



601 Pennsylvania Avenue, NW T 202.778.3200
South Building, Suite 500 F 202.331.7487
Washington, D.C. 20004 ahip.org

April 26, 2022

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Ave, NW
Washington, D.C. 20220

Submitted electronically via stateinnovationwaivers@cms.hhs.gov

RE: Maine Section 1332 Waiver Amendment Request – AHIP Comments

Dear Secretaries Becerra and Yellen:

On behalf of AHIP, we appreciate the opportunity to submit comments on the Maine Section 1332 Waiver Amendment Application which is currently under review by the Departments of Health and Human Services and Treasury Department (“the Departments”).¹

AHIP believes all Americans should have quality, affordable health insurance coverage and we are committed to working with states and the federal government to identify and implement policies that will further these goals. We appreciate the Departments’ commitment to fostering experimentation by states to meet the unique needs of their residents and believe this approach can both provide solutions for local markets and lead to new approaches that can improve coverage and affordability nationwide. We have historically supported state actions to reduce premiums and out-of-pocket costs, including 1332 reinsurance waivers, which have been successful in helping to keep premiums affordable.

Maine’s Waiver Amendment Request would merge the individual and small group markets and extend the Maine Guaranteed Access Reinsurance Association (MGARA) to the newly merged individual and small group market. Maine’s existing 1332 reinsurance waiver has been in place

¹ AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. We believe that when people get covered and get and stay healthy, we all do better. The best way to do that is to expand on the market-based solutions and public-private partnerships that are proven successes.

for the individual market since the 2019 plan year and has successfully lowered premiums for individual market enrollees.

We are writing to provide comments on two key issues:

- **First, we are concerned that merging the individual and small group markets will have a harmful impact on individual market premiums.** While the Waiver Amendment Request is projected to slow the decline in small group market enrollment, in a recent addendum to the 1332 Waiver Actuarial and Economic Report submitted by the state, Gorman Actuarial projects an average 9.7 percent increase in individual market premiums *compared to current policy*.² These premium increases would be especially harmful for current enrollees who are not eligible for premium tax credits (PTCs) or those who receive a small amount of PTC and could lose or see a decrease in PTC amount if the American Rescue Plan Act subsidies expire at the end of 2022. Gorman projects these premium impacts in the individual market would lead to nearly 1,800 fewer enrollees in the individual market compared to current policy. The projected one-time decrease in small group market premiums does not outweigh or justify the significant harm to the individual market premiums relative to current policy.
- **Second, we believe the Departments' approach to evaluating whether the Maine Waiver Amendment, and any 1332 waiver amendment request, meets the Section 1332 statutory guardrails is deeply flawed.** A waiver amendment request should be evaluated on the impact to affordability and coverage compared to *current policy*. The Departments should not compare the projected impacts of a waiver amendment request to a *pre-waiver baseline* before implementation of the state's existing waiver. This approach, adopted in the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Final Rule, is not appropriate and fails to reflect the true impact to consumers and the states' insurance markets of approving a waiver amendment request. Specifically in Maine, the Departments should use *current policy*—unmerged markets with reinsurance in the individual market—to determine whether the Waiver Amendment Request meets the section 1332 statutory guardrails, not a pre-waiver baseline. Evaluating the projected impact of Maine's Waiver Amendment Request against a pre-waiver baseline masks the adverse effects of the proposed waiver amendment for affordability in the individual market, could cause harm to state insurance markets, and is poor stewardship of federal spending.

Below we provide additional detailed comments on our recommendations.

Proposal to Merge Maine's Individual and Small Group Markets

If approved, the Waiver Amendment Request will merge Maine's individual market and small group market and extend reinsurance to the newly merged market. While this approach is intended to address declining enrollment and increasing premiums in the small group market, it

² <https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/appendix-h-actuarial-and-economic.pdf>.

would cause significant harm to the individual market and reverse recent gains in affordability since the implementation of reinsurance in Maine's individual market.

Relative to a *pre-waiver baseline*, Gorman Actuarial estimated small group rates would decrease by 6 percent in 2023 and 4 percent in 2024. Using the pre-waiver baseline, Gorman estimated individual market rates would decrease by 8 percent in 2023 and 6 percent decrease in 2024. The analysis indicated changes under the waiver amendment would be particularly beneficial to Mainers who are ineligible for PTCs in the individual market. However, spreading reinsurance over a larger risk pool would dilute the premium-stabilizing effects of reinsurance in the individual market. This would be particularly impactful for Mainers who are not eligible for PTCs or receive small premium subsidies (e.g., with incomes over 400 percent federal poverty level (FPL)). They would bear the largest brunt of the premium increase and some potentially would drop coverage. Further, if American Rescue Plan Act (ARPA) enhanced subsidies expire after 2022 the impact will be much more dramatic especially to those above 400% FPL. Thus, comparing to a pre-waiver baseline ignores the decrease in affordability to unsubsidized Mainers who represent a third of the individual market.

In an update submitted as an addendum to Maine's Waiver Amendment Request on March 22 ("Appendix H"), Gorman estimates merging markets and spreading reinsurance across the merged market would *increase* individual market rates by 9.7 percent in 2023 *relative to current policy*. Gorman likewise included an updated projection of enrollment impact in Appendix H, finding the Waiver Amendment Request would slow the decline in enrollment in the small group market but accelerate the enrollment decline in the individual market *relative to current policy*.

The one-time projected improvement to small group market premiums resulting from merging markets and extending reinsurance to the small group market does not outweigh the adverse consequences for individual market enrollees, especially those who are unsubsidized or receive modest subsidies. We believe the Waiver Amendment Request violates the affordability guardrail because it would increase individual market premiums *relative to current policy* in 2023 and should not be approved.

Baseline for Evaluating Waiver Amendment Request

On September 27, 2021, the Departments adopted procedures and processes to review and approve waiver amendment requests in the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance markets for 2022 and Beyond Final Rule. Under the final rule, the Departments will consider the "without-waiver" scenario, i.e., a pre-waiver baseline, and the "with-waiver" scenario to include the combined impact of the reinsurance program and section 1332 waiver amendment request. Further, with regard to pass-through funding, the Departments will make available annual pass-through funding for combined reductions in Federal financial assistance for the entire 1332 waiver plan, rather than receiving a separate pass-through funding amount for the waiver amendment component.

The continuation of Maine's reinsurance program in the individual market is not tied to approval of the Waiver Amendment Request. Reinsurance has become a critical feature of the Maine individual market and will continue to help make premiums affordable for consumers, especially unsubsidized enrollees. Using a pre-waiver baseline is inappropriate and an inaccurate approach to evaluating the actual impact of a waiver amendment for Maine's health insurance markets and consumers. It compares the effects of a merged market with a false alternative of the individual market without reinsurance when, in reality, if the Waiver Amendment Request is not approved the individual market would continue to benefit from its current reinsurance program.

A waiver amendment should improve on the current market. That is, if a state already has an existing 1332 waiver in place, the amendment should further improve affordability and coverage in the state, not undercut gains achieved under the existing waiver. Each waiver or waiver amendment request is a unique program and should be evaluated on its own merits.

The Departments' approach to review a waiver amendment request combined with an existing reinsurance waiver is bad policy. Such an approach allows states to attach proposals like a merged market on top of an existing reinsurance program, thus masking the negative impact the waiver amendment proposal would have in isolation. When examined together, the existing reinsurance program masks the adverse impacts for individual market premiums resulting from a merged market. Reinsurance should not be used to subsidize a program that would not pass the Section 1332 statutory guardrails on its own. This will negatively impact Maine's market and sets a precedent for states to implement approaches that could be detrimental to affordability or market stability that are disguised or buoyed by an existing reinsurance program.

In the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Final Rule, the Departments "determined that the guardrail interpretations codified in part 1 of the 2022 Payment Notice final rule were inconsistent with the Departments' goal of ensuring that the guardrails should be focused on the types of coverage residents actually purchase such that individuals are enrolled in affordable, comprehensive coverage..." (84 FR 53462). This means that, even if the waiver causes an overall increase in enrollment due to increased take up of small group plans, the fact that it is projected to cause individual market enrollees to drop coverage or enroll in less comprehensive coverage would violate the guardrails.

We are concerned the Departments' approach to combine pass-through funding for both the existing waiver and waiver amendment is not good stewardship of federal funds and sets a concerning precedent for other states that could consider a follow-on waiver amendment. Combining pass-through funds for both the waiver and waiver amendment is not transparent. A state could claim federal pass-through funds for the amendment that would have not materialized

in isolation, thus allowing the state to incorrectly claim success of the amendment and encourage other states to follow suit.

Finally, using a pre-waiver baseline fails to reflect the impact to Maine consumers, particularly those in the individual market, if the Waiver Amendment Request is approved. A 1332 waiver is intended to allow states to implement novel programs that will improve stability of health insurance markets and promote affordability of quality coverage for the state's residents. Consumers in the individual market, especially those who do not qualify for premium tax credits, have benefitted from premium reductions resulting from the Maine's reinsurance program. If the Waiver Amendment Request is approved, Maine consumers will compare premiums and affordability from one year to the next. That is, Mainers will not compare their 2023 premiums to premiums before reinsurance was implemented, instead they will compare the 2023 premiums relative to what they owed in 2022. The Departments should align its review of a waiver or waiver amendment with the consumer experience, in this case comparing projected premiums and coverage under the Waiver Amendment Request with the current market.

Recommendations

1. **The Departments should not approve Maine's Waiver Amendment Request and pause review until AHIP's concerns regarding the waiver amendment review process are addressed.** We have serious concerns, which have been echoed by other stakeholders over the last three years, that merging Maine's individual and small group markets will have adverse consequences for consumers in the individual market which outweigh the modest one-time gains for the small group market, specifically, increasing premiums in the individual market. As we have discussed, the analysis conducted by Gorman Actuarial and the recently adopted federal review process for evaluating 1332 waiver amendment requests rely on reinsurance to subsidize the waiver amendment, hiding the negative consequences of merged markets. The Departments should pause review of Maine's request until these concerns can be addressed.
2. **The Departments should revisit the waiver amendment process in the next Payment Notice and halt other waiver amendment reviews until these concerns can be addressed through notice-and-comment rulemaking.** In the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond proposed rule, the Departments described a high-level approach to review how the waiver, as amended, meets the section 1332 statutory guardrails, including an actuarial and/or economic analysis that includes the "with waiver" and "without waiver" status. However, this proposal did not make clear that the Departments would disregard the current state and instead compare to a baseline before the existing waiver. The Departments' intent was not clear from the proposed rule. Had the proposed approach been described in greater detail, AHIP would have commented strongly that this is not an appropriate approach and undermines the intent of the 1332 waiver program. We strongly encourage the Departments to pause review of current waiver amendment requests and address these concerns through notice-and-comment rulemaking. We urge the

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Departments to make an expeditious decision and announce next steps so Maine issuers can finalize 2023 offerings.

Thank you for the opportunity to provide comments on Maine's Waiver Amendment Request. We remain committed to working with states and the federal government to identify solutions to achieve our shared goals of ensuring more Americans have affordable, quality coverage.

Sincerely,

A handwritten signature in cursive script that reads "Jeanette Thornton". The signature is written in black ink and is positioned above the typed name and title.

Jeanette Thornton
Senior Vice President
Product, Employer and Commercial Policy
AHIP

Cc: Chiquita Brooks-LaSure, Administrator, CMS
Dr. Ellen Montz, Deputy Administrator and Director, CCIIO



Elizabeth Hall
Vice President, Public Policy and Issues Management
Anthem, Inc.
1001 Pennsylvania Avenue, NW, Suite 710
Washington, DC 20004
(202) 628-7844

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The Honorable Xavier Becerra
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200 Independence Avenue, SW
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The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Ave, NW
Washington, D.C. 20220

Re: Maine Section 1332 Waiver Amendment Request – Anthem Comments

Dear Secretary Becerra and Secretary Yellen:

Anthem, Inc. (Anthem) appreciates this opportunity to provide comments on Maine’s Section 1332 State Innovation Waiver Amendment Application (Waiver Amendment Application).

Anthem is one of the nation’s leading health companies, serving approximately 118 million people through its affiliated companies, including nearly 47 million within its family of health plans. Anthem has been at the forefront of participating in the Affordable Care Act (ACA) marketplaces since their launch in 2014, and we remain steadfast in our commitment to the success of the Individual and Small Group markets. In Maine specifically, Anthem is the largest commercial carrier, providing health insurance coverage to individuals, small employers, and large employers for over 80 years. As such, we evaluate the Waiver Amendment through the lens of our longstanding commitment to serving Maine consumers.

Anthem understands the state’s concerns regarding declining membership in the Small Group market, but we do not agree that the enrollment pattern over the last several years indicates there is a deterioration of Maine’s Small Group market. We further believe that a merger of the Individual and Small Group markets and an expansion of the Maine Guaranteed Access Reinsurance Association (MGARA) program to the merged market is not only unnecessary, but would have negative impacts on the stability of the Individual market. The expected modest one-time reduction in Small Group premiums that may result from this merger of markets does not justify the large premium increases that unsubsidized enrollees in the Individual market would experience.

Anthem has several specific and serious concerns with the Waiver Amendment. We therefore recommend that the U.S. Departments of Health and Human Services and Treasury (Departments) not approve the Waiver Amendment Application (Application). Our concerns include:

- **The individual market in Maine would suffer significant harm if the Individual and Small Group markets merge.** Individual market enrollees benefitted from significant premium reductions when Maine’s original Section 1332 Waiver implemented the MGARA reinsurance program beginning with the 2019 benefit year. If the Waiver Amendment is approved, however, a large percentage of those enrollees would see significant premium increases. Gorman Actuarial, Inc. prepared a 1332 Waiver Actuarial and Economic Report (Gorman Report) to accompany Maine’s Application. The report estimates that if MGARA reinsurance funds are extended to the Small Group market, Individual market 2023 premiums would increase 9.7%, on average, with Individual On-Exchange premiums increasing 9.4% and Off-Exchange premiums increasing 11.4%¹.
- **The State’s actuarial analysis has not demonstrated that the Waiver Amendment satisfies the necessary ACA Section 1332 guardrails.** While changes in the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Final Rule (Final Rule) do not require the Centers for Medicare & Medicaid Services (CMS) to consider the current market when it evaluates adherence to Section 1332 guardrails,² Anthem believes this approach is inconsistent with the original intent of the Section 1332 guardrails and could significantly harm consumers. The Section 1332 affordability guardrail requires a proposed waiver to “provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the State’s residents as would be provided” without the waiver. We believe Maine’s waiver violates the intent of the affordability guardrail because unsubsidized enrollees in the Individual market would have reduced affordability if the Waiver Amendment is approved, compared to the current market.
- **Any determination of whether the market should be merged must compare the current market to that under the proposed Waiver Amendment.** An appropriate evaluation of the impact of the Waiver Amendment on affordability must compare the individual market premium levels under the merged market scenario to the current Individual market with the MGARA program, which has been in place since 2019. Individuals will undoubtedly make enrollment decisions based on a comparison of merged market premiums to current individual market premiums. It does not make sense to compare merged market premiums to an artificial scenario without the MGARA program since that program has been in place since 2019. When evaluating the Waiver Amendment, it is critically important to consider that the MGARA reinsurance program will be in effect regardless of whether

¹ Gorman Actuarial, Inc.: *Appendix H: Actuarial and Economic Appendix, 1332 Waiver Actuarial and Economic Appendix to Report Submitted on February 10, 2022* (March 23, 2022):

<https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/appendix-h-actuarial-and-economic.pdf>, pages 17 and 19.

² *Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond*, 86 Fed. Reg. 53,412 (September 27, 2021): <https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver>.

the Departments approve or do not approve the Waiver Amendment. We believe this is the proper frame of reference for evaluating a Waiver Amendment which, instead of improving the current Individual market, would increase premiums by 9.7%, on average.

- **The Application overstates the contraction of the small group market.** The Application states that Maine requests a Waiver Amendment because “[i]n recent years, the small group market in Maine has experienced significant declines in membership.” We argue in our detailed comments below that Small Group enrollment declines and premium increases in recent years have actually been quite modest and do not support the state’s claim that a merged market is necessary to stabilize the Small Group market. Indeed, the average 2022 rate increase across all Small Group carriers was only 3.4%, which does not indicate a deteriorating market and compares favorably with the expected premium increases in the Individual market under the Waiver Amendment.

Detailed Comments

Since the introduction of the Made for Maine Healthcare Coverage Act (L.D. 2007, enacted as P.L. 2019, ch. 653) in 2020, Anthem has expressed significant concerns about merging Maine’s Individual and Small Group markets, especially given the negative impact such a merger would have on the Individual market. While those insured in the Small Group market would see minimal, one-time relief, most Individual market enrollees would see no benefit at all. In fact, Individual market members who do not receive subsidies in the form of Premium Tax Credits (PTC) would see their premiums increase substantially under the proposed amendment to Maine’s existing Section 1332 Waiver.

We provide details on our serious concerns below.

1. The Individual Market in Maine would suffer significant harm if the markets were merged.

As discussed above, the Gorman Report, prepared at the request of the state to accompany the Waiver Amendment Application, projects a staggering increase of almost 10% in individual market rates in 2023 when compared to the current landscape (separate markets with only the Individual market reinsured by the MGARA program). This increased cost would mostly be borne by the approximately 20,000 people, roughly one-third of the Individual market in Maine, who do not receive federal premium assistance in the form of PTC subsidies.

The Gorman Report also states that a merged market reinsured by the MGARA program “will be particularly beneficial to individuals not eligible for subsidized coverage.”³ However, that claim is based on a comparison with an Individual market not reinsured by the MGARA program, ignoring the reality that the Individual market today is already reinsured by the MGARA program. Expanding the MGARA program to a merged market would dilute the impact of the reinsurance funds, necessitate higher

³ State of Maine: *Section 1332 Waiver Amendment Application, Appendix C: Gorman Associates Actuarial and Economic Report* (January 26, 2022):

<https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/maine-section-1332%20waiver-complete-application-02-10-2022.pdf>, page 4.

attachment points, and reduce its favorable impact on the Individual market. This would result in increased premiums for those in the Individual market who do not receive PTC subsidies. Clearly the merged market would be detrimental, not beneficial, to those individuals.

