revenue related to each reinsured member is passed through to the ARP administrator, including premium, subsidies, prescription drug rebates, and reinsurance under the risk adjustment program. And all claims, up to a maximum aggregate threshold projected by the ARP, are reimbursed to the carriers. For 2019, this is projected to be $71 million.

Maine utilized a hybrid cost-based/condition-based reinsurance program. It consists of a cost-based reinsurance, with eight conditions that are also covered. Appendix E shows the federal HCC categories in order of severity based on the platinum risk factors and if the condition is included in Alaska (AK) or Maine (ME). Maine does not cover some of the most severe conditions (only covering one out of the top ten most severe conditions). Under the Maine methodology the cost-based reinsurance will cover the cost of non-specified conditions once the cost exceeds the attachment point.

At the time that the reinsurance in Alaska was implemented, there was only one carrier. In a situation where there are many carriers, a carrier cannot be guaranteed that they will enroll a member or multiple members with these high-cost conditions that would be their financial responsibility. Alaska covers five of the top ten most severe conditions. Carriers in Alaska with members needing heart or lung transplants would have to cover it without aid from the reinsurance. The result is that even if the condition-based reinsurance is structured to cover 21% of the claims, the carriers cannot reduce premiums by 21% because they do not know if their high-cost members will have the covered conditions or the non-covered conditions.

It cannot be predicted how carriers will price under this methodology. If the carriers do not reduce rates for the total cost of reinsurance there will be an increase in the reinsurance funding needed from Michigan. That is, if the condition-based reinsurance is structured to reduce claims cost by

[41] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

21% and, for example, the carriers only reduce total premiums by 18%, Michigan would be required to make up the 3% difference. Table 36 shows the federal pass-through and Michigan responsibility if the premium rates are 3% lower than the reinsurance savings would indicate. The adjustment to the premium of 3% for the uncertainty of the condition-based reinsurance would decrease the federal pass-through and increase the Michigan responsibility by $32 or $33 million dollars as can be seen by comparing Table 1 to Table 36.

**Table 36**
**Impact of Issuers Assuming 3% Lower Premium Decrease than Anticipated**

| | | | | | |
|---|---|---|---|---|---|
| Table 1 Premium Decrease (Anticipated based on Reinsurance Structure) | 21% | 10% | 18% | 25% | 29% |
| Premium Decrease Assumed by Issuers | 18% | 7% | 15% | 22% | 26% |
| Michigan Responsibility | $183,000,000 | $103,000,000 | $161,000,000 | $213,000,000 | $238,000,000 |
| Federal Pass-Through | $195,000,000 | $75,000,000 | $163,000,000 | $241,000,000 | $280,000,000 |
| Additional Cost to Michigan due to 3% Lower Premium * | $33,000,000 | $32,000,000 | $32,000,000 | $33,000,000 | $32,000,000 |

**Difference in Michigan Responsibility between Table 36 and Table 31*

Reinsuring all claims for all individuals treated with the chosen conditions rather than allowing carriers to choose which individuals to reinsure helps to limit adverse selection to the program that may occur if carriers only reinsure individuals whose claims are higher than the revenue components for members with the identified conditions.

Risk adjustment transfer amounts between carriers in a multiple-carrier state would need to be adjusted to account for the reinsurance program.

**Advantages of Conditions-Based Reinsurance**

- Conditions-based programs can be tailored to target specific conditions and be used to support public health programs. This can create synergy with existing public policy goals and could potentially dovetail with population health management goals.
- The risk adjustment amounts on reinsured members that would need to be accounted for between payers and receivers of risk adjustment transfers in a multiple-carrier state in a conditions-based reinsurance program can be identified. To accomplish this the conditions used for the program are determined based on the CMS risk adjustment hierarchical condition codes (HCCs).

- One design option for a program such as this is to include a maximum aggregate cap on reimbursed claims, as Alaska does. If there is a maximum aggregate cap on reimbursed claims to carriers, this provides certainty on the risk program from Michigan's perspective.
- As compared to a separate high-risk pool, since this is an "invisible" reinsurance program to individuals, the members are offered the same plans as everyone else in the individual market, and Michigan does not need to set up its own high-risk plan to offer.

**Disadvantages of Conditions-Based Reinsurance**

- The conditions used for the conditions-based reinsurance program would need to be reviewed regularly to maintain the goals of premium reduction in the individual commercial market. Some conditions may be able to be removed due to developing treatments, and new ones may need to be added. In addition, if experience is used to identify conditions, since the frequency of many high cost conditions is often very low, year-to-year changes in experience could result in missed opportunities with respect to certain conditions. For example, in the ARP, paraplegia was included in the initial list of 33 conditions, but quadriplegia was not (except for quadriplegia cerebral palsy), likely due to low levels of quadriplegia experience.[42]
- If the program has a maximum aggregate amount of claims reimbursed to carriers, this creates some uncertainty for carriers, with the potential of having no revenue on some members and having a portion of those members' claims not reimbursed by the program.
- If there is no aggregate max cap on reimbursement of claims, this could result in financial risk to the state program.
- If there is more than one carrier in the market in the state, and if an aggregate cap on reimbursed claims is implemented, and the aggregate cap on claims is hit, it may be difficult to determine how much to reimburse each carrier (e.g., prorated across all conditions, prorated by certain conditions, up to only a certain max by condition).
- New high-cost technology or conditions will not be covered until they are identified by the regular review as noted above.
- Since carriers would have a more difficult time predicting the number and cost of individuals with certain conditions, especially in a multi-carrier state, they may not reduce premiums as much as the projected reinsurance reimbursements would indicate. It may be possible to estimate the number of insureds in a market with a certain condition with some level of confidence, but not which carrier they would enroll with.

**Other Considerations**

As noted above under the first bullet of disadvantages, any list of conditions to include should also consider not only experience by carriers in the state, but also clinically appropriate conditions that are similar to the ones identified (quadriplegia versus paraplegia). If experience is not available for those clinically appropriate conditions, it may be more difficult to project target claims (for any aggregate cap) and for carriers to determine appropriate rate adjustments.

If the initial conditions are listed in any new law or regulation, it would be more difficult to change the conditions without changing the law or regulation.

[42] http://ncoil.org/wp-content/uploads/2018/03/Cecil-Bykerk-PP.pdf

**Federal Funding**

Conditions-based reinsurance will reduce premiums and therefore the federal premium tax credit (PTC). It will also reduce the federal income from the exchange user fee. The decrease in the premiums will be based on carrier specific estimates of the number and cost of individuals that they will cover with the conditions included in the program. The premium decrease will likely be less than the actual amount of claims covered by the program due to the wide confidence interval around conditions-based costs per carrier, which results from the low frequency of high cost conditions.

**Funding Mechanisms**

Additional funding may or may not be necessary, depending on how the program is designed. If an aggregate cap is used to balance claims and administrative costs of the program to the federal APTC subsidy savings, no additional funding should be needed. Unfortunately, any estimate for additional funding will have a wide confidence interval and therefore funding may be required that is not anticipated originally. The level of resulting premium decrease may be small in this situation. Therefore, additional funding may be desired to meet certain premium rate decrease targets or to meet certain goals of covering certain conditions. In addition, without an aggregate cap, due to the uncertainty of the number of individuals presenting each year with the identified conditions, the level of confidence on the funding requirements may be low, which may result in a need for additional funding. In general, funding options are state funds or assessments. Assessments are often used against group insurance, either as a percentage of premium or a per member per month fee. Assessments can also be used against TPA (self-insured) premium equivalents or member months. An assessment could also take the form of an increased premium tax on all lines of business or a provider tax on health care providers. Some States have decided to use general tax revenues to fund their 1332 Waivers.

**Likelihood of CMS Approval**

We would have to prove that all four guardrails would be met and provide a plan to coordinate the reinsurance with the federal risk-adjustment transfer amounts.

This was an option discussed in the CMS Waiver concept paper,[43] and we believe that CMS favors this concept along with the claims-cost based reinsurance option more than some of the other concepts. And since Alaska has already been approved a conditions-based reinsurance 1332 Waiver program, CMS has experience with this kind of program application.

**Impact on Michigan's Budget**

Michigan would have to provide administrative services for the conditions-based reinsurance program and may have financial risk if an aggregate max on reimbursed claims is not implemented. It will be more difficult to predict the funding needs of a conditions-based reinsurance program than a cost-based program, so the impact on state budgets will be more difficult to predict.

Administering a condition-based reinsurance may require the addition of more than one full-time equivalent employee. Some of the complication to New Hampshire is that there are multiple carriers in New Hampshire unlike Alaska.

[43] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

**Impact on Premiums**
A conditions-based reinsurance program will reduce premiums and, therefore, the premium tax credit. The reduction on the premium tax credit will be the main element in the federal pass-through funding.

If this is a reinsurance program Michigan would like to consider, we can estimate the premium impact once the list of conditions, historical cost of the conditions, and other components of the program (such as whether or not an aggregate max cap on reimbursed claims is desired) are determined, but the estimates will have a wide confidence interval due to the variability or standard deviation of these assumptions.

**Impact on Individual Market**
The conditions-based reinsurance program will reduce premiums in the individual market and increase affordability. Every year the experience of the program will be reviewed, and adjustments made that can react to the current market conditions, including review of the covered conditions. This will provide a mechanism to keep the individual market stabilized on an ongoing basis.

CMS Considerations and Questions[44]
These considerations and questions are taken directly from the CMS Waiver Concepts Guidance paper and apply to each of the high-risk pool/reinsurance programs discussed in this report.

1. How will the State implement a high-risk pool/reinsurance program?
    a. What is the entity that will administer the program? Is it a new or existing entity? To what extent will the entity be subject to State insurance laws?
    b. How much is the necessary funding for the high-risk pool and what premium reduction is the state trying to achieve?
    c. If State funding is required, how much funding does the State anticipate will be necessary to implement the State plan and how will the State generate the required state funding?
    d. If implementing a traditional high-risk pool, what are the eligibility requirements and plan metal tiers available (if applicable)?
2. What will be the data collection timing and mechanism for collecting claims information and generally for pay-out?
    a. How will the State identify and pay claims?
3. Will the State require issuers to include the impact of the high-risk pool in initial and/or final rates?
4. Are there any legislation and/or regulations related to the state high-risk pool?
    a. Are any additional regulations needed? If so what is the timing of those regulations?
5. Will the State specify a co-insurance amount, or a cap, based on available funds, similar to the federal program?
    a. When will the parameters be finalized?

[44] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

   b. Further, does the State have the ability to adjust the parameters to account for market changes? If so, what is the schedule and process for finalizing the parameters on a year-by-year basis?
6. Will the State require issuers to include the impact of the reinsurance program and/or high-risk pool in initial and/or final rates?
7. Are there any legislation and/or regulations related to the State reinsurance program?
   a. Are any additional regulations needed? If so what is the timing of those regulations?

## C. Establishing a Cost-Based Reinsurance Mechanism

In the context of 1332 Waivers, a cost-based reinsurance program refers to a reinsurance mechanism under which all members have the same coverage and the same premiums as other members, but the carrier is reimbursed for all or a portion of claims above a pre-defined threshold or attachment point. A discussion paper issued by CMS on November 29, 2018[45] refers to this type of risk stabilization program as a claims cost-based reinsurance model. Typically, this is a retrospective reinsurance model, reinsuring a portion of members' claims who have accumulated claims throughout the year that, in aggregate, are greater than the threshold. Sometimes a cap or maximum reimbursement to carriers is included, either in aggregate or by member. This is similar to the temporary transitional reinsurance that was part of the ACA during 2014 to 2016.

An example of a cost-based reinsurance program is the Wisconsin 1332 Waiver reinsurance program that has an attachment point of $50,000, a coinsurance rate of 50%, and a cap of $250,000 per reinsured claimant. Here claims are reinsured at 50% once a member has had aggregate claims for the year between $50,000 to $250,000. Another example is the reinsurance program tied to the ACA Risk Adjustment program, which reimburses carriers for claims above $1,000,000 at a 60% coinsurance rate.

Risk adjustment transfer amounts between carriers in a multiple-carrier state would need to be adjusted to account for the reinsurance program.

**Advantages of Cost-Based Reinsurance**

- If individuals are not moved out of the market into a separate high-risk pool, the program is invisible to the insured enrollee. Therefore, there is no stigma attached to eligible enrollees or disruption with provider availability in a high-risk pool network.
- The premium rates for insured enrollees are the same as other individuals with the same plan, age and geographic location.
- The same plan choices exist for high-risk enrollees and all others in the same geographic location.
- The administration is primarily a financial function, so it is typically less expensive than administering a traditional high-risk pool where members are moved to a separate plan.
- The program can be tailored to encourage carriers to manage care even on high-risk enrollees. To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold. High-risk reinsurance programs that reimburse insurers for 100% of the payment of large claims leave the insurer with less incentive to appropriately manage care and seek cost-saving alternatives.
- Cost-based retrospective reinsurance results in claims cost being more predictable and therefore can reduce risk charges or margins for unpredictability.
- Retrospective programs are straightforward. Retrospective analysis shows whether insurers qualify for reimbursement above the threshold. Large claims are always at least partially reimbursed.

[45] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

**Disadvantages of Cost-Based Reinsurance**

- Conditions that are high year after year, but do not reach the attachment point, may not be reimbursed.
- Using a dollar threshold approach to reimburse plans for high-cost enrollees can cause some inequities among insurers. Insurers that are able to attain lower provider payment rates and provide more care management and cost-effective care may benefit less than plans with higher spending. Similarly, insurers in low-cost areas may benefit less from this approach than insurers in high-cost areas. Considerations could be given to whether adjustments to reflect provider payment rates and regional unit cost differentials would be appropriate and feasible.
- If the program has a maximum aggregate amount of claims reimbursed to carriers, this creates some uncertainty for carriers, with the potential of having no revenue on some members and having a portion of those members' claims not reimbursed by the program.
- If there is no aggregate max cap on reimbursement of claims, this could result in financial risk to the state program.
- If there is more than one carrier in the market in the state, and if an aggregate cap on reimbursed claims is implemented, and the aggregate cap on claims is hit, it may be difficult to determine how much to reimburse each carrier.

**Other Considerations**

As with any reinsurance program, a cost-based reinsurance program will require ongoing work to determine if reinsurance parameters need to be updated, but for retrospective programs that work is more limited. Parameters for the retrospective programs include attachment point(s), coinsurance percentage(s), and the reinsurance cap. Each year staff would evaluate attachment point(s), the reinsurance cap, and coinsurance percentage(s) using inputs from carrier data calls and rate filings and consideration of funding constraints.

**Federal Funding**

Cost-based reinsurance will reduce premiums and therefore the federal advance premium tax credit (APTC). It will also reduce the federal income from the exchange user fee. The decrease in the premiums will be based on carrier specific estimates of the effect of reinsuring a portion of claims for high-cost claimants.

We have modeled two options one with a $100,000 attachment point and one with a $200,000 attachment point. Both use a 75% coinsurance and a maximum of $1,000,000 of individual claims. The results of the reduction in federal funding which could flow through as federal funding under a 1332 Waiver are presented in Table 37.

**Table 37**
**Cost-Based Reinsurance Options w/ 75% Coinsurance and a Maximum of $1,000,000**

| Attachment Point | 2020 Reduction in Federal Funding (in millions) |
|---|---|
| $100,000 | $228 |
| $200,000 | $107 |

We also modeled an attachment point $50,000, maximum claim level for $250,000 with coinsurance of 50%, 70% and 80%. The results are presented in Table 38.

**Table 38**
**Cost-Based Reinsurance Options w/ $50,000 Attachment Point and a Maximum of $250,000**

| Coinsurance | 2020 Reduction in Federal Funding (in millions) |
|---|---|
| 50% | $195 |
| 70% | $274 |
| 80% | $313 |

These amounts would be available to fund the reinsurance program as federal pass-through funding.

**Funding Mechanisms**
Additional funding will likely be necessary to meet certain premium rate decrease targets.

In general, additional funding options are state funds or assessments. Assessments are often used against group insurance, either as a percentage of premium or a per member per month fee. Assessments can also be used against TPA (self-insured) premium equivalents or member months. An assessment could also take the form of an increased premium tax on all lines of business or a provider tax on health care providers. Some states have decided to use general tax revenues to fund their 1332 Waiver.

**Likelihood of CMS Approval**
We would have to prove that all four guardrails would be met and provide a plan to coordinate the reinsurance with the federal risk-adjustment transfer amounts.

This was an option discussed in the CMS waiver concept paper,[46] and we believe that CMS favors this concept along with the conditions-cost based reinsurance option more than some of the other concepts. And since a number of other states have already been approved a cost-based reinsurance 1332 Waiver program (Maryland, Minnesota, New Jersey, Oregon, Wisconsin), CMS has experience with this kind of program application.

**Impact on Michigan Budget**
Michigan would have to provide administrative services for the cost-based reinsurance program and may have financial risk if an aggregate max on reimbursed claims is not implemented. It will be less difficult to predict the funding needs of a cost-based reinsurance program than a conditions-based program.

[46] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

We have modeled two options one with a $100,000 attachment point and one with a $200,000 attachment point. Both use a 75% coinsurance and a maximum of $1,000,000. The results are presented in Table 39 assuming the premium decreases shown below in Table 41.

| Table 39<br>Cost-Based Reinsurance Options w/ 75% Coinsurance and a Maximum of $1,000,000 | |
|---|---|
| Attachment Point | 2020 Michigan Cost (in millions) |
| $100,000 | $150 |
| $200,000 | $71 |

We also modeled attachment point $50,000, maximum claim level for $250,000 with coinsurance of 50%, 70% and 80%. The results are presented in Table 40 assuming the premium decreases shows below in Table 42.

| Table 40<br>Cost-Based Reinsurance Options w/ $50,000 Attachment Point and a Maximum of $250,000 | |
|---|---|
| Coinsurance | 2020 Michigan Cost (in millions) |
| 50% | $129 |
| 70% | $180 |
| 80% | $206 |

In addition to the Michigan funds needed to fund the reinsurance, Michigan would have responsibility for administering the reinsurance. Talking to states with similar programs, it is anticipated that administering the program could be done by one full-time equivalent employee. These amounts could be funded by one of the methods described above.

**Impact on Premiums**

A cost-based reinsurance program will reduce premiums and, therefore, the premium tax credit. The reduction on the premium tax credit will be the main element in the federal pass-through funding.

We have modeled two options one with a $100,000 attachment point and one with a $200,000 attachment point. Both use a 75% coinsurance and a maximum of $1,000,000. The results are presented in Table 41.

| Table 41<br>Cost-Based Reinsurance Options w/ 75% Coinsurance and a Maximum of $1,000,000 | |
|---|---|
| Attachment Point | 2020 Premium Reduction (%) |
| $100,000 | 21% |
| $200,000 | 10% |

We also modeled an attachment point $50,000, maximum claim level of $250,000 with coinsurance of 50%, 70% and 80%. The results are presented in Table 42.

**Table 42**
**Cost-Based Reinsurance Options w/ $50,000 Attachment Point and a Maximum of $250,000**

| Coinsurance | 2020 Premium Reduction (%) |
|---|---|
| 50% | 18% |
| 70% | 25% |
| 80% | 29% |

## *D. Expanding the Availability of Catastrophic Level Coverage to Everyone*

This section discusses the possibility of expanding the eligibility for catastrophic plans to individuals over the age of 30 who do not currently qualify for a hardship exemption.[47] Because a 1332 Waiver can be used to apply premium tax credits to catastrophic plans, that scenario is also discussed below.

The goal of expanding the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the ACA is to provide an affordable option for healthy individuals. The theory is that if more healthy individuals are covered by the single risk pool, the pool will be more stable and less expensive in total. The intent would be for healthy uninsureds to purchase the catastrophic coverage that would no longer have age and income restrictions. Having the more affordable coverage available may also be an alternative for individuals that currently have coverage but are considering dropping it because of unaffordable rate increases.

There are estimated to be 690,000 uninsured adults between the age of 18 and 64 and 93,000 uninsured children in Michigan.[48] Uninsured adults indicate that the primary reasons for being uninsured are that they could not afford it (36%) or they had lost/left a job with coverage (31%). For children the primary reasons for being uninsured are that they became ineligible (37%) or the family could not afford to purchase coverage (33%). These are the individuals and families that could benefit from catastrophic level coverage.

**Federal Funding**

If the catastrophic plan expansion was used in conjunction with a 1332 Waiver that expected federal pass-throughs from reduced premium tax credits, the pass-through may be reduced for any individuals that were eligible for tax credits and purchased the catastrophic plan with the tax credit.

**Funding Mechanisms**

In general, funding options are state funds or assessments. Assessments are often used against group insurance. Assessments can also be used against TPA premium equivalents. This will be discussed more thoroughly under the reinsurance topic once the carrier data is received.
If the catastrophic plans are not subsidized, there would be no funding needs.

**Likelihood of CMS Approval**

We would have to prove that all four guardrails would be met. Although this was an option discussed in the CMS Waiver concept paper,[49] it has not been done before and therefore will have a more detailed review by CMS to ensure that it meets all of the guardrails. In our experience this will add a level of complication and more time to the process.

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[47] Specific hardship exemptions are listed at https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/

[48] https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder49/WHO_ARE_THE_UNINSURED_IN_MICHIGAN_122705.pdf

[49] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

**Impact on Michigan Budget**
Michigan would need to take on responsibilities for certification of catastrophic plan eligibility based on the state's criteria, unless it was available to everyone. Also, Michigan would have to provide risk adjustment for the catastrophic plans.

Please note that if changes needed to be made to the Federally Facilitated Exchange software on HealthCare.gov, Michigan would have to pay for it.

Michigan would have to build an administrative manual and computer systems to verify eligibility of the catastrophic plan or fund changes to HealthCare.gov. Michigan would have to provide the risk adjustment for the catastrophic plan including the calculation of the catastrophic plan risk transfer amounts.

It is theoretically possible to use a Premium Tax Credit (PTC) to fund a catastrophic plan expansion under a 1332 Waiver, which could impact the budget. If a PTC were used, it would employ funds that could otherwise be used to fund the reinsurance or high-risk pool mechanism.

**Impact on Premiums**
The catastrophic plans are less expensive for two reasons; (1) they have reduced benefits and (2) they cover a younger population on average. If the catastrophic plans were sold to older individuals, the catastrophic adjustment that is currently used by insurers will probably increase resulting in the premium rates increasing. If premium rates increase, then adverse selection may occur resulting in healthy young enrollees dropping catastrophic coverage resulting in further premium increases for ACA plans.

The catastrophic adjustments in Michigan for the 2019 plan year vary between 0.786 and 0.885.[50] That implies that carriers could increase catastrophic premium from 13% up to 27% depending on their projections for the morbidity of the new population purchasing coverage. Some experts believe that CMS may consider catastrophic plans available to everyone as part of the single risk pool and not allow the catastrophic adjustment. In that case current catastrophic plan premiums would increase 13% to 27% depending on the specific carrier's catastrophic adjustment.

Using PTC for catastrophic plans rather than richer silver plans would result in the individuals enrolled in the catastrophic plans who would otherwise be eligible for silver plans and cost sharing reductions having higher out-of-pocket costs, which then may be unaffordable, or the cost may discourage individuals from getting the medical services that they need. Also, this may have an effect on the PTC and premiums for other plans, which CMS would review as part of the waiver analysis.

**Impact on Individual Market**
Catastrophic plans have not been very popular and there is no guarantee that expanding the age availability will encourage significantly more enrollment. With the increase in cost due to the expanded age range, income restrictions, and potential increase in the catastrophic factors used by

[50] This information was taken from the SERFF binder filings, https://filingaccess.serff.com/sfa/home/MI.

insurers, those individuals currently enrolled may drop coverage. In addition, if healthy individuals move to catastrophic plans, and catastrophic plans are allowed to stay out of the single risk pool as they currently are, the premiums are likely to increase in the single risk pool portion of the market, including the second lowest silver, increasing APTCs and causing Michigan to refund CMS.

**CMS Considerations and Questions**[51]

1) What new population will be newly eligible for the catastrophic plans?
2) How will the State implement a new subsidy structure?
    a. Which entity will administer the program? Is it a new or existing entity? To what extent will the entity be subject to State insurance laws? To what extent will the entity coordinate activities with other public programs (e.g., Medicaid and CHIP)?
    b. How much funding is necessary for the subsidy structure?
    c. What populations or eligibility requirements will the State have for this program (e.g., age, income, etc.)?
    d. What plan options will be available?
    e. If State funding is required, how much funding does the State anticipate it will need to implement the plan and how will the State generate the required funding?
3) When and how will consumers be notified of their subsidy amount?
4) Will there be a process for consumers to report changes to eligibility criteria (i.e. income, age, address etc.)?
5) What process will be used for consumers to appeal their eligibility determination and subsidy amount?
6) If a PTC applies:
    a. What sources is the State using to verify eligibility for coverage and/or the subsidy (if applicable)? Will the State be using their Medicaid/CHIP Agency or the FFE to manage eligibility verifications and determinations? Is the State using any State sources for verification?
    b. How will issuers receive payments for the subsidy? What is the timing and mechanism for pay- out?
    c. Will the State reconcile State subsidy amounts based on actual or earned income? If so, how will that be operationalized?
    d. Will the new subsidy program include incentives for providers, enrollees, and plan issuers to continue managing health care costs and utilization and lower overall health care spending (if any)?
    e. If implementing a State subsidy program what (if any) federal tax consequences will there be for the individuals enrolled and/or reporting requirements for the State as a result?
7) Does the State have the authority/ability to adjust the program requirements on a yearly or other basis to account for market changes? If so what is the schedule and process for this adjustment?