In fact, the Gorman Report projects there would be almost 1,800 fewer members in the Individual market in 2023 if the markets merge, compared to the member projections under the current market. The difference between the two scenarios is the projected loss of unsubsidized enrollees due to the significant increase in premiums.

The Waiver Amendment's dilution of the MGARA program savings in the Individual market will reduce the amount of federal pass-through funding received under the Section 1332 Waiver since the funding amount is calculated based on the difference between the Individual market premium of the Second Lowest Cost Silver Plan (SLCSP) offered on exchange with reinsurance and the SLCSP assuming no reinsurance. The Gorman Report estimates that the federal pass-through savings would decrease from \$42 million under the current scenario to \$23 million under the Waiver Amendment, resulting in a \$19 million reduction in federal pass-through funding. Essentially the state would receive less total funding dollars to cover the reinsurance program, and that funding will be spread across both the Individual and Small Group members, thereby significantly reducing MGARA's positive impact on Individual market premiums.

It may seem easy to dismiss the impact on the Individual market by stating that most Individual market policyholders are "insulated" from rate increases because of the PTC under the ACA, but Maine can ill afford to ignore the third of the Individual market without premium subsidies. The approximately 20,000 Mainers who receive no subsidies and would be forced to shoulder 100% of the premium increase must be given careful consideration. The Gorman Report estimates that the average annual increase in premiums for Individual market enrollees without PTC would be over \$650.

The American Rescue Plan Act (ARP), enacted in 2021, increased premium subsidies for individuals and families with household income between 138% and 400% of the Federal Poverty Level (FPL) and extended premium subsidies for the first time to those with household income above 400% FPL. Those subsidies are set to expire at the end of 2022, and all projections included in the Gorman Report assumed that the ARP subsidies are not extended. Although the extension of ARP subsidies would have a small favorable impact (less than 1%) to the merged market premiums, we agree with Gorman that the Departments should evaluate the Waiver Amendment Application assuming ACA law with no enhanced subsidies.⁴

2. The State's actuarial analysis has not demonstrated that the Waiver Amendment satisfies the necessary ACA Section 1332 guardrails.

Section 1332 Waivers must meet legislative guardrails to ensure that individuals and families benefit from waivers of ACA protections. Applications must demonstrate that the guardrails are satisfied for

⁴ [State of Maine](#): page 55.

each year of the waiver period. One of those guardrails requires that a state's Section 1332 Waiver does not reduce the affordability of ACA coverage, taking into consideration premiums and cost-sharing.

Maine submitted an original Section 1332 Waiver in 2018 to implement the MGARA reinsurance program for the individual market. The 2018 waiver application necessarily demonstrated that the waiver satisfied the affordability guardrail by providing premium projections showing reductions in the SLCSF monthly premiums over the 10-year period from 2019 to 2028. In addition, the Departments required the state to submit annual reports demonstrating the state's continued compliance with the affordability guardrail.

We believe the Maine Waiver Amendment does not comply with the requirements of the 2018 waiver because the Application projects that premiums in the Individual market would increase 9.7% in 2023 if the Waiver Amendment is approved. Certainly, the Departments would not have approved the 2018 waiver if it showed an almost 10% premium increase in the fifth year of the waiver period. As such, we strongly recommend that the Departments not approve Maine's Waiver Amendment Application. As discussed above, we believe the September 2021 Final Rule methodology is inconsistent with the intent of the ACA's Section 1332. The Departments should not approve any amendment waiver that results in increased premiums and reduced enrollment when compared to the current market.

President Biden signed Executive Order 14009 on January 28, 2021. The order directed heads of agencies to examine "policies or practices that may undermine the Health Insurance Marketplace or the individual, small group, or large group markets for health insurance." In addition, agencies should consider taking actions necessary to enforce the Administration's policy "to protect and strengthen Medicaid and the ACA and to make high-quality healthcare accessible and affordable for every American."⁵ The Maine Waiver Amendment would undermine the Individual health insurance market in Maine by reducing affordability in that market segment. Therefore, the Waiver Amendment is inconsistent with Executive Order 14009 and the Departments should not give their approval.

3. Any determination of whether the market should be merged must compare the current market to that under the proposed Waiver Amendment.

An unmerged ACA market without MGARA reinsurance in the individual market is an inappropriate baseline for comparison to a potential merged market with MGARA reinsurance in a pooled market of Individual and Small Group enrollees. Under the Made for Maine Health Coverage Act, a merger of the markets could only move forward if the Superintendent of Insurance projected that "both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent the provision of this section."⁶

⁵ Strengthening Medicaid and the Affordable Care Act, 86 Fed. Reg. 7,793 (February 2, 2021): <https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicaid-and-the-affordable-care-act>.

⁶ P.L. 2019, ch. 653: *Made for Maine Health Coverage Act*: https://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC653.asp.

The premise underlying the provisions of the Made for Maine Health Coverage Act, as it was originally enacted, was essentially “do no harm” — if the markets are merged, neither market should be worse off than it was with separate markets. When it became apparent that this standard could not be met under a merged market, L.D. 1725 was introduced (enacted as P.L. 2021, ch. 361), including a provision to amend the law to change the baseline for evaluating guardrails, ignoring the intent of the original legislation. Despite the statutory change that permits the disruption to the Individual market, we urge the Departments to honor the original Maine authorizing legislation and not approve the Waiver Amendment.

Absent the Waiver Amendment, MGARA would continue to reinsure only the individual market. This is true regardless of whether the federal agencies approve or deny the Waiver Amendment. Therefore, the State must compare the merged market premiums to the baseline scenario under which the Individual and Small Group markets are separate and the MGARA program provides reinsurance funding for the individual market only. This is, after all, how individuals will evaluate their 2023 coverage options. If the Departments approve the Waiver Amendment, individuals will compare their 2023 premiums in the merged market to their 2022 premiums in the Individual market, resulting in significant consumer abrasion for those Individuals without PTC who will experience premium increases of almost 10%. This would almost assuredly lead some unsubsidized Individual market enrollees to drop their coverage and become uninsured.

4. The Application Overstates the Maine Small Group Market Contraction and Deterioration.

The Application contends that the State should merge the Individual and Small Group ACA markets and extend the MGARA reinsurance program to address the unstable Small Group market in Maine. The market conditions that were present when L.D. 2007 was enacted do not exist today, however, and the proposal to merge the Individual and Small Group markets is no longer warranted. To provide evidence of a deteriorating market, the Application includes membership and rate increase data from 2017 and later that, although accurate, do not paint a true picture of the Maine Small Group market in recent years. Following are details about recent trends in Maine’s Small Group market.

Small Group Enrollment

The Application includes enrollment data showing an 18% decline in Small Group membership from 2017 to 2020. That data is based on March enrollment snapshots in each year, however, and not on average enrollment for each calendar year. Average annual enrollment metrics provide a more accurate picture of membership trends since enrollment snapshots fail to capture enrollment changes throughout the year. Furthermore, average rate increases for a particular market are based on the enrollment throughout the year so any analysis that includes average rate increases should also include average annual enrollment.

Using average annual enrollment for years 2017 to 2020 instead of enrollment snapshots, we see a much different Small Group enrollment trend. The table below shows the comparison of enrollment

trends from 2017 through 2020 using both March enrollment snapshots and average annual enrollment. The table clearly shows that using the more appropriate average enrollment metric results in a cumulative enrollment decline of just 6.9% over the four years compared to the stated cumulative decline of 18% using the March snapshot metric.

Enrollment Metric	2017	2018	2019	2020	Cumulative Decline
March Snapshot	61,218	56,368	51,994	50,228	18.0%
CY Average Enrollment	53,129	52,202	51,432	49,487	6.9%

The stability in small group enrollment in Maine is mirrored by national enrollment trends. A recent Urban Institute study found that the small group health insurance market remained relatively stable from 2013 – 2020⁷. The study concluded that “[s]teady offer rates likely reflect consistent demand for employer-sponsored coverage from small-firm employees and greater stability in health insurance costs resulting from ACA reforms.”

Small Group Rate Increases

The Gorman Report also cites average rate increases in the small group market as evidence of a deteriorating market, but the report fails to consider the pattern of average rate increases in the Small Group market from 2019 to 2022. While the report correctly states that the Maine Small Group market has had a cumulative rate increase of 31% from 2019 through 2022, it ignores the fact that rate increases in the small group market have grown at declining levels since 2019. The average rate change, weighted by small group carrier enrollment, was 11.0% in 2019, 8.8% in 2020, 5.5% in 2021 and 3.2% in 2022. While there was a double-digit rate increase in 2019 when legislation authorizing the merged market was enacted, the average rate increases were much lower in 2021 and 2022, signaling a stabilization in the Maine small group market.

Recent enrollment and rate increase data suggest a stabilized Small Group market; estimated minimal Small Group enrollment and rate increase improvements do not justify the significant disruption to the Individual market if the markets are merged.

5. The benefit to the small group market is extremely modest and does not outweigh the harm to the individual market.

The Gorman analysis indicates that if the proposed Waiver Amendment is implemented, premiums in the Small Group market would be approximately 6% lower in 2023 than if there is no Waiver Amendment. In 2024, the difference in premiums would be reduced to 4%. The Gorman analysis further estimates Small Group membership to be 2,500 higher in 2023 if the Waiver Amendment is approved, with the membership difference dropping to 1,600 by 2025. Although the proposed merging of the Individual and Small Group markets and reinsurance extension would have a slight immediate

⁷ Banthin J and Grazevich E: *Trends in Small-Group Market Insurance Coverage, 2013–20*. Urban Institute (January 13, 2022): <https://www.urban.org/research/publication/trends-small-group-market-insurance-coverage>.

positive impact in the small group market, it does not represent a meaningful long-term gain and comes at the expense of the individual market, which will see higher premiums and a drop in enrollment of 1,800 members in 2023 and 1,600 members in both 2024 and 2025.⁸

6. The merged market has the potential to reduce competition in the small group market.

The Gorman Report claims that a merger of the markets could increase the number of participating health insurance carriers because there are carriers in the Small Group market that do not currently offer coverage in the Individual Market. The converse could occur if the Small Group carriers not offering coverage in the Individual market choose to exit the market rather than participate in a merged market. They may choose not to actively market plans to Individuals, effectively limiting themselves to the Small Group market or they may choose to exit the Small Group market entirely, resulting in a decrease in the number of carriers offering Small Group coverage in Maine and a reduction in plan choice.

7. Further analysis is needed before the State moves forward with a merger of the markets.

Finally, the subsidization of the market in any form provides only temporary relief—absent steps to address the underlying cost of health care, premiums will continue to rise, and enrollment will continue to decline. The State must also consider solutions that will address the cost of care and reduce costs not only in the small group market, but across all markets in Maine. We will continue to work with stakeholders in Maine to pursue actions that will reduce health care costs.

Thank you for the opportunity to share these comments. Please do not hesitate to contact me if you have any questions.

Anthem appreciates the opportunity to provide the above information to the Departments. If you would like to discuss these comments or have any questions, please contact me at (202) 628-7844 or Elizabeth.Hall@anthem.com.

Sincerely,



Elizabeth P. Hall

⁸ Gorman Actuarial, Inc.: pages 5-6.

Anthem is a leading health company dedicated to improving lives and communities, and making healthcare simpler. Through its affiliated companies, Anthem serves approximately 118 million people, including more than 47 million within its family of health plans. Delivering health beyond healthcare, Anthem is expanding from being a partner in health benefits to a lifetime, trusted health partner. For more information, please visit www.antheminc.com or follow @AnthemInc on Twitter.



MAINE ASSOCIATION
OF
HEALTH PLANS

April 26, 2022

stateinnovationwaivers@cms.hhs.gov

RE: Public Comment on Maine's 1332 Waiver Application

I am writing on behalf of the Maine Association of Health Plans (MeAHP) to offer comments on Maine's 1332 Waiver application.

The Plans have been active participants in Maine's recent exploration of a market merger as a policy approach to reduce rates, especially for small groups. We are in solidarity with the desire to reduce the cost of health insurance. We have long analyzed the parameters of both coverage and affordability within both the individual and small group markets. Our experience within both markets and our understanding of market dynamics and behavior have informed both our product development as well as our policy framework. In addition to the in-house expertise at the Plans, MeAHP has also commissioned work from BerryDunn, requesting research and analysis of Maine's proposed merging of the individual and small group markets, further review of the findings of various consultants who have worked on the issue, and a description of the experience of other states with merged markets.

MeAHP's concerns are centered around the impact of merging the markets on rates and membership.

Rates:

MGARA has worked well for the individual market, showing savings that have increased over time as carriers' reliance upon the program increased. Expanding reinsurance across a pooled market, while creating modest benefit for the small group market, decreases the benefit to the individual market thereby putting upward pressure on rates for 2023 and beyond. While those insureds accessing coverage on exchange with subsidies will largely be sheltered from premium increases, those without APTC will bear the brunt of this transfer payment from the individual market to the small group market.

This effect of the market merger on the impact of MGARA was disguised by the modeling of the merger in comparison with the state of the market prior to MGARA's resumption in 2019. MeAHP continues to believe that this use of a base year without reinsurance is not logical. We were disappointed to see the Mills Administration formally change the base year calculation via legislation because it could not otherwise meet the statutory test that originally existed in the enabling legislation, PL 653. We object to the use of a baseline year without reinsurance because that is not what currently exists. This choice was made deliberately to inflate the positive impact of a merged market. In our view, a modest and likely one-time benefit to small group rates at the expense of individual market rates is not a sound policy choice. As the BerryDunn Report concludes, individual rates will increase relative to current policy and MGARA's resources will be diluted by being spread across the larger merged market.

Membership:

Our Plans are concerned with the impact that merging the markets will have on membership. The BerryDunn Report finds that while implementation of the merged market may slow the decline in small group membership, it will lead to membership declines in the individual market even though the overall size of the combined markets will remain similar, whether merged or separate.

Other factors of concern impacting membership include the migration of small groups to self-insurance, a trend already underway. The ability to select in or out of the merged market pool depending on claims experience means the small group market will likely experience even greater selection issues that further erode the health of the pool.

Experience of other states:

Maine will be the first state to merge its individual and small group markets combined with reinsurance. Massachusetts, Vermont, and Washington D.C. are the states that have operated versions of merged markets over the past decade. Vermont has recently separated markets that have been merged since 2014 because of the unique policy circumstances and the availability of federal funds via ARPA. Massachusetts has had a merged market since 2007 that was studied in depth in 2016 and continued. Washington D.C. uses a "modified merged market" approach which in many respects operates as separate markets.

In sum, health insurers do not believe that the projected modest and short-lived benefit to the small group market at the expense of the individual market provides the rationale justifying the massive shift. We see the merged market accelerating trends that worsen the acuity of the fully insured community-rated pool and thereby furthering the market exodus by healthier groups. This change combined with plan standardization and new coverage

mandates mean substantial disruption to the markets. Overall, carriers remain opposed to the merging of the markets.

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Katherine D. Pelletreau". The signature is written in black ink and is positioned above the printed name and title.

Katherine D. Pelletreau
Executive Director

Cc: Acting Superintendent of Insurance Schott
MeAHP Board



Merger of Individual and Small Group Health Insurance Markets for

Maine Association of Health Plans

Presented by
BerryDunn

Jennifer Elwood, Principal | jelwood@berrydunn.com
Larry Hart, Project Manager | lhart@berrydunn.com
Donna Friedsam, Health Policy Manager | donna.friedsam@berrydunn.com

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1.0 Executive Summary

The Mills administration considered merging Maine’s individual and small group health insurance markets. Both markets experienced significant membership declines over the past five years. The individual market premiums have stabilized as a result of a reinsurance program that started in 2019 through a federal Section 1332 waiver—the Maine Guaranteed Access Reinsurance Association (MGARA). Much of the membership decline in the individual market occurred with the expansion of MaineCare, the state’s Medicaid program, and the migration of newly eligible lower-income people to Medicaid coverage. The small group membership declines have resulted from various economic circumstances, the COVID-19 pandemic, and changes in public policy. In the past two years, the state retained two firms, Milliman and Gorman Actuarial, to provide estimates of the impact of the merged market and also the federal pass-through funding. These firms provided varying perspectives on the resulting effects of merging the individual and small group markets. BerryDunn was retained by the Maine Association of Health Plans (MEAHP) to review the existing actuarial studies, relevant literature, and studies in other states that have either considered or initiated a merged market.

1.1 Merged Market Impacts

The impacts and the logic underlying a merged market in Maine are as follows:

- Spreading risk across an expanded, combined risk pool reduces individual market premiums when compared to a baseline with no reinsurance.
- The resulting federal savings provide available federal pass-through funds. Reinsurance payments are spread across both the individual and small group markets.
- Inclusion in the reinsurance program for the small group market offsets the increased risk (and potential premium increases) that would otherwise occur when merging with the individual market. Small group market premiums thereby decrease.
- For the individual market, which currently has reinsurance, the spread of the reinsurance across both markets offsets the premium-decreasing effects of the merged market. That is, the individual market’s premiums increase relative to current policy.
- About 70% of the individual membership is significantly insulated for this premium increase because of federal premium tax credits (PTCs) and current American Rescue Plan Act (ARPA) enhancements.
- The individual market gains some premium-reduction effect from the merged market due to sharing a better risk pool, and also may gain stability by joining a larger risk pool.

The overall goal—to reduce premiums and stabilize enrollment in the small group and individual markets—depends on federal pass-through funds available for reinsurance. But the net change in the pass-through depends on the combined effect of the two changes—merged market and reinsurance.

1.2 Literature Review

Massachusetts, Vermont, and Washington, D.C. are the only jurisdictions that have operated merged markets in the past decade. These merged markets have operated without a reinsurance program. Their experiences differ in this and several other ways from what Maine will experience under a merged market with an expanded reinsurance program.

Vermont merged its individual and small group markets in 2014. But, for the 2022 plan year, Vermont moved back to an unmerged market. The Commonwealth of Massachusetts merged the individual and small group risk pools in 2007. Rates in the merged market in Massachusetts increased by 2.6% for small businesses after the merger, but state officials maintained then that coverage for Massachusetts' residents also became more affordable overall. Washington, D.C. merged the risk pools of its individual and small group markets in 2014 for rating purposes. Washington, D.C. uses a hybrid approach—a “modified merged market.” In many respects, this model operates as separate markets.

1.3 Actuarial Studies

Gorman Actuarial estimated a 7.1% decrease in individual market premiums. Milliman, however, incorporated expected insurer conservatism into its model, to estimate a 3% reduction in premiums. This differences then result in differing estimates for the available federal savings and pass-through amounts.

In December 2020, the Wakely Consulting Group prepared a Comparative Analysis of the Estimated Impacts of a Merged Market and MGARA.¹ This study compared analyses previously conducted by the other actuarial firms in order to identify the reasons that the studies produced diverging estimates. The differences between the Gorman and Milliman estimates, Wakely reported, primarily stemmed from different approaches and levels of conservatism each included in their modeling. Wakely asserts that reasonable assumptions and expectations would not include excessive conservatism in the issuer rate development or reinsurance parameters for 2022. As such, Wakely concludes, Gorman Actuarial estimate may align better with other states' experiences with retrospective reinsurance based 1332 waivers.²

In December 2021, Gorman completed an updated study in preparation for Maine's submission of a Section 1332 waiver application.³ The results of this study, and the conclusions of the Maine Bureau of Insurance, are posted for review.⁴ That study concluded the following related to a combined risk pool with a federally supported reinsurance program:

- These changes will particularly benefit individuals not eligible for subsidized coverage and small employers (and their employees), both of whom should experience lower premiums.
- Combining the individual and small group markets into a single risk pool should provide greater stability to these market segments and may increase the number of insurers offering health plans to individuals.

Lowering premiums and stabilizing the markets should slow the decline in membership that has recently occurred in both the individual and small group markets

1.4 Summary

The actuarial studies conducted to review the impact of the Maine merged market used a baseline absent MGARA. Relative to an unmerged baseline with no reinsurance, Gorman projects a 6% decrease in small group rates in 2023, and a 4% decrease in 2024. In the individual market, Gorman projects an 8% decrease in rates in 2023 and a 6% decrease in 2024. In the individual market, despite the favorable impact of lowering premium rates in a merged market, the dilution of the MGARA reinsurance across both markets partially offsets this improvement. Gorman projects a 9.7% increase in rates relative to current policy in 2023, and a 6.6% increase in 2024 and beyond, when compared to current policy. The proposed policy change will likely impact projected membership. Gorman projects that including the Section 1332 waiver is expected to increase merged market membership by 3.7% in 2023 and by 2.5% in 2024 relative to a market with no reinsurance. This comparison includes current policy in small group. However, the current policy in the individual market includes the MGARA reinsurance program and rates would be higher under the proposed merged market policy. Gorman's updated membership projection, which includes a comparison to current policy in the individual market, illustrates a tradeoff between the individual and small group markets. Implementation of the merged market slows the decline in membership in the small group, but accelerates the membership decline in the individual market. Overall, the merged market policy has a very small impact on the combined membership of the two markets. In fact, Gorman projects that in 2025, the merged market will have a small negative impact on combined membership.

A merged market has the potential to provide longer-term stability because of the larger risk pool. However, as the Milliman study points out, the small group market will likely continue to experience selection issues. As this selection occurs, the risk scores are likely to continue to climb, and this will further erode the impact that MGARA can have on the small group market. This selection may be in part due to the ability of small groups to purchase self-insured plans when their claims experience is favorable. These same small businesses could opt back in to the merged market pool at open enrollment if their claims experience turned unfavorable.

The merged market could impact the number of carriers offering coverage in the small and individual markets. Currently, Maine has three carriers offering plans in the individual market, and they are among the five total carriers that offer plans in Maine's small group market. The three carriers (Anthem, Maine Community Health Options, and Harvard Pilgrim) that offer in both markets have 94% of the small group market membership. The other two (Aetna and United HealthCare) that participate only in the small group market enroll a small portion of the small group membership; as of the first quarter of 2021, Aetna had 0.5% and United had 5.4% of the small group membership, covering approximately 4,000 of the over 51,000 Maine residents in small group coverage. Merging the markets would require carriers to participate in both markets or withdraw. Given the already lower membership of United HealthCare and Aetna in Maine's market, they may decide to exit the market.

2.0 Background

The Mills administration considered merging Maine’s individual and small group health insurance markets. Both markets have experienced significant membership declines over the past five years. The individual market premiums have stabilized as a result of a reinsurance program that started in 2019 through a federal Section 1332 waiver—the MGARA. Much of the membership decline in the individual market occurred with the expansion of MaineCare, the state’s Medicaid program, and the migration of newly eligible lower income persons to Medicaid coverage. The small group membership declines have resulted from various economic circumstances, the COVID-19 pandemic, and changes in public policy. In 2020, both the Congressional Budget Office⁵ and the House Committee on Energy and Commerce⁶ delivered reports focusing on enrollment in short-term limited duration plans (STLDP) insurance plans. STLDP plans are used by people with a gap in health coverage. STLDP plans typically have limitations, including the types of services covered, and they may include a dollar maximum. The Trump administration issued an executive⁷ order directing the Secretary of Health and Human Services to take steps to expand the availability of short-term health insurance policies. In the past two years, the state retained two firms, Milliman and Gorman Actuarial, to provide estimates of the impact of the merged market and also the federal pass-through funding. These firms provided varying perspectives on the resulting effects of merging the individual and small group markets.

BerryDunn was retained by the MEAHP to review the existing actuarial studies, relevant literature, and studies in other states that have either considered or initiated a merged market.

2.1 Merged Market

A merged market, as defined under the U.S. 45 CFR § 156.80, treats the individual and small group markets as a single merged risk pool, meaning all risk is shared across both markets.⁸ Any product developed for either market must be available to all enrollees in either market. A larger risk pool through merger has potential advantages, for stability and otherwise. Merging also has distributional implications, in that premiums may increase for one market and decrease for another.

The state and the Bureau of Insurance considered the impact of the merger. Rule Chapter 856⁹ left discretion to the Superintendent on whether the markets would be merged. The rule requires a demonstration of savings to both markets, requiring the use of a base year without MGARA. The comparisons done by both Gorman and Milliman adhere to state law regarding baseline and to the federal Section 1332 waiver application requirement. The two actuarial firms used baseline experience that removes the current individual reinsurance (MGARA). The comparison shows benefit to both markets in a merged market environment, with the addition of reinsurance.

However, it is important to consider the impact of the merged market relative to current policy, which includes an existing reinsurance program for the individual market. This report reviews the existing studies and additional experience in other states, and it considers the effect of Maine’s merging of the markets relative to current policy.

2.2 Reinsurance Program

Maine now plans to merge the markets, and to pursue a waiver under the Affordable Care Act §1332 waiver, expanding its existing reinsurance program, MGARA. Under a federal Section 1332 waiver,

federal pass-through funding would be based on the amount of federal savings in PTC savings relative to baseline, by reducing premiums for the state's second-lowest cost, silver-level plan (SLCSP).

Such a federal waiver relies on reforms that result in lower individual market premiums, thereby reducing the needed federal subsidies (PTCs). These federal savings are then returned to the state as a federal pass-through, for use as a reinsurance program. Maine plans to use these federal funds to augment MGARA, extending reinsurance to the small group market.

2.3 Merged Market Impacts

The impacts and the logic underlying a merged market in Maine are as follows:

- Spreading risk across an expanded, combined risk pool reduces individual market premiums when compared to a baseline with no reinsurance.
- The resulting federal savings provide available federal pass-through funds. Reinsurance payments are spread across both the individual and small group markets.
- Inclusion in the reinsurance program for the small group market offsets the increased risk (and potential premium increases) that would otherwise occur when merging with the individual market. Small group market premiums thereby decrease.
- For the individual market, which currently has reinsurance, the spread of the reinsurance across both markets offsets the premium-decreasing effects of the merged market. That is, the individual market's premiums increase relative to current policy.
- About 70% of the individual membership is significantly insulated for this premium increase because of federal PTCs and current ARPA enhancements.
- The individual market gains some premium-reduction effect from the merged market due to sharing a better risk pool, and also may gain stability by joining a larger risk pool.

Figure 1 displays this reasoning. The boxes in green are generally observed effects (although subject to some debate), generally accepted in reallocating risk across groups. The boxes in red, however, represent points of substantial contention, where assumptions and estimates vary, and conclusions remain debated.

The overall goal—to reduce premiums and stabilize enrollment in the small group and individual markets—depends on federal pass-through funds available for reinsurance. But the net change in the pass-through depends on the combined effect of the two changes: merged market and reinsurance. Figure 2 displays the two through-lines affecting the level of federal pass-through funding, operating in parallel.

Figure 1: Merged Market Logic Model

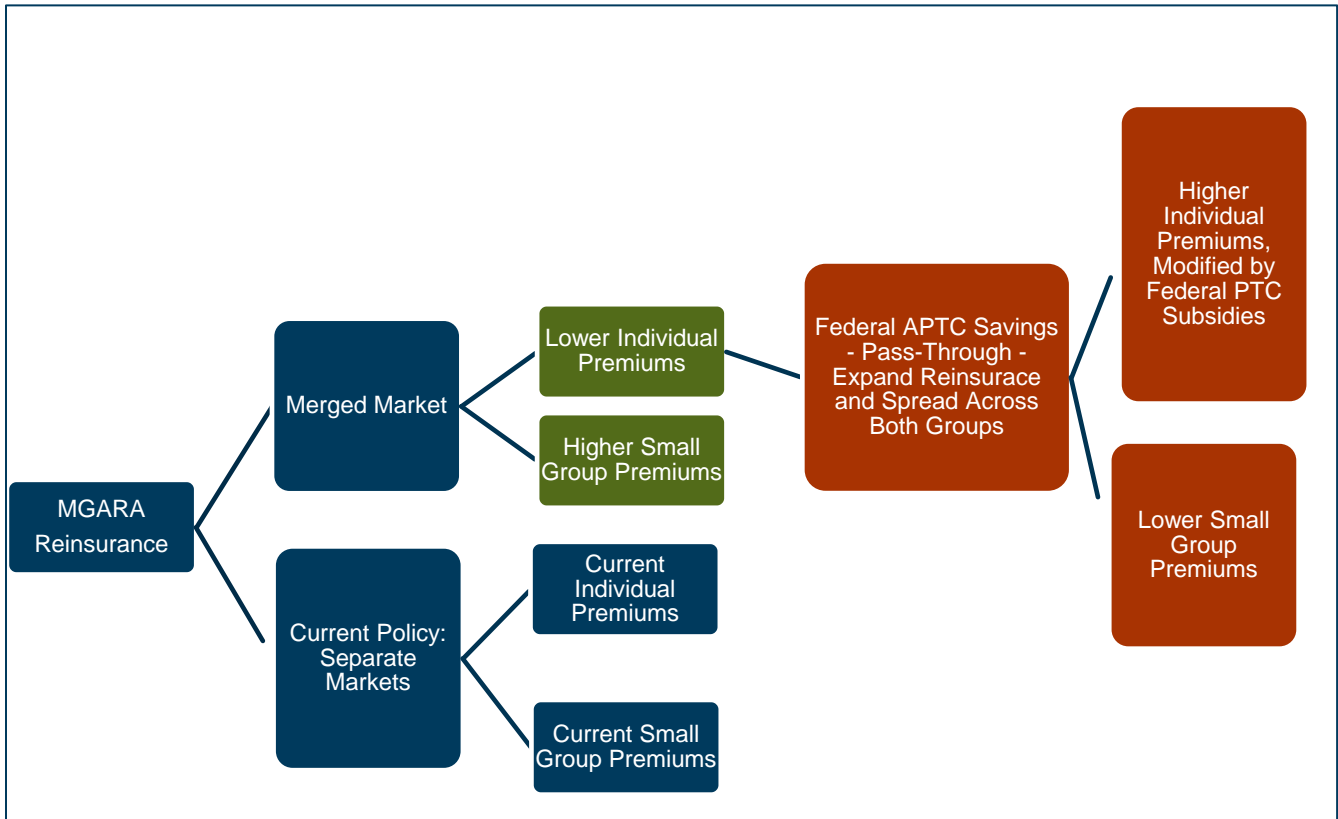
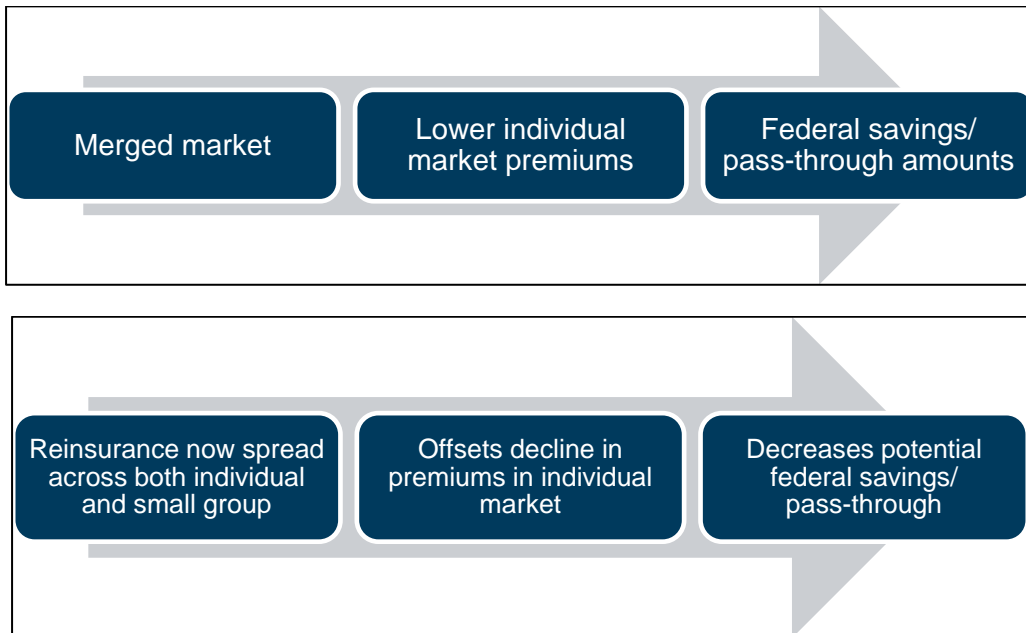


Figure 2: Through-Lines That Influence Levels of Federal Pass-Through Funding



The modeling of estimates depends on the level of conservatism that the model assumes. Given the uncertainty about the potential level of federal pass-through, and thus, the amount of reinsurance available, insurance carriers would reasonably include some probability that expected reinsurance payments may not fully materialize. Issuers cover that risk by including, within the premiums, a factor for anticipated non-payments of reinsurance. Thus, anticipatory conservatism becomes self-fulfilling, diminishing the reinsurance program's ability to reduce premiums. Section 4 of this report further details the implications around conservative reinsurance assumptions.

3.0 Literature Review

This section reviews available literature for states that have merged or have considered merging their individual and small group markets.

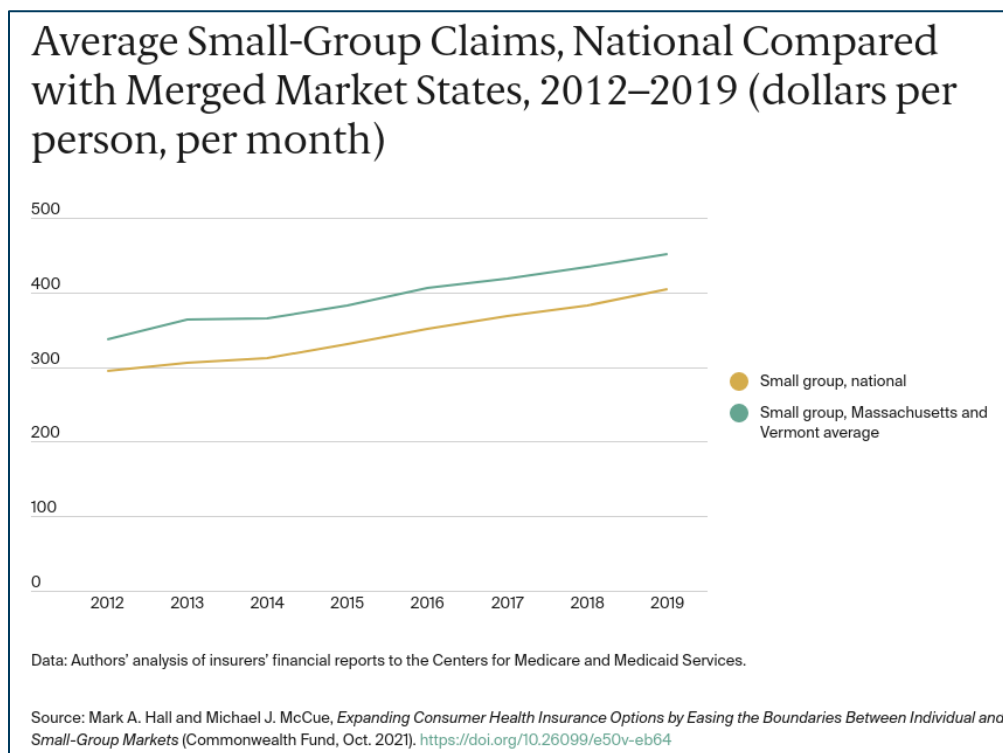
A recent Commonwealth Fund study considered the potential advantages for easing the boundaries between the individual and small group markets, although not specifically focusing on full merging of the markets.¹⁰ The study analyzed unsubsidized premium rates in 2021 for identical levels of coverage in eight states where carriers offer in both the individual and small-group markets. Findings of this rate comparison:

- In half of the states, individual premiums are substantially higher than small group rates.
- In half of the states, individual rates are lower or fairly similar.