[51] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

8) Will the State require issuers to include the impact of the program in initial and/or final rates?
9) Are there any existing legislation and/or regulations related to the State program, or is new State legislation and/or regulation needed?
10) If the State is leveraging the FFE's system, does the State anticipate requesting any changes to the FFE? If the State is leveraging the SBE, does the State anticipate requesting any changes to the SBE? Related to question #2 above, does the State envision that applicants will be able to see their subsidy amount during the plan selection process?
11) How does the State plan to ensure access to health insurance that is at least as comprehensive and affordable as would be provided under the ACA when compared to insurance without the waiver?
12) How will the State monitor affordability?

## *E. Change the Age Rating Curve so that Those Ages 19-26 have the Same Premium Ratios Applied to Them as an 18-Year Old*

The RFP asks for analysis of modifying the age curve such that those ages 19-26 have the same age rating factor applied to them as an 18-year old.

**Analysis**

We modeled the impact on rates using the Michigan baseline projected 2020 age distribution in Michigan's individual market and assuming no further change in enrollment. If this is an option that Michigan decides to pursue, we can model the impact of the modified age curve on enrollment using assumed elasticity of demand and taking into consideration the proportion of enrollees who are shielded from the rate impact due to premium subsidies in Phase Two. However, for reasons discussed below, we do not believe the impact would be significant.

We modified the age curve by using the current age 18 factor for ages 18-26 and capping the factor of the older ages at three times the age 21 factor and then prorating all factors so that the age 18-26 factor is 1.0 and the age 64+ factor is 3.0. The result is a decrease in rates at ages 19-26 (0.8% to 8.8%) and 61-64+ (0.3% to 6.6%) and an increase at all other ages of about 2.3%. This results in a year-to-year increase of nearly 15% from age 26 to age 27. We also looked at a further modification that smooths the increase going from one age to another by capping the year-to-year increase for adults at 5%. With the smoothing, the result is a decrease in rates relative to the current age curve of 0.5% to 8.6% at ages 19-29 and 0.1% to 6.4% at 61-64+ and an increase at ages 0-18 and 31-60 of about 2.5%. Due to the smoothing, the rate change at ages 27-30 would range from a 6.2% decrease at age 27 to a 0.3% increase at age 30. It should be noted that these changes will take effect at renewal and will usually result in a dampening of the regular rate increase rather than an actual rate decrease. Note also that the 3:1 requirement results in a factor of 2.739, which is 3:1 (2.739/.913).

As stated above, this analysis assumes no change in enrollment. We would expect the change in the age curve to result in at least somewhat higher enrollment at ages 19-26 (19-29 with the smoothed version) and 61-64+ than without the age curve modification and some decrease at all other ages. However, we would expect these changes to be minimal for the following reasons:

- For those receiving Advance Premium Tax Credits (APTCs), the premium paid is limited to a percentage of income and therefore would not be affected by the change in the age curve. Therefore, enrollment for these people would not be affected.
- Many enrollees at ages 19-26 are covered under their parents' policies. As a percentage of premium, the impact of the age curve modification on the family premium would be much smaller than the impact on the young person's premium.
- For many young adults who have made the decision to be uninsured due to the high cost of coverage, the relatively small decrease in premium would not be enough to change that decision, particularly when combined with the annual renewal rate change, which would typically result in a net increase in premium rather than a decrease.

The modified age curves are estimated in Table 43.

**Table 43**
**Modified Age Curve**

| Age | Current (Federal Age Curve) | Modified | Modified with Smoothing | Age | Current (Federal Age Curve) | Modified | Modified with Smoothing |
|---|---|---|---|---|---|---|---|
| 0-14 | 0.765 | 0.838 | 0.838 | 40 | 1.278 | 1.4 | 1.4 |
| 15 | 0.833 | 0.912 | 0.912 | 41 | 1.302 | 1.426 | 1.426 |
| 16 | 0.859 | 0.941 | 0.941 | 42 | 1.325 | 1.451 | 1.451 |
| 17 | 0.885 | 0.969 | 0.969 | 43 | 1.357 | 1.486 | 1.486 |
| 18 | 0.913 | 1.000 | 1.000 | 44 | 1.397 | 1.53 | 1.53 |
| 19 | 0.941 | 1.000 | 1.000 | 45 | 1.444 | 1.582 | 1.582 |
| 20 | 0.97 | 1.000 | 1.000 | 46 | 1.5 | 1.643 | 1.643 |
| 21 | 1 | 1.000 | 1.000 | 47 | 1.563 | 1.712 | 1.712 |
| 22 | 1 | 1.000 | 1.000 | 48 | 1.635 | 1.791 | 1.791 |
| 23 | 1 | 1.000 | 1.000 | 49 | 1.706 | 1.869 | 1.869 |
| 24 | 1 | 1.000 | 1.000 | 50 | 1.786 | 1.956 | 1.956 |
| 25 | 1.004 | 1.000 | 1.000 | 51 | 1.865 | 2.043 | 2.043 |
| 26 | 1.024 | 1.000 | 1.000 | 52 | 1.952 | 2.138 | 2.138 |
| 27 | 1.048 | 1.148 | 1.050 | 53 | 2.04 | 2.234 | 2.234 |
| 28 | 1.087 | 1.191 | 1.103 | 54 | 2.135 | 2.338 | 2.338 |
| 29 | 1.119 | 1.226 | 1.158 | 55 | 2.23 | 2.442 | 2.442 |
| 30 | 1.135 | 1.243 | 1.216 | 56 | 2.333 | 2.555 | 2.555 |
| 31 | 1.159 | 1.269 | 1.269 | 57 | 2.437 | 2.669 | 2.669 |
| 32 | 1.183 | 1.296 | 1.296 | 58 | 2.548 | 2.791 | 2.791 |
| 33 | 1.198 | 1.312 | 1.312 | 59 | 2.603 | 2.851 | 2.851 |
| 34 | 1.214 | 1.330 | 1.330 | 60 | 2.714 | 2.973 | 2.973 |
| 35 | 1.5 | 1.338 | 1.338 | 61 | 2.81 | 3 | 3 |
| 36 | 1.23 | 1.347 | 1.347 | 62 | 2.873 | 3 | 3 |
| 37 | 1.238 | 1.356 | 1.356 | 63 | 2.952 | 3 | 3 |
| 38 | 1.246 | 1.365 | 1.365 | 64+ | | 3 | 2.739 |
| 39 | 1.262 | 1.382 | 1.382 | | | | |

**Federal Funding of 1332 Waiver**

There would be no additional impact on federal funding. A modification to the age curve would not require a waiver.

If it were included in a 1332 Waiver or alongside a 1332 Waiver, it would decrease the cost of the second lowest silver plan at some ages and increase it at others. It may increase or decrease the pass-through funding to the extent that it impacts overall premium, but that would depend on the projected membership and the impact on APTCs.

**Funding Mechanisms**
This change in age curve would not need to be funded.

**Likelihood of CMS Approval**
Changing the age curve does not require a Section 1332 Waiver. Eight states have modified age curves already. See table at the end of this discussion. As long as the differential between age 21 and age 64 and older is no more than 1:3, only notification to CMS is required, not approval. The 1:3 limit cannot be waived.

**Impact on Michigan**
This would have no impact on Michigan budget.

**Impact on Premiums**
Using the Michigan age distribution, the result is a decrease in rates at ages 19-26 and 61-64+ and an increase at all other ages of about 2.2%. Smoothing the increase going from one age to another by capping the year-to-year increase for adults at 5%, results in a decrease in rates at ages 19-29 and 61-64+ and an increase at all other ages of about 2.5%.

**Impact on Individual Market**
The reduction in the premium rates at the younger ages may encourage younger, healthier individuals to purchase coverage or keep their current coverage. The reduction in premium rates at the ages over 60 may encourage more enrollment at the higher ages. On the other hand, the increase in premium rates at the other ages may cause some to drop coverage or select more affordable plans.

Table 44 presents age curves used by other states.

| Table 44: State Specific Age Curve Variations | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Band | Default<br><br>Premium Ratio | Alabama<br><br>(Individual) | District of Columbia | Massachusetts | Minnesota | Mississippi | New Jersey (Small Group) | Oregon | Utah |
| 0-14 | 0.765 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.765 | 0.635 | 0.793 |
| 15 | 0.833 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.833 | 0.635 | 0.793 |
| 16 | 0.859 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.859 | 0.635 | 0.793 |
| 17 | 0.885 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.885 | 0.635 | 0.793 |
| 18 | 0.913 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.913 | 0.635 | 0.793 |
| 19 | 0.941 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.941 | 0.635 | 0.793 |
| 20 | 0.970 | 0.635 | 0.654 | 0.751 | 0.890 | 0.635 | 0.970 | 0.635 | 0.793 |
| 21 | 1.000 | 1.000 | 0.727 | 1.183 | 1.000 | 1.000 | 1.250 | 1.000 | 1.000 |
| 22 | 1.000 | 1.000 | 0.727 | 1.183 | 1.000 | 1.000 | 1.250 | 1.000 | 1.050 |
| 23 | 1.000 | 1.000 | 0.727 | 1.183 | 1.000 | 1.000 | 1.250 | 1.000 | 1.113 |
| 24 | 1.000 | 1.000 | 0.727 | 1.183 | 1.000 | 1.000 | 1.250 | 1.000 | 1.191 |
| 25 | 1.004 | 1.004 | 0.727 | 1.183 | 1.004 | 1.004 | 1.250 | 1.004 | 1.298 |
| 26 | 1.024 | 1.024 | 0.727 | 1.183 | 1.024 | 1.024 | 1.250 | 1.024 | 1.363 |
| 27 | 1.048 | 1.048 | 0.727 | 1.220 | 1.048 | 1.048 | 1.250 | 1.048 | 1.390 |
| 28 | 1.087 | 1.087 | 0.744 | 1.250 | 1.087 | 1.087 | 1.250 | 1.087 | 1.390 |
| 29 | 1.119 | 1.119 | 0.760 | 1.275 | 1.119 | 1.119 | 1.275 | 1.119 | 1.390 |
| 30 | 1.135 | 1.135 | 0.779 | 1.287 | 1.135 | 1.135 | 1.287 | 1.135 | 1.390 |
| 31 | 1.159 | 1.159 | 0.799 | 1.305 | 1.159 | 1.159 | 1.305 | 1.159 | 1.390 |
| 32 | 1.183 | 1.183 | 0.817 | 1.323 | 1.183 | 1.183 | 1.323 | 1.183 | 1.390 |
| 33 | 1.198 | 1.198 | 0.836 | 1.334 | 1.198 | 1.198 | 1.334 | 1.198 | 1.390 |
| 34 | 1.214 | 1.214 | 0.856 | 1.346 | 1.214 | 1.214 | 1.346 | 1.214 | 1.390 |
| 35 | 1.222 | 1.222 | 0.876 | 1.352 | 1.222 | 1.222 | 1.352 | 1.222 | 1.390 |
| 36 | 1.230 | 1.230 | 0.896 | 1.358 | 1.230 | 1.230 | 1.358 | 1.230 | 1.390 |
| 37 | 1.238 | 1.238 | 0.916 | 1.363 | 1.238 | 1.238 | 1.363 | 1.238 | 1.404 |
| 38 | 1.246 | 1.246 | 0.927 | 1.369 | 1.246 | 1.246 | 1.369 | 1.246 | 1.425 |
| 39 | 1.262 | 1.262 | 0.938 | 1.381 | 1.262 | 1.262 | 1.381 | 1.262 | 1.450 |

| Age Band | Default<br><br>Premium Ratio | Alabama<br><br>(Individual) | District of Columbia | Massachusetts | Minnesota | Mississippi | New Jersey (Small Group) | Oregon | Utah |
|---|---|---|---|---|---|---|---|---|---|
| 40 | 1.278 | 1.278 | 0.975 | 1.393 | 1.278 | 1.278 | 1.393 | 1.278 | 1.479 |
| 41 | 1.302 | 1.302 | 1.013 | 1.410 | 1.302 | 1.302 | 1.410 | 1.302 | 1.516 |
| 42 | 1.325 | 1.325 | 1.053 | 1.427 | 1.325 | 1.325 | 1.427 | 1.325 | 1.562 |
| 43 | 1.357 | 1.357 | 1.094 | 1.450 | 1.357 | 1.357 | 1.450 | 1.357 | 1.616 |
| 44 | 1.397 | 1.397 | 1.137 | 1.478 | 1.397 | 1.397 | 1.478 | 1.397 | 1.681 |
| 45 | 1.444 | 1.444 | 1.181 | 1.511 | 1.444 | 1.444 | 1.511 | 1.444 | 1.748 |
| 46 | 1.500 | 1.500 | 1.227 | 1.550 | 1.500 | 1.500 | 1.550 | 1.500 | 1.818 |
| 47 | 1.563 | 1.563 | 1.275 | 1.593 | 1.563 | 1.563 | 1.593 | 1.563 | 1.891 |
| 48 | 1.635 | 1.635 | 1.325 | 1.641 | 1.635 | 1.635 | 1.641 | 1.635 | 1.966 |
| 49 | 1.706 | 1.706 | 1.377 | 1.688 | 1.706 | 1.706 | 1.688 | 1.706 | 2.045 |
| 50 | 1.786 | 1.786 | 1.431 | 1.741 | 1.786 | 1.786 | 1.741 | 1.786 | 2.127 |
| 51 | 1.865 | 1.865 | 1.487 | 1.792 | 1.865 | 1.865 | 1.792 | 1.865 | 2.212 |
| 52 | 1.952 | 1.952 | 1.545 | 1.847 | 1.952 | 1.952 | 1.847 | 1.952 | 2.300 |
| 53 | 2.040 | 2.040 | 1.605 | 1.902 | 2.040 | 2.040 | 1.902 | 2.040 | 2.392 |
| 54 | 2.135 | 2.135 | 1.668 | 1.961 | 2.135 | 2.135 | 1.961 | 2.135 | 2.488 |
| 55 | 2.230 | 2.230 | 1.733 | 2.019 | 2.230 | 2.230 | 2.019 | 2.230 | 2.588 |
| 56 | 2.333 | 2.333 | 1.801 | 2.080 | 2.333 | 2.333 | 2.080 | 2.333 | 2.691 |
| 57 | 2.437 | 2.437 | 1.871 | 2.142 | 2.437 | 2.437 | 2.142 | 2.437 | 2.799 |
| 58 | 2.548 | 2.548 | 1.944 | 2.206 | 2.548 | 2.548 | 2.206 | 2.548 | 2.911 |
| 59 | 2.603 | 2.603 | 2.020 | 2.280 | 2.603 | 2.603 | 2.280 | 2.603 | 3.000 |
| 60 | 2.714 | 2.714 | 2.099 | 2.365 | 2.714 | 2.714 | 2.280 | 2.714 | 3.000 |
| 61 | 2.810 | 2.810 | 2.181 | 2.365 | 2.810 | 2.810 | 2.280 | 2.810 | 3.000 |
| 62 | 2.873 | 2.873 | 2.181 | 2.365 | 2.873 | 2.873 | 2.280 | 2.873 | 3.000 |
| 63 | 2.952 | 2.952 | 2.181 | 2.365 | 2.952 | 2.952 | 2.280 | 2.952 | 3.000 |
| 64 and Older | 3.000 | 3.000 | 2.181 | 2.365 | 3.000 | 3.000 | 2.280 | 3.000 | 3.000 |

## *F. Allowing Changes to Essential Health Benefits Prescription Drug Formulary to Allow Only One Drug for Each Pharmacy Therapeutic Class*

This task quantifies the impact of allowing specific changes to the Essential Health Benefits prescription drug formulary to allow only one drug for each pharmacy therapeutic class or other formulary adjustments for the Individual fully compliant ACA market in Michigan. We note the ACA requirement: Pursuant to 45 CFR 156.122, all health plans offering essential health benefits must cover at least the greater of: (1) one drug in every United States Pharmacopeia (USP) category and class; or (2) the same number of prescription drugs in each category and class as the EHB-benchmark plan. Via conference call Michigan DIFS explained that "other formulary adjustments" should include consideration of modifying the EHB by selecting another state's EHB-benchmark plan drug count.

**Additional Flexibility**

On January 24, 2019, HHS published its Proposed 2020 Payment Parameters Rule giving additional flexibility to carriers offering fully compliant ACA products. This allows mid-year changes to formularies to account for the release of new generic drugs.

**Initial Analysis**

We reviewed the Pharmacy Templates for 2019 rate filings in Michigan and focused on one broad plan (BCBS PPO which **does** provide benefits for out-of-network retail pharmacies) and one narrow plan (Physician's Health Plan which **does not** provide benefits for out-of-network retail pharmacies). We focused on the Silver plans since they will drive the APTC and have the most enrollment for the ACA. From these Pharmacy Templates, we used their Cost Sharing parameters and reviewed their Formulary for Step Therapy and Prior Authorization. Both Plans utilize Step Therapy and Prior Authorization on some of the drugs.

We made the following settings in our model:

Geographic Area:

- Michigan - Total state

Population Characteristics:

- High proportion of premium and CSR subsidies
- Dampened the impact of cost sharing provisions given the subsidies in place

Program Characteristics:

- No penalties for multi-source drug utilization
- No physician or pharmacy incentives in place
- No DUR program
- Patient education programs and online support available but not used proactively
- Step therapy provisions in place

Prior Authorization provision in place (but varies between the 2 plans modeled - degree of care management)

- No Multi-Source Brand Penalty
- No mandatory mail order (home delivery) program

Mail order (home delivery) scripts are 8.1% of total scripts
Brand Non-Formulary utilization equal to 3.7% of branded drugs
No Usual & Customary screen applied

Benefit Characteristics:
Office visit cost sharing based on the 2 plan designs
No coverage for lifestyle drugs
Industry average discounts off AWP; industry average dispensing fees

Current Plan Formulary:
Open Formulary (Broad list of preferred drugs)

Formulary Options:
Open Formulary (Broad list of preferred drugs) - Current Provision
Open Formulary (Narrow list of preferred drugs)
Closed Formulary
Generics First (Mandatory Generics)

**Further Analysis**

We evaluated every jurisdiction's EHB-benchmark plan comparing drug count lists across the 113 common therapeutic classes. Colorado has the most restrictive drug count at 460, while Michigan has 591, and the average count is 749 (considering Illinois' 2017 EHB, not its 2020 EHB). Across the common classes, Colorado has less than the 5th percentile of drug counts of the jurisdictions 96 times out of 113 classes, while the second most restrictive States (California and Utah tied for second) had less than the 5th percentile 77 times. Michigan has less than the 5th percentile 46 times.

Utilizing our actuarial cost model, we matched therapeutic classes to the EHB specifications provided by HHS. Our model only matched therapeutic classes for 9 categories. We then modified the drug lists by reducing the Michigan drugs to achieve lists needed to meet more restrictive formularies going from Open Formulary with a Broad list of preferred drugs, to Open Formulary with a Narrow list of preferred drugs, to Closed Formulary, and to Mandatory Generics. This enables an approximation of the savings by reducing drug counts in therapeutic classes to simulate moving from the Michigan to Colorado drug lists.

We assumed reductions in drugs would first remove the most expensive drug from the class, followed by the next expensive, and so on, regardless of drug efficacy. We did not remove all Specialty Drugs and Preferred Brand Drugs from the lists, but instead removed the most expensive leaving one drug of each class (Specialty and Preferred Brand) in all cases except Mandatory Generics. By comparing relative reductions in drug counts and evaluating the cost slope of the actuarial cost model, we interpolated the savings that may be achieved by moving from the Michigan to Colorado drug lists. **Please note if the classes not represented by the matching classes within our actuarial cost model have cost slopes that differ materially from our representative classes then savings may vary from those approximated.**

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**Results**
We did not calibrate the model to Michigan Rx claims experience. Instead we would suggest evaluating the decrease in Rx spending when moving to a more restrictive EHB-benchmark plan drug count or to a **closed formulary** or to a more restrictive **closed formulary with a generic mandate.**

**Potential Refinements**
We could evaluate Michigan enrollment to ensure we have the most representative plans. We could use URRTs for the 2019 filings and calibrate our actuarial cost models based on Rx claims in the filings.

**Federal Funding of 1332 Waiver**
*Closed Formulary / Generic Mandate*
Table 45 shows the potential expected prescription drug savings under the various restrictions modeled.

| Table 45: Potential Expected Rx Savings with Certain Restrictions | | MI Drug Counts |
|---|---|---|
| PHP Plan: No Formulary | N/A | N/A |
| PHP Plan: Open Formulary, Broad list of preferred drugs | 0.0% | 591 |
| PHP Plan: CO EHB BP Drug Count List | 2.3% | 460 |
| PHP Plan: Open Formulary, Narrow list of preferred drugs | 3.0% | 366 |
| PHP Plan: Closed Formulary | 6.1% | 250 |
| PHP Plan: Mandatory Generics | 7.9% | 195 |
| BCBS Plan: No Formulary | N/A | N/A |
| BCBS Plan: Open Formulary, Broad list of preferred drugs | 0.0% | 591 |
| BCBS Plan: CO EHB BP Drug Count List | 2.1% | 460 |
| BCBS Plan: Open Formulary, Narrow list of preferred drugs | 2.7% | 367 |
| BCBS Plan: Closed Formulary | 5.3% | 252 |
| BCBS Plan: Mandatory Generics | 7.1% | 197 |

If the formulary change is part of a 1332 Waiver for reinsurance or high-risk pool, it would increase federal funding of the 1332 Waiver to the extent that it reduced premiums for the second level silver plan. This reduction in premium is estimated to be between 1.3% and 1.9%. This decrease is lower than the expected decrease in prescription drug savings shown in Table 45, as prescription drugs are only a portion of total costs.

*Colorado EHB-benchmark plan drug count*
The change in EHB-benchmark plan selecting Colorado's drug list is allowed outside of a 1332 Waiver and therefore this EHB modification would not be allowed with a 1332 Waiver.

**Funding Mechanisms**
This change in EHB would not need to be funded.

**Likelihood of CMS Approval**

*Closed Formulary / Generic Mandate*

Based upon review of the EHB guidance under the 2019 Benefit and Payment Parameters, we believe moving to a Closed Formulary or a Generic Mandate would have to be done under a 1332 Waiver. To obtain CMS approval, we would have to prove that all four guardrails would be met, which may be possible since this change would have no impact on the matters listed in the guardrails. We would have to prove that a Closed Formulary could be just as comprehensive coverage as an Open Formulary.

Only one state has attempted to restrict its formulary, although not through a 1332 Waiver. Alabama attempted to cut down the size of its drug list in the EHB Benchmark via the allowance in the 2019 Payment Parameters Rule. The proposal was not a full move to a Closed Formulary. They took comments on this change through 8/3/18, and then withdrew their application within a week.

The 1332 process requires a public comment period in Michigan. A change to the formulary will likely attract a lot of public criticism in Michigan as it did in Alabama. This has not been done before in a 1332 Waiver and therefore will have a more detailed review by CMS to ensure that it meets all of the guardrails. In our experience this will add a level of complication and more time to the process.

**EHB-benchmark plan drug count**

The process to select a plan year 2020 or beyond EHB is straightforward. A state may replace one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.

**Impact on Michigan Budget**

This would have minor impact on Michigan budget due to a reduction in premium tax.

**Impact on Premiums**

This should lower premiums in plans that choose to offer benefits at the level of the EHB Benchmark. As long as some carriers in each rating area offer this benefit level in their silver plans, the second lowest silver premium will be reduced. Based upon 2019 URRT data, the projected reductions in Single Risk Pool Gross Premium are generated in the URRT worksheet are presented in Table 46.

| Table 46<br>Impact on Premiums | | | | |
|---|---|---|---|---|
| **Carrier** | **Reduction in Rx** | **Cost PMPM*** | **Gross Premium PMPM**** | **Percent Reduction** |
| BCBS | | $ 118.81 | $ 661.81 | |
| CO EHB Rx List | 2.1% | $ 116.37 | $ 658.25 | 0.5% |
| Closed Formulary | 5.3% | $ 112.51 | $ 652.61 | 1.4% |
| + Generic Mandate | 7.1% | $ 110.37 | $ 649.49 | 1.9% |
| | | | | |
| PHP | | $ 83.14 | $ 450.43 | |
| CO EHB Rx List | 2.3% | $ 81.19 | $ 448.18 | 0.5% |
| Closed Formulary | 6.1% | $ 78.07 | $ 444.55 | 1.3% |
| + Generic Mandate | 7.9% | $ 76.57 | $ 442.82 | 1.7% |

* Cost PMPM is in Experience Period, cell G29 URRT Wksh 1
**Gross Premium PMPM is Average Rate for the Single Risk Pool, cell V43 URRT Wksh 1

**Impact on Individual Market**

Lowering pharmacy costs will reduce premiums in the individual market and increase affordability. Reductions in the second lowest silver premium plan will reduce APTC and allow for pass-through funding that can help fund a state-based reinsurance program. This will lower premiums via reduced pharmacy costs and provide some funding for a state-based reinsurance mechanism to keep the individual market stabilized on an ongoing basis.

## *G. Using State-Based Adjustments to Federal Risk Adjustment Calculations*

Carriers have expressed interest in using state-based adjustments to the federal risk adjustment system. Two proposals are being considered – to include an adjustment to the state average premium for state and local taxes and fees, or to limit the statewide average premium in the calculation to true medical expenses only.

**Analysis**

Currently, the federal risk adjustment formula adjusts the statewide average premium by reducing it 14%. This reduction is an attempt to exclude non-claim expenses from the calculation of the statewide average premium.

The percentage of Michigan's premiums that are spent on administrative cost, taxes, and profit (in total the retention amounts) are often higher than the national average used by CMS. Using the Michigan retention amounts or adding the state and local taxes and fees to the federal estimate of 14% would have the effect of reducing the risk adjustment transfer amounts whether receivables or payables.

Using the Supplemental Health Care Exhibit filed with the National Association of Insurance Commissioners, Table 47a shows the estimated adjustment to the statewide average premium used in the risk adjustment formula using 1) an addition to the 14% adjustment CMS uses to account for state and local taxes and 2) using total retention experienced by carriers and reflected in the SHCE, calculated as 1 minus the loss ratio. With the variability of loss ratio from year to year, it may be beneficial to use an average of three years. The three-year average of retention from 2015 to 2017 would be 16.2%

**Table 47a**
**Adjustment to Statewide Average Premium Using the SHCE**

| | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| State and local taxes | 1.70% | 1.60% | 2.20% | 2.40% |
| 1) CMS plus taxes | 15.70% | 15.60% | 16.20% | 16.40% |
| Loss Ratio | 83.90% | 81.70% | 87.60% | 82.10% |
| 2) SHCE Retention | 16.10% | 18.30% | 12.40% | 17.90% |

We calculated the adjustment using the URRT experience loss ratios for years 2014 to 2017, weighted by URRT experience member month and presented in Table 47b. In order to avoid annual fluctuations, we recommend using the three-year average of retention from 2015 to 2017 of 14%.

| Table 47b<br>Adjustment to Statewide Average Premium Using the Actual URRT Loss Ratio | | | | |
|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** |
| Loss Ratio | 90.07% | 88.12% | 89.62% | 80.27% |
| Actual URRT Retention | 9.93% | 11.88% | 10.38% | 19.73% |

We calculated the adjustment using the URRT projected retention (1 minus the projected loss ratios) for years 2014 to 2019 as shown in Table 47c, weighted by URRT experience member months. In order to avoid annual fluctuations, we recommend using the three-year average of retention from 2015 to 2017 of 22.8%.

| Table 47c<br>Projected URRT Loss Ratio and Reduction for Retention | | | | | | |
|---|---|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| Loss Ratio | 78.39% | 73.16% | 79.06% | 74.11% | 79.40% | 78.19% |
| Projected URRT Retention | 21.61% | 26.84% | 20.94% | 25.89% | 20.60% | 21.81% |

When we use these statewide average retentions from the SHCE (Table 47a) in the risk adjustment formula and compare the adjustment due to state and local taxes from the SHCE, we get the following adjustments to the risk-adjustment transfer amounts relative to using the CMS estimate of 14% retention.

| Table 48<br>Adjustment to Risk Adjustment (Increase or Decrease to State Average Premium and risk transfer amount)[52] | | | | |
|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** |
| CMS 14% plus taxes | 1.9% | 1.8% | 2.6% | 2.8% |
| MI Retention | 2.5% | 4.9% | -1.8% | 4.5% |

As demonstrated in the previous tables, using historical adjustments for state and local taxes or total retention results in relatively large swings in the transfer amounts. In particular, using total retention shows a swing of over 6.7% from 2015 to 2016. Using state and local taxes show increasing adjustments each year, as seen in Table 48, from 2015 to 2017. Thus, it may be difficult to determine a single adjustment value that is stable from year to year. A stable value is helpful for

[52] A negative number represents an increase in the risk transfer amount.

carriers in projecting appropriate premium rates. Using an average of the last three years would add more stability. Then the adjustment could be updated in the future if more recent three-year averages would prove to be more appropriate.

Using the lowest adjustment of -1.8% and the highest adjustment of 4.5% (Table 48) the resulting 2017 risk adjustment transfer would be as shown in Table 49.

**Table 49**
**Sample Risk Adjustment Transfer Amounts**

| Company Legal Name | Individual Market Risk Adjustment Amounts (Total $) 2017 | Lowest Adjustment of -1.8% | Highest Adjustment of 4.5% |
|---|---|---|---|
| Alliance Health and Life Insurance Company | ($1,365,333) | ($1,340,757) | ($1,426,773) |
| Aetna Life Insurance Company | $135,740 | $133,296 | $141,848 |
| Blue Care Network of Michigan | ($19,733,632) | ($19,378,427) | ($20,621,645) |
| Blue Cross Blue Shield of Michigan | $117,129,874 | $115,021,536 | $122,400,718 |
| Health Alliance Plan (HAP) | ($11,031,209) | ($10,832,647) | ($11,527,613) |
| Humana Medical Plan of Michigan, Inc. | $100,718 | $98,905 | $105,251 |
| McLaren Health Plan Community | $1,623,984 | $1,594,752 | $1,697,063 |
| Meridian Health Plan of Michigan | ($7,261,482) | ($7,130,775) | ($7,588,249) |
| Molina Healthcare of Michigan, Inc. | ($25,642,431) | ($25,180,867) | ($26,796,340) |
| Physicians Health Plan | ($4,143,564) | ($4,068,980) | ($4,330,024) |
| Priority Health | ($51,264,050) | ($50,341,297) | ($53,570,932) |
| Total Health Care USA, Inc. | $1,451,384 | $1,425,259 | $1,516,696 |

If a 1332 cost-based reinsurance waiver using a $100,000 attachment point, 75% reinsurance, and a maximum of $1,000,000 in claims was in place in 2017. Table 50 shows what each carrier would have received for reinsurance recoveries. The risk adjustments would have to be adjusted for the reinsurance amounts so that carriers would not be reimbursed twice for high-cost claims.

| Table 50<br>Hypothetical 2017 Reinsurance By Carrier<br>$100K Attachment Point, 75% Coinsurance, $1M Cap | |
|---|---|
| **Carrier** | **Reinsurance Receivable** |
| Aetna | $616,028 |
| BCBSM | $139,471,315 |
| BCN | $87,963,046 |
| GRIC | - |
| Molina Healthcare of Michigan, Inc. | $3,471,721 |
| PHIC | - |
| Physicians Health Plan | $2,531,082 |
| Priority Health | $65,128,475 |
| UnitedHealthcare Community Plan, Inc. | - |
| UnitedHealthcare Life Insurance Co. | - |
| Meridian Choice | $581,441 |
| 37651 (HAP) | $7,887,060 |
| 67577 (HAP) | $3,259,922 |
| 20393 (McLaren) | - |
| 74917 (McLaren) | $2,789,642 |
| Total Health | $3,125,483 |
| Total | $316,825,214 |

**Federal Funding of 1332 Waiver**

The change in the risk adjustment may impact the second lowest silver plan. If a carrier that has the second lowest silver plan in an area received a risk adjustment transfer and the risk adjustment receivable is lowered, the premium could theoretically be increased. That higher premium from the second lowest silver plan carrier would increase the advance premium tax credits. If a carrier that has the second lowest silver plan in an area had to pay in risk adjustment and the risk adjustment payable is lowered, the premium could theoretically be reduced.

If the risk adjustment results in a lower second lowest silver plan, the advance premium tax credits (APTCs) will be reduced and, therefore, the federal transfer amount would be reduced unless CMS will allow this modification to the risk adjustment as part of the 1332 Waiver. Since this may be done outside of the waiver it may not be allowed as part of the 1332 Waiver. If it is allowed as part of the waiver the lowering of the second lowest silver rate level would likely be included in the federal transfer amount.

Table 51 shows the companies with the second lowest silver plan in each area for 2018 and 2019. Most of the companies with the second lowest silver plan paid a transfer amount; thus, it is possible

that changing the adjustment to the risk adjustment transfer formula as described above may decrease the second lowest silver plan rate, and if risk adjustment changes are not allowed as part of the waiver, this could decrease the amount of federal transfer to the state under the waiver.

**Table 51**
**Companies with the Second Lowest Silver Plan**

| Area | 2018 Company | 2019 Company |
|---|---|---|
| Area 1 | Priority Health | Oscar Insurance Company |
| Area 2 | Priority Health | Blue Care Network of Michigan |
| Area 3 | Blue Care Network of Michigan | McLaren Health Plan Community |
| Area 4 | Priority Health | Priority Health |
| Area 5 | Total Health Care USA, Inc. | Priority Health |
| Area 6 | Priority Health | Meridian Health Plan of Michigan |
| Area 7 | Physicians Health Plan | Physicians Health Plan |
| Area 8 | Blue Care Network of Michigan | Blue Care Network of Michigan |
| Area 9 | McLaren Health Plan Community | McLaren Health Plan Community |
| Area 10 | McLaren Health Plan Community | Priority Health |
| Area 11 | Priority Health | Blue Care Network of Michigan |
| Area 12 | Physicians Health Plan | Blue Care Network of Michigan |
| Area 13 | Priority Health | Blue Care Network of Michigan |
| Area 14 | Priority Health | McLaren Health Plan Community |
| Area 15 | Priority Health | Priority Health |
| Area 16 | Blue Care Network of Michigan | Blue Cross Blue Shield of Michigan |

The purpose of a 1332 Waiver is generally to reduce the statewide average premium and therefore, reduce the risk adjustment transfer amounts. Additionally, CMS requires a 1332 reinsurance mechanism to coordinate with the risk adjustment. Typically, this will be done using a "muting factor" against the risk adjustment, potentially decreasing risk adjustment further. This muting factor will need to be considered as part of the waiver, and if Michigan is considering an additional adjustment to account for state and local taxes, or full retention, the impact of those changes may decrease the projected pass-through funding.

**Funding Mechanisms**

This change in the federal risk adjustment transfer amounts would not need to be funded but may impact the amount of funding needed for the 1332 reinsurance waiver.

**Likelihood of CMS Approval**

The Payment Parameters rule states further reduction in the Risk Adjustment transfer amount would be approved if a state's circumstances vary compared to the national norm. This is called a State Flexibility Adjustment, which allows an adjustment of up to 50% if the actuarial risk is different in the state as compared to national risk. We are concerned that an adjustment based on an average loss ratio/retention amount could be considered by CMS as an actuarial risk adjustment.

Since an actuarial risk adjustment is already allowed, CMS may not approve this under a 1332 Waiver.

If premiums are increased, we would have to prove affordability.

Currently, there are no states that have their own risk adjustment program. Massachusetts did have their own but moved to the federal program in 2017. No states have yet requested an adjustment to the risk adjustment program as part of their 1332 Waiver application, as far as we are aware.

In addition, the Waiver Concepts Guidance paper from CMS does not include a discussion of adjusting the risk adjustment transfer formula as an option to consider. Also, adjusting the risk adjustment transfer formula does not appear to be a waivable component under 1332 Waivers, as outlined in Appendix 1 of the Hawaii Waiver application[53].

That does not mean, however, that CMS would not allow adjusting the risk adjustment transfer formula. The 4 guardrails would need to be tested. If this adjustment creates lower premiums granting greater affordability, it may be allowed. However, since some carriers' premiums may increase, while others' decrease, this change may not necessarily result in more affordable rates for all carriers.

**Impact on Michigan Budget**
If the change in the risk adjustment reduced the federal transfer amounts and a 1332 Waiver was implemented excluding the effect of the adjustment to risk adjustment, it may increase the amount for which Michigan was responsible. In addition, if Michigan were required to perform any additional administrative efforts to finalize a Michigan specific adjustment, this would also add to the Michigan's budget.

**Impact on Premiums**
Premiums for carriers receiving risk adjustment transfer amounts may be increased based on each carrier's pricing methodology. Premiums for carriers paying transfer amounts may decrease based on each carrier's pricing methodology.

If the adjustment to the risk adjustment transfer formula was done at the same time but separately from a 1332 Waiver, it would have to be coordinated with the waiver. The impact of the adjusted risk adjustment transfer amount would be significantly reduced since coordination with the 1332 Waiver reduces the transfer amounts.

**Impact on Individual Market**
Adjusting the transfer amounts, which would reduce the amount each carrier either receives or pays, may encourage some small carriers to stay in the market since there would be less risk of paying what, for them, might be considered "overwhelming" transfer amounts. On the other hand, some carriers that are receiving risk adjustment transfer amounts may feel that they cannot be profitable with lower amounts and leave the market.

[53] http://governor.hawaii.gov/wp-content/uploads/2015/09/ACA-Waiver-Proposal-Sept-4-2015-DRAFT.pdf

# *H. Modify Risk Adjustment for a Michigan Based Program*

Carriers have expressed interest in using Michigan-based adjustments to the federal risk adjustment system. This discussion considers making modifications to the current method of assigning risk points to diagnoses, which may miss the capability of each insurer to manage the cost of care through value-based benefit designs and case management. Essentially, this would require the development of a Michigan-based risk adjustment program, including revising the risk weights, potentially the methodology, and likely the transfer formula.

**Analysis**

An important consideration in the development of a risk adjustment program is the purpose of risk adjustment. Typically, risk adjustment normalizes costs between different insurers (or providers). In other words, risk adjustment predicts what an individual or group would cost, under normative circumstances. The typical risk adjustment model (for example Medicare's HCC models or some of the commercially-available models) applies a linear regression model to a large dataset to derive additive coefficients that predict the marginal cost expected to be incurred to treat each disease category.

Risk Adjustment models developed in this way when applied to a population or group then predict the expected cost of that group. Used in revenue transfer situations, revenue may be transferred between insurers to adjust for the disease burden of different populations.

Risk Adjustment models include age, sex and diagnosis categories. Because they are normative and predict an average, models do not include provider propensity to treat, procedure codes, drug codes, patient propensity to seek care, contracting (pricing per unit of care) or medical management programs applied, because inclusion of these factors would cause the model to deviate from the prediction of the "average" cost of care and, instead, tailor the model to a particular treatment pathway or protocol or degree of medical management. Stated in a different way, when used for revenue transfer purposes, risk adjustment models do not account for the specific treatment, quality, contract terms or medical management program that a particular population may be subject to; instead, they reimburse for the "average" treatment/quality/contract terms of the population on which the model is based. If a particular provider happens to be less efficient or apply more expensive treatments (even if those treatments result in better outcomes) or a payer's contracts are subject to lower discounts, or a payer applies no medical management (resulting in higher costs), that provider or payer will be under-reimbursed, compared with the actual cost of care.

Given that the purpose of risk adjustment is normative, it is important that different entities subject to risk adjustment be treated equally.

As noted in the Minnesota State-Based Risk Adjustment System Assessment and Feasibility study, the federal risk adjustment model "has "prediction biases" - meaning it produces less accurate results - for certain subpopulations." Some subpopulations' costs are under-predicted (too low), and some subpopulations' costs are over-predicted (too high).

If Michigan wanted to run its own risk adjustment program, it could use the CMS methodology, adjusting portions of it, or it could develop its own methodology. If it chooses to adjust the CMS

methodology, it might be easier to adjust using a state-flexibility option, as discussed in the section on adjusting the risk adjustment program for non-claims.

If Michigan has enough data to be credible, it could develop its own risk adjustment methodology that could better predict costs for specific conditions. This could potentially result in lower premiums if carriers have less uncertainty with respect to the transfer formula that is part of the Michigan-based risk adjustment program.

Of course, if a Michigan-based risk adjustment program is developed, it will need to get operational approval and methodology certification from CMS. CMS would also require additional reporting on the program. In addition, support from all carriers in Michigan would be advisable, such that smaller carriers did not feel the larger carriers influenced the development in their favor.

**Federal Funding of 1332 Waiver**

It is unclear whether a Michigan-based risk adjustment program will impact the second lowest silver premium rate. However, since states are allowed to develop their own Michigan-based risk adjustment programs outside of a 1332 Waiver, it may be argued that there is no Federal Funding available for the development of a Michigan-based risk adjustment program should it lower the second lowest silver premium rate.

**Funding Mechanisms**

Funding for the cost of a Michigan-based risk adjustment program, especially if no federal funds are available under a 1332 Waiver as noted above, could be collected as charges to carriers, similar to the current funding of the federal-based risk adjustment program. However, since this method would charge only participating carriers, the charges would likely be higher than the federal charges due to spreading the cost over a smaller number of members/carriers.

**Likelihood of CMS Approval**

Under 45 CFR 153.310(b), a state cannot have its own risk adjustment program unless it also has its own State-run Exchange. To receive CMS approval Michigan would have to implement its own state-based exchange.

Because states are allowed to develop their own State-based risk adjustment programs outside of a 1332 Waiver, we are concerned that CMS would not approve a Michigan-based risk adjustment program with different risk weights and methodologies under a 1332 Waiver application.

Currently, there are no states that have their own risk adjustment program. Massachusetts did have one but moved to the federal program in 2017.

In addition, the Waiver Concepts Guidance paper from CMS does not include a discussion of adjusting the risk adjustment transfer formula as an option to consider, which is likely necessary when developing a new Michigan-based risk adjustment program. Also, adjusting the risk adjustment transfer formula does not appear to be a waivable component under 1332 Waivers, as outlined in Appendix 1 of the Hawaii Waiver application.

**Impact on Michigan Budget**
If Michigan were to develop its own Michigan-run Exchange and its own risk adjustment program, the impact to the Michigan budget would be very large. We have not attempted to estimate the additional cost, but a feasibility analysis for Minnesota to develop their State-based program cost over $600,000 and took 17 months to perform. Minnesota has its own State-based Exchange; thus, the feasibility study did not include analysis of developing a State-based Exchange, which Michigan would likely need to do in order to have their own Michigan-based risk adjustment program.

**Impact on Premiums**
It is unclear what the effect of a Michigan-based risk adjustment program would be on premiums. Theoretically, if the program provides a higher correlation to actual costs of care and reflects medical management efforts, it is possible that more certainty around the transfer formula might result in carriers decreasing their risk charge in the premiums, thus helping to decrease premiums. However, that could only be determined based on a more detailed feasibility analysis, discussions with all carriers in Michigan, and ultimately on review of the rate filings.

If the added cost of building a Michigan-based Exchange and a Michigan-based risk adjustment program is charged to carriers and is more than those costs charge for the federally run Exchange and program, this could increase premiums.

**Impact on Individual Market**
Adjusting the risk adjustment program's risk weights and methodologies may encourage some carriers to stay in the market if it is expected to have a better correlation to costs than the federal program.

If the new program requires different administration from carriers, it could result in dissatisfaction if the cost and effort is large to change to the new program and could possibly discourage smaller carriers from participating in the market.

# *I. Other (CSR funding to replace the federal funding)*

The RFP asks for an overview of waiver options not utilized in other states that may be worth consideration. One such option is state funding of Cost Sharing Reductions (CSR) to replace the federal funding that was eliminated beginning in 2018. This option was suggested by Steven Chen in a 2017 Health Affairs blog,[54] but to date no state has pursued it.

**Analysis**

At the time federal CSR funding was terminated, several analyses found that the savings in CSR payments would more than offset the increase in Advance Premium Tax Credits (APTCs).[55] This is because increasing premiums to cover CSR costs results in a higher premium for the Second Lowest Silver Plan (SLSP), which is the basis for APTCs. This effect is magnified when CSR costs are entirely loaded into Silver plan premiums, as they are in Michigan and most other states. This creates the potential to recoup state expenditures to fund CSR through the pass-throughs under a 1332 Waiver.

It may be necessary to require carriers to file 2 sets of rates to determine the pass-through amounts each year: 1) assuming silver loading, and 2) assuming funding of the CSR subsidies through the 1332 Waiver.

The advantages and disadvantages of this approach include:

**Advantages**

- If approved, federal pass-through funds would likely more than cover the entire cost of the CSR subsidies.
- This approach could be used in conjunction with reinsurance or other initiatives, which in turn could help all enrollees, including those who are unsubsidized.
- Any excess pass-through funds could be used to fund other initiatives.
- The reduced Silver plan premiums across all on-exchange silver plans would benefit those receiving APTCs who purchase Silver plans more expensive than the SLSP.

**Disadvantages**

- The reduction in APTCs would increase costs for those receiving APTCs who purchase non-Silver plans due to reduced subsidies.
- Funding CSRs would have little or no benefit for those above 400% of poverty because they can currently purchase unloaded Silver plans off-exchange. Rates for non-Silver plans would not be affected.
- Administration of the program could be challenging. If Michigan chooses to make estimated payments to carriers from the pass-through funds they receive from CMS, a system would be needed to collect data on which to base payments and a reconciliation process would need to be developed. This system would likely be similar to the CSR

[54] https://www.healthaffairs.org/do/10.1377/hblog20170815.061550/full/

[55] See for example "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments" by Larry Levitt, Cynthia Cox, and Gary Claxton of the Kaiser Family Foundation. https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/

reconciliation process that CMS used originally. If Michigan does not pay estimated payments, administration would be less complex, but it would still be necessary to collect data on which to base payments after the end of the plan year and some sort of audit program would be needed.

Note: The first disadvantage could be ameliorated if excess pass-through funds are used to partially fund reinsurance or other initiatives, especially if the reinsurance or other initiatives attract healthy uninsured and retain healthy price sensitive enrollees.

**Federal Funding of 1332 Waiver**
For the reasons discussed above, funding CSRs would reduce the premium for the SLSP in each rating area, thereby reducing APTCs and generating pass-through funds.

**Funding Mechanisms**
Pass-through funding provided under the waiver may be enough to entirely fund the CSRs as well as administration of the program.

**Likelihood of CMS Approval**
CSR funding would satisfy the four guardrails, but it is not clear whether CMS would regard it as an attempt to circumvent Congressional intent in defunding CSR. The proposed 2020 Payment Parameters on-exchange rule states the "Administration supports a legislative solution that would appropriate CSR payments and end silver loading and is seeking other ways to address Silver loading for plan year 2021 or later." If Silver loading is eventually ended, approval of a CSR 1332 Waiver and its calculation of pass-through would be re-evaluated.

**Impact on Michigan Budget**
If pass-through funding is enough to entirely fund CSR subsidies plus Michigan's administrative costs for the program, the impact to Michigan would be the effort to administer the program, including any reconciliation efforts. If the pass-through funding does not fully cover CSR plus administrative costs, there would be some funding required from Michigan.

**Impact on Premiums**
Premiums for on-exchange Silver plans would decrease substantially because they would no longer be loaded to cover CSR. A 2017 Kaiser Family Foundation analysis estimated that termination of CSR funding would increase the average premium for a benchmark Silver plan by 15% in Medicaid expansion states.[56] Premiums for other metal levels would not be affected other than possible minor changes to enrollment shifts. Michigan's Bulletin regarding 2019 Form and Rate Filing Requirements for Medical Plans requires that carriers address the Silver loading in their actuarial memorandums for the rate filing. This data along with feedback from Michigan DIFS should enable a calculation of the premium impact.

[56] https://www.kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/

**Impact on Individual Market**

The lower Silver plan rates would likely cause some enrollees in Bronze and Gold plans to switch to Silver plans. It is unlikely that overall enrollment levels would change because rates for Catastrophic and Bronze plans would not be significantly affected. Outreach to the public would be vital since auto re-enrollment could put enrollees in more expensive plans due to this change.

## *J. Administrative Requirements*

A listing of general 1332 Waiver administrative functions required of a state and of the federal government is included at the end of this section.

A number of administrative functions will be needed in order to administer a 1332 Waiver program that includes a reinsurance program. Claims will have to be filed by the carriers and reinsurance reimbursements will have to be paid. Also, amounts will have to be collected from the federal government for APTC reductions and from the assessments against those identified in the legislation once it is finalized. In addition, revenue from carriers may also need to be collected, if that is part of the funding of the program.

**Claims Processing**

Carriers will provide claim information to the administrator. The administrator will accumulate the claims and determine the reinsurance payment owed to the carrier.

Under a cost-based reinsurance program, it may be possible to only require claims for covered individuals who meet the cost threshold for reinsurance recovery. This could potentially be performed during an annual audit. However, collecting all claims on all covered individuals from all carriers would be important for the budgeting and forecasting process to determine the various benefit parameters of the program, such as the threshold level and projected total claims cost of the program from one year to the next.

Under a condition-based reinsurance program, collecting all claims for all covered individuals from all carriers is also important for budgeting and forecasting, but also for claims processing, such that carriers do not exclude individuals with the identified conditions under the program who have low claims costs. It is important for identifying the members in the program for revenue collection purposes, as well, if premium revenue on members reinsured is provided to Michigan.

Once the payment amount is determined, the administrator will verify that adequate funds are available and either pay the claim or notify the carrier that payment will be delayed.

The administrator will also monitor the total claims and notify the carrier once the maximum claim level is reached.

If funding becomes an issue, the administrator will have to monitor funding levels and pay claims as adequate funding is available.

**Funding Collections**

It is NovaRest's understanding that federal APTC funds are made available in the first half of the year for the estimated annual funding amount. The administrator will have to coordinate with the appropriate federal office to ensure that funding is made available on a timely basis.

Premium from carriers and other assessments will be received on a periodic basis from those providing the additional funding needed for the program. The administrator will follow-up on

premium and assessments that are not received on a timely basis. NovaRest assumes that assessments will be based on premium or claim levels and, therefore, the assessed entities will calculate the assessment amount and not the administrator.

**Periodic Audits**

The administrator should periodically audit the carrier claim submission, the carrier revenue submission and the assessments. An audit can be done by the administrator or an outside vendor. An outside vendor would cost approximately $9,000.

The audit would verify that the carrier claims were processed appropriately and only included covered services for the contracted rates.

Under a conditions-based reinsurance program, where premium revenue is provided by carriers for those members with one of the covered conditions, the claims audit can also provide the information necessary to make sure premium revenue is tied to the identified members.

Assessment audits would verify that the assessment base (premium, claims, etc.) was accurate and that the appropriate percentage was used to calculate the assessment.

**Miscellaneous Tasks**

There will be various additional tasks such as opening banking accounts and balancing account statements. See the list at the end of this section.

Tasks would also include reporting requirements back to the Michigan authority that is responsible for the reinsurance program, and to the federal authority, as required.