This Commonwealth Fund study also looked more broadly at the experience of other states. Massachusetts and Vermont, the two existing states with merged market models, show small-group claims increasing at a rate similar to the national average, despite entering the Affordable Care Act (ACA) reform period with rates somewhat higher than the national average.

Nonetheless, this study does not explore in detail how premiums might change, and where the relative advantages and disadvantages might fall, in merging the markets today. Several states have assessed the potential for merging the individual and group markets. Only Massachusetts, Vermont, and Washington, D.C. have operated versions of merged markets within the past decade.

Figure 3. Increases in Small Group Claims



3.1 Summaries of States with Merged Markets

This section reviews the experiences of Massachusetts, Vermont, and Washington, D.C—the only jurisdictions that have operated merged markets in the past decade.

It is important to note that these merged markets have operated without a reinsurance program. Their experiences differ in this and several other ways from what Maine might experience under a merged market with an expanded reinsurance program.

3.1.1 Vermont

Vermont—a state somewhat similar to Maine in size and demographics¹¹—merged its individual and small group markets in 2014. But, for the 2022 plan year, Vermont moved back to an unmerged market. A detailed review of its experience provides insight about the various considerations pertaining to merged markets.

Vermont's previously merged market had the following features:¹²

- Plans and rates were identical for individuals and small businesses.
- The state had only two carriers offering coverage.
- Employers enrolled directly with carriers.
- No age rating. (New York is the only other state with no age rating.)
- No reinsurance program.

For the 2022 plan year, for which Vermont opted to unmerge its individual and small group markets, the rates and changes are different for each market. (In previous years, the same rate change would apply to both types of coverage).

Splitting up the markets resulted in lower premiums for the small group market and higher premiums for the individual market.¹³ Most of Vermont's individual market exchange enrollees are eligible for subsidies, which shield them from the increase in premiums due to the structure of the federal PTCs. And for 2022, the ARPA has temporarily eliminated the income cap for subsidy eligibility, extending subsidies to virtually all individual market enrollees. The Vermont Green Mountain Care Board notes that the unmerging occurred to “to take advantage of the enhanced subsidies available to individuals under ARPA. Unmerging the markets had the effect of lowering small group premiums and increasing individual premiums, compared to what they otherwise would have been with the enhanced subsidies offsetting the increased premiums in the individual market.”¹⁴

Vermont's decision to unmerge its market occurred due to the specific policy environment in 2021 – 2022, and the available federal funds under ARPA. In this circumstance, Vermont took the opportunity offered by an unmerged market to lower premiums for small businesses, while holding the individual market enrollees harmless, with the available expanded federal subsidy structure.

Unlike Maine, Vermont has not operated a reinsurance program for its individual market. Had that been in place, such an unmerging would have had a different effect on premiums. Removing small businesses from existing reinsurance protection may have raised premiums in the small group market,

if the value of a reinsurance program was worth more than the morbidity change from unmerging the markets.

In 2019, Wakely Consulting Group evaluated the impact of moving from a merged market to an unmerged market where the risk pools and market reform rules would be separate for the small group and individual markets.¹⁵ The Wakely study goals:

- Evaluate the impact on health insurance premiums and access from going from the current structure with a fully merged individual and small group market to two fully separated markets.
- Analyze the best marketplace structure and policy options to maximize federal resources through potential 1332 waivers and *for addressing insurance premium prices for unsubsidized purchasers and younger Vermonters* (emphasis added).

The Vermont legislature's primary target for premium reduction was the unsubsidized individual market—specifically the younger enrollees—“since the value proposition is less, relative to other state's individual market, for these individuals given community rating,” and reducing small group premiums.

An important distinction to note: Vermont's policy interest here specifically targeted the unsubsidized individual market members, and adding tools (reinsurance and others being studied then) to lower premiums in the individual market. In Maine's case, the individual market already benefits from reinsurance. Maine now seeks to extend the benefits of reinsurance to the small group market—considered high and unstable in an unmerged circumstance—in order to lower premiums there. And Maine seeks other ways to maintain stable premiums in the individual market, noting that the Maine individual market has already been somewhat stabilized due to the MaineCare expansion and the MGARA program.¹⁶

The Wakely report concluded, for Vermont:

- Unmerged market has policy trade-offs between two groups of enrollees.
- Unmerging the markets and doing nothing else would reduce premiums for the small group at the expense of the individual market.
- Premium increases for the individual market could be offset by other policy options targeted at the unsubsidized individual market.
- Under a merged market: “Policies designed to reduce premiums for unsubsidized enrollees in the individual market, such as reinsurance, have a harder time targeting only the individual market.”¹⁷

With this, the report concludes:

- Merged market requires more funding to decrease premiums for the unsubsidized individual market, since the impact of reinsurance would need to be spread across both markets.
- While the merged market has some policy advantages in terms of stability, it reduces options in regard to policy flexibility.

- An unmerged structure allows the potential for increasing federal pass-through amounts to fund reinsurance, under a Section 1332 waiver, in the individual market, which could lead to reductions for the whole of the market.
- The impact of the reinsurance program could be applied only to the individual market instead of spreading the payments to the small group market as well.
- Because of federal Advanced Premium Tax Credits (APTCs), the entire individual market would not experience a full impact of premium increases resulting from unmerging.
- Subsidized members in the individual market (64% of the market) are mostly unaffected by premium changes since their PTCs and premiums are based on income. However, if a subsidized member purchases a plan other than the second-lowest cost silver plan, it is possible their net premiums could increase. Under a silver loading circumstance, subsidized individuals may experience a premium decrease for other plans.
- Unsubsidized enrollees (36% of the market) will experience the premium increase, but most are protected for 2022 due to the temporary expansion of federal PTCs.
- The major beneficiary of the reinsurance program would be unsubsidized enrollees in the individual market, who represent 36% of the market.
- A claims-based reinsurance program and a reference-based pricing plan will be most effective if implemented in an unmerged or partially unmerged market structure.
- Reinsurance is a short-term fix, based on the amount of federal PTC savings that result from moving from baseline to new policy.

Another important note here: For Vermont, Wakely notes that federal funding would be substantially lower under the merged market structure. This results because Vermont is already merged, so layering a reinsurance program on already diminished individual market premiums results in lower available federal savings (and resulting pass-through) via a 1332 waiver. An unmerged market would increase individual market premiums, increasing the potential savings (pass-through under a reinsurance premium).

Conversely, in Maine, where a reinsurance program already operates, merging the market as part of a 1332 waiver targets different outcomes. The reinsurance element targets reductions for small group (not available without merging), while the merging targets reductions in individual premiums from merging (but blunting the effects of reinsurance, due to spreading the existing reinsurance across a larger pool, which more than offsets the merging reductions). In 2022, ARPA shields Maine individuals from the net increase in individual rates. It is not clear whether these ARPA-enhanced subsidies will be extended beyond calendar year (CY) 2022. If not, the 30% of individual market members not otherwise eligible for standard ACA subsidies are likely to later experience significant premium impact in 2023 once the ARPA-enhanced subsidies expire.

Table 1 illustrates the impact of the unmerged market in Vermont, and Table 2 illustrates the estimated impact of reinsurance in an unmerged market.

Table 1: Unmerged Market: Estimated Impact

Small Group		Likely Positive	Likely Negative
			XX
Individual Market			
Younger Adults (ages 21 – 44)		Likely Positive	Likely Negative
Subsidized	25% of market	XX	
Unsubsidized	8% of market		XX
Older Adults (ages 45+)			
Subsidized	36% of market	XX	
Unsubsidized	22% of market		XX

Source: Table 2, Wakely, November 2019

Table 2: Reinsurance: Estimated Impact in an Unmerged Market

Small Group		Likely Positive	Likely Negative
			XX
Individual Market			
Younger Adults (ages 21 – 44)		Likely Positive	Likely Negative
Subsidized	25% of market		XX
Unsubsidized	8% of market	XX	
Older Adults (ages 45+)			
Subsidized	36% of market		XX
Unsubsidized	22% of market	XX	

Source: Wakely, November 2019, Table 3

Table 3 provides a summary of the changes in Vermont.

Table 3: Summary of Changes in Vermont

<p><i>Baseline:</i> Merged market, no reinsurance</p> <p><i>Moving to unmerged without reinsurance</i></p> <ul style="list-style-type: none">▪ Unsubsidized individual premiums increase, but take advantage of ARPA subsidies▪ Subsidized increase by shielded by PTCs▪ Small group market premiums lower; no longer sharing risk with individual market <p><i>Moving from baseline to unmerged, with reinsurance:</i></p> <ul style="list-style-type: none">▪ Lower small group market premiums, due to unmerging▪ Higher premiums for subsidized and unsubsidized individual enrollees, due to unmerging, but offset by reinsurance, resulting in net lower net premiums lower than baseline▪ Higher premiums, pre-reinsurance offset, result in higher federal PTC requirements and lower federal PTC savings, decreasing federal pass-through amounts available for reinsurance (thereby requiring more state funding of reinsurance)
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3.1.2 Massachusetts

The Commonwealth of Massachusetts combined its risk pools with unified plan offerings in 2007 as part of comprehensive health reform.¹⁸ Rates in the merged market in Massachusetts increased by 2.6% for small businesses after the merger, but state officials maintained then that coverage for Massachusetts’ residents also became more affordable overall.

The Centers for Medicare & Medicaid Services (CMS) has recognized Massachusetts as operating a shared individual and small group risk pool while retaining various enrollment and rating practices typical of non-merged markets.¹⁹ In particular, small businesses are not required to renew coverage on a calendar year basis, and carriers may update their small group rates quarterly.

In 2016, the legislature studied the potential effects of separating the small group and individual risk pools. The report asserts several factors “outside of the merged market” responsible for the rising cost of healthcare premiums, noting that the composition of the merged market has changed since the individual and small group markets were first merged in 2007. The trends include the following:

- Membership growth of individual market under the ACA.
- Small group market membership decline with changes in the broader economic landscape, the rise of the “gig economy,” multiple recessions, and most recently, the economic impact of the COVID-19 pandemic.
- The majority of small business enrollment tends to congregate in higher-cost products that offer an “all-inclusive” provider network, despite lower-cost options being available to them, in needing to compete with the benefits of larger employers.

The 2016 studied concluded that unmerging the markets would achieve a one-time reduction in small group rates (2 – 4%), and a one-time increase in individual market rates (4 – 6%), but both risk pools

would continue to grow with medical trend. This study also assesses the effect of adopting a reinsurance program.

- If the merged market were split into separate risk pools for individuals and small groups, premiums for individuals would increase in the first year separate from increases resulting from medical trend.
- An increase in premiums requires higher federal PTCs; the potential for federal funding through a Section 1332 waiver is unlikely because state policy would increase federal outlay for PTCs rather than generating savings.
- Absent federal funding to hold individuals harmless from premium increases associated with a demerger, any reinsurance program would need to be funded by resources and/or assessments within the Commonwealth.
- The establishment of a reinsurance program in the merged market could lower premiums, but would require funding from state revenue or other sources.

This report also studies the trends for non-ACA-compliant alternative coverage and in migration of small employers to self-funded plans. It concludes:

- If a small group experiences medical claims that exceed expectations or a member is diagnosed with a high-cost condition, the self-funding stop-loss arrangement may no longer be financially viable. At that point, the group may choose to return to the merged market, with its guarantee-issue, community rating, and consumer protections. This cycle of individuals and groups coming back to the merged market only when they have material and costly healthcare needs could result in increasing costs in the merged market.

The Massachusetts study, overall, endorses the benefits of continuing the current merged market model, noting:

- Splitting the markets will increase premiums in the individual market, while access to federal funding for a reinsurance program is unlikely.
- The merged market offers a diversity of products and price points.
- The merged allows self-employed individuals and sole proprietors to obtain coverage as small employer groups of one, with access to small employer group coverage options.²⁰ In a split market, they would be required to obtain coverage in the individual market.
- In recent years, however, small group market enrollment in lower-cost options that use a more limited provider network has begun to increase, which will help decrease premiums in that market.

3.1.3 Washington, D.C.

Washington, D.C. merged the risk pools of its individual and small group markets in 2014 for rating purposes.²¹

Washington, D.C. uses a hybrid approach—a “modified merged market.” In many respects, this model operates as separate markets. The features include the following:

- Insurers must use a single risk pool for individual and small group claims in the development of the index rate.
- The index rate is adjusted to be specific to each market, based on factors (e.g., risk adjustment, actuarial value, product/network, non-EHB items adjustment, administrative/retention expense, and a catastrophic adjustment factor) that are not uniform across the two markets.
- The merged risk pool does not change how carriers may choose to offer plans in the individual or small group markets.
- For federal reporting purposes, carriers use unmerged market standards.
- All other aspects of rate development are separate for each market.
- Insurers may offer different plans in the individual and small group markets.
- Insurers are allowed to make quarterly adjustments to the index rate for the small group market instead of once per year.

As noted previously, Washington, D.C. does not operate a reinsurance program for its market.

3.2 Other Studies and Other States

An accumulation of studies and experience over the past decade lend deeper perspective, beyond the states that elected to merge their markets in various ways.

3.2.1 ACA Preparation Studies (2011 – 2013)

In the early years following passage of the ACA, as states sought information about how to structure their exchanges and markets, several studies addressed the potential of merged markets. These studies ranged in their conclusions. Some focused on risk of increased premiums, small groups switching to self-insurance, and small groups dropping coverage. Others emphasized the potential lower premiums that a larger pool could bring. Overall, the studies identify various risks and benefits, and document the difficulty in making a blanket recommendation. Table 4 includes a summary of these early studies.

Also in the years 2011 and 2012, in preparation for ACA implementation, several states conducted or commissioned their own studies to consider merging the individual and small group markets. These states included California,²² Colorado,²³ Connecticut,²⁴ Illinois,²⁵ Indiana,²⁶ Maryland,²⁷ New Jersey,²⁸ Ohio,²⁹ Rhode Island,³⁰ and Washington.³¹

These states generally concluded that circumstances were too uncertain, and that it would be prudent to wait until after the 2014 ACA policies took effect before making these decisions. The New Jersey study clearly recommended against a merged market, asserting that New Jersey’s markets already appeared large enough to function as viable marketplaces, and the same carriers already served both the individual and small group markets.

Meanwhile, a legislative study committee in the State of Connecticut affirmatively recommend merging the markets, based largely on theoretical assertions. But Connecticut did not ultimately merge these markets.

Milliman conducted studies for both Indiana and Ohio, similarly concluding that premiums would decrease for the individual market and increase for the small group market. And, enrollment in the individual market would increase, while enrollment in the small group market would decline. Milliman noted that some carriers may not have the capability or desire to serve both markets and therefore may choose to exit if the markets were to merge. Milliman (along with other) studies also noted that merging the markets may limit new carrier entry and that fewer carriers in the market, with less competition, may increase premiums. Even with these caveats, Milliman did not advise Indiana and Ohio against merging the markets. Rather, Milliman concluded in both states' reports that they should "Monitor the emerging experience resulting from the changes to the markets [related to the 2014 ACA implementation] before making a decision to merge them."

3.2.2 Post-ACA Implementation (2014 – 2020) Studies

States vary significantly in their demographics, economies, and in their healthcare and insurance markets. Many factors contribute to the cost and competition history and current experience in individual states. Various states' approaches to insurance market regulation will have varying effects on observed outcomes related to premiums, enrollment, plan participation, and market stability. In a complex policy environment, it is not possible to attribute causal effects between a single policy (merged or unmerged markets) and an observed outcome (premium trends, for example).

Among the factors that influence states' considerations related to merging their markets:

- 1. Goals:** States may emphasize the individual market or small group market premiums and stability. Vermont, as noted above, focused on reducing premiums in the individual market for unsubsidized members, and also for decreasing premiums in the small group market. Massachusetts focused on premiums in the individual market, expecting that existing options would serve its small group market.
- 2. Relative size of the markets:** Reports in California and New Jersey both emphasized the substantial size of their existing markets in recommending against merging the markets. The American Academy of Actuaries addresses the degree to which the size of the risk pool affects the stability of the individual market.³² It notes: "Although larger risk pools are typically more stable, a large risk pool does not necessarily mean lower premiums. The key factor is the average health care cost of the enrollees in the pool."

After the 2014 ACA implementation, California and Maryland also studied the potential for a merged market. While they and other states have considered merging their individual and small group markets over the past decade, only Massachusetts, Vermont, and Washington, D.C. have actually adopted a version of a merged market.

3.2.3 California³³

- Merging the markets would create a larger risk pool.

- Decreases in individual market premiums may encourage additional individuals to purchase insurance, particularly those who are most price-sensitive, such as younger and healthier individuals. This would positively impact the risk pool.
- However, due to income-based PTCs, subsidized enrollees are not expected to realize much of the benefit.
- Only individuals who do not receive subsidies would receive the full benefit of the premium reductions.
- Premium decreases would accrue savings to the federal government in the form of reduced premium subsidy costs.
- Merged markets will substantially increase premiums for small groups while decreasing premiums for individuals, due to the subsidization of the higher risk individual pool by the lower-risk, small group pool.
- The individual and small group markets in California are both sufficiently large and relatively stable with sufficient issuer participation that most participants in these markets have a choice among a number of carriers and products.
- Issuers have adapted to provide products that meet the different needs of each.
- No evidence that a merged market would lead to reductions in health plan administrative costs due to economies of scale or reductions in duplication of resources.
- In order to save on premium costs, small employers are likely to offer lower-cost products or more limited networks to enrollees, reduce contributions, move toward alternative funding arrangements that remove them from the risk pool (such as self-funding), or stop offering coverage to employees altogether. All of these actions are detrimental to small group employees and employers, as well as to a merged risk pool.
- Short-term merging of the markets would have very significant impacts to premiums, and those changes would be highly destabilizing to both markets.
- Long-term impacts of merging the markets cannot be predicted.