Relationship management will require an executive director level person that would interact with the federal government, Michigan legislators, carriers, and the public.

**Administrative Expenses of the Reinsurance Program**

The CMS Waiver Concept paper[57] states that the administrative expenses for managing a reinsurance program should be between 1% and 3% of claims. Review of the waiver applications for states that have an approved 1332 Waiver reinsurance program shows that the expected administrative costs range from minimal (where the state already has the capability to manage at least some of the administrative functions noted above) to less than 1% of either claims or revenue.

The Waiver Concepts Paper goes on to state that the expenses would likely be lower for a retrospective type program that looks back at claims that occurred during the year than a prospective high-risk pool program that identifies up front individuals who may be eligible to be moved into a separate high-risk pool program.

[57] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

As expected, initial startup costs may be higher than continuing costs once the program is established. In addition, as noted in the paper, transitional assistance for the first two years of the waiver program is available from CMS, although Michigan must pay CMS for this support.

The paper also states that a state can request assistance from CMS with a state data base – for example CMS has made the EDGE server software that issuers use in relation to CMS's risk adjustment program available for states to use for developing their own database for the state's reinsurance program. The software available is for the enrollment and claims data processing, and program calculation.

*Administrative Function Differences Between Cost-Based and Conditions-Based Programs*
Assuming the claim information required for both a cost-based program and a condition-based program are the same, and include all claim information, the main difference in the administrative functions and cost would be an added cost for the conditions-based program to monitor claims to determine clinically and financially appropriate conditions to include in the reinsurance program each year.

*Administrative Functions Required of a State and of the Federal Government*
Functions that are required of Michigan to manage a 1332 Waiver program include the following:

- Developing governance structure and mechanisms (board, operations plan, etc.)
- Contracting for administrative services and systems
- Contracting for professional services (legal, accounting, audit, actuarial, HR)
- Acquiring claims and accounting software
- Acquiring budgetary and financial systems (reserving, banking services)
- Establishing IT Security applications
- Distributing federal pass-through funds
- Monitoring compliance with federal law
- Collecting and analyzing data related to the waiver, possibly using EDGE server capabilities
- Performing reviews of the implementation of the waiver
- Holding annual public forums to solicit comments on the progress of the waiver
- Submitting annual (and quarterly, as needed) reports to the federal government
- Monitoring the governance and solvency of the program
- Communicating with carriers

Michigan may already have administrative capabilities for some of these services.

Functions required of the federal government under a 1332 Waiver program include the following:

- Reviewing and approving the waiver application
- Modifying the EDGE Server infrastructure
- Reviewing documented complaints, if any, related to the waiver
- Reviewing Michigan reports
- Periodically evaluating Michigan's 1332 Waiver program
- Calculating and facilitating the transfer of pass-through funds to Michigan

# VI. Limitations of Data

There were a few limitations in the data received and the availability of more accurate assumptions. Even with these limitations, NovaRest believes that the baseline projections included in this report are appropriate for decision making purposes. NovaRest performed sensitivity testing to verify that varying the assumptions used would not significantly change the results. Actual federal funding through reduced APTC will be based on actual enrollment and filed premiums rather than on NovaRest's or other projections.

1. The data that NovaRest used was a snap shot. With the turnover in the individual market this may overstate 2019 due to later 2019 migration from the market.
2. NovaRest had little information on individuals eligible for 100% CSR. From the data provided NovaRest knows that they are all eligible for APTCs, but not the actual poverty level. NovaRest allocated the 100% CSR to the CSR levels for the non-100% CSR individuals.
3. For Grandfathered, Transitional, Short-Term Limited Duration, and Association Health Plans, NovaRest had member months from 2014 to June 2018. NovaRest converted the member months to members using 12 months, which may understate the actual number of members in these markets.

# VII. Appendix

## *Appendix A - NRMM Model*

The NRMM uses 2017 and 2018 carrier data as well as 2018 and 2019 carrier premium rates to determine member health insurance shopping behavior and to capture and project annual enrollment and premium by metal level for 2018 and 2019. Because it is possible that carriers change plans throughout a year which would result in double counting members, we only use the members who were enrolled in a plan at the end of the period, which was as of June 2018.

The 2018 carrier data we received was only through June of 2018, so the NRMM model assumes that all members will maintain their current plan for the remainder of the 2018 year.

For 2019, if a member's total family paid claims in 2017 were greater than their total family premium in 2017, the member is assumed to re-enroll in their current plan for 2019, or if that plan is not available, they will find another plan at a similar level of coverage. If the total family paid claims are not greater than the total family premium, the member will look to decrease coverage. The NRMM assumes the member will look to enroll with the same carrier so they can keep their current providers. If their current carrier does not offer plans at a lower level of coverage they will look at the average plan at that level of coverage in the market. The NRMM also assumes that a member will keep their exchange status, except for the silver tier. Because of CSR loading on on-exchange silver plans that began in 2018, an unsubsidized member is assumed to never enroll in an on-exchange silver plan and will instead look at the off-exchange silver plan.

When a member is projected to decrease coverage, the amount of coverage they will reduce to is determined by the rate change from their current plan to the level of coverage they are shopping for in 2019 and elasticities presented at a Society of Actuaries training session. The NRMM assumes older members and larger families are less sensitive to rate increases. If the rate change is a rate decrease, the NRMM assumes the member will pocket the extra premium instead of opting for more coverage. If a member is projected to decrease coverage from the bronze or catastrophic tier, they are projected to go uninsured. Although it is possible for a catastrophic member to age out of a catastrophic plan, we assume this will be offset by younger members joining.

For the subsidized members, we assumed members enrolled in 94% CSR and 87% CSR plans will continue to enroll in the second lowest silver plan in 2019 and maintain their subsidy status. For members in the 73% CSR plans, because of their lower subsidy amount, they may decide to decrease coverage if their rate increase is too high as determined by elasticities. Members in 100% CSR plans, because we do not have any information about the members' poverty or income level, are equally distributed among the other subsidy levels. This is a simplifying assumption on a very small number of members, so we believe it is a reasonable assumption. We also assume APTC non-CSR members will continue to enroll in their current level of coverage.

The aggregate premium for 2019 is based on the 2019 premium for the member plan selected in the model, including the impact of a member aging one year. The NRMM assumes 12 months of coverage for 2019. No other member trend was assumed for 2019 other than the assumptions in

the NRMM as described above. The maximum premium for subsidized members is based on CCIIO data and family size.

2019 is then projected to 2020 through 2029. The assumptions and methodology used are described in the section Baseline Projections for 2020 through 2029.

# *Appendix B - Definitions and Abbreviations*

**Allowed Claims -** The maximum amount a plan will pay for a covered health care service.

**Advance Premium Tax Credit "APTC" or "PTC"** – A tax credit taken by enrollee to lower monthly health insurance payment. The enrollee will estimate yearly income when they apply for coverage in the Health Insurance Marketplace. The APTC will be based on the estimate of the income entered.

**Centers for Medicare & Medicaid Services "CMS"** - The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

**Children's Health Insurance Program "CHIP"** - The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

**Congressional Budget Office "CBO"** – An agency that produces independent analyses of budgetary and economic issues to support the Congressional budget process.

**Cost Sharing** - The share of costs covered by an insurance plan that an enrollee will pay out of their pocket. In general, cost sharing includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

**Cost Sharing Reduction "CSR" -** A discount that lowers the amount an enrollee will have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called "extra savings."

**Essential Health Benefits "EHB"** - A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

**Federal Poverty Level "FPL"** - A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

**Health Insurance Marketplace "Marketplace" or "exchange"** http://www.healthcare.gov - A shopping and enrollment service for medical insurance created by the Affordable Care Act in

2010. In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families.

**High-Risk Pool Plan -** States offer plans that provide coverage if an individual has been denied health insurance because of a pre-existing condition. High-risk pool plans offer health insurance coverage that is subsidized by a state government.

**Metal Level, Metal Plans or Metal Categories** - Plans in the Health Insurance Marketplace are presented in 4 “metal” categories: Bronze, Silver, Gold, and Platinum.

**Patient Protection and Affordable Care Act “ACA” or “Affordable Care Act”** - United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

**Per Member Per Month “PMPM” -** Per Member Per Month, or the average cost of services per individual per month.

**Premium** - A health insurance premium is a monthly fee paid to an insurance company or health plan to provide health coverage.

**Risk Adjustment** - A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

**Third Party Administrator “TPA” -** A third-party administrator is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.

# *Appendix C – Recommended Premium Trend*

**Recommendation of Trend for Michigan 1332 Waiver Study**

Task 1 of the project includes delivery of Market Projections from 2020 to 2029 – Develop the Baseline Projection. In order to construct the forecast in our model, an allowed trend must be selected. Federal guidance has been issued that requires usage of National Health Expenditure (NHE) data for 1332 Waiver application trends, except in the limited circumstances when a state can justify it will experience substantially different trends than the nation.[58] It is unclear what aspects of Michigan's market would justify usage of a different trend.

Given the likelihood of CMS approval, it is recommended that the NHE Projection data be used to perform the Michigan 1332 Study. Alternative projection rates such as Michigan individual market observed trends, actual carrier trends used in rate filings, and national healthcare cost benchmarks are discussed below.

Ultimately, regardless of trend assumption selected, it is recommended that projections be performed under multiple scenarios to inform MI DIFS. The NovaRest projection model can perform an alternative trend scenario based upon Michigan specific data. This will inform stakeholders of the impact the trend assumption has on Pass Thru Funding, Reinsurance Costs, and Alternative Funding Sources. It will also provide a more realistic projection of premium levels and claims costs for informational purposes.

**National Health Expenditure Projection Rates**

Table 17 of the NHE Projection data splits out spending for Private Insurance into Employer-Sponsored Insurance (ESI) and Direct Purchase.[59] Direct Purchase includes coverage purchased through the Marketplaces along with other plans such as Medicare supplemental coverage and individually-purchased plans. This category seems to be the best fit for projecting individual spending among the NHE data. It has been used for other 1332 Waiver applications such as Wisconsin and Oregon (which were approved by CMS). The current NHE Projection uses 2016 as the latest year with actual data and projects from 2017 through 2027.

The NHE trends, as shown in Table 52, are allowed trends appropriate to project total claims costs.

Our model currently uses 2017 historic claims with projected trends to determine market claims in 2018 and beyond. A better representation would be to use actual premiums and membership in 2018 and actual filed premiums in 2019 with projected membership for 2019 along with market wide target loss ratios to determine projected claims in 2018 and 2019. In 2020 and beyond, the recommendation would project 2019 PMPM amounts forward using the NHE trends listed below.

[58] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf
[59] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

| Table 52<br>National Health Expenditure Trends (NHE Table 17 Health Spending by Source of Insurance Coverage Spending Direct Purchase) | |
|---|---|
| Year | Annual Growth Rate |
| 2020 | 3.2% |
| 2021 | 5.2% |
| 2022 | 4.7% |
| 2023 | 4.7% |
| 2024 | 4.7% |
| 2025 | 4.8% |
| 2026 | 5.0% |
| 2027+ | 4.6% |

**Alternative Trend Rates**

As suggested above, an alternative scenario may be produced for stakeholders. A reasonable approach would be to compare how much actual trends and rate filing trends have exceeded the NHE trends that were projected for 2017-2019. Except for recent and potentially future changes to the underlying rules of the ACA, the ACA market should be approaching stability and the carriers know their contracted provider costs and enrolled population costs best. If desired, further analysis on the excess of these trends over NHE trends can be performed. The excess could then be applied to the NHE forecasts from 2020-2026 for a more realistic scenario.

Trends for Michigan's individual market have fluctuated widely for the fully compliant ACA business as shown below by Claim Level. Factors driving these trends include pent up demand, and enrollee churn. Tables 53 and 54 presents the paid and allowed trends, respectively, based upon the market data call.

| Table 53<br>Michigan Fully Compliant ACA Individual Market Trends by Annual Claim Level Paid Claims Annual Trend | | | | |
|---|---|---|---|---|
| **All Companies** | **2014-2015** | **2015-2016** | **2016-2017** | **2014-2017** |
| Under $50,000 | -10.4% | -1.5% | -4.8% | -5.6% |
| $50,000 to $99,999 | -7.5% | 0.3% | -3.9% | -3.8% |
| $100,000 to $199,999 | -7.5% | 0.6% | -0.4% | -2.5% |
| $200,000 to $499,999 | -7.9% | 3.4% | -3.0% | -2.6% |
| $500,000 to $749,999 | -2.8% | -4.2% | 1.2% | -2.0% |
| $750,000 to $999,999 | 2.3% | -8.2% | -6.9% | -4.4% |
| $1,000,000 to $1,249,999 | 8.2% | -7.9% | 16.5% | 5.1% |
| $1,250,000 to $1,499,999 | | | | |
| over $1,500,000 | -5.4% | -11.5% | -10.7% | -9.2% |
| **TOTAL** | **-5.6%** | **4.2%** | **-3.7%** | **-1.8%** |

| Table 54<br>Michigan Fully Compliant ACA Individual Market Trends by Annual Claim Level Allowed Claims Annual Trend | | | | |
|---|---|---|---|---|
| **All Companies** | **2014-2015** | **2015-2016** | **2016-2017** | **2014-2017** |
| Under $50,000 | -6.9% | -0.9% | -1.3% | -3.1% |
| $50,000 to $99,999 | -7.2% | -0.6% | -2.7% | -3.5% |
| $100,000 to $199,999 | -7.1% | 0.1% | -0.3% | -2.5% |
| $200,000 to $499,999 | -7.8% | 3.6% | -2.2% | -2.2% |
| $500,000 to $749,999 | -4.2% | -2.1% | 0.1% | -2.1% |
| $750,000 to $999,999 | 2.3% | -7.6% | -7.3% | -4.3% |
| $1,000,000 to $1,249,999 | 7.8% | 5.1% | 2.1% | 5.0% |
| $1,250,000 to $1,499,999 | | | | |
| over $1,500,000 | -5.4% | -11.6% | -10.7% | -9.3% |
| **TOTAL** | **-4.0%** | **3.6%** | **-1.6%** | **-0.7%** |

Rate filings for 2017, 2018 and 2019 include PMPM allowed claims trends for carriers participating in the individual fully compliant ACA market. These trends by carrier with 2017 membership based upon 2017, 2018 and 2019 URRTs are presented in Table 55.

| Table 55<br>Michigan Individual Fully Compliant ACA – Rate Filings 2019 PMPM Allowed Claims Trends | | | | | | |
|---|---|---|---|---|---|---|
| | | | | URRT Allowed | Actuarial Memo Allowed Trend | |
| Carrier | 2017 MMs | Market Share | Cumulative Share | 2017 to 2019 | 2017 to 2018 | 2018 to 2019 |
| Blue Care Network of Michigan | 1,436,984 | 33% | 33% | 8.0% | 8.2% | 7.8% |
| Priority Health | 1,140,185 | 26% | 59% | 4.1% | 4.2% | 4.2% |
| Blue Cross Blue Shield of Michigan | 995,411 | 23% | 82% | 10.4% | 10.0% | 10.8% |
| Molina Healthcare of Michigan, Inc. | 279,553 | 6% | 88% | 8.1% | 8.0% | 8.0% |
| Health Alliance Plan | 189,089 | 4% | 93% | 7.6% | 7.6% | 7.6% |
| Total Health Care USA, Inc. | 94,964 | 2% | 95% | 7.4% | 7.7% | 7.7% |
| Physicians Health Plan | 73,993 | 2% | 96% | 4.3% | 7.3% | 7.3% |
| Meridian Health Plan of Michigan | 69,678 | 2% | 98% | 3.7% | 3.7% | 3.7% |
| Alliance Health and Life | 50,434 | 1% | 99% | N/A | N/A | N/A |
| McLaren Health Plan Community | 35,201 | 1% | 100% | N/A | N/A | N/A |
| Total | 4,365,492 | Weighted Average | | 7.3% | 7.4% | 7.5% |
| Note: The two smallest market share carriers have been left out of the weighted average because their experience is not credible. The new entrant in 2019, Oscar, has been left out also | | | | | | |

National benchmarks for health expenditures are shown in Table 56. Care must be used when evaluating these benchmarks since they often include employer provided insurance (ESI) which can represent much more membership than the Individual market component. The Health Care Cost Institute publishes annual reports of ESI costs. "This report focuses on per-person health care spending for the ESI populations from Aetna, Humana, Kaiser and UnitedHealthcare. We calculate total (payer plus out-of-pocket) spending, out-of-pocket (OOP) spending, prices, and utilization for four broad categories of health care services: inpatient, outpatient, professional services, and prescription drugs." Furthermore, "We find that health care spending on the ESI population grew by 4.6% in 2016, an increase over the lower rates observed between 2012 and 2015."[60] The growth rates for 2013-2016 are listed in Table 56.

[60] https://www.healthcostinstitute.org/research/publications/

| Table 56<br>HCCI Actual Trends Total Health Care Expenditures Per Person for Employer Sponsored Insurance | |
|---|---|
| **Year** | **Annual Growth Rate** |
| 2013 | 2.75 |
| 2014 | 2.70 |
| 2015 | 4.14 |
| 2016 | 4.64 |

# *Appendix D – Market Coverage by Metal Level by Area*

**Table 57**
**Count of Carriers by Area, Platinum Metal Level**

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| Area 1 | 5 | 7 | 5 | 1 | 0 | 0 |
| Area 2 | 5 | 7 | 5 | 1 | 0 | 0 |
| Area 3 | 4 | 5 | 3 | 1 | 0 | 0 |
| Area 4 | 3 | 5 | 3 | 1 | 0 | 0 |
| Area 5 | 4 | 6 | 5 | 2 | 1 | 1 |
| Area 6 | 3 | 4 | 3 | 1 | 0 | 0 |
| Area 7 | 3 | 5 | 4 | 2 | 1 | 1 |
| Area 8 | 3 | 5 | 4 | 2 | 1 | 1 |
| Area 9 | 2 | 3 | 3 | 1 | 0 | 0 |
| Area 10 | 2 | 3 | 4 | 1 | 0 | 0 |
| Area 11 | 2 | 3 | 2 | 0 | 0 | 0 |
| Area 12 | 3 | 6 | 5 | 2 | 1 | 1 |
| Area 13 | 3 | 5 | 4 | 2 | 1 | 1 |
| Area 14 | 3 | 4 | 3 | 1 | 0 | 0 |
| Area 15 | 3 | 4 | 3 | 1 | 0 | 0 |
| Area 16 | 2 | 3 | 2 | 0 | 0 | 0 |

**Table 58**
**Count of Carriers by Area, Gold Metal Level**

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| Area 1 | 15 | 17 | 14 | 9 | 7 | 8 |
| Area 2 | 15 | 16 | 15 | 9 | 8 | 8 |
| Area 3 | 10 | 12 | 9 | 5 | 6 | 4 |
| Area 4 | 10 | 12 | 9 | 6 | 7 | 7 |
| Area 5 | 13 | 14 | 13 | 8 | 8 | 7 |
| Area 6 | 10 | 11 | 9 | 6 | 6 | 5 |
| Area 7 | 9 | 9 | 9 | 7 | 7 | 6 |
| Area 8 | 10 | 12 | 9 | 6 | 7 | 5 |
| Area 9 | 8 | 8 | 8 | 5 | 5 | 5 |
| Area 10 | 8 | 8 | 9 | 5 | 5 | 5 |
| Area 11 | 8 | 7 | 7 | 4 | 5 | 5 |
| Area 12 | 8 | 10 | 9 | 7 | 7 | 7 |
| Area 13 | 9 | 10 | 9 | 5 | 5 | 5 |
| Area 14 | 7 | 8 | 7 | 4 | 4 | 4 |
| Area 15 | 9 | 11 | 8 | 5 | 5 | 5 |
| Area 16 | 7 | 5 | 4 | 2 | 2 | 2 |

| Table 59<br>Count of Carriers by Area, Silver Metal Level | | | | | | |
|---|---|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| Area 1 | 16 | 20 | 17 | 10 | 8 | 8 |
| Area 2 | 16 | 19 | 18 | 10 | 8 | 8 |
| Area 3 | 12 | 15 | 12 | 6 | 6 | 4 |
| Area 4 | 12 | 15 | 12 | 8 | 7 | 7 |
| Area 5 | 14 | 17 | 16 | 10 | 8 | 8 |
| Area 6 | 12 | 14 | 12 | 7 | 6 | 5 |
| Area 7 | 11 | 12 | 11 | 8 | 7 | 6 |
| Area 8 | 12 | 15 | 12 | 7 | 7 | 5 |
| Area 9 | 10 | 11 | 10 | 5 | 5 | 5 |
| Area 10 | 10 | 11 | 11 | 6 | 5 | 5 |
| Area 11 | 10 | 10 | 9 | 4 | 5 | 5 |
| Area 12 | 10 | 13 | 11 | 7 | 7 | 7 |
| Area 13 | 11 | 13 | 11 | 5 | 5 | 5 |
| Area 14 | 9 | 11 | 9 | 4 | 4 | 4 |
| Area 15 | 11 | 14 | 11 | 6 | 6 | 5 |
| Area 16 | 9 | 8 | 6 | 2 | 2 | 2 |

| Table 60<br>Count of Carriers by Area, Bronze Metal Level | | | | | | |
|---|---|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| Area 1 | 14 | 20 | 18 | 12 | 9 | 9 |
| Area 2 | 14 | 19 | 19 | 12 | 9 | 9 |
| Area 3 | 11 | 16 | 13 | 8 | 7 | 6 |
| Area 4 | 12 | 16 | 13 | 10 | 8 | 8 |
| Area 5 | 14 | 17 | 16 | 12 | 9 | 9 |
| Area 6 | 11 | 15 | 13 | 9 | 7 | 7 |
| Area 7 | 12 | 13 | 12 | 10 | 8 | 8 |
| Area 8 | 13 | 16 | 13 | 9 | 8 | 7 |
| Area 9 | 10 | 12 | 11 | 7 | 5 | 5 |
| Area 10 | 10 | 12 | 12 | 8 | 5 | 5 |
| Area 11 | 10 | 11 | 10 | 6 | 5 | 5 |
| Area 12 | 11 | 14 | 12 | 9 | 7 | 6 |
| Area 13 | 12 | 14 | 12 | 7 | 5 | 5 |
| Area 14 | 8 | 12 | 10 | 6 | 4 | 4 |
| Area 15 | 10 | 15 | 12 | 8 | 7 | 7 |
| Area 16 | 9 | 9 | 7 | 4 | 2 | 2 |

| Table 61<br>Count of Carriers by Area, Catastrophic Metal Level | | | | | | |
|---|---|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| Area 1 | 10 | 13 | 9 | 7 | 6 | 7 |
| Area 2 | 10 | 13 | 10 | 7 | 6 | 7 |
| Area 3 | 9 | 12 | 8 | 5 | 6 | 5 |
| Area 4 | 8 | 12 | 8 | 6 | 6 | 7 |
| Area 5 | 9 | 13 | 11 | 8 | 7 | 7 |
| Area 6 | 9 | 10 | 7 | 5 | 5 | 5 |
| Area 7 | 9 | 10 | 8 | 7 | 7 | 7 |
| Area 8 | 9 | 12 | 8 | 6 | 7 | 6 |
| Area 9 | 8 | 9 | 6 | 4 | 4 | 4 |
| Area 10 | 8 | 9 | 7 | 5 | 4 | 4 |
| Area 11 | 8 | 7 | 5 | 2 | 3 | 3 |
| Area 12 | 8 | 11 | 8 | 5 | 5 | 5 |
| Area 13 | 9 | 10 | 7 | 3 | 3 | 3 |
| Area 14 | 7 | 8 | 5 | 2 | 2 | 2 |
| Area 15 | 9 | 10 | 6 | 4 | 5 | 5 |
| Area 16 | 7 | 6 | 4 | 1 | 1 | 1 |

# *Appendix E – Conditions Covered in Alaska and Maine*

| Federal Severity with AK and ME Conditions Indicated | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME |
| 1 | Hemophilia | X | | 45 | Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections | | | 89 | Adrenal, Pituitary, and Other Significant Endocrine Disorders | | |
| 2 | End Stage Renal Disease | X | | 46 | Opportunistic Infections | | | 90 | Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption | | |
| 3 | Heart Assistive Device/Artificial Heart | | | 47 | Hydrocephalus | | | 91 | Inflammatory Bowel Disease | X | |
| 4 | Heart Transplant | | | 48 | Central Nervous System Infections, Except Viral Meningitis | | | 92 | Ischemic or Unspecified Stroke | | |
| 5 | Intestine Transplant Status/Complications | | | 49 | End-Stage Liver Disease | X | | 93 | Muscular Dystrophy | | |
| 6 | Respirator Dependence/Tracheostomy Status | | | 50 | Non-Hodgkin`s Lymphomas and Other Cancers and Tumors | X | | 94 | Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders | X | |
| 7 | Lung Transplant Status/Complications | | | 51 | Intestinal Obstruction | X | | 95 | Cirrhosis of Liver | | |
| 8 | Stem Cell, Including Bone Marrow, Transplant Status/Complications | X | | 52 | Necrotizing Fasciitis | | | 96 | Chronic Ulcer of Skin, Except Pressure | | |
| 9 | Metastatic Cancer | X | X | 53 | Bone/Joint/Muscle Infections/Necrosis | | | 97 | Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease | X | |
| 10 | Cystic Fibrosis | X | | 54 | Heart Infection/Inflammation, Except Rheumatic | | | 98 | Fibrosis of Lung and Other Lung Disorders | | |

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| Federal Severity with AK and ME Conditions Indicated | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME |
| 11 | Myelodysplastic Syndromes and Myelofibrosis | | | 55 | Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy | X | | 99 | Major Depressive and Bipolar Disorders | | |
| 12 | Aplastic Anemia | | | 56 | Spinal Cord Disorders/Injuries | | | 100 | Reactive and Unspecified Psychosis, Delusional Disorders | | |
| 13 | Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia | | | 57 | Combined and Other Severe Immunodeficiencies | | | 101 | Severe illness x End-Stage Liver Disease | X | |
| 14 | Protein-Calorie Malnutrition | X | | 58 | Disorders of the Immune Mechanism | | | 102 | Severe illness x Acute Liver Failure/Disease, Including | X | |
| 15 | Liver Transplant Status/Complications | | | 59 | Unstable Angina and Other Acute Ischemic Heart Disease | | | 103 | Severe illness x Atherosclerosis of the Extremities with Ulceration or Gangrene Neonatal Hepatitis | | |
| 16 | Traumatic Complete Lesion Cervical Spinal Cord | | | 60 | Hemiplegia/ Hemiparesis | | | 104 | Severe illness x Vascular Disease with Complications | | |
| 17 | Quadriplegia | | | 61 | Pancreas Transplant Status/Complications | | | 105 | Severe illness x Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections | | |
| 18 | Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis | | | 62 | Chronic Pancreatitis | X | | 106 | Severe illness x Artificial Openings for Feeding or Elimination | | |

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| Federal Severity with AK and ME Conditions Indicated | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME |
| 19 | Atherosclerosis of the Extremities with Ulceration or Gangrene | | | 63 | Viral or UnspecifiedMeningitis | | | 107 | Severe illness x HCC group G03 (G03 is HCC Group 3 which includes the following HCCs in the musculoskeletal disease category: 54, 55) | | |
| 20 | Hip Fractures and Pathological Vertebral or Humerus Fractures | | | 64 | Acute Liver Failure/Disease, Including Neonatal Hepatitis | X | | 108 | Cleft Lip/Cleft Palate | | |
| 21 | Multiple Sclerosis | X | | 65 | Colorectal, Breast (Age < 50), Kidney, and Other Cancers | | X | 109 | Seizure Disorders and Convulsions | | |
| 22 | Non-Traumatic Coma, and Brain Compression/Anoxic Damage | | | 66 | Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes | | | 110 | Chronic Kidney Disease, Stage 5 | | |
| 23 | Artificial Openings for Feeding or Elimination | | | 67 | Pathological Fractures, Except of Vertebrae, Hip, or Humerus | | | 111 | Chronic Kidney Disease, Stage 4 | | |
| 24 | Acute Myocardial Infarction | | | 68 | Drug Psychosis | | | 112 | Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors | | |
| 25 | Respiratory Arrest | | | 69 | Drug Dependence | | | 113 | Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism | | X |
| 26 | Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes | | | 70 | Amputation Status, Lower Limb/Amputation Complications | X | | 114 | Miscarriage with Complications | | |

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| Federal Severity with AK and ME Conditions Indicated | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME |
| 27 | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | X | | 71 | Pulmonary Embolism and Deep Vein Thrombosis | | | 115 | Miscarriage with No or Minor Complications | | |
| 28 | Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn | X | | 72 | Completed Pregnancy With Major Complications | | | 116 | Personality Disorders | | |
| 29 | Sickle Cell Anemia (Hb-SS) | X | | 73 | Completed Pregnancy With Complications | | | 117 | Autistic Disorder | | |
| 30 | Thalassemia Major | X | | 74 | Completed Pregnancy with No or Minor Complications | | | 118 | Pervasive Developmental Disorders, Except Autistic Disorder | | |
| 31 | Severe illness x Opportunistic Infections | | | 75 | Rheumatoid Arthritis and Specified Autoimmune Disorders | X | X | 119 | Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes | | |
| 32 | Severe illness x Metastatic Cancer | X | X | 76 | Cerebral Aneurysm and Arteriovenous Malformation | | | 120 | Systemic Lupus Erythematosus and Other Autoimmune Disorders | | |
| 33 | Severe illness x Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia | | | 77 | Schizophrenia | | | 121 | Chronic Obstructive Pulmonary Disease, Including Bronchiectasis | | X |
| 34 | Severe illness x Non-Hodgkin`s Lymphomas and Other Cancers and Tumors | | | 78 | Congestive Heart Failure | | X | 122 | Asthma | | |

| Federal Severity with AK and ME Conditions Indicated | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME | Severity based on Federal Risk Factor | Condition | AK | ME |
| 35 | Severe illness x Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy | X | | 79 | Monoplegia, Other Paralytic Syndromes | | | 123 | Chronic Viral Hepatitis C | | |
| 36 | Severe illness x Heart Infection/Inflammation, Except Rheumatic | | | 80 | Coagulation Defects and Other Specified Hematological Disorders | X | | 124 | Chronic Hepatitis, Other/Unspecified | | |
| 37 | Severe illness x Intracranial Hemorrhage | | | 81 | Osteogenesis Imperfecta and Other Osteodystrophies | | | 125 | HIV/AIDS | X | X |
| 38 | Severe illness x HCC group G06 (G06 is HCC Group 6 which includes the following HCCs in the blood disease category: 67, 68) | | | 82 | Congenital/Developmental Skeletal and Connective Tissue Disorders | | | 126 | Diabetes with Acute Complications | | |
| 39 | Severe illness x HCC group G08 (G08 is HCC Group 8 which includes the following HCCs in the blood disease category: 73, 74) | | | 83 | Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors | | X | 127 | Diabetes with Chronic Complications | | |
| 40 | Intracranial Hemorrhage | | | 84 | Anorexia/Bulimia Nervosa | X | | 128 | Diabetes without Complication | | |
| 41 | Traumatic Complete Lesion Dorsal Spinal Cord | | | 85 | Specified Heart Arrhythmias | | | 129 | Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies | | |
| 42 | Paraplegia | X | | 86 | Mucopolysaccharidosis | X | | 130 | Quadriplegic Cerebral Palsy | X | |
| 43 | Kidney Transplant Status | | | 87 | Lipidoses and Glycogenosis | X | | 131 | Cerebral Palsy, Except Quadriplegic | X | |
| 44 | Vascular Disease with Complications | | | 88 | Amyloidosis, Porphyria, and Other Metabolic Disorders | X | | | | | |

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# *Appendix F – Qualifications*

NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. NovaRest employs some of the most senior actuaries in the industry. The NovaRest actuaries are experts in the Affordable Care Act (ACA), modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects.

NovaRest
ACTUARIAL CONSULTING

# Michigan Section 1332 State Innovation Waiver Application

## Actuarial and Economic Analysis for a Cost-Based Individual Reinsurance Program

## April 15, 2019

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# I. Executive Summary

## Intent of This Report

The NovaRest team was hired by the Michigan Department of Insurance and Financial Services (DIFS) to provide the actuarial and economic analysis related to Michigan's proposal for a waiver under §1332 of the Affordable Care Act. This actuarial and economic report meets the requirement for an actuarial certification to be included in Michigan's 1332 Waiver application. Specifically, it addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the Centers for Medicare and Medicaid Service (CMS) checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Additionally, the report details the assumptions and methodologies used to develop the actuarial and economic projections. Reliance on this report should include a review of the full report and should only be reproduced in its entirety.

## Michigan's 1332 Reinsurance Waiver Program

It is Michigan's goal to utilize a 1332 Waiver to reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims starting in 2021. Michigan believes this could be accomplished using a reinsurance mechanism to help fund high cost claims. The result, therefore, would be a market in which insurers continue to write policies in all 83 Michigan's counties and more individuals stay in the market. Both of these results would help maintain stability in the individual health insurance market in Michigan.

The projections in this report were developed using NovaRest's micro-simulation model referred to as the NovaRest Market Migration Model (NRMM). The NRMM uses economic assumptions and detailed individual membership data to project family buying decisions based on premium rate increases, morbidity, family size, and age. More detail on the methodology and assumptions used are contained in the report and in Appendix D.

## Reinsurance

This section focuses on projections for the base year of 2021, while the 10-year projections are detailed in Section IV Actuarial Economic: Ten Year Projections.

Under its 1332 Waiver, Michigan proposes to implement a reinsurance mechanism that would be similar to traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. Michigan is considering reinsurance parameters that are estimated to reduce premiums by approximately 10% (Scenario 1) and 20% (Scenario 2) compared to the baseline premium (without the waiver). Due to the reduced premiums, the membership in the 2021 individual market is projected to increase 2.3% to 3.6%, respectively, compared to the baseline without the waiver. Details on the membership projections are included in Section IV Actuarial and Economic Analysis: Ten Year Projections.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance[61]. The approach of an "invisible" reinsurance mechanism allows enrollees to remain in the individual market with their current plan and carrier, but a portion of their claims are reimbursed by the reinsurance pool. The enrollee is not aware that their claim is being paid via the reinsurance pool. This means there is no effect on the enrollee, as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

Michigan is reviewing two reinsurance scenarios, both beginning in 2021. The elements in each of these two reinsurance scenarios were assumed in the ten-year future projections, without change, even though Michigan may have the flexibility to change the parameters of the chosen program in the future.

Table I shows the reinsurance parameters for the two scenarios being considered.

| Table I | | |
|---|---|---|
| Reinsurance Parameters | | |
| | Scenario 1 | Scenario 2 |
| Attachment Point | $90,000 | $50,000 |
| Coinsurance | 50% | 55% |
| Maximum Paid Claims Reinsured | $250,000 | $250,000 |

The reinsurance payable under the Waiver is estimated to be approximately $187.8 million in 2021 under Scenario 1 and $363.5 million in 2021 under Scenario 2. The reinsurance payable is expected to increase over the next ten years due to medical inflation. The actual amount that will be paid under the reinsurance will depend on submitted claims. Ten-year reinsurance projections are detailed in Tables I.2a, I.2b, I.3a, and I.3b.

## Meeting the 1332 Waiver Guardrails

CMS has determined four "guardrails" that must be met before a 1332 Waiver can be approved.

Table I.1 summarizes the expected impact of the proposed Section 1332 Waiver on the required guardrails. Our analysis demonstrates the proposed Section 1332 Waiver is expected to meet the guardrails starting in 2021 and continuing each of the next ten years. Section IV Actuarial and Economic Analysis: Meeting the Section 1332 Waiver Guardrails provides more detailed analysis of the results.

[61] Jonathan Keisling. "Invisible High-Risk Pools." April 11, 2017. https://www.americanactionforum.org/insight/invisible-high-risk-pools/ . Accessed April 9, 2019.

| Table I.1 | |
|---|---|
| Guardrail Requirement | Impact of Proposed 1332 Waiver |
| **Comprehensiveness of Coverage:** Coverage under the Section 1332 Waiver will be at least as comprehensive as would be provided absent the waiver. | The proposed Waiver does not make alterations to the required scope of benefits offered in the insurance market in Michigan. It will result in an increase in the number of individuals with coverage that meet the ACA's EHB requirements. |
| **Affordability of Coverage:** The Section 1332 Waiver will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided absent the waiver. | In each year the reinsurance is in effect, the cost of individual coverage will be lower than it would be absent the waiver. |
| **Scope of Coverage:** Coverage under the Section 1332 Waiver will be provided to at least a comparable number of residents as would be provided absent the waiver. | The number of residents covered under the Michigan waiver are projected to be higher than would be absent the waiver. |
| **Deficit Neutrality:** The Section 1332 Waiver will not increase the Federal deficit. | The Michigan waiver will not increase the Federal deficit since the federal pass-through funding will be the APTC savings less the reduced income from exchange user fees. |

## *Funding*

A portion of the funding for the reinsurance would come from the federal government due to the reduction in advanced premium tax credits (APTC) being passed to Michigan. The reduction in premiums for the second lowest Silver plan in each region directly reduces the APTC for the individuals eligible for APTCs.

The additional funding required by the reinsurance program could be assessed against the group health insurance market. We estimate a 0.65% of premium assessment on the group health insurance market for Scenario 1 and a 1.19% of premium assessment for Scenario 2.

An assessment could also take the form of an increased premium tax on all lines of business or a provider tax on health care providers.

Tables I.2a and I.2b present the projected reinsurance payable, the projected Federal pass-through available, and the State of Michigan's financial responsibility for the balance of the reinsurance payable for Scenario 1 reinsurance program for calendar years 2021 through 2030. Tables I.3a and I.3b present the same information under the Scenario 2 reinsurance program.

| Table I.2a<br>Projected Reinsurance, Federal Pass-Through, and Michigan Responsibility, Scenario 1 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Reinsurance by Year | $187,758,428 | $196,583,074 | $205,822,479 | $215,496,135 | $225,839,950 |
| Federal Pass-Through | $115,956,813 | $121,434,492 | $127,169,067 | $133,172,632 | $139,591,602 |
| Michigan Responsibility | $71,801,615 | $75,148,582 | $78,653,412 | $82,323,504 | $86,248,348 |

| Table I.2b<br>Projected Reinsurance, Federal Pass-Through, and Michigan Responsibility, Scenario 1 | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Reinsurance by Year | $237,131,947 | $248,040,017 | $259,449,858 | $271,384,551 | $283,868,240 |
| Federal Pass-Through | $146,598,487 | $153,366,540 | $160,445,482 | $167,849,630 | $175,593,956 |
| Michigan Responsibility | $90,533,460 | $94,673,477 | $99,004,376 | $103,534,922 | $108,274,284 |

| Table I.3a<br>Projected Reinsurance, Federal Pass-Through, and Michigan Responsibility, Scenario 2 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Reinsurance by Year | $363,541,988 | $380,628,462 | $398,518,000 | $417,248,346 | $437,276,266 |
| Federal Pass-Through | $231,678,720 | $242,639,363 | $254,113,654 | $266,125,787 | $278,968,718 |
| Michigan Responsibility | $131,863,269 | $137,989,099 | $144,404,346 | $151,122,558 | $158,307,548 |

| Table I.3b<br>Projected Reinsurance, Federal Pass-Through, and Michigan Responsibility, Scenario 2 | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Reinsurance by Year | $459,140,079 | $480,260,523 | $502,352,507 | $525,460,723 | $549,631,916 |
| Federal Pass-Through | $292,987,580 | $306,528,184 | $320,690,457 | $335,503,033 | $350,995,862 |
| Michigan Responsibility | $166,152,500 | $173,732,339 | $181,662,050 | $189,957,690 | $198,636,054 |

As can be seen in Tables I.2 and I.3, the projected reinsurance payable, Federal pass-through, and Michigan responsibility for the balance of reinsurance payable not funded by the Federal pass-through increases each year. Scenario 2 results are not quite 2 times the values for Scenario 1 to get twice the premium discount (approximately 10% for Scenario 1 and approximately 20% for Scenario 2). The portion of reinsurance payable funded by the Federal pass-through is roughly 62% for Scenario 1 and 64% for Scenario 2. In addition, the membership is projected to be higher under Scenario 2 as compared to Scenario 1 due to the lower premiums.

Premium decreases will also reduce premium tax revenue in Michigan. The current premium tax in Michigan is 1%. The following tables show the total of the impact on Michigan with the state funding of the reinsurance and the reduction in the premium tax.

| Table I.4a<br>Projected Reduction in State Premium Tax, and Michigan Responsibility for Reinsurance, Scenario 1 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Reduction in State Premium Tax | $1,791,784 | $1,854,294 | $1,919,365 | $1,987,117 | $2,059,158 |
| Michigan Responsibility Reinsurance | $71,801,615 | $75,148,582 | $78,653,412 | $82,323,504 | $86,248,348 |
| Total Michigan Impact | $73,593,399 | $77,002,876 | $80,572,777 | $84,310,621 | $88,307,505 |

| Table I.4b<br>Projected Reduction in State Premium Tax, and Michigan Responsibility for Reinsurance, Scenario 1 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Reduction in State Premium Tax | $2,137,348 | $2,212,584 | $2,290,928 | $2,372,527 | $2,457,534 |
| Michigan Responsibility Reinsurance | $90,533,460 | $94,673,477 | $99,004,376 | $103,534,922 | $108,274,284 |
| Total Michigan Impact | $92,670,808 | $96,886,061 | $101,295,304 | $105,907,448 | $110,731,819 |

| Table I.5a<br>Projected Reduction in State Premium Tax, and Michigan Responsibility for Reinsurance, Scenario 2 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Reduction in State Premium Tax | $3,814,126 | $3,934,414 | $4,059,967 | $4,191,020 | $4,330,672 |
| Michigan Responsibility Reinsurance | $131,863,269 | $137,989,099 | $144,404,346 | $151,122,558 | $158,307,548 |
| Total Michigan Impact | $135,677,395 | $141,923,512 | $148,464,313 | $155,313,578 | $162,638,219 |

| Table I.5b<br>Projected Reduction in State Premium Tax, and Michigan Responsibility for Reinsurance, Scenario 2 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Reduction in State Premium Tax | $4,482,546 | $4,629,046 | $4,781,870 | $4,941,307 | $5,107,659 |
| Michigan Responsibility Reinsurance | $166,152,500 | $173,732,339 | $181,662,050 | $189,957,690 | $198,636,054 |
| Total Michigan Impact | $170,635,046 | $178,361,386 | $186,443,921 | $194,898,997 | $203,743,713 |

## *Conclusion*

Michigan's 1332 Waiver reinsurance program is projected to reduce premiums and provide lower-cost options for comprehensive coverage. As can been seen in the ten-year projections in Section IV, this is expected to result in more ACA membership and a continuing stable individual market.

The program will also protect carriers from unpredictable, high cost claims. and make the claims costs more predictable. This would result in carriers being more willing to continue to participate in Michigan's individual insurance market.

Michigan would be required to fund the difference between the cost of the reinsurance and the federal reduction in APTCs. There will also be a cost to Michigan for administering the program, but the administrative cost is expected to be minimal compared to the reinsurance funding. See Appendix B for a description of Michigan's administrative responsibility.

# II. Background

## *Section 1332 Waivers*

Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.[62]

## *Guardrails*

In 2012, the Department of Health and Human Services (HHS) issued regulations for Section 1332 Waivers.[63] In 2015, the Department of Treasury and HHS released guidance on how they would interpret the law's guardrail requirements.[64] On October 24, 2018, the Department of Treasury and HHS released additional guidance providing more flexibility in meeting the Waiver guardrails[65] and this 2018 guidance supersedes the 2015 guidance.

As this report shows, the proposed Waiver will meet the required guardrail conditions as described below:

Comprehensive Coverage – 1332(b)(1)(A). The proposed waiver will not make alterations to the required scope of benefits offered in the insurance market in Michigan and will not result in a decrease in the number of individuals with coverage that meet the ACA's Essential Health Benefits requirements.

Affordability – 1332(b)(1)(B). The proposed waiver will not decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The waiver will not result in any decrease in affordability for individuals.

[62] "Section 1332: State Innovation Waivers." The Center for Consumer Information & Insurance Oversight. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html . Accessed December 20, 2018.
[63] "Application, Review, and Reporting Process for Waivers for State Innovation." Department of Health and Human Services. February 27, 2012. https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf . Accessed April 9, 2019.
[64] "Waivers for State Innovation." Department of Health and Human Services. December 16, 2015. https://www.govinfo.gov/content/pkg/FR-2015-12-16/pdf/2015-31563.pdf . Accessed April 9, 2019.
[65] "State Relief and Empowerment Waivers." Department of Health and Human Services. October 24, 2018. https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf . Accessed April 9, 2019.

Scope of Coverage – 1332(b)(1)(C). The proposed waiver will provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver in Michigan.

Federal Deficit Neutrality – 1332(b)(1)(D). The proposed waiver will not result in increased spending, administrative, or other expenses to the federal government.

When examining the options available to stabilize the individual health insurance market in Michigan each of these guardrails must be met.

## *Actuarial Certification*

A 1332 Waiver also requires an actuarial certification that is conducted and signed by a member of the American Academy of Actuaries.

The requirements of the actuarial certification have changed since 2012. This report is intended to meet the following requirements:[66]

A. *Actuarial analyses and actuarial certifications.* Actuarial analyses and actuarial certifications to support Michigan's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement.

B. *Economic analyses*. Economic analyses to support Michigan's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the federal deficit requirement, including:
    a. A detailed 10-year budget plan that is deficit neutral to the federal government, as prescribed by section 1332(a)(1) and section 1332(B)(ii) of the Affordable Care Act, and includes all costs under the waiver, including administrative costs and other costs to the federal government, if applicable; and
    b. A detailed analysis regarding the estimated impact of the waiver on health insurance coverage in Michigan.

C. *Data and assumptions.* The data and assumptions used to demonstrate that Michigan's proposed waiver is in compliance with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the federal deficit requirement, including:
    a. Information on the age, income, health expenses and current health insurance status of the relevant State population; the number of employers by number of employees and whether the employer offers insurance; crosstabulations of these variables; and an explanation of data sources and quality; and
    b. An explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer

[66] "Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High-Rick Pool/State-Operated Reinsurance Program Applications." https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf . Accessed April 9, 2019.

participation rates, behavioral changes, premium and price effects, and other relevant factors.

# Current Environment

## Current State of the Affordable Care Act (ACA)

As federal healthcare reform efforts continue to face significant challenges, the ACA continues to strain Michigan's individual insurance market. Nationally, the cost of health care is still a major barrier to obtaining coverage. Nationally, ACA market conditions have resulted in carriers leaving the market or reducing the counties in which they offer plans. Michigan desires to maintain a robust market despite these headwinds.

Under the ACA if a family income falls between 100% and 400% of the FPL, they may be eligible for cost sharing and premium subsidies.[67] Cost sharing reductions (CSR) lower the amount of cost sharing that an individual pays out of pocket. The CSR's are available to those between 100% to 250% of the federal poverty line and Native American Indians, with families with lower incomes paying less out-of-pocket. APTCs reduce the premium that a family pays based on their income level and are available up to 400% of FPL.

## Michigan Characteristics

According to Census.gov, Michigan's total population has been fairly stable with an increase of 0.8% from April 2010 to July 2017.[68] The population increase over the same period for the entire United States is 5.5%.[69] As of July 1, 2017, the Michigan population was estimated to be 9,962,311.[70] Table II.1 provides a breakdown of the population demographics.[71]

[67] "2018 Federal Poverty Level". Obamacare.net. https://obamacare.net/2018-federal-poverty-level/ . Accessed March 27, 2019.
[68] "Quickfacts: Michigan; United States". United States Census Bureau. https://www.census.gov/quickfacts/fact/table/mi,US/PST045217. Accessed March 27, 2019.
[69] Ibid.
[70] Ibid.
[71] "American FactFinder." United States Census Bureau. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S0101&prodType=table . Accessed February 20, 2019.

| Table II.1<br>2017 MI Population Estimates by Age | |
|---|---|
| Under 20 | 2,482,416 |
| 20-24 | 723,180 |
| 25-29 | 628,736 |
| 30-34 | 590,859 |
| 35-39 | 576,824 |
| 40-44 | 599,940 |
| 45-49 | 655,163 |
| 50-54 | 715,261 |
| 55-59 | 725,670 |
| 60-64 | 652,286 |
| 65 years and over | 1,575,233 |

Michigan's Gross Domestic Product (GDP) was $509 billion in 2017.[72]
The median household income in Michigan for 2017 was $52,668.[73] The median household income for the entire United States was $57,652. The income and benefits distribution for the Michigan population, in 2017 inflation adjusted dollars, is shown in Table II.2.[74]

[72] "GDP by State." Bureau of Economic Analysis. US Department of Commerce. https://apps.bea.gov/itable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1. Accessed March 28, 2019.
[73] "Quickfacts: Michigan; United States". United States Census Bureau. https://www.census.gov/quickfacts/fact/table/mi,US/PST045217. Accessed March 27, 2019.
[74] "2013-2017 American Community Survey 5-Year Estimates." United States Census Bureau. https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml . Accessed February 20, 2019.

| Table II.2<br>Population by Income & Benefits | | |
|---|---|---|
| | **Estimate** | **Percent** |
| Total households | 3,888,646 | 100% |
| Less than $10,000 | 284,882 | 7.3% |
| $10,000 to $14,999 | 193,880 | 5.0% |
| $15,000 to $24,999 | 411,782 | 10.6% |
| $25,000 to $34,999 | 403,426 | 10.4% |
| $35,000 to $49,999 | 549,638 | 14.1% |
| $50,000 to $74,999 | 720,755 | 18.5% |
| $75,000 to $99,999 | 474,850 | 12.2% |
| $100,000 to $149,999 | 500,924 | 12.9% |
| $150,000 to $199,999 | 183,124 | 4.7% |
| $200,000 or more | 165,385 | 4.3% |
| **Median household income (dollars)** | **52,668** | |
| **Mean household income (dollars)** | **72,091** | |

Per the most recent U.S. Census Bureau estimates, the number of persons in poverty in Michigan is 14.2%, which is higher than the estimated 12.3% for the entire United States.[75]

The Federal Poverty Level (FPL) is utilized to determine if a citizen is eligible for subsidies to off-set the cost of their monthly premiums. The FPL is also used to determine eligibility for Medicaid and Children's Health Insurance Program (CHIP). In 2018, 2.7 million individuals (27% of the population) were under 200% FPL in Michigan.[76]

Michigan has a state-federal partnership exchange. Michigan oversees plan management, and Healthcare.gov is used for enrollment. Michigan expanded Medicaid under the ACA, and the exchange can enroll people in Medicaid or qualified health plans (QHPs), depending on their income.[77]

The approved 2018 average rate increases for the individual market, including off-exchange are included in Table II.3.[78, 79] These rate increases include the one-time increase for the on-exchange Silver plans due to the federal defunding of CSRs.