3.2.4 Maryland, 2016

Maryland's small group market was judged to be robust at that time, with the risk that merging the markets could lead to additional carriers leaving the state altogether. There was concern that the carriers currently participating in the small group market only would leave the state if they were required to participate in the individual market.

Recommendation: That the state defer a policy decision at that time and revisit the issue when further data are available, and the individual market is more stable.

- Rate impact – Premiums in the small group had been fairly stable, while the individual market was more volatile; insufficient data at that time to predict actual rate impact.

- Carrier participation – Not all carriers participated in both markets. Merging would require carriers to participate in both or withdraw.
- Plan year – Federal rules required merged markets to operate on a calendar year basis, while the small group was not required to do so. However, this rule does not control the merged markets in Massachusetts or the District of Columbia.
- Timing of rate adjustments – Federal rules require merged markets to make annual adjustments, while the small group can do so quarterly. However, this rule does not control the merged markets in Massachusetts or the District of Columbia.
- Essential health benefits – Benefit is slightly different between individual and small group.
- Risk adjustment – Merging markets may affect risk adjustment payments.
- Other states – Only Washington, D.C., Massachusetts, and Vermont have versions of merged markets, and none of these are fully ACA compliant.

**Table 4: Summary of Early Studies, 2011 – 2013
Addressing Merger of Individual and Small Group Markets**

National Association of Health Underwriters³⁴

- Likely cause adverse selection to the small-group pool, leading to higher costs to consumers and health plans.
- The individual and small group risk pools should remain separate.

American Academy of Actuaries³⁵

- Rates in the combined market can be expected to increase. These rates may increase rapidly if employers and individuals opt out of coverage in a guaranteed issue environment, resulting in adverse selection.
- Projections related to increases in rates do not support merging the markets.

RAND Corporation³⁶

- For all states analyzed, individual market enrollees will be slightly older and less healthy than small group enrollees.
- These estimates imply that, for many states, small group premiums could increase in a combined risk pool.

Milliman Actuarial and Consulting³⁷

- Both negative and positive consequences. May create a hidden tax on small employers. But subsidy from small groups could help make individual policies more affordable. Potentially could decrease the number of uninsured people.
- Merging the markets or keeping them separate both have their advantages and disadvantages.

Center on Budget and Policy Priorities³⁸

- Due to the large number of anticipated changes in the individual and small group markets in 2014, first implement federal premium rating rules in the two markets separately before considering merging the markets.
- Eventually, merging the markets would expand the pool to spread risk between the healthy and the sick, and improve stability.

Urban Institute Health Policy Center³⁹

- Health Insurance Policy Simulation Model suggests that merged markets would increase coverage and decrease premiums in the individual market, while premiums remain relatively unchanged in the small group market.
- Merging the risk pools would decrease uninsurance and lower premiums in the individual market.

Small Business Majority⁴⁰

- Market merger should be considered several years after the major market reforms of 2014.
- Potential rate disruption is reason to defer the decision.

The next section provides a review of the relevant actuarial studies.

4.0 Review of Actuarial Studies

The Maine Bureau of Insurance, in 2020, contracted with Gorman Actuarial to assess the potential for merging the individual and small group markets and pursue a federal Section 1332 waiver to expand the existing reinsurance program.⁴¹ Maine's existing reinsurance program, MGARA, separately contracted with Milliman to conduct a similar analysis.⁴² Both firms estimated a baseline of no reinsurance and no merger, compared to a waiver with reinsurance and a merged market. The difference in federal savings (e.g., PTCs) between the baseline and waiver scenarios equals the pass-through amount.

The two firms differed substantially in estimating the potential PTC savings and available federal pass-through amounts and the resulting effect of reinsurance on premiums.

4.1 Gorman Actuarial

Gorman Actuarial estimated a 7.1% decrease in individual market premiums. Milliman, however, incorporated expected insurer conservatism into its model, to estimate a 3% reduction in premiums. These differences then result in differing estimates for the available federal savings and pass-through amounts.

These differences underpin differences in the reports' conclusions. Gorman then reported that, for all scenarios tested, the premium rates under the proposed policy (merged markets plus Section 1332 waiver) for the individual and small group markets are lower than rates in an environment with no reinsurance program in place.

- Combining the two relatively small markets to form a larger pool offers greater market stability with less premium rate volatility from one year to the next.
- The proposed policy will provide some premium relief to both markets by coupling this change with a reinsurance program that maximizes federal funding.

4.2 Milliman

Milliman, in its 2020 study, estimated a smaller federal pass-through under the merged market. They indicated that the pass-through amount was going down in part because of fewer subsidized members after the Medicaid expansion. This is not a result of the merger. The other reason for smaller federal pass-through dollars is that there is less spread in the individual rates with and without reinsurance because of the relative risk of the two pools. Milliman also points out that the small group market will likely continue to experience selection issues. As this selection occurs, the risk scores are likely to continue to climb, and this will further erode the impact that MGARA can have on the small group market. This selection may be in part due to the ability of small groups to purchase self-insured plans when their claims experience is favorable. These same small business could opt back into the merged market pool at open enrollment if their claims experience turned unfavorable.

Milliman, reaches a less optimistic conclusion:

- The proposed policy will have “a small one-time positive impact on the small group market. It will negatively impact the ability of MGARA to benefit the individual market.”

4.3 Wakely

In December 2020, the Wakely Consulting Group prepared a Comparative Analysis of the Estimated Impacts of a Merged Market and MGARA.⁴³ This study compared analyses previously conducted by the other actuarial firms in order to identify the reasons that the studies produced diverging estimates. Wakely reviewed multiple differences between Gorman and Milliman in their assumptions in estimating the initial baseline and the impact of a merged market and reinsurance on premiums.

The differences between the Gorman and Milliman estimates, Wakely reported, primarily stemmed from different approaches and levels of conservatism each included in their modeling. Wakely asserts that reasonable assumptions and expectations would not include excessive conservatism in the issuer rate development or reinsurance parameters for 2022. As such, Wakely concludes, Gorman Actuarial estimate may align better with other states' experiences with retrospective reinsurance based 1332 waivers.⁴⁴

Wakely also notes the following:

- Conservatism should not be included when assessing the pass-through estimates since any conservatism in the initial estimates will most certainly result in lower pass-through amounts and reduce the effectiveness of the program.
- The state has a number of policy tools to protect consumers (via rate review process) or its own costs (via changes to reinsurance parameters) that can be used to maximize the impact of the reinsurance program while also balancing the risk among all parties.
- Issuers may have an incentive to avoid excessive conservatism, whether for competitive pressure or to avoid large Medical Loss Ratio rebate payments.

4.4 Gorman Updated

In December 2021, Gorman completed an updated study in preparation for Maine's submission of a Section 1332 waiver application.⁴⁵ The results of this study, and the conclusions of the Maine Bureau of Insurance, are posted for review.⁴⁶ That study concluded the following related to a combined risk pool with a federally supported reinsurance program:

- These changes will particularly benefit individuals not eligible for subsidized coverage and small employers (and their employees), both of whom should experience lower premiums.
- Combining the individual and small group markets into a single risk pool should provide greater stability to these market segments and may increase the number of insurers offering health plans to individuals.
- Lowering premiums and stabilizing the markets should slow the decline in membership that has recently occurred in both the individual and small group markets.

4.5 Additional Considerations

The Gorman and Milliman actuarial studies compared the proposed policy (merged market, with reinsurance), to a baseline condition of no merged market with no reinsurance. That approach does not

capture current policy in Maine, which operates as an unmerged market with an existing reinsurance program. The individual market in Maine currently benefits from a state-based reinsurance program, which includes a federal Section 1332 waiver as a component of its funding. A merged market would be expected to have two effects relative to current policy in Maine:

- Extend reinsurance to small group plans that currently lack this protection, providing new premium-lowering effect to the small-group market.
- Expanding the existing reinsurance program that operates for the individual market, but spreading the reinsurance across a larger group (due to the merged markets), and thereby blunting the effect of the reinsurance on the individual market.

The success on the program depends on the degree to which the following occurs:

- For small group plans, the benefits (premium-reducing effects) of new reinsurance more than offset the premium-increasing effects of the merged market.
- For individual market plans, the benefits (premium-reducing effects) of the merged market more than offset premium-increasing effects of sharing the reinsurance program more widely, and if not, then the extent to which individual members are protected by the PTCs.

Table 5 reviews the advantages and disadvantages of a merged market.

Table 5: Impacts of Merging the Markets: Pros and Cons

Potential Advantages	Disadvantages
Larger risk pool, with more stable and potentially lower premiums in individual market.	Small group premiums increase due to pooling risk with individual market.
Risk pool continues to grow if potential reductions in premiums could stabilize or increase participation by individuals and/or employers in the market.	Potential premium increases can induce individuals or employers to drop coverage.
Lower premiums in the individual market reduce federal APTC requirements, increasing available federal pass-through funds for reinsurance.	Unclear whether premium increases for small group can be sufficiently offset by reinsurance benefits. Depends on assumptions regarding conservatism of carriers in pricing, effect on premiums, PTCs, federal pass-through, and features of the reinsurance program.
A larger risk pool may attract new insurers to enter the market.	Could discourage insurers from offering coverage if they do not want to offer coverage for individual and small group.
	If merging markets results in premium increases and/or additional administrative burden for the small group market, more small business may choose to self-insure. This may lead to adverse selection and premium increases in the fully-insured market.
Combining functions of certification and rating of qualified health plans may reduce administrative costs.	Operations for group coverage, such as employer contributions to premiums, billing, and enrollment processes differ from the individual market, requiring different enrollment, coverage, and rate adjustment periods. A PricewaterhouseCoopers (PwC) study notes no evidence of administrative savings from merged markets in its California study. ³³
Could ease the transition for groups who move between individual and employer coverage as circumstances change.	Difficulty predicting the net effect of merging may challenge carriers in their pricing and their use of conservatism in their estimates.

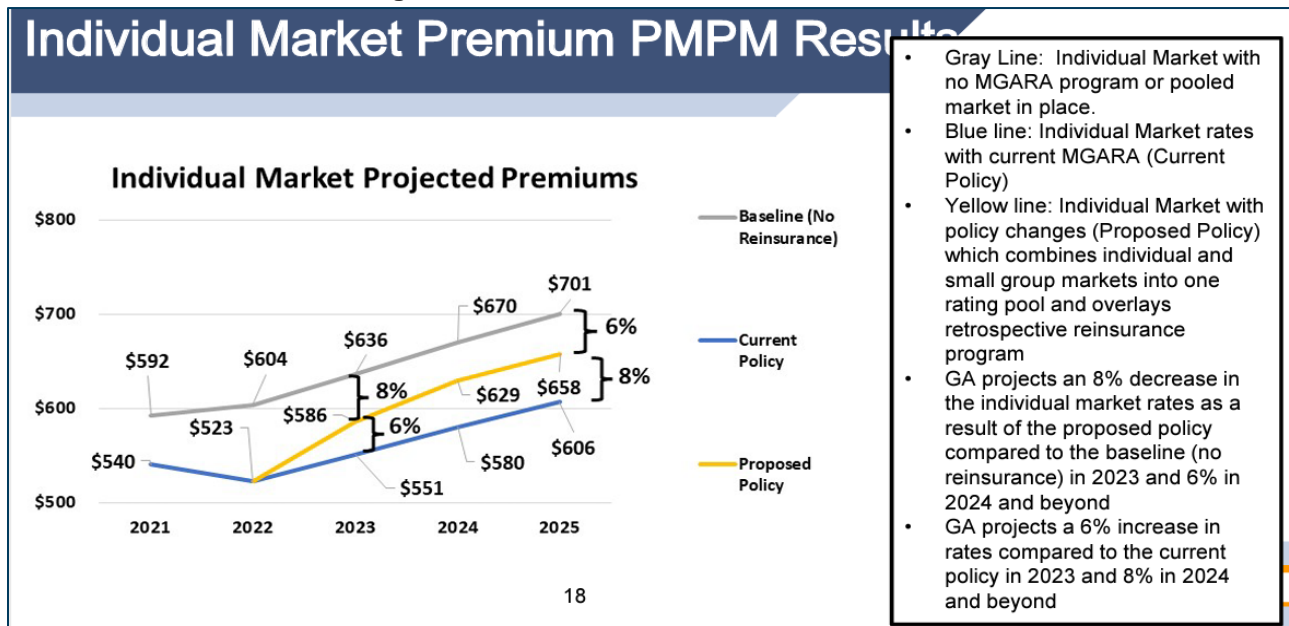
4.5.1 Premium Impact

In order to merge the individual and small group markets, state law requires a demonstration of savings to both markets. The recently issued Rule Chapter 856⁴⁷ leaves discretion to the Superintendent on whether the markets will be merged, and includes the use of a base year without MGARA. The actuarial studies conducted to review the impact of the Maine merged market, including the recent Gorman report used to support the updated Section 1332 waiver application, used a baseline absent MGARA.

However, as discussed, despite the favorable impact of lowering premium rates in a merged market, the dilution of the MGARA reinsurance across both markets partially offsets this improvement. Individual rates will increase relative to current policy; federal PTC subsidies shield most individual market enrollees from these changes. In a public hearing on January 28, 2022, held by the Maine Bureau of Insurance, Gorman presented its premium impact projection in the individual market relative to the current policy (including MGARA in the individual market).

Gorman projected a 6% increase in rates relative to current policy in 2023, including ARPA-enhanced pass-through funds. Then, with the projected end of ARPA-enhanced funding, Gorman estimates an 8% increase in 2024 and beyond, when compared to current policy as shown in Figure 4.

Figure 4: Individual Market Premium Results



After the State of Maine submitted Gorman's 1332 Waiver Actuarial and Economic Report on February 10, 2022, Gorman submitted Appendix H of the report. Appendix H, dated March 23, 2022, is an addendum to Maine's application, and it includes an updated impact on individual premium.⁴⁸ Based on the updated analysis, Gorman projects a 9.7% increase in rates relative to current policy in 2023, and a 6.6% increase in 2024. For 2023, Gorman assumed an additional \$8.6 million in reinsurance program funding that was received by Maine in 2021 as a result of the American Rescue Plan Act (ARPA). This assumption further reduces premiums in the individual market under current policy.

BerryDunn analyzed how this will impact monthly premium costs for the consumer, under the merged market. Given the structure of PTC, members that are eligible for subsidies are mostly insulated from the estimated premium increase relative to currently policy. Table 6 provides the amount of premium consumers would pay expressed as a percentage of income, for consumers purchasing the SL CSP under with ACA. The table illustrates the percent of income paid with and without the additional subsidies included under ARPA.⁴⁹

Table 6: The % of Income Paid Toward Premium for SLCSP Sliding Scale Percentage by Income Level

Income Level as a Percentage of Federal Poverty Level	ACA with PTC	ACA With ARPA-Enhanced PTC
100% – 133%	2.07%	0.0%
133% – 150%	3.10% – 4.14%	0.0%
150% – 200%	4.14% – 6.52%	0% – 2.0%
200% – 250%	6.52% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6.0% – 8.5%
400+%	Not Eligible for Subsidies	8.5%

From publicly available rate filings, BerryDunn obtained the 2022 Consumer Adjusted per member per month (PMPM) premium rates for the Anthem Silver X Clear Choice Tiered 5500 plan, which is the SLCSP in Maine’s rating area 2. We assumed the family lives in geographic rating area 2. We selected area 2 because it was closest to the statewide average cost. Based on area and age-rating factors, also included in the public rate filings, we calculated monthly PMPM rates for a subscriber and their dependents. The PMPM rate charged to a member is the product of the carrier’s Consumer Adjusted PMPM, the area factor, and the age factor. For this illustration, BerryDunn assumed all non-smoking members, an individual subscriber age 48, a 47-year-old spouse, and three children, ages 21, 18, and 16. Table 7 illustrates the PMPM rate calculation for each of these five members. BerryDunn then added the appropriate member rates together to calculate a single rate, a two-person (subscriber and spouse) rate, and a family rate, per subscriber per month. BerryDunn used trend projections from the most recent National Health Expenditures trend report⁵⁰ to project premium increases for 2023 and 2024. Premium rates were trended to each of those years. Per subscriber per month rates for the three subscriber types are shown in Table 8.

Table 7: Monthly Premium PMPM Rate Calculation for SLCSP

Member Category	Consumer Adjusted PMPM	Age Factor	Area Factor	Final Monthly Premium PMPM (before PTC)
Subscriber Age 48	\$328.95	1.635	0.9849	\$529.71
Spouse Age 47	\$328.95	1.563	0.9849	\$506.39
Child Age 21	\$328.95	1.000	0.9849	\$323.98
Child Age 18	\$328.95	0.913	0.9849	\$295.80
Child Age 16	\$328.95	0.859	0.9849	\$278.30

Table 8: Monthly Premium Rate per subscriber for SLCSP

Subscriber Category	2022 Subscriber Rate	2023 Subscriber Rate	2024 Subscriber Rate
Single	\$529.71	\$557.79	\$586.79
Two Person	\$1,036.10	\$1,091.01	\$1,147.74
Family	\$1,934.18	\$2,036.69	\$2,142.60
Premium Trend		5.3%	5.2%

Using the rates calculated in Table 8, and the estimated 9.7% increase due to the merged market, we calculated the impact to monthly premium rates. This monthly impact represents the additional amount consumers will pay as a result of moving from current policy, to the merged market policy. In 2022, ARPA and the ACA subsidies insulated virtually all of the income levels from premium differences. It is uncertain if the expanded PTCs under ARPA will continue in 2023, so consumers above 400% of the federal poverty level will be impacted much more significantly by the policy change. The monthly rate impact of merged market policy change is shown for consumers above 400% of poverty in Table 9.

Table 9: 2023 Consumer Impact of Merged Market from Current Policy

Subscriber Category	Total Rate	APTC	Member Paid	Merger Impact
Single	\$557.79	\$0.00	\$557.79	\$54.11
Two Person	\$1,091.01	\$0.00	\$1,091.01	\$105.83
Family	\$2,036.69	\$0.00	\$2,036.69	\$197.56

The projected impact of the proposed policy change in 2024 is shown in Table 10.