**Table II.3**
**Michigan 2018 Final Average Individual Market Rate Increases by Company**

[75] "Quickfacts: Michigan; United States". United States Census Bureau. https://www.census.gov/quickfacts/fact/table/mi,US/PST045217. Accessed March 27, 2019.
[76] "Medicaid In Michigan", Kaiser Family Foundation, November 2018, http://files.kff.org/attachment/fact-sheet-medicaid-state-MI . Accessed February 20, 2019.
[77] "Michigan health insurance marketplace history and news of the state's exchange." Health Insurance.org https://www.healthinsurance.org/michigan-state-health-insurance-exchange/ Accessed February 21, 2019.
[78] SERFF Filing Access. NAIC. https://filingaccess.serff.com/sfa/home/MI . Accessed February 15, 2019.
[79] In 2018, Michigan insurers began loading silver premiums for CSR's not being funded.

| Company | 2018 Rate Increase |
|---|---|
| Alliance Health and Life Insurance Company | 19.8% |
| Blue Care Network of Michigan | 22.6% |
| Blue Cross Blue Shield of Michigan | 31.7% |
| Health Alliance Plan of Michigan | 29.6% |
| McLaren Health Plan Community | 26.6% |
| Meridian Health Plan of Michigan | 53.2% |
| Molina Healthcare of Michigan, Inc. | 42.8% |
| Physician's Health Plan | 26.0% |
| Priority Health | 19.0% |
| Total Health Care USA | 27.6% |

The approved 2019 average rate increases for the individual market, including off-exchange, are included in Table II.4.[80]

**Table II.4**
**Michigan 2019 Final Average Individual Market Rate Increases by Company**

| Company | 2019 Rate Increase |
|---|---|
| Alliance Health and Life Insurance Company | 0.0% |
| Blue Care Network of Michigan | 1.1% |
| Blue Cross Blue Shield of Michigan | 4.2% |
| Health Alliance Plan of Michigan | 0.0% |
| McLaren Health Plan Community | 11.1% |
| Meridian Health Plan of Michigan | 0.7% |
| Molina Healthcare of Michigan, Inc. | 2.2% |
| Oscar Insurance Company | New |
| Physician's Health Plan | 3.0% |
| Priority Health | -2.5% |
| Total Health Care USA | 7.6% |

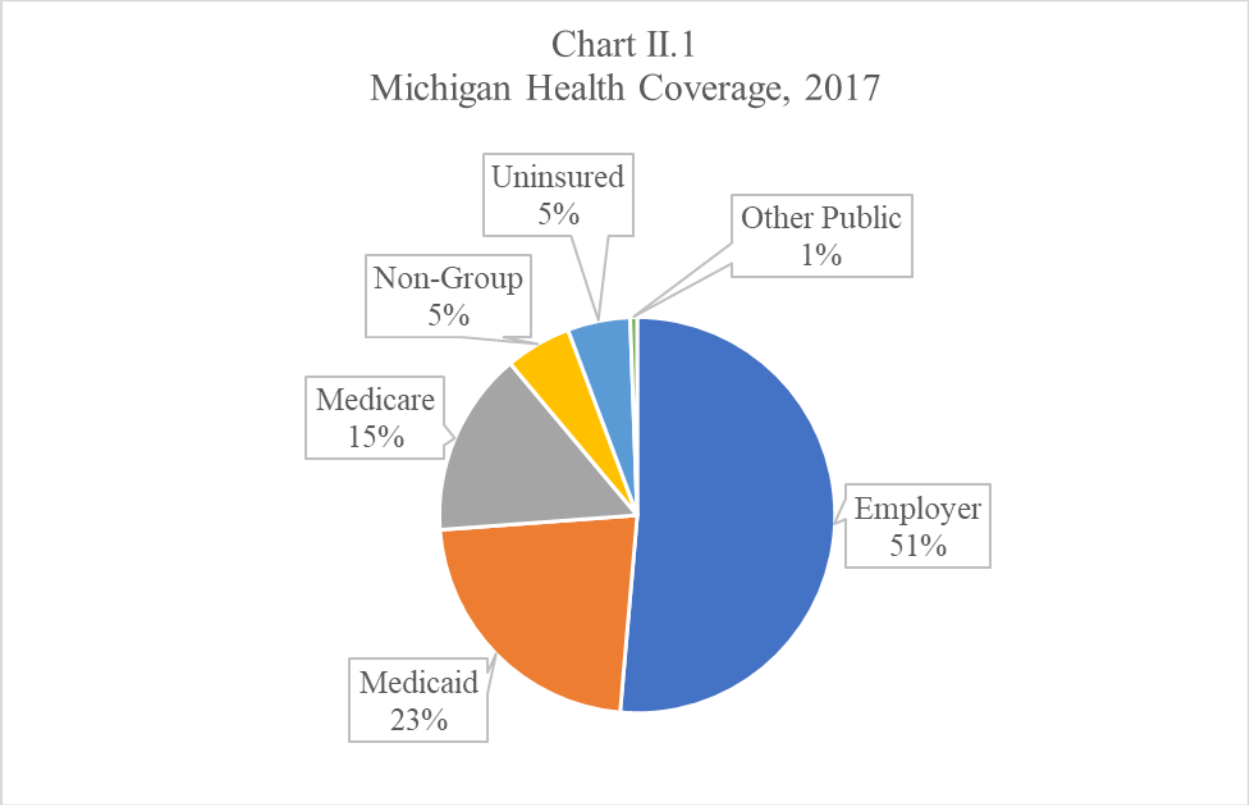
Michigan carriers provided NovaRest with data for each individual as of December 31, 2017 and June 30, 2018. Based on the data received, the individual insurance market membership, average premium and total premium are shown in Table II.5. Please note, because 2018 data was provided through June 30, 2018, we used actual carrier data for the first half of 2018, and then estimated the second half of 2018 assuming all members active as of June 30, 2018 would continue to be active for the remainder of the year at their current premium rate. Since the premium is the average based on the age mix in the category, the premiums are not totally comparable, but give a sense of what individuals are paying in each market segment. Note also that the "APTC premium rate" reflects the premium collected by the carrier including the APTC and member premium. It is shown as a comparison to the non-APTC premium rates.

[80] SERFF Filing Access. NAIC. https://filingaccess.serff.com/sfa/home/MI . Accessed February 15, 2019.

| Table II.5<br>Current Michigan Individual Market | | | |
|---|---|---|---|
| **Membership Active** | | **2017** | **2018** |
| | On Exchange | | |
| | APTC | 259,496 | 173,692 |
| | Non-APTC | 88,683 | 76,637 |
| | **Total On-Exchange** | 348,179 | 250,329 |
| | Off Exchange | 130,154 | 88,363 |
| | **Total ACA** | 478,333 | 338,692 |
| | Transitional | 28,261 | 24,907 |
| | Grandfathered | 5,295 | 4,644 |
| | **Total Individual Market** | 511,889 | 368,242 |
| **Average Premium** | | | |
| | On Exchange | | |
| | APTC premium rate | $425.85 | $524.30 |
| | Non-APTC | $368.51 | $431.71 |
| | **Total On-Exchange** | $411.09 | $495.96 |
| | Off Exchange | $411.66 | $476.96 |
| | **Total ACA** | $411.26 | $491.00 |
| | Transitional | $222.87 | $241.68 |
| | Grandfathered | $293.70 | $296.21 |
| | **Total Individual Market** | $396.51 | $471.68 |
| **Total Annual Premium** | | | |
| | Total ACA | $1,824,346,506 | $1,995,577,988 |
| | Transitional | $75,582,203 | $72,233,644 |
| | Grandfathered | $18,662,959 | $16,505,174 |
| | **Total Individual Market** | $1,918,591,668 | $2,084,316,806 |

A breakdown of the type of health insurance coverage in Michigan in 2017 is shown in Chart II.1.[81]

[81] "Health Insurance Coverage of the Total Population." Henry J Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0 . Accessed February 20, 2019.




Although Michigan has a relatively stable individual health insurance market with numerous carriers as noted in Tables II.3 and II.4, federal changes including the removal of the individual mandate penalty, the new rules around short term limited duration insurance (STLDI) and association health plans (AHPs), and the loss of the funding of CSRs, these market pressures continue to create uncertainty with respect to future sustainability of the ACA market, nationally as well as in Michigan. Michigan has an opportunity to consider a Section 1332 Waiver or other market reforms to ensure future stability in the individual health insurance market.

## *Michigan Employer Market*

Many employers in Michigan offer health insurance for their employees and dependents. The employer negotiates the terms of the group policy with the health insurer. The employer can reduce or change the benefits and coverage, increase the employees share of the premium cost, switch health insurers, or stop providing coverage entirely. If an employer provides health coverage, the contract must include certain minimum benefits required by Michigan law[82]. The following tables are created utilizing Medical Expenditure Panel Survey (MEPS) data[83]. Table II.6 tabulates the number of private -sector employees by firm size. Table II.7 displays the percentage of employers that offer insurance by firm size.

[82] "Health Coverage Basics". DIFS. https:// www. michigan. gov /difs /0,5269,7-303-12902_35510-263908--,00.html Accessed 4/14/2019 (no longer accessible)

[83] "Table II.B.3.b Percent of private-sector full-time employees at establishments that offer health insurance by firm size and State: United States, 2017". MEPS.

https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2017/tiib3b.htm Accessed 4/14/2019.

**Table II.6:**
**Number of private-sector employees by firm size and State: United States, 2017**

| State | Total | Less than 10 employees | 10-24 employees | 25-99 employees | 100-999 employees | 1000 or more employees | Less than 50 employees | 50 or more employees |
|---|---|---|---|---|---|---|---|---|
| United States | 125,415,757 | 14,008,120 | 10,766,705 | 17,645,813 | 23,563,744 | 59,431,375 | 33,412,777 | 92,002,980 |
| **Michigan** | **3,890,148** | **386,580** | **382,174** | **596,543** | **938,083** | **1,586,768** | **1,045,228** | **2,844,920** |

**Table II.7:**
**Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2017**

| State | Total | Less than 10 employees | 10-24 employees | 25-99 employees | 100-999 employees | 1000 or more employees | Less than 50 employees | 50 or more employees |
|---|---|---|---|---|---|---|---|---|
| United States | 46.9% | 23.5% | 49.2% | 74.6% | 96.3% | 99.3% | 30.2% | 96.6% |
| **Michigan** | **49.3%** | **26.1%** | **48.4%** | **72.0%** | **97.8%** | **99.9%** | **32.8%** | **96.4%** |

# III. Overview of Michigan's Reinsurance 1332 Waiver

## *Reinsurance Design*

Under its 1332 Waiver, Michigan is reviewing two reinsurance scenarios which are estimated to reduce premiums by approximately 10% (Scenario 1) and 20% (Scenario 2) compared to the baseline premium (without the waiver). The premium reduction is due to the claims paid by the reinsurance and the improved morbidity that is reflected in the NRMM micro-simulation model results. The reinsurance mechanism would be "invisible reinsurance", like traditional reinsurance or the temporary federal ACA reinsurance that was effective from 2014 to 2016.

The first proposed reinsurance program (Scenario 1) would cover 50% of paid claims between the attachment point and $250,000. The attachment point proposed is $90,000.

The second proposed reinsurance program (Scenario 2) would cover 55% of paid claims between the attachment point and $250,000. The attachment point proposed is $50,000.

In addition to reducing premiums, the reinsurance would allow carriers to better predict their health care claims costs and protect against unpredictable high-cost claimants.

The reinsurance would be funded by pass-through funding associated with the reduction in federal Advanced Premium Tax Credits (APTC) and by state funds or assessments.

The reduction in premiums in Michigan results in the reduction in APTCs. The APTCs funded by the federal government are the difference between the second lowest Silver premium in a region and the maximum amount that a family pays in premium based on its income and family size. As the Silver premiums are reduced, the APTC is reduced due to the reduction in premiums. The reduction in APTC is slightly offset by exchange user fees, which the federal government will not be able to collect. The fourth guardrail - Federal Deficit Neutrality, requires that any savings from APTC be offset by any loss of income, which will be discussed in Section IV.

Michigan would be responsible for the difference between the reinsurance cost and the federal savings. One option to pay for this responsibility would be to collect assessments from the group market. Since the individual market is only 9.5% of the total health insurance commercial market, the assessments from the group market would be allocated to a much larger base. NovaRest estimates a 0.65% of premium assessment on the group health insurance market for Scenario 1 and a 1.19% of premium assessment for Scenario 2.

An assessment could also take the form of an increased premium tax on all lines of business or a tax on health care providers.

The reinsurance program would reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims. The result therefore, should be more individuals staying in the market and more insurers being willing to continue writing policies in Michigan counties. Both of these scenarios will help the individual health insurance market in Michigan remain stable.

# IV. Actuarial and Economic Analysis

The following actuarial and economic analysis meets the requirements under 45 CFR 155.1308(f)(4)(i) and the additional analysis requested by CMS's Checklist for a Section 1332 State Innovation Waiver Application[84]. As previously noted, NovaRest utilized our micro-simulation model to examine the impact of the proposed Section 1332 Waiver. The model is able to predict how the waiver will affect the insurance markets in Michigan and ensure the meeting of the guardrails. The NRMM uses economic assumptions and detailed individual membership data to project family buying decisions based on premium rate increases, morbidity, family size, and age.

## *Meeting the Section 1332 Waiver Guardrails*

This section will demonstrate that the four 1332 Waiver guardrails will be met by Michigan's proposed 1332 Waiver structure.

## *Comprehensive Requirement 1332(b)(1)(A)*

The waiver will have no material effect on the comprehensiveness of coverage for Michigan residents. Regardless of whether the waiver is granted, all Michigan ACA-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits provided by other types of coverage such as Medicaid, CHIP, and grandfathered plans will not be impacted. The waiver is expected to increase the number of individuals with health coverage. Individuals gaining health coverage under the waiver will have coverage for more comprehensive health benefits than they would absent the waiver.

## *Affordability Requirement 1332(b)(1)(B)*

In each year the reinsurance program is in effect, the cost of individual coverage will be lower than it would be absent the waiver. For this purpose, affordability refers to the ability of state residents to pay for health care, and is measured by comparing their net out-of-pocket spending for health coverage and services to their incomes. Out-of-pocket expenses are assumed to include premium contributions and any plan level cost-sharing that is the responsibility of the individual.

Our estimates predict the proposed waiver will not have a material impact on the affordability of coverage for individual, employer, Medicaid, Medicare, or any other public insurance plan. The waiver will reduce premium and increase affordability (See Table IV.1).

[84] "Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High-Rick Pool/State-Operated Reinsurance Program Applications." https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf . Accessed April 9, 2019.

| Table IV.1<br>2021 Premium Difference from Base Line | | |
|---|---|---|
| **Average Premium** | **2021** | |
| | **Scenario 1; $90,000 Attachment Point 50% Coins, $250,000 Cap** | **Scenario 2; $50,000 Attachment Point 55% Coins, $250,000 Cap** |
| On Exchange | | |
| APTC Aggregate Premium Rate | -10.0% | -20.0% |
| APTC Maximum Premium Paid | 0.0% | 0.0% |
| APTC | -13.7% | -27.5% |
| Non-APTC | -10.2% | -20.2% |
| **Total On-Exchange** | -10.2% | -20.2% |
| Off Exchange | -10.3% | -20.5% |
| **Total ACA** | -10.2% | -20.3% |
| **APTC Savings** | $119,382,385 | $238,764,767 |
| **Exchange Fee Reduction** | $3,425,572 | $7,086,047 |
| **Net Federal Savings** | $115,956,813 | $231,678,720 |

As can be seen in Table IV.1, the waiver program is not expected to change the amount of the premium which subsidy eligible individuals would pay (APTC Maximum Premium Paid), but it does decrease the premium for non-subsidy eligible individuals both on and off the exchange.

The values in the line "APTC" reflect that the subsidy amounts will decrease by 13.7% and 27.5%, respectively, for Scenario 1 and 2, which is the source of the federal pass-through funding.

## *Scope of Coverage Requirement 1332(b)(1)(C)*

The proposed waiver is projected to cover more individuals in Michigan than would be covered absent the waiver. The lower costs of coverage will allow for more Michigan residents to purchase or maintain coverage in the individual market. Lower premiums will result in individuals retaining coverage rather than dropping coverage due to unaffordable premium rates. As indicated in Table IV.2, enrollment in the individual market is expected to increase by approximately 2.3% in 2021 under Scenario 1 and 3.6% in 2021 under Scenario 2, with similar increases in later years. The waiver will have no material impact on the availability of other types of coverage, such as Medicaid, CHIP, and employer-based insurance, so no impact is expected on the number of individuals with those types of coverage. The waiver will have a positive impact on vulnerable

populations who buy coverage in the individual market since premiums will be lower (See Table IV.2).

**Table IV.2**
**2021 Membership Difference from Base Line**

| Membership | 2021 | |
|---|---|---|
| | **Scenario 1, $90,000 Attachment Point 50% Coins** | **Scenario 2, $50,000 Attachment Point 55% Coins** |
| On Exchange | | |
| 94% CSR (133% to 150% FPL) | 0.0% | 0.0% |
| 87% CSR (150% to 200% FPL) | 0.0% | 0.0% |
| 73% CSR (200% to 250% FPL) | 0.0% | 0.0% |
| APTC (250% to 300% FPL) | 0.0% | 0.0% |
| APTC (300% to 400% FPL) | 0.0% | 0.0% |
| Total APTC | 0.0% | 0.0% |
| Total Non- APTC (> 400%) | 4.1% | 4.7% |
| **Total On-Exchange** | 0.9% | 1.0% |
| Off Exchange | 5.1% | 8.9% |
| **Total ACA** | 2.3% | 3.6% |

Table IV.2 shows that the projected number of subsidy eligible people buying insurance under the waiver program does not change, since their premium after subsidy is based on their income, not on the total premium rate.

## *Federal Deficit Neutrality Requirement – 1332(b)(1)(D)*

The proposed waiver will not result in increased spending, administrative, or other expenses to the federal government. There will be no increase in federal administrative expense. The federal funding will be calculated based on actual APTC subsidized enrollment and will be decreased by any reductions in exchange user fees. The waiver scenarios are expected to lower premiums by 10% to 20%, which will reduce the APTC that would be paid by the federal government. Since the exchange user fees are a percentage of premium, the reduced premium will in turn reduce the exchange user fees collected by the federal government. The intention is for the lower APTCs less the reduced exchange user fees to be passed on to Michigan and used to fund the reinsurance program under the waiver.

### *Aggregate Premium*

The NRMM also calculates the aggregate premium rate for individuals and families that are eligible for APTCs and the maximum a family will actually pay.

The aggregate premium rate is the premium that the individuals would pay, if they did not receive the APTC. This is the second lowest Silver rate in each region. Table IV.3 below shows the estimated premium in 2021 for a person age 40, assuming a 2% FPL trend, assuming no 1332 Waiver. The tobacco rate charged to smokers was not considered since it is not used in the APTC determination.

**Table IV.3**
**2021 Second Lowest Silver Plans by Area, Age 40**

| Area | Age 40 Monthly Premium Rate |
|---|---|
| Rating Area 1 | $346.82 |
| Rating Area 2 | $338.36 |
| Rating Area 3 | $432.26 |
| Rating Area 4 | $391.27 |
| Rating Area 5 | $375.93 |
| Rating Area 6 | $442.99 |
| Rating Area 7 | $390.95 |
| Rating Area 8 | $419.09 |
| Rating Area 9 | $470.30 |
| Rating Area 10 | $473.18 |
| Rating Area 11 | $491.46 |
| Rating Area 12 | $378.91 |
| Rating Area 13 | $470.66 |
| Rating Area 14 | $425.80 |
| Rating Area 15 | $439.20 |
| Rating Area 16 | $586.97 |

## *Calculation of an Individual's Maximum Payable Premium for the Advanced Premium Tax Credit*

The family Federal Poverty Level (FPL) for 2019 is $12,490 for the first person plus $4,420 for each additional person.[85] A family of 4 would be $12,490 plus 3 times $4,420 or $25,750 total. The single person FPL rate has been increasing by 1% to 3% a year and the additional person cost has been increasing by 0% to 4% a year.[86] We used an assumption that the FPL increased 2.9% for 2018 to 2019 and then will increase 2% a year thereafter.

[85] "Prior Poverty Guidelines and Federal Register References". Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references . Accessed April 4, 2019.
[86] Ibid.

Maximum premium paid by low income as a percent of income.[87]

- For 133% to 150% of FPL the percentage is between 3.11% and 4.15%.[88]
- For 150% to 200% it is between 4.15% and 6.54%.
- For 200% to 250% it is between 6.54% and 8.36%.
- For 250% to 300% it is between 8.36% and 9.86%.
- For 300% to 400% it is 9.86%

Table IV.4 presents the maximum premium paid by APTC eligible families for 2019.

**Table IV.4**
**2019 Maximum Premium Paid by APTC Eligible Families**

| FPL Range | FPL Mid-point | Percent of Income | Annual Premium | | Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Single at $12,490 | Additional at $4,420 | Single at $12,490 | Additional at $4,420 |
| 133% to 150% | 144% | 3.69% | $664.41 | $235.12 | $55.37 | $19.59 |
| 150% to 200% | 175% | 5.35% | $1,168.28 | $413.44 | $97.36 | $34.45 |
| 200% to 250% | 225% | 7.45% | $2,093.64 | $740.90 | $174.47 | $61.74 |
| 250% to 400% | 325% | 9.52% | $3,862.38 | $1,366.83 | $321.86 | $113.90 |

If there is one person in a family, the single premium is used. If there is more than one family member, the family premium is increased by the additional amount for each additional family member. For example, as can be seen from Table IV.4, a family of 4 at the 200% to 250% of FPL income level, the annual family premium would be $2,093.64 plus 3 times $740.90 or $4,316.34 for the year, which would be a monthly premium of $359.70.

The CSR levels are the key to the FPLs used in the calculation.

**138%-150% FPL** = 94% Actuarial Value (CSR 94)
**150%-200% FPL** = 87% Actuarial Value (CSR 87)
**200%-250% FPL** = 73% Actuarial Value (CSR 73)

Families between the 250% and 400% FPL are eligible for APTCs, but not CSRs. According to CCIIO's 2018 report approximately forty-six percent of these families are in the lower category (250% to 300%) and the other fifty-four percent are in the second (300% to 400%).

## *Calculation of the APTC*

An individual's APTC is the difference between the second lowest cost Silver plan in the region for the individual's age and the maximum premium for an individual. For a family it is the sum of all of the second lowest cost Silver plans in the region for the individual's age for each individual and the maximum family premium.

[87] "Rev. Proc. 2018-34, IRS update of the Applicable Percentage." Internal Revenue Service. https://www.irs.gov/pub/irs-drop/rp-18-34.pdf . Accessed April 4, 2019.
[88] Note families between 0%-133% FPL are covered under Medicaid.

For the waiver scenario, the APTC is reduced because the second lowest Silver premium for each region is reduced due to the reinsurance. The reinsurance lowers the premiums for all plans, but the second lowest Silver plan is the one that impacts the APTC. NovaRest assumed that the premium reduction was the same percentage for all plans due to the single risk pool requirement.[89] The difference in the premiums for the second lowest Silver plans with and without the reinsurance is the difference in the APTC between the two scenarios. This is the amount that CMS will save in APTC and that can be applied to the reinsurance funding.

The amount that the federal government can contribute and remain budget neutral is the savings from the reduced APTCs less the loss of the exchange user fees. Exchange user fees for the individual market are 2.5% of premium paid on exchange plans in 2019.[90] When the premium is reduced, this income to the federal government is also reduced. The amount of federal budget savings is the reduction in APTC less the exchange user fees. For example, if APTC has a 15% reduction in premiums, the net amount of savings to the federal government is 15% less the 2.5% or 12.5%.

## *Calculation of the Federal Savings Available for Pass-Through Funding*

The reduced APTC saves the federal government money. To offset this savings are some potential losses to income for the federal government.

The shared responsibility or individual mandate penalty would be reduced if individuals remain insured rather than becoming uninsured and subject to the penalty. In December 2017, Republican lawmakers passed H.R.1, the Tax Cuts and Jobs Act, which repealed the individual mandate penalty.[91] The repeal is effective for the 2019 plan year. Therefore, there is no impact on the federal deficit for individuals becoming insured for the period of the Michigan Waiver.

The Patient-Centered Outcomes Research Institute (PCORI) fee payable to the federal government is based on enrollment. This fee is only applicable for plan years ending between October 1, 2012 and October 1, 2019.[92] Since the fee is not applicable in 2021, it will not impact the federal deficit for the period of the Michigan Waiver.

[89] Rate increases are rarely the same for all plans due to changes such as changes in morbidity that vary between plans and geographic factor changes. It is not possible to predict these types of factors with an appropriate amount of accuracy.
[90] "HHS Notice of Benefit and Payment Parameters for 2020." The Centers for Medicare & Medicaid Services. January 24, 2019. https://www.federalregister.gov/documents/2019/01/24/2019-00077/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020 . Accessed March 28, 2019.
[91] Norris, Louise. "With the GOP tax bill and the president's 2017 executive order, will the IRS still enforce the individual mandate penalty?" HealthInsurance.org. January 22, 2018. https://www.healthinsurance.org/faqs/does-the-presidents-executive-order-mean-the-irs-wont-enforce-the-individual-mandate-penalty/ . Accessed April 9, 2019.
[92] "Patient-Centered Outcomes Research Institute Fee." Internal Revenue Service. June 6, 2018. https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee . Accessed April 9, 2019.

The Health Insurance Providers Fee (HIF) for 2018 was an annual amount of $14.3 billion.[93] There is a moratorium for the HIF in 2019. For 2020 and beyond, the applicable amount is the amount in the preceding fee year increased by the rate of premium growth of covered entities (within the meaning of section 36B(b)(3)(A)(ii)).

A covered entity is generally any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under subchapter L, Part I or II, or that would be subject to tax under subchapter L, Part I or II, but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).[94]

The fee is assessed as a percentage of net premium. For entities with less than $25,000,000 no fee will be assessed.[95] For entities with net premium between $25,000,000 and $49,999,999, 50% of the net premiums will be taken into account and for entities with over $50,000,000 in net premium, the total net premium will be taken into account.[96] If the Waiver reduces premiums enough to impact the national premium growth rate, the HIF collected by the federal government would be reduced. Otherwise since the HIF is a national budgeted amount, the Waiver will not impact the HIF. We assume that the waiver program in Michigan, which only impacts the individual ACA market, will not, by itself, decrease the national premium growth rate and therefore will have no impact on the federal deficit.

Since the Michigan 1332 individual market waiver will not have a measurable impact on the federal deficit, it will not be considered in determining the federal deficit neutrality.

The Exchange User Fee is a federally mandated fee used to fund the federal and state exchanges. Because Michigan did not establish a state-based exchange, the exchange is facilitated by the federal government. The fee is calculated as a percent of on-exchange premiums.[97] Although the fee is calculated on on-exchange business, it is included in the premium for all non-grandfathered on-and-off exchange ACA business. The current fee rate in the individual market is 2.5%.[98]

[93] "Affordable Care Act Provision 9010 - Health Insurance Providers Fee." Internal Revenue Service. September 4, 2018. https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010 . Accessed April 9, 2019.
[94] Ibid.
[95] Ibid.
[96] Ibid.
[97] "HHS announces applicable user fees." Blue Cross Blue Shield Blue Care Network of Michigan. May 6, 2013. https://www.bcbsm.com/health-care-reform/reform-alerts/hhs-announces-applicable-user-fees1.html . Accessed April 9, 2019.
[98] "HHS Notice of Benefit and Payment Parameters for 2020." The Centers for Medicare & Medicaid Services. January 24, 2019. https://www.federalregister.gov/documents/2019/01/24/2019-00077/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020 . Accessed March 28, 2019.

**Table IV.5**
**Budget Neutrality Projection, 2021-2030**

| **Base** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** | **2030** |
|---|---|---|---|---|---|---|---|---|---|---|
| **APTC Agg Prem** | $1,193,823,842 | $1,249,933,563 | $1,308,680,440 | $1,370,188,421 | $1,435,957,465 | $1,507,755,338 | $1,577,112,084 | $1,649,659,240 | $1,725,543,565 | $1,804,918,569 |
| **APTC Max Prem** | $324,711,947 | $331,206,186 | $337,830,310 | $344,586,916 | $351,478,654 | $358,508,227 | $365,678,392 | $372,991,960 | $380,451,799 | $388,060,835 |
| **Total APTC** | $869,111,895 | $918,727,377 | $970,850,130 | $1,025,601,505 | $1,084,478,811 | $1,149,247,111 | $1,211,433,692 | $1,276,667,280 | $1,345,091,766 | $1,416,857,734 |
| **Scenario 1 $90,000 Attach, 50% Coins** | | | | | | | | | | |
| **APTC Agg Prem** | $1,074,441,457 | $1,124,940,205 | $1,177,812,395 | $1,233,169,578 | $1,292,361,717 | $1,356,979,803 | $1,419,400,874 | $1,484,693,314 | $1,552,989,207 | $1,624,426,710 |
| **APTC Max Prem** | $324,711,947 | $331,206,186 | $337,830,310 | $344,586,916 | $351,478,654 | $358,508,227 | $365,678,392 | $372,991,960 | $380,451,799 | $388,060,835 |
| **Total APTC** | $749,729,510 | $793,734,019 | $839,982,085 | $888,582,662 | $940,883,063 | $998,471,576 | $1,053,722,482 | $1,111,701,355 | $1,172,537,408 | $1,236,365,875 |
| **APTC Savings** | $119,382,385 | $124,993,357 | $130,868,045 | $137,018,843 | $143,595,748 | $150,775,535 | $157,711,210 | $164,965,925 | $172,554,358 | $180,491,858 |
| **Exchange Fee Reduction** | $3,425,572 | $3,558,865 | $3,698,978 | $3,846,211 | $4,004,146 | $4,177,048 | $4,344,670 | $4,520,443 | $4,704,728 | $4,897,902 |
| **Net Federal Savings** | $115,956,813 | $121,434,492 | $127,169,067 | $133,172,632 | $139,591,602 | $146,598,487 | $153,366,540 | $160,445,482 | $167,849,630 | $175,593,956 |
| **Scenario 2 $50,000 Attach 55% Coins** | | | | | | | | | | |
| **APTC Agg Prem** | $955,059,075 | $999,946,852 | $1,046,944,354 | $1,096,150,739 | $1,148,765,974 | $1,206,204,273 | $1,261,689,669 | $1,319,727,394 | $1,380,434,854 | $1,443,934,858 |
| **APTC Max Prem** | $324,711,947 | $331,206,186 | $337,830,310 | $344,586,916 | $351,478,654 | $358,508,227 | $365,678,392 | $372,991,960 | $380,451,799 | $388,060,835 |
| **Total APTC** | $630,347,128 | $668,740,666 | $709,114,044 | $751,563,823 | $797,287,320 | $847,696,045 | $896,011,277 | $946,735,434 | $999,983,055 | $1,055,874,023 |
| **APTC Savings** | $238,764,767 | $249,986,711 | $261,736,086 | $274,037,682 | $287,191,491 | $301,551,066 | $315,422,415 | $329,931,846 | $345,108,710 | $360,983,711 |
| **Exchange Fee Reduction** | $7,086,047 | $7,347,347 | $7,622,432 | $7,911,895 | $8,222,773 | $8,563,486 | $8,894,231 | $9,241,389 | $9,605,678 | $9,987,850 |
| **Net Federal Savings** | $231,678,720 | $242,639,363 | $254,113,654 | $266,125,787 | $278,968,718 | $292,987,580 | $306,528,184 | $320,690,457 | $335,503,033 | $350,995,862 |

# Ten Year Projections

## Assumptions

NovaRest used the metal level elasticities of demand provided in a Society of Actuaries training session against the National Health Expenditure Projections.[99] We assumed members will decrease their level of coverage prior to becoming uninsured.

To project the 2021 premiums that resulted from the NRMM modeling, NovaRest used historic changes in FPL and National Health Expenditure Projections.[100] For the FPL increase, we used 2%.

The National Health Expenditure Projections show a 3.2% health care cost increase from 2019 to 2021 and ranges from 4.6% to 5.2% thereafter as shown in Appendix A. The NRMM model output premium was trended from 2019 to 2030 using the National Health Expenditure Projections for both the base projections and the Waiver projections. Two Waiver scenarios were modeled. Scenario 1 used a $90,000 attachment point with a 50% coinsurance for the reinsurance up to $250,000, and Scenario 2 used a $50,000 attachment point with a 55% coinsurance up to $250,000.

## Process

Projections were done for membership and premium Per Member Per Month (PMPM) for the following categories:[101]

- 94% CSR (133% to 150% FPL)
- 87% CSR (150% to 200% FPL)
- 73% CSR (200% to 250% FPL)
- APTC (250% to 300% FPL)
- APTC (300% to 400% FPL)
- Total Non- APTC (> 400% FPL)
- Off-Exchange
- Uninsured

The 2019 NRMM model output is used to project the 2019 base line and the following ten years. NovaRest reviewed the CCIIO public use files[102] to determine a membership trend for the CSR and APTC not CSR levels. The CCIIO data did not show a consistent pattern of subsidized enrollment. NovaRest also reviewed historic trends in Michigan for on-exchange non-subsidized membership and off-exchange membership. The increase in the off-exchange membership was

[99] "Session 76 L, Understanding Stakeholder Behavior: Hidden Forces in the U.S. Healthcare System." Society of Actuaries. https://www.soa.org/pd/events/2017/health-meeting/pd-2017-06-health-session-076.pdf . Accessed April 9, 2019.
[100] "National Health Expenditure Projections 2017-2026." The Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf . Accessed April 9, 2019.
[101] Since Michigan expanded Medicaid to 133% FPL, a project of the population under 133% FPL was not necessary.
[102] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services

primarily driven by individuals leaving Grandfathered and Transitional policies and did not appear to be a good predictor of the future. Again, the historic pattern could not be used. It was decided to use a steady state in membership for the 10-year projections for subsidized APTC members. The NRMM model does show decreasing membership for the non-APTC members due to increasing premiums.

NovaRest used the National Health Expenditure Projections[103] for health care spending increases. These projections showed a 3.2% health care cost increase from 2019 to 2020 and ranges from 4.6% to 5.2% thereafter.

## *Projections*

The ten-year projections for the base line and for the two potential reinsurance attachment points are included in the three tables that follow.

[103] "Projected." Centers for Medicare & Medicaid Services. August 1, 2018. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html . Accessed April 9, 2019.

| Table IV.6<br>2021-2030 Base Line Without Waiver | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Membership** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** | **2030** |
| On Exchange | | | | | | | | | | |
| 94% CSR | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 |
| 87% CSR | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 |
| 73% CSR | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 |
| APTC 250%-300% | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 |
| APTC 300%-400% | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 |
| Total APTC | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 |
| Total Non-APTC | 47,345 | 44,291 | 41,448 | 38,799 | 36,276 | 33,830 | 31,739 | 29,785 | 27,958 | 26,249 |
| **Total On-Exchange** | **218,149** | **215,095** | **212,252** | **209,603** | **207,080** | **204,634** | **202,543** | **200,589** | **198,762** | **197,053** |
| Off Exchange | 109,127 | 104,445 | 99,982 | 95,723 | 91,569 | 87,440 | 83,819 | 80,352 | 77,033 | 73,852 |
| **Total ACA** | **327,276** | **319,541** | **312,234** | **305,325** | **298,650** | **292,074** | **286,362** | **280,942** | **275,795** | **270,905** |
| **Average Premium** | | | | | | | | | | |
| On Exchange | | | | | | | | | | |
| APTC Agg Prem | $582.45 | $609.83 | $638.49 | $668.50 | $700.59 | $735.62 | $769.46 | $804.85 | $841.87 | $880.60 |
| APTC Max Prem | $158.42 | $161.59 | $164.82 | $168.12 | $171.48 | $174.91 | $178.41 | $181.98 | $185.62 | $189.33 |
| APTC | $424.03 | $448.24 | $473.67 | $500.38 | $529.10 | $560.70 | $591.04 | $622.87 | $656.26 | $691.27 |
| Non-APTC | $476.93 | $500.56 | $525.31 | $551.24 | $578.99 | $609.31 | $638.63 | $669.31 | $701.45 | $735.10 |
| **Total On-Exchange** | **$559.55** | **$587.33** | **$616.39** | **$646.79** | **$679.29** | **$714.74** | **$748.95** | **$784.72** | **$822.12** | **$861.22** |
| Off Exchange | $558.63 | $585.85 | $614.27 | $643.97 | $675.67 | $710.22 | $743.53 | $778.34 | $814.71 | $852.71 |
| **Total ACA** | **$559.25** | **$586.84** | **$615.71** | **$645.91** | **$678.18** | **$713.38** | **$747.37** | **$782.90** | **$820.05** | **$858.90** |
| **Total Premium** | | | | | | | | | | |
| Total APTC Agg Prem | $1,193,823,842 | $1,249,933,563 | $1,308,680,440 | $1,370,188,421 | $1,435,957,465 | $1,507,755,338 | $1,577,112,084 | $1,649,659,240 | $1,725,543,565 | $1,804,918,569 |
| Total APTC Max Prem | $324,711,947 | $331,206,186 | $337,830,310 | $344,586,916 | $351,478,654 | $358,508,227 | $365,678,392 | $372,991,960 | $380,451,799 | $388,060,835 |
| Total APTC | $869,111,895 | $918,727,377 | $970,850,130 | $1,025,601,505 | $1,084,478,811 | $1,149,247,111 | $1,211,433,692 | $1,276,667,280 | $1,345,091,766 | $1,416,857,734 |
| Total Non-APTC | $270,962,709 | $266,045,087 | $261,275,249 | $256,646,911 | $252,042,511 | $247,355,573 | $243,235,117 | $239,229,140 | $235,333,598 | $231,544,703 |
| **Total On Exchange** | **$1,464,786,551** | **$1,515,978,650** | **$1,569,955,689** | **$1,626,835,332** | **$1,687,999,976** | **$1,755,110,911** | **$1,820,347,200** | **$1,888,888,380** | **$1,960,877,163** | **$2,036,463,272** |
| Off Exchange | $731,541,657 | $734,265,337 | $736,989,976 | $739,709,745 | $742,446,133 | $745,215,766 | $747,865,956 | $750,497,130 | $753,107,344 | $755,695,107 |
| **Total ACA** | **$2,196,328,207** | **$2,250,243,987** | **$2,306,945,666** | **$2,366,545,076** | **$2,430,446,109** | **$2,500,326,677** | **$2,568,213,157** | **$2,639,385,510** | **$2,713,984,507** | **$2,792,158,379** |

## Table IV.7
## 2021-2030 Scenario 1: $90,000 Attachment Point and 50% Coinsurance

| **Membership** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** | **2030** |
|---|---|---|---|---|---|---|---|---|---|---|
| On Exchange | | | | | | | | | | |
| 94% CSR | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 |
| 87% CSR | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 |
| 73% CSR | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 |
| APTC 250%-300% | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 |
| APTC 300%-400% | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 |
| Total APTC | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 |
| Total Non-APTC | 49,280 | 46,097 | 43,133 | 40,371 | 37,742 | 35,192 | 33,013 | 30,976 | 29,072 | 27,291 |
| **Total On-Exchange** | **220,084** | **216,901** | **213,937** | **211,175** | **208,546** | **205,996** | **203,817** | **201,780** | **199,876** | **198,095** |
| Off Exchange | 114,639 | 109,593 | 104,791 | 100,216 | 95,762 | 91,341 | 87,470 | 83,771 | 80,234 | 76,850 |
| **Total ACA** | **334,723** | **326,494** | **318,727** | **311,391** | **304,308** | **297,336** | **291,287** | **285,551** | **280,110** | **274,945** |
| **Average Premium** | | | | | | | | | | |
| On Exchange | | | | | | | | | | |
| APTC Agg Prem | $524.21 | $548.85 | $574.64 | $601.65 | $630.53 | $662.06 | $692.51 | $724.37 | $757.69 | $792.54 |
| APTC Max Prem | $158.42 | $161.59 | $164.82 | $168.12 | $171.48 | $174.91 | $178.41 | $181.98 | $185.62 | $189.33 |
| APTC | $365.78 | $387.25 | $409.82 | $433.53 | $459.05 | $487.14 | $514.10 | $542.39 | $572.07 | $603.21 |
| Non-APTC | $428.37 | $449.57 | $471.77 | $495.03 | $519.92 | $547.12 | $573.41 | $600.93 | $629.76 | $659.93 |
| **Total On-Exchange** | **$502.75** | **$527.75** | **$553.90** | **$581.27** | **$610.51** | **$642.42** | **$673.22** | **$705.42** | **$739.08** | **$774.27** |
| Off Exchange | $501.13 | $525.57 | $551.11 | $577.79 | $606.28 | $637.32 | $667.27 | $698.55 | $731.24 | $765.41 |
| **Total ACA** | **$502.19** | **$527.02** | **$552.98** | **$580.15** | **$609.18** | **$640.85** | **$671.43** | **$703.40** | **$736.83** | **$771.79** |
| **Total Premium** | | | | | | | | | | |
| Total APTC Agg Prem | $1,074,441,457 | $1,124,940,205 | $1,177,812,395 | $1,233,169,578 | $1,292,361,717 | $1,356,979,803 | $1,419,400,874 | $1,484,693,314 | $1,552,989,207 | $1,624,426,710 |
| Total APTC Max Prem | $324,711,947 | $331,206,186 | $337,830,310 | $344,586,916 | $351,478,654 | $358,508,227 | $365,678,392 | $372,991,960 | $380,451,799 | $388,060,835 |
| Total APTC | $749,729,510 | $793,734,019 | $839,982,085 | $888,582,662 | $940,883,063 | $998,471,576 | $1,053,722,482 | $1,111,701,355 | $1,172,537,408 | $1,236,365,875 |
| Total Non-APTC | $253,322,199 | $248,683,851 | $244,184,177 | $239,817,298 | $235,472,432 | $231,049,205 | $227,159,525 | $223,377,328 | $219,698,826 | $216,120,469 |
| **Total On Exchange** | **$1,327,763,656** | **$1,373,624,056** | **$1,421,996,572** | **$1,472,986,876** | **$1,527,834,149** | **$1,588,029,008** | **$1,646,560,399** | **$1,708,070,642** | **$1,772,688,033** | **$1,840,547,180** |
| Off Exchange | $689,386,163 | $691,190,546 | $693,012,610 | $694,846,467 | $696,696,209 | $698,562,828 | $700,394,376 | $702,222,101 | $704,043,822 | $705,857,795 |
| **Total ACA** | **$2,017,149,819** | **$2,064,814,602** | **$2,115,009,182** | **$2,167,833,343** | **$2,224,530,359** | **$2,286,591,836** | **$2,346,954,775** | **$2,410,292,743** | **$2,476,731,855** | **$2,546,404,975** |

| Table IV.8<br>2021-2030 Scenario 2: $50,000 Attachment Point and 55% Coinsurance | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Membership** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** | **2030** |
| On Exchange | | | | | | | | | | |
| 94% CSR | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 | 34,961 |
| 87% CSR | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 | 45,110 |
| 73% CSR | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 | 25,202 |
| APTC 250%-300% | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 | 30,144 |
| APTC 300%-400% | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 | 35,386 |
| Total APTC | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 | 170,804 |
| Total Non-APTC | 49,565 | 46,363 | 43,381 | 40,603 | 37,958 | 35,393 | 33,201 | 31,152 | 29,236 | 27,444 |
| **Total On-Exchange** | **220,369** | **217,167** | **214,185** | **211,407** | **208,762** | **206,197** | **204,005** | **201,956** | **200,040** | **198,248** |
| Off Exchange | **118,825** | **113,504** | **108,444** | **103,628** | **98,945** | **94,301** | **90,240** | **86,362** | **82,657** | **79,117** |
| **Total ACA** | **339,194** | **330,671** | **322,629** | **315,035** | **307,707** | **300,497** | **294,245** | **288,318** | **282,698** | **277,366** |
| **Average Premium** | | | | | | | | | | |
| On Exchange | | | | | | | | | | |
| APTC Agg Prem | $465.96 | $487.86 | $510.79 | $534.80 | $560.47 | $588.49 | $615.56 | $643.88 | $673.50 | $704.48 |
| APTC Max Prem | $158.42 | $161.59 | $164.82 | $168.12 | $171.48 | $174.91 | $178.41 | $181.98 | $185.62 | $189.33 |
| APTC | $307.54 | $326.27 | $345.97 | $366.68 | $388.99 | $413.58 | $437.15 | $461.90 | $487.88 | $515.15 |
| Non-APTC | $380.45 | $399.27 | $418.99 | $439.64 | $461.74 | $485.90 | $509.24 | $533.68 | $559.28 | $586.08 |
| **Total On-Exchange** | **$446.73** | **$468.95** | **$492.20** | **$516.52** | **$542.52** | **$570.88** | **$598.26** | **$626.88** | **$656.80** | **$688.09** |
| Off Exchange | $444.33 | $466.00 | $488.65 | $512.31 | $537.58 | $565.13 | $591.69 | $619.45 | $648.47 | $678.79 |
| **Total ACA** | **$445.89** | **$467.94** | **$491.00** | **$515.14** | **$540.93** | **$569.08** | **$596.25** | **$624.66** | **$654.37** | **$685.43** |
| **Total Premium** | | | | | | | | | | |
| Total APTC Agg Prem | $955,059,075 | $999,946,852 | $1,046,944,354 | $1,096,150,739 | $1,148,765,974 | $1,206,204,273 | $1,261,689,669 | $1,319,727,394 | $1,380,434,854 | $1,443,934,858 |
| Total APTC Max Prem | $324,711,947 | $331,206,186 | $337,830,310 | $344,586,916 | $351,478,654 | $358,508,227 | $365,678,392 | $372,991,960 | $380,451,799 | $388,060,835 |
| Total APTC | $630,347,128 | $668,740,666 | $709,114,044 | $751,563,823 | $797,287,320 | $847,696,045 | $896,011,277 | $946,735,434 | $999,983,055 | $1,055,874,023 |
| Total Non-APTC | $226,285,603 | $222,137,902 | $218,114,047 | $214,208,795 | $210,323,098 | $206,367,202 | $202,888,307 | $199,505,431 | $196,215,195 | $193,014,432 |
| **Total On Exchange** | **$1,181,344,679** | **$1,222,084,754** | **$1,265,058,401** | **$1,310,359,534** | **$1,359,089,072** | **$1,412,571,475** | **$1,464,577,976** | **$1,519,232,825** | **$1,576,650,049** | **$1,636,949,290** |
| Off Exchange | $633,570,927 | $634,717,839 | $635,890,528 | $637,083,535 | $638,289,878 | $639,500,596 | $640,730,552 | $641,965,655 | $643,203,785 | $644,443,211 |
| **Total ACA** | **$1,814,915,606** | **$1,856,802,594** | **$1,900,948,929** | **$1,947,443,069** | **$1,997,378,950** | **$2,052,072,071** | **$2,105,308,528** | **$2,161,198,480** | **$2,219,853,834** | **$2,281,392,500** |

# Analysis Process and Assumptions

## Data

### Carrier Data Call

With the assistance of DIFS, NovaRest sent a data call to Michigan carriers that DIFS selected based on market presence. The list of carriers is provided in Table IV.9. The table also provides a reason why a carrier was not included. The data call requested data for fully compliant individual market ACA policies in years 2014 to 2018, as well as for grandfathered and transitional plans. The data for 2018 was only for 6 months, through June 2018. We requested enrollment, premium, claims, and advanced premium tax credit (APTC) information. Since health insurance buying decisions are family based, we requested the information needed to group individuals into families. Data on membership and average premium was also provided by Cost Sharing Reduction (CSR) and metal level.

**Table IV.9**
**Carrier Data Request**

| Company | Used in Study | Reason not used |
|---|---|---|
| Aetna Life Insurance Company | Y | |
| All Savers Insurance Company | N | No Individual Business |
| Alliance Health & Life | Y | |
| Blue Care Network (BCN) | Y | |
| Blue Cross Blue Shield of Michigan (BCBSM) | Y | |
| Freedom Life Insurance Company of America | N | No Individual Business |
| Golden Rule Insurance Co | N | No Individual Business |
| Harbor Health Plan | N | Minimum membership amount |
| HAP | Y | |
| Humana Insurance Company | Y | |
| Humana Med Plan of Michigan | Y | |
| McLaren Health Plan Community | Y | |
| Meridian Health Plan of Michigan | Y | |
| Molina Healthcare of Michigan | Y | |
| Physicians Health Plan (PHP) | Y | |
| Priority Health | Y | |
| Priority Health Insurance Company | Y | |
| Total Health Care USA | Y | |
| UnitedHealthcare Community Plan (UHCCP) | Y | |
| UnitedHealthcare Life Insurance Company (UHCLIC) | Y | |

NovaRest performed a data call for the individual market carriers and identified the number of members in each of the following FPL ranges. Those from 0% of the FPL to 133% of the FPL are covered by Medicaid. Members are eligible for APTC up to 400% FPL. Members at the 100% CSR level who are eligible for APTC (of which there were 1,006 according to the data call) were evenly distributed between the 133% to 400% FPL ranges. For members eligible for ATPC but not CSR, 46% were allocated to the 250%-300% FPL level and 54% were allocated to the 300%-400% CSR level based on 2018 Consumer Information and Insurance Oversight (CCIIO) data.[104]

### *Individual Files*

The data provided is for fully compliant ACA policies. The individual file was used to simulate a decision-making process to predict market migration based on rate increases. Since health insurance buying decisions are family based, NovaRest requested information that allowed individuals to be grouped into families when modeling the decision-making process.

The individual files contained a record for each covered individual as of December 31 for 2017, and June 30 for 2018. Data includes premium and claim information, data on individuals such as date of birth, plan information, any cost sharing reductions (CSR) or APTC for which they are eligible. The 2018 file did not include claim information as claim data was not complete at the time of the data request.

### *Historic Claim Distributions*

This data requested information for ACA-compliant policies only. NovaRest received data from years 2014 to 2017. Following is a list of all claim ranges:

- Under $50,000
- $50,000 to $99,999
- $100,000 to $199,999
- $200,000 to $499,999
- $500,000 to $749,999
- $750,000 to $999,999
- $1,000,000 to $1,249,999
- $1,250,000 to $1,499,999
- over $1,500,000

### *Historic Membership and Premium Information*

This data included membership and premium information for ACA-compliant, transitional, grandfathered, short-term duration health plans, and association health plans.

[104] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html . Accessed April 9, 2019.

### *CCIIO Public Reports*

NovaRest used public reports on the CCIIO website to estimate the membership changes in the Michigan CSR and APTC populations over time.[105]

### *Rate Filing Information*

NovaRest used 2018 and 2019 rate filing information from:

- Alliance Health and Life Insurance Company
- Blue Care Network of Michigan
- Blue Cross Blue Shield of Michigan
- Health Alliance Plan
- McLaren Health Plan Community
- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan, Inc.
- Oscar Insurance Company
- Physician's Health Plan
- Priority Health
- Total Health Care USA

The Unified Rate Review Templates (URRTs) include the plan metal levels and indicate if the plans were offered on-and-off exchange or off-exchange only. The Rate Templates were used to access the 2018 and 2019 premium rates.