Table 10: 2024 Consumer Impact of Merged Market from Current Policy

Subscriber Category	Total Rate	APTC	Member Paid	Merger Impact
Single	\$586.79	\$0.00	\$586.79	\$39.32
Two Person	\$1,147.74	\$0.00	\$1,147.74	\$76.90
Family	\$2,142.60	\$0.00	\$2,142.60	\$143.55

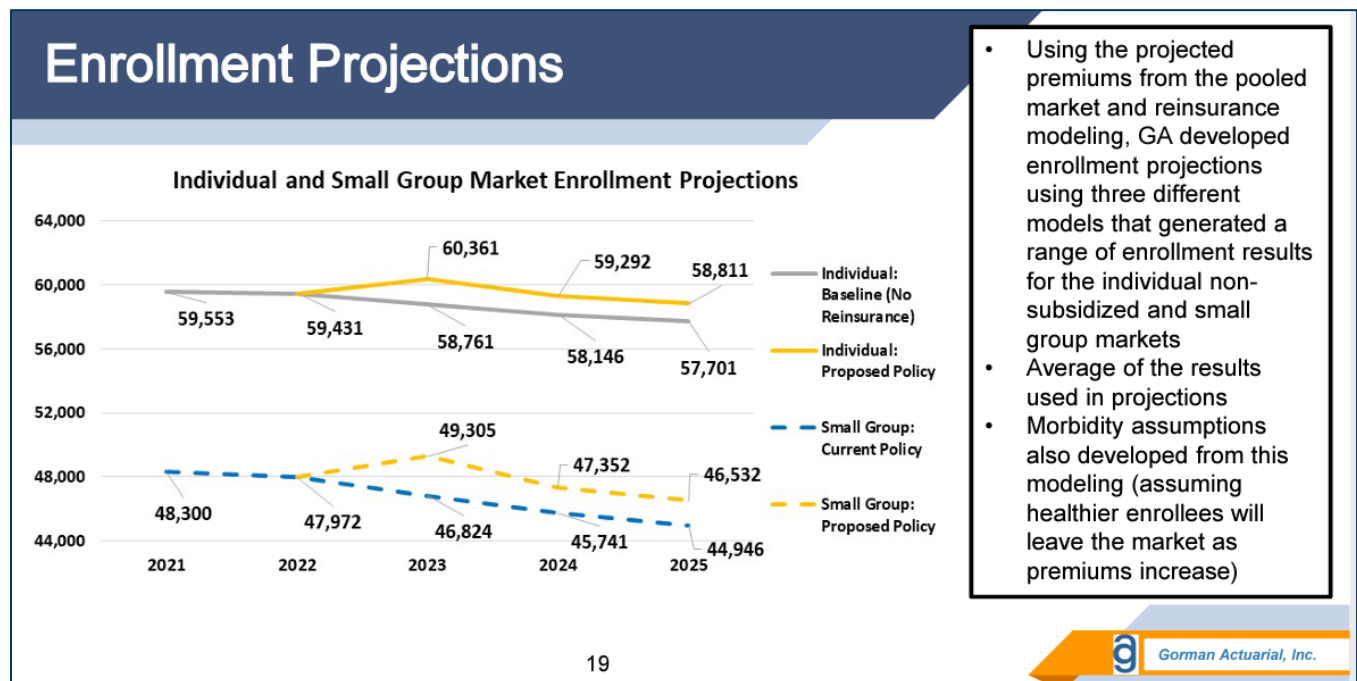
Consumers who purchase off the exchange or who are at or above 400% of FPL will be significantly impacted by the proposed policy. This, in turn, will likely impact membership relative to current policy.

4.5.2 Membership Impact

The proposed policy change will likely impact projected membership. Gorman’s updated report provides merged market membership projections with and without reinsurance.

Gorman projects that including the Section 1332 waiver is expected to increase merged market membership in 2023 by 3.7%, and by 2.6% in 2024, relative to a market with no reinsurance. This compares to current policy in small group. Relative to current policy, Gorman projects premium reductions in the small group market, with small group membership increasing under the proposed policy. Compared to current policy, Gorman projects small group membership increasing by 2,481 members in 2023 and by 1,611 members in 2024. This is based upon 6% premium savings in 2023, and 4% premium savings in 2024.

As noted, current policy in the individual market includes the MGARA reinsurance program. The Gorman 1332 Waiver and Economic Report did not project membership under current policy, but rather projected membership in the merged individual market with and without reinsurance. With the reinsurance, Gorman projects that individual membership would be about 1,600 members higher in 2023 and about 1,146 members higher in 2024.



The membership improvement is relative to a merged market without reinsurance (not current policy), and is based on net premium savings of 8% in 2023, and 6% in 2024, both due to the inclusion of reinsurance.

Gorman projected that the merged market individual premiums (with reinsurance) would be 6% higher than current policy (with existing MGARA) in 2023 and 8% higher than current policy in 2024. Normally,

a premium increase would forecast a reduction in enrollment. However, ACA PTC subsidies shield about 70% of the current individual market members from this increase. In 2022, ARPA-enhanced subsidies substantially expanded these benefits, shielding virtually all marketplace enrollees from premium increases.⁵¹

ARPA’s enhanced premium subsidies may not be available in 2023, exposing consumers to higher net premiums.⁵² Eliminating subsidies for those enrollees that only qualify under ARPA, smaller premium subsidies for others, along with marginally higher premiums following the merged market policy, may bring declines in individual market enrollment.

Appendix H of Gorman’s 1332 Waiver Actuarial and Economic Report, the addendum to Maine’s application, also includes an individual membership projection under current policy in Maine.⁵³ This updated membership projection allows for a direct comparison between current policy and the merged market policy with the reinsurance waiver. Table 11 summarizes the updated projection and shows the difference between the merged market and current policy projections.

Table 11: Individual and Small Group Membership Projections

Current Policy	2023	2024	2025
Individual	62,132	60,525	59,995
Small Group	46,824	45,741	44,946
Total	108,956	106,266	104,941
Merged Market			
Individual	60,361	59,292	58,111
Small Group	49,302	47,352	46,532
Total	109,663	106,644	104,643
Impact			
Individual	-1,771	-1,233	-1,884
Small Group	2,478	1,611	1,586
Total	707	378	-298

Gorman’s updated membership projection illustrates a tradeoff between the individual and small group markets. Implementation of the merged market slows the decline in membership in the small group, but accelerates the membership decline in the individual market. Overall, the merged market policy has a very small impact on the combined membership of the two markets. In fact, Gorman projects that in 2025, the merged market will have a small negative impact on combined membership. Many factors could impact the merged market membership in 2023 and beyond. These include availability and levels of federal premium subsidies; economic and pandemic effects on employment, wages, and access to employer-sponsored insurance; and the degree to which small employers seek to self-insure.

Estimates of enrollment under the merged market depend on reasonable assumptions about the various factors, all within a rapidly changing environment. Most recently (and prior to the 2022 merged-

market policy), the ACA open enrollment period for plan year 2022 resulted in a substantial gain in individual market enrollment. CMS reported that about 65,000 individual members in Maine selected marketplace plans for 2022.⁵⁴ In the 2021 plan year open enrollment period, there were 63,015 plan selections; so under the prior policy, membership increased by about 3.2%.

5.0 Conclusion

The actuarial studies conducted to review the impact of the Maine merged market, including the recent Gorman report, used to support the updated Section 1332 waiver application, used a baseline absent MGARA. Relative to an unmerged baseline with no reinsurance, Gorman projects a 6% decrease in small group rates in 2023, and a 4% decrease in 2024. In the individual market, Gorman projects an 8% decrease in rates in 2023 and a 6% decrease in 2024. In the individual market, despite the favorable impact of lowering premium rates in a merged market, the dilution of the MGARA reinsurance across both markets partially offsets this improvement. Individual rates will increase relative to current policy. Gorman projects a 9.7% increase in rates relative to current policy in 2023, including ARPA-enhanced pass-through funds. Then, with the projected end of ARPA-enhanced funding, Gorman estimates a 6.6% increase in 2024 and beyond, when compared to current policy.

The proposed policy change will likely impact projected membership. Gorman's updated report provides merged market membership projections with and without reinsurance. Gorman projects that including the Section 1332 waiver is expected to increase merged market membership by 3.7% in 2023, and by 2.6% in 2024, relative to a market with no reinsurance. This comparison includes current policy in small group plans. However, the current policy in the individual market includes the MGARA reinsurance program, and rates would be higher under the proposed merged market policy. Appendix H of Gorman's report provides a membership projection under current policy. Implementation of the merged market slows the decline in membership in small group, but accelerates the membership decline in the individual market. Compared to current policy, membership in the merged market with the Section 1332 waiver is expected to increase merged market membership by 0.6% in 2023, by 0.4% in 2024, and then reduce membership by 0.3% in 2025. The merged market has a small impact on the combined membership of the two markets.

A merged market has the potential to provide longer-term stability because of the larger risk pool. However, as the Milliman study points out, the small group market will likely continue to experience selection issues. As this selection occurs, the risk scores are likely to continue to climb, and this will further erode the impact that MGARA can have on the small group market. This selection may be in part due to the ability of small groups to purchase self-insured plans when their claims experience is favorable. These same small business could opt back in to the merged market pool at open enrollment if their claims experience turned unfavorable.

The merged market could impact the number of carriers offering coverage in the small and individual markets. Currently, Maine has three carriers offering plans in the individual market, and they are among the five total carriers that offer plans in Maine's small group market. The three carriers (Anthem, Maine Community Health Options, and Harvard Pilgrim) that offer plans in both markets have 94% of the small group market membership. The other two (Aetna and United HealthCare) that participate only in the small group market enroll a small portion of the small group membership; as of the first quarter of 2021, Aetna had 0.5% and United had 5.4% of the small group membership, covering approximately 4,000 of

the over 51,000 Maine residents in small group coverage. Merging the markets would require carriers to participate in both markets or withdraw. Given the already lower membership of United HealthCare and Aetna in Maine's market, they may decide to exit the market.

Table 12 Carriers and Market Share in Maine Individual and Small Group Markets^{55, 56}

Carriers	Individual Market		Small Group	
	Number Insured	Market Share	Number Insured	Market Share
Anthem	26,456	38.5%	16,037	31.1%
Maine Community Health Options	17,216	25.0%	8,560	16.6%
Harvard Pilgrim & HPHC	25,091	36.5%	22,475	46.6%
Aetna Health Insurance	Not participating	--	3,887	0.7%
United HealthCare	Not participating	--	232	5.4%

On February 15, 2022 Maine Superintendent of Insurance issued an Order that will merge Maine's Individual and Small Group Health Insurance Markets starting on January 1, 2023.⁵⁷ The action will pool the two markets and expand MGARA to include protection against high dollar claimants for the small group market. The intent of the merger is to reverse the trend of steady premium increases and declining enrollment in the small group market, while maintaining stable pricing in the individual market. The State of Maine has applied to the federal Centers for Medicare and Medicaid Services (CMS) to amend Maine's 1332 State Innovation Waiver to enable MGARA to include the small group market in its coverage. If approved, the amended waiver will be the first in the nation under the Affordable Care Act's 1332 waiver program to include both the individual and small group markets.

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April 26, 2022

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Maine Section 1332 State Waiver Amendment Application

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to submit comments on Maine's Section 1332 Waiver Amendment Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting state health insurance marketplaces and the patients that they serve. We urge the Department of the Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that any changes to the healthcare system achieve coverage that is adequate, affordable and accessible for patients. A strong, robust marketplace is essential for people with serious, acute and chronic health conditions to access comprehensive coverage that includes all of the treatments and services that they need to stay healthy at an affordable cost. Our organizations support Maine's efforts to extend its current reinsurance program to a pooled individual and small group market, and we urge the Departments to approve the application.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help

insurance companies cover the claims of very high-cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10% to 14% in its first year.¹ More recently, a data brief released by the Center for Medicare and Medicaid Services showed that states with reinsurance waivers have experienced significantly lower individual market premiums than they would have otherwise and have seen gains in insurer participation.² Maine's application is consistent with this and estimates that premiums will be lowered by 8% in the individual market and 6% in the small group market.

Maine's proposal to establish a reinsurance program will serve to lower premiums for patients, including those with pre-existing conditions, who might otherwise struggle to afford healthcare. This proposal increases health affordability and equity for patients in Maine and will help to strengthen the state's overall health insurance market. Our organizations support Maine's state reinsurance proposal and urge the Departments to approve it.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation
Cancer Support Community
Epilepsy Foundation
Hemophilia Federation of America
National Organization for Rare Disorders
The Leukemia & Lymphoma Society

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JANUARY 2017

AN EVALUATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET AND IMPLICATIONS OF POTENTIAL CHANGES

American Academy of Actuaries
Individual and Small Group Markets
Committee



AMERICAN ACADEMY of ACTUARIES

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Richard Diamond, MAAA, FSA
James Drennan, MAAA, FSA, FCA
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Beth Fritchen, MAAA
Rebecca Gorodetsky, MAAA, ASA
Audrey Halvorson, MAAA, FSA
David Hayes, MAAA, FSA
Juan Herrera, MAAA, FSA
Shiraz Jetha, MAAA, CERA, FCIA, FSA
Raymond Len, MAAA, FCA, FSA
Rachel Killian, MAAA, FSA

Kuanhui Lee, MAAA, ASA
Timothy Luedtke, MAAA, FSA
Scott Mack, MAAA, ASA
Barbara Niehus, MAAA, FSA
Donna Novak, MAAA, ASA, FCA
Jason Nowakowski, MAAA, FSA
James O'Connor, MAAA, FSA
Bernard Rabinowitz, MAAA, FSA, FIA, FCIA, CERA
David Shea, MAAA, FSA
Steele Stewart, MAAA, FSA
Martha Stubbs, MAAA, ASA
Karin Swenson-Moore, MAAA, FSA
David Tuomala, MAAA, FSA, FCA
Rod Turner, MAAA, FSA
Cori Uccello, MAAA, FSA, FCA
Dianna Welch, MAAA, FSA, FCA
Tom Wildsmith, MAAA, FSA

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Executive Summary

In this issue paper, the American Academy of Actuaries' Individual and Small Group Markets Committee examines experience in the Affordable Care Act (ACA) individual market. It outlines the conditions necessary for a sustainable individual health insurance market, examines whether these conditions are currently being met, and discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

What is necessary for a sustainable individual health insurance market?

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Slow spending growth and high quality of care.

How does the ACA individual market measure up to these conditions?

- Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected.
- For the most part, competing plans face the same rules; however, some rules might disadvantage insurers participating on the ACA marketplaces (or exchanges) compared to off the marketplaces.
- The uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.
- In recent years, health care spending has been growing relatively slowly compared with historical averages, but there are signs that growth rates are increasing.

What options have been proposed to improve the sustainability of the individual market?

Many options have been put forward to improve the sustainability of the individual market under the ACA. In addition, ACA replacement approaches have been proposed. The impact of any option or set of options depends on the specific details. This paper makes no recommendations and instead assesses the positive and negative implications of various options, including:

- **Stronger incentives to purchase coverage.** Strengthening the incentives to purchase coverage, through increased penalties for non-enrollment, increased premium subsidies, or a permanent reinsurance program, could help increase enrollment and improve the risk pool. Reducing the 90-day grace period and tightening special enrollment period (SEP) eligibility also have the potential to improve the risk pool by decreasing the potential for abuse of these protections.
- **Greater variation in premiums by age.** Widening premium variations by age could increase participation by young adults, but could result in higher uninsured rates among older adults and increased federal costs for premium subsidies, due to higher premiums for older adults.
- **Restructured premium subsidies.** Current premium subsidies are based on premium levels relative to income. The impact on enrollment, net premiums, and federal spending of basing premium subsidies instead on age or other factors depends on the amount of the subsidies relative to premiums.
- **Reduced regulatory uncertainty.** Releasing rules in a timely fashion would help reduce uncertainty for insurers. In addition, applying rules consistently among insurers is important to maintain a level playing field.
- **Allow insurance sales across state lines.** Allowing insurers to sell coverage across state lines, which states already have the ability to permit, could create an unlevel playing field and threaten the viability of insurance markets in states with more restrictive rules. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.
- **Enhanced state flexibility.** States could pursue approaches tailored to their specific situations through Section 1332 State Innovation Waivers or through other enhancements to state flexibility. Such efforts could include the pursuit of different enrollment incentives, subsidy structures, benefit coverage requirements, premium rating rules, etc.

An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes

Now that the individual market under the Affordable Care Act (ACA) is entering its fourth year of operation, experience is available from 2014–2016 that can be used to help assess the sustainability of the market over the longer term. In this paper, the American Academy of Actuaries' Individual and Small Group Markets Committee outlines the conditions necessary for the individual health insurance market to be sustainable over the long term and examines whether these conditions are currently being met. The paper then discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

SECTION 1

What Is Necessary for a Sustainable Individual Health Insurance Market?

This section outlines the conditions necessary for the sustainability of the individual health insurance market. In general, a financial security program is sustainable if it can be reasonably expected to be maintained over time without requiring significant curtailment or restructuring.¹ This determination involves considering whether all significant stakeholders accept the balance of benefits and costs and whether the program will achieve its goals over its time horizon. The ACA's goals include increasing access to affordable health insurance coverage, enhancing the quality of care, and addressing health spending growth.

With respect to the individual market, the conditions necessary for a sustainable market include achieving enrollment that is sufficient and balanced, a regulatory environment that is stable and facilitates fair competition, participation by health plans that is sufficient for market competition and consumer choice, and slow spending growth and high quality of care. These factors will affect premium affordability; in turn, premium affordability will affect enrollment numbers and risk pools. Subsequent sections of this paper will examine the extent to which the ACA individual market meets these conditions, including the feedback between enrollment and premiums.

Individual enrollment at sufficient levels and a balanced risk pool

Sufficient enrollment levels.

At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year. In states that fund health insurance marketplace operations through user fees, market-wide enrollment must be sufficient to generate adequate user fee revenues. At the insurer level, enrollment must be high enough to achieve stability and predictability of claims and to benefit from economies of scale, so that per-enrollee administrative costs are low relative to average claims.

A balanced risk pool.

Because the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less-healthy individuals can be spread. Enrollment of only individuals with high health care needs, typically referred to as adverse selection, can produce unsustainable upward premium spirals. Attracting healthier individuals (e.g., through the ACA individual mandate and premiums subsidies) is needed to keep premiums more affordable and stable.

A stable regulatory environment that facilitates fair and sufficient insurer competition

Consistent rules and regulations applied to competing health plans.

Health plans competing to enroll the same participants must operate under the same rules. If one set of plans operates under rules that are more advantageous to healthy individuals, then those individuals will migrate to those plans; less-healthy individuals will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to higher-risk individuals will suffer from adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to higher-risk individuals.

Stable effective regulatory environment.

The rules and regulations governing the health insurance market need to be announced with sufficient lead time, relatively stable over time, and not overly burdensome in terms of costs or restrictions on innovation.

Reasonable expectation of earning a fair return.

Insurers operating in the ACA-compliant individual market rely on premium payments from enrollees, federal funding for premium tax credits and cost-sharing reduction subsidies, and risk-mitigation transfers. In total, these revenues must be adequate to cover claims and administrative costs. They must also provide a reasonable margin for contribution to reserves and surplus in order to meet solvency requirements and support ongoing business activities.

Sufficient health insurer participation and plan offerings

Sufficient number of participating health insurers.

Health insurance market competition can provide incentives for health plans to improve the efficiency of health care delivery, lower administrative costs, and provide products that are attractive to consumers. The optimal number of insurers likely differs by area and local market conditions (e.g., the number of eligible enrollees, the degree of provider concentration). Rural areas can support fewer insurers, for instance, due to low potential enrollment numbers and the presence of sole community providers.

Sufficient plan offerings.

The number and range of plan offerings must be sufficient to provide appropriate choice to consumers with respect to plan design features including a variety of out-of-pocket costs, provider networks, and plan type. This does not preclude requiring standardized plan designs. Offerings should not be so numerous that they impose an overwhelming burden on consumers that results in less-than-optimal choices.

Slow health spending growth and high quality of care

Reasonable health care costs and moderate health spending growth.

Long-term sustainability of the individual market requires containing the growth in health spending.

High quality of care.

There must be a focus not only on containing the growth in health care spending but also on improving health care quality, measured for instance based on health care outcomes.

SECTION 2

Assessment of Progress to Date

This section addresses each of the conditions for sustainability identified in Section 1 and assesses progress that has been made as well as challenges that remain to be addressed. Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. For the most part, competing plans face the same rules. However, the uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and declined further in 2017.

Individual enrollment at sufficient levels and a balanced risk profile

Sufficient enrollment levels.

The number of individuals selecting marketplace plans during the annual open enrollment periods increased from 8.0 million in 2014 to 11.6 million in 2015, and to 12.7 million in 2016.² Enrollment numbers decline during the year, as individuals shift to other coverage sources (or to being uninsured) and insurers cancel coverage for consumers who don't pay their premiums. Offsetting part of this decline is enrollment during special enrollment periods (SEPs) for individuals who experience a qualifying event, such as a loss of coverage through a job. At the end of 2015, 8.8 million individuals had marketplace coverage, down from 11.6 million during the open enrollment period.³

Because of differences in populations and other factors, such as consumer outreach and enrollment systems, marketplace enrollment varies among the states. In 2016, the number of individuals with marketplace selections ranged from about 15,000 in Hawaii to 1.7 million in Florida.⁴ Hawaii had a state-based marketplace, but moved to using the federal marketplace because its low enrollment numbers were not enough to generate sufficient revenues to sustain marketplace operations.⁵ Other state-based marketplaces with relatively low enrollment numbers could be at similar risk. For instance, of the 13 remaining state-based marketplaces in 2016, three had fewer than 35,000 individuals with plan selections through the marketplaces during open enrollment (District of Columbia, Rhode Island, and Vermont).⁶

The ACA requires that insurers use a single risk pool when developing premiums. ACA-compliant off-marketplace plans are included as part of this single risk pool. In other words, insurers must pool all of their individual market enrollees together when setting the prices for their products. Therefore, premiums reflect insurer expectations of medical spending for enrollees both inside and outside of the marketplace. Although there are no official off-marketplace enrollment numbers, the Department of Health and Human Services (HHS) estimates that in 2016, about 7 million individuals enrolled in individual market coverage outside of the marketplace.⁷ The majority of these individuals are likely to have ACA-compliant coverage; the Kaiser Family Foundation estimates that in 2016, only 12 percent of all individual market plans are non-ACA-compliant (i.e., grandfathered and transitional plans).^{8,9} This suggests a total ACA-compliant individual market enrollment in 2016 of about 17-18 million.

Enrollment, both on the marketplace and in total, was lower than initially projected by the Congressional Budget Office (CBO) and others. In its May 2013 baseline estimates, CBO projected a total individual market enrollment in 2016 of about 37 million—22 million on the marketplace and about 15 million off marketplace.¹⁰ In updated estimates from its March 2016 baseline, CBO lowered its 2016 enrollment projection to 21 million—12 million on the marketplace and 9 million off.¹¹ One major reason for the downward adjustment is that more employers than projected are continuing to offer coverage, resulting in fewer individuals moving from employer coverage to coverage in the individual marketplace. Lower-than-expected enrollment also suggests that affordability remains a challenge—in 2015, 46 percent of uninsured adults said that they had tried to obtain coverage but it was too expensive.¹² In addition, the ACA's individual mandate may be too weak to provide sufficient enrollment incentives. Outreach efforts may be insufficient to raise consumer awareness of the mandate and availability of premium assistance.

Even with enrollment lower than expected, uninsured rates have declined under the ACA. For instance, the National Health Interview Survey reports that the share of individuals under age 65 who were uninsured at the time of the interview declined from 18.2 percent in 2010 to 10.4 percent during the first six months of 2016.¹³

Despite these coverage gains, about 27 million nonelderly people remain uninsured in 2016.¹⁴ Of these, the Kaiser Family Foundation estimates that 19 percent are eligible for a premium tax credit and 24 percent are eligible for Medicaid. These individuals may be unaware of their eligibility or, in the case of those eligible for premium subsidies, they may still find premiums unaffordable. Forty-seven percent of the uninsured are ineligible for premium assistance—20 percent due to their immigration status, 17 percent because they have an employer offer of coverage that is deemed affordable, and 11 percent because they have incomes that are too high. Another 10 percent of the uninsured would have been eligible for Medicaid if their state had expanded Medicaid coverage. Affordability may also be an issue for these groups. Notably, these are national estimates; percentages will vary among and within states.

A balanced risk pool.

A sustainable market requires not only enrollment at sufficient numbers, but also a balanced risk profile. That is, enrollment should not be skewed toward those with high health care costs; sustainability requires the enrollment of healthy individuals as well. The ACA includes several provisions that aim to reduce the potential adverse selection effects of allowing guaranteed access to coverage at standard premiums regardless of pre-existing health conditions. These provisions include providing premium and cost-sharing subsidies to lower the cost of coverage and imposing a financial penalty for individuals who remain uninsured. Each encourages even healthy individuals to obtain coverage. However, affordability issues and the weakness of the individual mandate could have disproportionately suppressed enrollment among individuals with low expected health care costs.

Lower-than-expected marketplace enrollment has been accompanied by concerns that the risk profile of enrollees was worse than many insurers expected.¹⁵ The average risk profile for a given population in a guaranteed issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher individual market participation rates will tend to reflect a larger share of healthy individuals enrolling, and therefore a more balanced risk profile. In contrast, lower participation rates will tend to reflect a less-healthy risk profile, and in turn higher average costs. This is because those previously uninsured individuals with greater health care needs are more likely to enroll than those with lesser needs.

As expected, evidence from the 2014 open enrollment period suggests that less-healthy individuals were more apt to sign up first. For instance, early marketplace enrollees were more likely to be older and use more medications than later enrollees.¹⁶ Examinations of how the risk pool has been changing over time have yielded some mixed results. A Center for Consumer Information and Insurance Oversight (CCIIO) analysis of per-enrollee costs in 2014 and 2015 suggests that slower cost growth may have resulted from a broader and healthier risk pool and that states with stronger enrollment growth had greater improvements in their enrollee risk profiles.¹⁷ Similarly, an analysis of Covered California marketplace data found that the risk profile at the end of the open enrollment period improved from 2014 to 2015¹⁸ and nationwide estimates suggest an improvement from 2014 to 2015 in the share of marketplace enrollees self-reporting very good or excellent health status.¹⁹ In contrast, an analysis of the ACA risk adjustment program shows an increase in risk scores from 2014 to 2015.²⁰ Although this result suggests a deterioration of the risk pool, other factors could have played a role, such as increased diagnostic coding and better data submission to the Centers for Medicare & Medicaid Services (CMS). In addition, similar to the CCIIO analysis, the report finds that enrollment growth is correlated with an improvement in the risk profile when other factors such as a state's transition policy and Medicaid expansion decisions are controlled for.

The risk corridor results for 2014 and 2015 also support assertions that enrollment was sicker than insurers expected; for many insurers, 2014 and 2015 premiums were too low relative to actual claims.²¹ Some of this understatement was likely due to the implementation of the transitional policy that allowed individuals to keep their prior non-ACA-compliant coverage. In states adopting the transition policy, ACA-compliant plans exhibited less favorable experience because lower-cost individuals were more likely to retain their prior policies. But even in many states that didn't allow for transition policies, insurers were more likely to receive risk corridor payments, suggesting that market average claim costs were higher than assumed in premium pricing.

Except for grandfathered plans, individuals will not be allowed to renew non-ACA-compliant plans beyond Dec. 31, 2017. In states that allowed transition policies, an influx of individuals from these plans to ACA-compliant plans could help improve the risk profile in 2018.

Risk profile concerns may have continued into 2016. The Kaiser Family Foundation estimated that during the 2016 open enrollment period, nationwide only 46 percent of the potential marketplace population selected a marketplace plan, ranging from a low of 22 percent in Iowa to a high of 74 percent in the District of Columbia.²² However, these figures understate total ACA-compliant enrollment to the extent that individuals enrolled off marketplace (notably, the District of Columbia does not offer plans off marketplace).

The availability of SEPs for individuals who encounter certain life events—such as losing health insurance coverage, moving, or getting married—also can affect average claim costs. Eligibility requirements for SEPs in the marketplaces have not been stringently enforced, thereby creating opportunities for individuals to delay enrollment until health care services are needed. On average, SEP enrollees have had higher claim costs and higher lapse rates than individuals enrolling during the open enrollment period.²³ The worse experience exhibited by SEP enrollees could be resulting from a combination of higher enrollment among SEP-eligible higher-cost individuals, lower enrollment among SEP-eligible low-cost individuals, and enrollment among higher-cost individuals who would not meet SEP eligibility criteria if validation were required. CCIIO is exploring additional verification requirements for individuals who purchase coverage on the marketplaces.

The availability of long premium payment grace periods for subsidized enrollees could also contribute to an unhealthy risk profile. Individuals who receive premium subsidies on the marketplace and have paid at least one month's premium are allowed a grace period of 90 days for future premium payments. States govern the grace period, typically 30 days, for individuals not receiving subsidies and those purchasing coverage off marketplace. Longer grace periods for on-marketplace plans can worsen the risk pool profile by allowing healthy people to pay premiums for nine months and be assured of 12 months of coverage if needed. In other words, individuals who develop health problems can retroactively pay premiums in order to maintain coverage; individuals who remain healthy can skip payments for the last three months of the year and simply enroll for the next year's coverage during the open enrollment period. The risk adjustment program does not mitigate lost revenue problems arising due to healthy people not paying a full year of premium. It's unclear the extent to which subsidized enrollees may be taking advantage of the extended grace period.

A recognition by insurers of worse-than-expected risk pool profiles in 2015 was likely a factor that contributed to 2017 premium increases. Insurers have more information now than they did last year regarding the risk profile of the enrollee population and used that information to adjust their 2017 assumptions accordingly.²⁴

A stable regulatory environment facilitating fair competition

Consistent rules and regulations applied to competing health plans.

A stable marketplace requires that rules be consistently applied to all competitors in order to prevent particular insurers from being inappropriately advantaged or disadvantaged. Inconsistent regulations distort the market, reducing competition and limiting consumer choices. Fair competition also requires rules to prevent insurers from gaming the system. These conditions are generally met under the ACA, but not completely.

The same issue and rating requirements apply to all individual market insurers in a state, regardless of whether coverage is offered on or off the state marketplace. However, many states decided to take up the federal option of allowing individuals to keep non-ACA-compliant coverage, which put ACA-compliant plans at a disadvantage with respect to enrolling healthier individuals. This transition policy expires at the end of 2017; beginning in 2018, individuals in these plans will need to purchase ACA-compliant coverage.

ACA-compliant plans on and off the marketplaces participate in the risk adjustment program. By transferring funds between insurers based on the relative risk of their plan participants, the risk adjustment program aims to reduce incentives for insurers to avoid enrolling people at risk of high health spending. An Academy analysis found that for the 2014 plan year, the risk adjustment program compressed the loss ratio differences among health plans—risk adjustment transfers increased average loss ratios among health plans with low loss ratios and reduced loss ratios for health plans with high loss ratios, indicating that the program generally worked as intended for the individual market.²⁵ Nevertheless, risk adjustment payments can be affected by diagnostic coding and operational issues, and risk adjustment transfers as a percent of premium are much more variable among smaller insurers, which can produce unexpected results.

Non-ACA-compliant plans are not part of the risk adjustment program. Therefore, the program cannot mitigate the differences in enrollment patterns between non-ACA-compliant plans, which are more attractive to healthy individuals, and ACA-compliant plans.

One example of rules that apply differently on and off marketplace is the length of the premium grace period. As noted above, a 90-day grace period is available for individuals receiving premium subsidies, whereas the grace period is typically 30 days for other enrollees, including those purchasing coverage off the marketplaces. This can create a minor advantage for insurers selling off marketplace only.

There are also some differences in how fees are levied among insurers. Marketplace user fees are collected to support marketplace operations. The fee is charged only on marketplace business, but insurers must spread the fee across its marketplace and off-marketplace business. Insurers that operate only off marketplace do not need to reflect the fee in their premiums.

Stable effective regulatory environment.

Uncertainty in the regulatory environment can impact premium adequacy and stability, and ultimately insurer solvency. ACA regulations put into place standardized and effective processes for premium rate development, actuarial value determinations, and rate review processes that contribute to relative stability in the year-by-year rate filing processes. However, certain regulatory and legislative changes have seriously undermined this stability, negatively affecting the risk pool profiles, premium adequacy, and insurer financial results. In addition, delays in the release of important information can negatively affect stability.

- **Allowing individuals to retain pre-ACA coverage.** The decision to allow individuals to retain pre-ACA coverage was not made until 2014 premiums were finalized. In states that allowed pre-ACA plans to be renewed, this decision resulted in the risk pool profiles of ACA-compliant coverage being worse than expected and contributed to premiums being low relative to actual claims.
- **Constraints on risk corridor payments.** Risk corridors were included in the ACA to mitigate the pricing risk in the early years of the program. Although originally not specified to be budget neutral, subsequent legislative and regulatory actions have limited risk corridor payments to those that can be paid through risk corridor collections. If there is a shortfall, risk corridor payments are made on a pro rata basis. Due to such a shortfall for the 2014 plan year, only 12.6 percent of risk corridor payments were made.²⁶ The failure to pay the full amounts led to financial difficulty for many plans, in particular many Consumer Operated and Oriented Plans (CO-Ops). For instance, the Kentucky Health Cooperative specifically cited the lack of full risk corridor payments as a reason for closure.²⁷ HHS has indicated that no funds will be available for 2015 risk corridor payments, as any 2015 risk corridor collections will be used toward remaining 2014 risk corridor payments.²⁸
- **Legal challenges to the ACA.** The steady flow of lawsuits has created additional costs and uncertainty. For instance, many states using the federal marketplace required dual premium submissions for the 2016 plan year because the Supreme Court had not yet

ruled on *King v. Burwell* (regarding the availability of premium subsidies) at the time premium filings had to be submitted for review. This required additional resources and expenses. Other cases are currently working their way through the courts. One that could have significant implications for premiums and insurer financial stability involves whether the administration has the legal authority to make cost-sharing reduction payments to health plans.²⁹

- **Timing of available risk adjustment information.** Because the risk adjustment program depends on the market-wide risk profile, there is uncertainty regarding the amount that insurers expect to pay or receive under the program. Risk adjustment results in 2014 and 2015 were much different than expected for some insurers, resulting in unexpected losses. This risk adjustment “shock” is another reason cited for causing solvency problems for CO-OPs and other smaller plans.³⁰ Because of the lag in reporting, final risk adjustment results for a given plan year are not released until the middle of the next year, after premiums have already been filed for the year after that. In recognition of this time lag, CCIIO has begun to release interim reports that provide summary risk adjustment information. This information is not available for all states and insurers using the reports must do so with caution because the final results can differ significantly from interim estimates.
- **Timing of final rules.** The rulemaking process is understandably long and involved. Nevertheless, the earlier that rules are finalized, the easier it is for insurers to meet deadlines for product and rate filings in May. The final rules applicable to 2018 premium filings were released in December, earlier than in prior years. This earlier release will reduce rulemaking uncertainty, especially if this timeframe is continued in future years.

Reasonable expectation of earning a fair return.

Like all businesses, insurers participating in the individual market have an obligation to protect their viability and solvency, requiring that they must earn a fair return that supports ongoing business activities. Premiums net any of other payments or receipts (e.g., through the risk adjustment and reinsurance programs) must be adequate to cover claims and all administrative costs, taxes, and fees, and still provide a margin for profit or contribution to reserves and surplus.