## *2019 and 2020 Market Projections*

The data for individuals covered in 2017 and through June 2018 included a record for each individual and information that allowed individuals to be grouped into families.

Family information is needed because the maximum amount that individuals pay when eligible for APTC is based on family size and family income. Also, decisions to shop for other coverage based on rate increases is a family decision rather than an individual decision for those with families.

Individuals that were eligible for 94% CSR, 87% CSR, 73% CSR and APTC non-CSR were determined to be the ones most likely to retain coverage. Although many circumstances can arise that result in turnover in this market segment, such as becoming employed by an employer that offers health insurance or moving out of state, in general Michigan has seen an increase in the 94% CSR, 87% CSR, 73% CSR membership. NovaRest found that individuals eligible for APTC, but not CSR, were in Gold, Silver and Bronze metal levels. NovaRest again assumed that these individuals were likely to retain their coverage, unless obtaining employer coverage or moving. Since NovaRest cannot predict employment or moving out-of-state, we treated these members as a stable block.

[105] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html . Accessed April 9, 2019.

For non-APTC individuals, total family claims cost was also calculated to determine the probability of a family retaining coverage even when faced with large rate increases.

For all other individuals NovaRest used the elasticity of demand for each metal level from a Society of Actuaries (SOA) training session[106], which was consistent with other reports on elasticity that we have reviewed. The elasticity estimates the percentage of membership that will shop for other coverage based on the percent of rate increase. Based on the rate increase for Gold level individuals, a percentage will decide to shop for alternative coverage. Those that decide to shop may decide to purchase Silver coverage, based on the difference in the current Gold level premium and the Silver coverage. Others may find the Silver coverage too expensive and may look at Silver off-exchange coverage, Bronze coverage, or may decide to drop coverage and become uninsured.

It was assumed that all non-subsidized individuals that currently have Platinum, Gold or Silver plans would not select on-exchange Silver plans, but rather would shop for off-exchange Silver plans. This is due to the decision to allow loading of CSR costs into the on-exchange Silver plans starting in 2018, which raised Silver on-exchange premiums significantly. Otherwise, we assume that if a member purchased their current coverage on-exchange and decided to seek alternative coverage, they would shop on-exchange and if they purchased current coverage off-exchange, they would seek alternative coverage off-exchange.

Individuals in Catastrophic coverage may age out or, based on the rate increase, decide to drop coverage and become uninsured. For the loss of membership due to aging, NovaRest used a steady state and decided that the individuals aging out would be replaced by new entrants. For the portion of the individuals deciding to drop coverage, NovaRest used a Catastrophic-specific elasticity from the SOA training session.

NovaRest used its proprietary migration model (NRMM) to project the movement between the metal levels and individuals becoming uninsured without a waiver (base line scenario), with the Waiver with a $90,000 attachment point and 50% coinsurance (Scenario 1), and with the Waiver with a $50,000 attachment point and 55% coinsurance (Scenario 2). This allowed NovaRest to project the number of individuals that would be covered by health insurance under base line and the two alternative scenarios. The NRMM aggregates individuals into families and performs an analysis, using elasticity assumptions, of the likelihood of the individual and families staying with their current plan, shopping for a less expensive option or becoming uninsured. The NRMM projects the 2019 membership and increases in the uninsured with and without the reinsurance under the 1332 Waiver.

The migration model provides the 2019 APTC membership, non-APTC membership on and off the exchange and the increase in the uninsured. Using the projected 2019 membership and the rates filed by the eleven carriers for 2019, NovaRest calculated the average premium for APTC and Non-APTC without the waiver's reinsurance. The 2019 Membership and average premiums

[106] "Session 76 L, Understanding Stakeholder Behavior: Hidden Forces in the U.S. Healthcare System." Society of Actuaries. June 2017. https://www.soa.org/pd/events/2017/health-meeting/pd-2017-06-health-session-076.pdf . Accessed April 9, 2019.

are shown for the base line and the two waiver scenarios. Note that the off-exchange membership jumps in 2021 assuming transition policies going away. If rules change allowing extension of transition plans into 2021 or beyond, these projections would need to be updated.

**Table IV.10**
**2019 and 2020 Projections**

| | 2019 | 2020 |
|---|---|---|
| **Membership** | | |
| On Exchange | | |
| 94% CSR (133% to 150% FPL) | 34,961 | 34,961 |
| 87% CSR (150% to 200% FPL) | 45,110 | 45,110 |
| 73% CSR (200% to 250% FPL) | 25,202 | 25,202 |
| APTC (250% to 300% FPL) | 30,144 | 30,144 |
| APTC (300% to 400% FPL) | 35,386 | 35,386 |
| Total APTC | 170,804 | 170,804 |
| Total Non- APTC (> 400%) | 53,367 | 51,004 |
| **Total On-Exchange** | **224,171** | **221,808** |
| Off Exchange | 105,275 | 102,370 |
| **Total ACA** | **329,446** | **324,178** |
| **Average Premium** | | |
| On Exchange | | |
| APTC Aggregate Premium | $536.49 | $553.66 |
| APTC Maximum Premium Paid | $152.27 | $155.32 |
| APTC | $384.22 | $398.35 |
| Non-APTC | $437.30 | $452.08 |
| Total On-Exchange | **$512.88** | **$530.30** |
| Off Exchange | $517.24 | $534.52 |
| **Total ACA** | **$514.27** | **$531.63** |
| **Total Annual Premium** | | |
| Total APTC Aggregate Premium | $1,099,625,521 | $1,134,813,538 |
| Total APTC Maximum Premium Paid | $312,102,986 | $318,345,046 |
| Total APTC | $787,522,535 | $816,468,492 |
| Total Non-APTC | $280,050,873 | $276,691,683 |
| **Total On-Exchange Premium** | **$1,379,676,394** | **$1,411,505,222** |
| Off Exchange | $653,429,109 | $656,622,317 |
| **Total ACA** | **$2,033,105,503** | **$2,068,127,539** |

NovaRest estimates that if the Michigan 1332 Waiver is not implemented that there will be more than 2,170 additional uninsureds from 2019 to 2021.

## *Projection of 2021 Base Line Market*

The following table shows the 2021 1332 Waiver Base Line, compared to the 1332 Waiver alternatives. The base line was projected by taking the 2019 and 2020 NRMM model output and trending membership and premiums. NovaRest did not include the 100% FPL to 133% FPL, since they are covered by Medicaid in Michigan. NovaRest did not project changes in the subsidized population, but rather assumed a steady state for the subsidized population.

**Table IV.11a**
**2021 Membership Difference from Base Line**

| **Membership** | **2021** | | |
|---|---|---|---|
| | **Without Waiver** | **Scenario 1, $90,000 Attachment Point 50% Coins** | **Scenario 2, $50,000 Attachment Point 55% Coins** |
| On Exchange | | | |
| 94% CSR (138% to 150% FPL) | 34,961 | 34,961 | 34,961 |
| 87% CSR (150% to 200% FPL) | 45,110 | 45,110 | 45,110 |
| 73% CSR (200% to 250% FPL) | 25,202 | 25,202 | 25,202 |
| APTC (250% to 300% FPL) | 30,144 | 30,144 | 30,144 |
| APTC (300% to 400% FPL) | 35,386 | 35,386 | 35,386 |
| Total APTC | 170,804 | 170,804 | 170,804 |
| Total Non- APTC (> 400%) | 47,345 | 49,280 | 49,565 |
| **Total On-Exchange** | 218,149 | 220,084 | 220,369 |
| Off Exchange | 109,127 | 114,639 | 118,825 |
| **Total ACA** | 327,276 | 334,723 | 339,194 |

**Table IV.11b**
**2021 Premium Difference from Base Line**

| | 2021 | | |
|---|---|---|---|
| | **Without Waiver** | **Scenario 1, $90,000 Attachment Point 50% Coins** | **Scenario 2, $50,000 Attachment Point 55% Coins** |
| **Average Premium** | | | |
| On Exchange | | | |
| APTC Agg Premium Rate | $582.45 | $524.21 | $465.96 |
| APTC Max Premium Paid | $158.42 | $158.42 | $158.42 |
| APTC | $424.03 | $365.78 | $307.54 |
| Non-APTC | $476.93 | $428.37 | $380.45 |
| **Total On-Exchange** | $559.55 | $502.75 | $446.73 |
| Off Exchange | $558.63 | $501.13 | $444.33 |
| **Total ACA** | $559.25 | $502.19 | $445.89 |
| **Total Premium** | | | |
| On Exchange | | | |
| APTC Agg Premium Rate | $1,193,823,842 | $1,074,441,457 | $955,059,075 |
| APTC Max Premium Paid | $324,711,947 | $324,711,947 | $324,711,947 |
| APTC | $869,111,895 | $749,729,510 | $630,347,128 |
| Non-APTC | $270,962,709 | $253,322,199 | $226,285,603 |
| **Total On-Exchange** | $1,464,786,551 | $1,327,763,656 | $1,181,344,679 |
| Off Exchange | $731,541,657 | $689,386,163 | $633,570,927 |
| **Total ACA** | $2,196,328,207 | $2,017,149,819 | $1,814,915,606 |

The following table projects the 2021 age 40 non-smoker premium rates for the second lowest Silver plan.

**Table IV.12**
**2021 Second Lowest Silver Plans by Area, Age 40**

| Area | Without Waiver | Scenario 1: With $90,000 Attachment Point and 50% Coins | Scenario 2: With $50,000 Attachment Point and 55% Coins |
|---|---|---|---|
| Rating Area 1 | $346.82 | $312.14 | $277.46 |
| Rating Area 2 | $338.36 | $304.53 | $270.69 |
| Rating Area 3 | $432.26 | $389.04 | $345.81 |
| Rating Area 4 | $391.27 | $352.14 | $313.02 |
| Rating Area 5 | $375.93 | $338.33 | $300.74 |
| Rating Area 6 | $442.99 | $398.69 | $354.39 |
| Rating Area 7 | $390.95 | $351.86 | $312.76 |
| Rating Area 8 | $419.09 | $377.18 | $335.27 |
| Rating Area 9 | $470.30 | $423.27 | $376.24 |
| Rating Area 10 | $473.18 | $425.86 | $378.54 |
| Rating Area 11 | $491.46 | $442.31 | $393.17 |
| Rating Area 12 | $378.91 | $341.01 | $303.12 |
| Rating Area 13 | $470.66 | $423.60 | $376.53 |
| Rating Area 14 | $425.80 | $383.22 | $340.64 |
| Rating Area 15 | $439.20 | $395.28 | $351.36 |
| Rating Area 16 | $586.97 | $528.27 | $469.57 |

## *Reinsurance and Funding Needs Projection*

The reinsurance was calculated for several combinations of attachment point, coinsurance, and maximum claim level. Based on the results, DIFS is considering a $90,000 attachment point with a 50% coinsurance (Scenario 1) or $50,000 attachment point with a 55% coinsurance (Scenario 2), both with a maximum claim level for reinsurance of $250,000.

NovaRest used the National Health Expenditure Projections from 2019 and beyond because we considered it a reasonable trend and it had the endorsement of CMS. See the trend in Appendix A.

After researching the issue, NovaRest decided to equate paid claim cost reduction to premium reduction. Typically, premiums increase at a higher rate than claims due to deductible leveraging and changes in morbidity, as well as, influences such as changing geographic factors and network changes. When NovaRest reviewed Michigan's allowed and paid claim trends they did not follow typical patterns. Also, paid claim trends and premium trends did not follow typical patterns, so there was no apparent basis for converting claim reduction to premium reduction based on Michigan experience. Therefore, it was decided to use the simplifying assumption to equate reduction in claim costs to reduction in premium rates.

# V. Actuarial Certification

**Actuarial Certification**

In my opinion, the State of Michigan's proposed Section 1332 Waiver application complies with the following requirements:

- The coverage provided under this 1332 Waiver is at least as comprehensive as the coverage available absent the 1332 Waiver.
- The coverage provided under this 1332 Waiver is at least as affordable as the coverage available absent the 1332 Waiver.
- The 1332 Waiver will provide coverage to at least a comparable number of residents as would be available absent the 1332 Waiver.
- The 1332 Waiver will not increase the federal deficit.

This actuarial certification applies solely for the use of supporting Michigan's Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act. Michigan seeks a waiver of §1312(c)(1) of the Affordable Care Act, which requires all enrollees in all health plans offered by an insurance carrier in the individual market be members of a single risk pool. The intended users of this report are Michigan Department of Insurance and Financial Services. Distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by us and is done at their own risk.

**Reliance**

In the analysis described in this report, we relied on information provided by the insurers offering coverage in the Michigan individual health insurance market, information published by the federal government, and information provided by insurers offering coverage in the Individual market in Michigan.

We relied upon this information without independent investigation or audit. If information is inaccurate or incomplete, our findings and conclusions may need to be revised. We have reviewed the data for consistency and reasonableness. Where data was inconsistent or unreasonable, we requested clarification.

The actuarial methodologies utilized in order to arrive at our opinion were those considered generally accepted within the industry and are consistent with all applicable Actuarial Standards of Practice (ASOP).

I, Donna Novak, am the President and CEO of NovaRest Actuarial Consulting. I am an Associate in the Society of Actuaries, a Member of the American Academy of Actuaries, and I am qualified to render this opinion.

If you have any questions, do not hesitate to call me at 520-908-7246.

Sincerely,

Donna C. Novak

Donna C. Novak, FCA, ASA, MAAA, MBA

# VI. Appendices

| | | |
|---|---|---|
| Appendix A | Claim Trend Assumptions | Discussion on National Health Expenditure trends used in projections |
| Appendix B | Administrative Requirements for Michigan Reinsurance Program | Discussion on functions that will be needed in order to administer the Michigan reinsurance program. |
| Appendix C | Definitions and Abbreviations | Glossary |
| Appendix D | NRMM Model and Assumptions | Discussion on NovaRest Market Migration Model and Functionality |
| Appendix E | Qualifications | About the NovaRest model team |
| Appendix F | Reliance | Data reliance |
| Appendix G | Limitations | Limitations on the data received |

# *Appendix A – Claim Trend Assumptions*

**National Health Expenditure Projection Rates**

Table 17 of the NHE Projection data splits out spending for Private Insurance into Employer-Sponsored Insurance (ESI) and Direct Purchase.[107] Direct Purchase includes coverage purchased through the Marketplace along with other plans such as Medicare supplemental coverage and individually purchased plans. This category seems to be the best fit for projecting individual spending among the NHE data. It has been used for other 1332 Waiver applications such as Wisconsin and Oregon (which were approved by CMS). The current NHE Projection uses 2017 as the latest year with actual data and projects from 2017 through 2027.

The NHE trends, as shown in the table below, are allowed trends appropriate to project total claims costs.

Our model currently uses actual filed premiums in 2019 with projected membership for 2019 along with projected claims in 2018 and 2019 using the premium trends for 2018 and 2019. In 2021 and beyond we use the trends from the NHE per CMS guidance.[108]

| National Health Expenditure Trends (NHE Table 17 Health Spending by Source of Insurance Coverage Spending Direct Purchase) | |
|---|---|
| **Year** | **Annual Growth Rate** |
| 2020 | 3.2% |
| 2021 | 5.2% |
| 2022 | 4.7% |
| 2023 | 4.7% |
| 2024 | 4.7% |
| 2025 | 4.8% |
| 2026 | 5.0% |
| 2027+ | 4.6% |

[107] NHE Projections. Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html . Accessed April 4, 2019.

[108] "State Relief and Empowerment Waivers." Department of Health and Human Services. October 24, 2018. https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers. Accessed April 4, 2019.

# Appendix B - Administrative Requirements for Michigan Reinsurance Program

A number of functions will be needed in order to administer this program. Claims will have to be filed by the carriers and reinsurance reimbursements will have to be paid. Also, amounts will have to be collected from the federal government for APTC reductions and from the assessments against those identified in the legislation once it is finalized.

## Claims Processing

Carriers will provide claim information to the administrator once the initial attachment point is reached. The administrator will accumulate the claims and determine the reinsurance payment owed to the carrier.

Once the payment amount is determined, the administrator will verify that adequate funds are available and either pay the claim or notify the carrier that payment will be delayed.

The administrator will also monitor the total claims and notify the carrier once the maximum claim level is reached.

If funding becomes an issue, the administrator will have to monitor funding levels and pay claims as adequate funding is available.

## Funding Collections

It is NovaRest's understanding that federal APTC funds are made available in the first half of the year for the estimated annual funding amount. The administrator will need to coordinate with the appropriate federal office to ensure that funding is made available on a timely basis.

Assessments will be received on a periodic basis from those providing the additional funding needed for the program. The administrator will follow-up on assessments that are not received on a timely basis. NovaRest assumes that assessments will be based on premium or claim levels and therefore the assessed entities will calculate the assessment amount and not the administrator.

## Periodic Audits

The administrator should periodically audit both the carrier claim submission and the assessments. An audit can be done by the administrator or an outside vendor. An outside vendor would cost approximately $10,000.

The audit would verify that the carrier claims were processed appropriately and only included covered services.

Assessment audits would verify that the assessment base (premium, claims, etc.) was accurate and that the appropriate percentage was used to calculate the assessment.

## Miscellaneous Tasks

There will be various additional tasks such as opening banking accounts and balancing account statements.

Tasks would also include reporting requirements back to the State authority that is responsible for the reinsurance program, and to the federal authority, as required.

Relationship management will require an executive director level person to interact with the federal government, state legislators, carriers, and the public.

# *Appendix C - Definitions and Abbreviations*

**Allowed Claims -** The maximum amount a plan will pay for a covered health care service.

**Advance Premium Tax Credit "APTC" or "PTC"** – A tax credit taken by enrollee to lower monthly health insurance payment. The enrollee will estimate yearly income when they apply for coverage in the Health Insurance Marketplace. The APTC will be based on the estimate of the income entered.

**Centers for Medicare & Medicaid Services "CMS"** - The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

**Children's Health Insurance Program "CHIP"** - The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

**Cost Sharing** - The share of costs covered by an insurance plan that an enrollee will pay out of their pocket. In general, cost sharing includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

**Cost Sharing Reduction "CSR" -** A discount that lowers the amount an enrollee will have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called "extra savings".

**Essential Health Benefits "EHB"** - A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

**Federal Poverty Level "FPL"** - A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

**Health Insurance Marketplace "Marketplace" or "exchange"** http://www.healthcare.gov - A shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010. In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families.

**High-Risk Pool Plan -** States offer plans that provide coverage if an individual has been denied health insurance because of a pre-existing condition. High-risk pool plans offer health insurance coverage that is subsidized by a state government.

**Metal Level, Metal Plans or Metal Categories** - Plans in the Health Insurance Marketplace are presented in 4 "metal" categories: Bronze, Silver, Gold, and Platinum.

**Patient Protection and Affordable Care Act "ACA" or "Affordable Care Act" -** United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

**Per Member Per Month "PMPM" -** Per Member Per Month, or the average cost of services per individual per month.

**Premium -** A health insurance premium is a monthly fee paid to an insurance company or health plan to provide health coverage.

**Risk Adjustment -** A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

# *Appendix D - NRMM Model and Assumptions*

The NRMM uses 2017 and 2018 carrier data as well as 2018 and 2019 carrier premium rates to determine member health insurance shopping behavior and to capture and project annual enrollment and premium by metal level for 2018 and 2019 and project forward to 2030. Because it is possible that carriers change plans throughout a year which would result in double counting members, we only use the members who were enrolled in a plan at the end of the period, which was as of June 2018.

The 2018 carrier data we received was only through June of 2018, so the NRMM model assumes that all members maintained their plan through the remainder of 2018.

If a member's total family paid claims in 2017 were greater than their total family premium in 2017, the member is assumed to re-enroll in their 2018 plan for 2019, or if that plan is not available, they will find another plan at a similar level of coverage. If the total family paid claims are not greater than the total family premium, the member may shop for a lower level of coverage based on the premium rate change from their current plan. The NRMM assumes the member will look to enroll with the same carrier so they can keep their current providers. If their current carrier does not offer plans at a lower level of coverage they will look at the average plan at that level of coverage in the market. The NRMM also assumes that a member will keep their exchange status, except for the silver tier. Because of CSR loading on on-exchange silver plans that began in plan year 2018, an unsubsidized member is assumed to never enroll in an on-exchange silver plan and will instead look at the off-exchange silver plan.

The members that shop for a lower level of coverage are determined by the premium rate change from their current plan to the level of coverage they are shopping for in 2019 and elasticities presented at a Society of Actuaries training session. The NRMM assumes older members and larger families are less sensitive to rate increases. If the rate change is a rate decrease, the NRMM assumes the member will pocket the extra premium instead of opting for more coverage. If a member is projected to decrease coverage from the bronze or catastrophic tier, they are projected to go uninsured. Although it is possible for a catastrophic member to age out of a catastrophic plan, we assume this will be offset by younger members joining.

For the subsidized members, we assumed members enrolled in 94% CSR, 87% CSR, or 73% CSR plans will continue to enroll in the second lowest silver plan in 2019 and maintain their subsidy status. Members in 100% CSR plans, because we do not have any information about the members' poverty or income level, are equally distributed among the other subsidy levels. This is a simplifying assumption on a very small number of members, so we believe it is a reasonable assumption. We also assume APTC non-CSR members will continue to enroll in their current level of coverage.

The aggregate premium for 2019 is based on the 2019 premium for the member plan selected in the model, including the impact of a member aging one year from the 2018 data. The NRMM assumes 12 months of coverage for 2019. No other member trend was assumed for 2019 other than the assumptions in the NRMM as described above. The maximum premium for subsidized members is based on CCIIO data and family size.

Projections for 2019 is then projected to 2020 through 20230. NovaRest used the metal level elasticities of demand provided in a Society of Actuaries training session against the National Health Expenditure Projections for non-subsidized members. We assumed members will decrease their level of coverage prior to becoming uninsured.

To project the 2021 premiums that resulted from the NRMM modeling, NovaRest used historic changes in FPL and National Health Expenditure Projections.[109] For the FPL increase, we used 2.9% for 2018 to 2019 and 2% thereafter.

The National Health Expenditure Projections show a 3.2% health care cost increase from 2019 to 2021 and ranges from 4.6% to 5.2% thereafter as shown in Appendix A. The NRMM model output premium was trended from 2019 to 2030 using the National Health Expenditure Projections for both the base projections and the Waiver projections. Two Waiver scenarios were modeled. Scenario 1 used a $90,000 attachment point with a 50% coinsurance for the reinsurance and Scenario 2 used a $50,000 attachment point with a 55% coinsurance, both with a maximum claim amount of $250,000.

[109] "National Health Expenditure Projections 2017-2026." The Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

# *Appendix E – Qualifications*

## About the Model Team

NovaRest Actuarial Consulting (NovaRest) was hired by the Michigan Department of Insurance and Financial Services to perform a study of the Michigan individual health insurance market. The goal was to model the individual health insurance market and to study options to avoid the destabilization of the marketplace. Ultimately, the study pointed to the creation of a reinsurance plan and the request for a Section 1332 Waiver. NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. The 1332 project included four accredited actuaries, an actuarial student, and two research assistants. The core team members have worked on healthcare economic analysis and section 1332 waiver projects. In addition to our unique section 1332 experience, we have performed studies to analyze the cost drivers of health insurance and have analyzed the impact of proposed legislation. NovaRest employs some of the most senior actuaries in the industry. The NovaRest actuaries are experts in the Affordable Care Act (ACA), modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects.

The primary tool that NovaRest used for the 1332 Waiver application analysis is the NovaRest Migration Model (NRMM). The NRMM is an actuarial tool for analyzing the impact of market migration, take-up and lapse rates resulting from proposed legislative changes.

# *Appendix F – Reliance*

In performing the analyses, NovaRest relied on information provided by the Department of Insurance and Financial Service (DIFS), issuers offering coverage in Michigan, annual and quarterly financial statements submitted to the National Association of Insurance Commissioners, and additional public information published by the Federal government.

NovaRest relied on this information without audit or investigation. However, NovaRest believes that this analysis is based on accurate, reasonable, and complete data. When data appeared to be inconsistent or unreasonable, clarification was requested. NovaRest believes the best available data for determining the impact of the proposed Section 1332 Waiver was utilized.

Other information relied on is footnoted as to the source.

NovaRest made assumptions in modeling the Section 1332 Waiver. Although we believe these assumptions to be accurate, variances in the assumptions could impact the results. The NovaRest assumptions were reviewed by DIFS for reasonability.

# *Appendix G –Limitations*

There were a few limitations in the data received and the availability of more accurate assumptions. Even with these limitations, NovaRest believes that the baseline projections included in this report are appropriate for decision-making purposes. NovaRest performed sensitivity testing to verify that varying the assumptions used would not significantly change the results. Actual federal funding through reduced APTC will be based on actual enrollment and filed premiums rather than on NovaRest's or other projections.

1. The data that NovaRest used was a snap shot. With the turnover in the individual market this may overstate 2019 due to later 2019 migration from the market.
2. NovaRest had little information on individuals eligible for 100% CSR. From the data provided NovaRest knows that they are all eligible for APTCs, but not the actual poverty level. NovaRest allocated the 100% CSR to the CSR levels for the non-100% CSR individuals.
3. For Grandfathered and Transitional Health Plans, NovaRest had member months from 2014 to June 2018. NovaRest converted the member months to members using 12 months, which may understate the actual number of members in these markets.