The ACA reforms implemented in 2014 significantly changed insurance market rules and increased business risks. The most fundamental of these risks is related to projecting claim costs. Insurers had very limited data available to estimate who would enroll in plans under the new rules and what their health spending would be. It was likely that the composition of the insured population would change dramatically due to the elimination of underwriting and the introduction of premium subsidies. The risk adjustment and transitional reinsurance programs also needed to be factored in, while the temporary risk corridor program could be viewed as providing a partial safety net for premium rate development uncertainty.

Even with all the known risks, issuers were further subject to circumstances that could not reasonably have been anticipated. As noted above, these include the ability for individuals in many states to continue non-ACA-compliant transitional coverage in 2014 and beyond, as well as the federal government's failure to make risk corridor payments in full.

In an analysis of 2014 experience, McKinsey & Company found much variation in financial performance among insurers, with about 40 percent of the market covered by insurers with positive margins; the aggregate post-tax margin in 2014 was -4.8 percent.³¹ The transition policy may have contributed to losses, as did insurer-specific factors, with CO-OPs and insurers offering preferred provider organization (PPO) plans and broad networks experiencing larger losses. Health maintenance organizations (HMOs), insurers with narrower networks, and Medicaid-based plans had more favorable experience, on average.

Once financial losses have been suffered, they cannot easily be recouped through future gains in the individual marketplace. Pricing margins can be limited by the rate review process and competitive pressures, which often puts downward pressure on rates, and health plans are not allowed to build in provisions to recoup past losses into premium rates.

Prior to the ACA, normal fluctuations in year-by-year margins could result in poorer-than-expected margins being offset by better-than-expected margins in subsequent years. The ACA's medical loss ratio (MLR) requirements limit the extent to which this can occur. These requirements stipulate that if claims plus quality improvement expenses fall below 80 percent of premium net of taxes and fees (in effect meaning that administrative costs and profit exceed 20 percent of premium), insurers may be required to return the difference to plan members.

Insurers and regulators now have more experience that can be used to develop and review future premiums. S&P Global Ratings recently forecast that insurer financial performance will improve, with smaller aggregate losses in 2016 than in 2015 and continued improvement in 2017 with more insurers becoming profitable.³²

Nevertheless, continuing uncertainty and ACA legal challenges mean that pricing and solvency challenges in the market remain. This has caused many issuers to question their ability to earn a fair return—resulting in some issuers withdrawing from existing markets and fewer issuers having an interest in entering new markets.

Sufficient health plan participation and plan offerings

Sufficient number of participating health insurers.

Although there is no definitive minimum number of health insurers that are needed to ensure a competitive marketplace, it is generally recognized that competition can be difficult with fewer than three insurers.³³ This threshold may be lower than in other markets due to consumers' ability to compare plans under the ACA.³⁴

The average number of ACA marketplace insurers per state increased from 5.0 in 2014 to 6.1 in 2015, and then declined to 5.7 in 2016.³⁵ Due to the failure of a number of small carriers, especially the CO-OPs, and market withdrawal announcements by some larger carriers (e.g., Aetna, Humana, UnitedHealth), the number of insurers is decreasing further in 2017. These averages mask tremendous variation among states. For instance, in 2017, five federal marketplace states (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming) have only one insurer. On the other end of the spectrum, Wisconsin has 15 insurers, Ohio has 11, and Texas has 10. Within states, the number of insurers offering coverage can vary by county, with rural counties having fewer participating insurers. Avalere estimates that in states using the federal marketplace, the average number of insurers per county has fallen from 5.3 in 2016 to 2.9 in 2017, and 21 percent of enrollees have only one participating insurer for 2017.³⁶

It was expected that insurer exits and entries would occur during the early years of the ACA as insurers adjust to the new market rules. Nevertheless, recent marketplace pullbacks, especially among some major insurers, raise a concern that the current ACA marketplace environment is not viable from a business perspective. (Notably, some of the insurers pulling back from offering marketplace coverage continue to offer ACA-compliant coverage outside of the marketplace.) A reduction in competition due to fewer participating insurers can reduce consumer options as well as impact premiums. The ability of insurers to effectively compete depends in large part on their ability to manage costs, which in turn reflects their ability to effectively negotiate with providers to lower utilization and costs (e.g., through narrower networks). Insurers with larger market shares in a particular area may have more leverage in provider contracting. (The dynamic may be different in rural areas with a limited number of providers—rural providers can have more negotiating power even if there is only one insurer.) On the other hand, having a more competitive market could provide insurers more incentives to negotiate aggressively and to pass along savings to consumers. Research based on 2014 and 2015 ACA premiums suggest that the addition of an additional competitor leads to lower premium increases, but the competitive effects shrink after two or three additional entrants.³⁷

Due in part to lower potential enrollment, rural areas can support fewer insurers, so it is not surprising that there are fewer participating insurers in rural counties and states. Nevertheless, having only one or even no participating insurers in some areas is a cause for concern.

Sufficient plan offerings.

Consumers have choices with respect to their particular plans. The ACA provides for four metal levels, which reflect relative plan generosity, as well as a catastrophic plan available to young adults and individuals who qualify for a hardship exemption from the individual mandate. Insurers offering marketplace coverage must offer silver and gold metal plans, but are not required to offer the other metal levels. In most states, insurers have flexibility within metal levels to set particular benefit design and cost-sharing requirements. Some state marketplaces impose standardized plan options, but may allow non-standardized options as well. Standardized benefit options may help simplify consumer choices and facilitate plan comparisons,³⁸ but could also inhibit innovative plan designs. For the 2017 plan year, the federal marketplace is offering standardized benefit designs, called Simple Choice plans, on an optional basis. Insurers can also offer choices across additional plan dimensions, such as plan type (e.g., HMO, PPO), which can affect the level of care management, how broad or narrow the provider network is, and the availability of out-of-network benefits.

Over the first three years of the ACA, the average number of marketplace plans offered per county in federal marketplace states increased from 51 in 2014 to 55 in 2015, and then decreased to 48 in 2016; plan offerings per county is further decreasing to 30 in 2017.³⁹ Plan offerings and enrollment are concentrated in silver plans, which would be expected given that premium subsidies are based on silver plans and cost-sharing subsidies are available only for silver plans.

Forty-seven percent of 2017 federal marketplace plans are silver plans; 33 percent are bronze. On average, only one platinum plan is offered per county, and many areas have no platinum plan offerings at all. Enrollment has been even more concentrated; as of March 31, 2016, 70 percent of enrollment nationwide is in silver plans and 22 percent is in bronze.⁴⁰

The type of plans offered in the marketplaces has been changing, with a decline in less restrictive network PPO offerings. This shift may reflect consumers' willingness to forgo access to a broad set of providers and looser utilization management in return for lower premiums and cost sharing. Among silver plan offerings, PPO plans have declined from 52 percent of plan offerings in 2014 to 35 percent in 2016, and were expected to decline further in 2017, especially among competitively priced plans.⁴¹ Some areas have few or no PPO marketplace offerings.⁴² More restrictive network plans, such as HMOs and exclusive provider organizations (EPOs), are becoming a larger share of marketplace offerings. Low- and moderate-income consumers may be more open to narrower networks,⁴³ and Medicaid-based marketplace plans are particularly based on HMO and EPO plans.⁴⁴ Nevertheless, the high deductibles associated with lower-metal-level plans have generated concerns regarding high out-of-pocket costs.⁴⁵ On average, plan offerings are broader off marketplace, both in terms of plan type and metal tier,⁴⁶ but premium subsidies are not available for off-marketplace plans.

Insurers are shifting toward narrower provider networks in marketplace plans to lower premiums.⁴⁷ Health insurers negotiate provider payment rates and other network participation terms, such as those related to quality and sharing financial risk. Providers often accept lower payment rates in return for being included on a plan's network. Deep provider discounts have been negotiated in some cases, particularly when the health insurer is able to leverage rate negotiations between two competing health care systems.

Slow health spending growth and high quality of care

Because most premium dollars go toward paying medical claims, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires controlling health care costs. Medical spending trends for the individual market reflect those for the health system as a whole. In recent years, health spending has been growing relatively slowly compared with historical averages. Nevertheless, national health spending made up 17.8 percent of the economy in 2015.⁴⁸ Because health spending has been growing faster than the gross domestic product (GDP), this share is increasing.

There are signs that health spending growth rates are beginning to increase. Prescription drug spending growth has been particularly high recently, due to price increases and the introduction of high-cost specialty drugs. According to national health spending projections from the CMS Office of the Actuary, annual per capita spending growth for those with private health insurance will increase from 3.2 percent in 2014 to 4.9 percent from 2016 to 2019.⁴⁹ This higher growth rate remains lower than the 7.1 percent annual growth rate from 2007 to 2013, but exceeds projected annual per capita GDP growth by 1.0 percentage point. Growth in per capita health spending will directly result in premium increases.

Not only is national health spending high and growing, there is evidence that we are not spending our health care dollars wisely. For instance, the Institute of Medicine estimated that 10-30 percent of health spending is for unnecessary care or other system inefficiencies and that missed prevention opportunities also add to excess spending.⁵⁰ Although the medical care that people receive can vary dramatically across and within geographic regions, those variations are unrelated to health outcomes,⁵¹ also indicating inefficient spending. In addition, medical errors are now the third leading cause of death,⁵² raising quality concerns.

SECTION 3

Addressing ACA Individual Market Challenges

This section discusses the potential implications—both positive and negative—of several options that have been proposed to address the challenges in the individual market under the ACA. This section focuses on options to improve the risk pool profile, increase insurer participation, and improve the regulatory environment. Although the long-term sustainability of the individual market depends on containing health care spending, this is a health system-wide issue and not unique to the individual market. As such, an examination of payment and delivery system reform options is beyond the scope of this paper.

Options to Achieve Sufficient Enrollment Levels and a Balanced Risk Profile

One of the most popular elements of the ACA is that people with pre-existing health conditions cannot be denied health insurance coverage or charged more for that coverage. For this provision to work, however, healthy people must enroll at levels high enough to spread the costs of those who are sick. Otherwise, average costs, and therefore premiums, will rise. This section explores options related to approaches that aim to increase enrollment and attain a balanced risk profile.

Impose penalties for non-enrollment

One way of increasing enrollment is to penalize individuals who do not enroll. An individual mandate may be the best way of using penalties to increase enrollment, but only if it is effective and enforceable. Other options that impose penalties on individuals who initially forgo coverage but later enroll may provide some incentives to enroll when first eligible. However, their effect on the risk pool may come more from suppressing later enrollment or mitigating the costs of future adverse selection.

- **Individual mandate.** The ACA individual mandate penalty (\$695 or 2.5 percent of income, whichever is greater) may not be strong enough to encourage healthy consumers to enroll. For instance, an annual income of \$50,000 would result in a tax penalty of \$1,250, which is about half of the national average premium for a bronze plan.⁵³ A larger financial penalty would increase the incentives for individuals to enroll, especially as the amount of the penalty approaches the amount of the premium.

Strengthening the mandate's enforcement could also increase its effectiveness. Currently, the mandate penalty is reported on the federal income tax form and is deducted from any tax refund. If no refund is owed, however, there are no consequences to the taxpayer if the penalty goes unpaid. Enforcing payment regardless of whether there is a tax refund would increase the mandate's effectiveness.

Increased outreach to ensure that consumers are aware of and understand the penalty as well as their coverage options and potential eligibility for premium subsidies would help increase the mandate's effectiveness, as would reducing allowed exemptions to the mandate.

- **Continuous coverage requirement/reduce access to coverage for late enrollees.** Another form of a late enrollment penalty would be to remove the pre-existing condition coverage protections for late enrollees or for those who haven't had continuous coverage for a specified period of time, such as 18 months. In other words, insurers would be allowed to underwrite individuals who do not enroll when first eligible or do not meet continuous coverage requirements. Individuals with pre-existing conditions could be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions.

If this type of approach were structured to allow insurers to offer preferred premiums to individuals who meet underwriting requirements, however, the marketplace would in effect return to a pre-ACA environment. Healthy individuals, even those who had continuous coverage, would have an incentive to undergo underwriting. As a result, healthy individuals would be charged lower premiums and less healthy individuals would face higher premiums and potentially less generous or no coverage options. Similarly, if this approach moved away from requiring a single risk pool with risk adjustment among all plans, market fragmentation could occur and plans insuring higher-cost individuals would require higher premiums and could become less viable.

A continuous coverage requirement in effect imposes a one-time open enrollment period. Instead of having only a one-time open enrollment period, or annual open enrollment periods as under the ACA, an intermediate approach would be to offer open enrollment periods every two to five years.

- **Late enrollment premium penalty.** In addition to or instead of an individual mandate penalty, individuals who do not enroll in coverage when it is first available could be subjected to a premium surcharge if they later enroll. For instance, the Medicare program increases Part B and D premiums by 10 percent of premium for every 12 months that enrollment is delayed past the initial eligibility date. (Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums probably play a larger role.) The higher premium is paid for the lifetime of the enrollee. Such a penalty would be more challenging to implement under the ACA. It would be difficult to track an individual's eligibility and enrollment over time, especially when individuals change employers or move between different coverages. Communicating the nature of the penalty to consumers could also be difficult. In addition, as the penalty accumulates over time, premiums could become prohibitively expensive, potentially further suppressing subsequent enrollment, potentially more so among healthy individuals.

Provide enrollment incentives

In the ACA, the individual mandate is the stick and premium subsidies are the carrot used to encourage enrollment, especially among healthy individuals. Although much attention is focused on the enrollment experience among young adults, who on average have lower health care costs, enrolling low-cost individuals of all ages should be the goal. Enrolling healthy older adults can be even more advantageous than enrolling healthy younger adults, because of the higher premiums paid by older adults. Regardless of age, attracting low-cost individuals depends on whether they deem that the value of the health insurance available exceeds the premiums charged. Reducing premiums through premium subsidies, tax credits, or other means could increase the perceived value of insurance, even to healthy individuals. The impact of any change in subsidies on enrollment, premiums, and government spending would depend on the details of the approach.

- **Premium subsidies.** Premium subsidies for ACA coverage are based on income and the cost of the second-lowest silver tier plan, and are available for individuals with incomes up to 400 percent of the federal poverty level (FPL). Nevertheless, premium affordability appears to continue to be a problem. Premium subsidies could be increased, perhaps targeting different subsets of enrollees. One option would be to increase the premium subsidies for all individuals currently eligible for premium subsidies—those with incomes between 100 and 400 percent of FPL. This would help address the concern that premiums remain unaffordable for low- and moderate-income individuals. Another option would be to increase subsidies for a subset of individuals currently eligible for premium subsidies (e.g., individuals with incomes of 250-400 percent of FPL, younger adults, older adults) if affordability issues are seen as greater for those subgroups. A third approach would be to extend subsidies to individuals with incomes exceeding 400 percent of FPL, in recognition that even higher-income individuals can face affordability problems. By increasing subsidies, net premiums would decline, increasing the incentives for even healthy individuals to obtain coverage.

- **Restructured premium subsidies.** The ACA premium subsidy structure sets a cap on premiums as a share of income, and the cap increases with income as a share of FPL. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit, which can be used toward any plan in the marketplace. If the plan chosen costs less than the second-lowest silver tier plan (e.g., the lowest silver tier plan, a bronze tier plan), the enrollee will pay less than the premium cap. Because premiums for older adults are more expensive than premiums for younger adults, older adults will receive a higher premium subsidy than younger adults with the same income. Using that subsidy toward a lower-priced plan could result in an older adult paying a lower net premium than a younger adult with the same income. Conversely, if a higher-cost plan is chosen, older adults would pay a higher net premium than younger adults with the same income.

The subsidy structure could be changed so that subsidies vary by age, instead of or in addition to varying by income. For instance, subsidies could be targeted to increase enrollment among young adults. Regardless of how they are structured, subsidies need to be sufficient so that premiums are affordable, especially for low- and moderate-income households.

- **Reimbursement for high-risk enrollees.** The ACA includes a transitional reinsurance program that uses contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. To the extent that the group insurance market (including self-funded plans) has a healthier risk profile than the individual market, this mechanism in effect acts as a risk adjustment program between the individual and group markets. The program was in effect from 2014-2016 only. A permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums. For instance, during the reinsurance program's first year, the \$10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.⁵⁴ Such a program to pool high risks could be implemented at the state or federal level and could use the current funding mechanism or another. For instance, the state of Alaska recently established a comprehensive health insurance fund that will act like a reinsurance program, thereby lowering 2017 premium rate increases.

Modify insurance rules

Under the ACA, premiums cannot vary by health status, but are allowed to vary by age, up to a 3:1 ratio. The ACA also imposes rules regarding the comprehensiveness of coverage. These rules can affect average premiums and out-of-pocket costs. They also affect how premiums vary across individuals.

- **Wider premium variations by age.** Widening the allowable age variation from a 3:1 ratio to a 5:1 ratio would more closely align premiums to underlying costs by age. One study estimates that such a change would reduce premiums for 21-year-olds by 22 percent (\$70 per month), resulting in an increase in young adult enrollment.⁵⁵ However, premiums for 64-year-olds would increase by 29 percent (\$274 per month), likely reducing older adult enrollment while also increasing federal costs for premium subsidies due to the higher premiums. Unsubsidized healthy older adults may be the most likely to drop coverage. On net, the study estimates that loosening the age bands would increase federal premium and cost-sharing subsidies by \$11 billion in 2018 under the current ACA subsidy structure.
- **Increased access to catastrophic coverage or the addition of a lower tier “copper” plan.** Less generous coverage could be appealing to younger adults and healthy people of all ages more generally. The ACA offers a catastrophic plan option to adults under age 30 and older adults who have a hardship exemption from the individual mandate. However, individuals are not allowed to use premium tax credits toward catastrophic plans and the actuarial value of catastrophic plans is similar to bronze plans. As a result, current participation in catastrophic plans is quite low—less than 1 percent of marketplace enrollees.⁵⁶

Allowing broader access to catastrophic coverage with even lower actuarial values and allowing premium tax credits to be used toward this coverage could increase enrollment, especially among healthy individuals. Under current law, however, increased enrollment in catastrophic plans won’t affect premiums for the metal level plans—although catastrophic plans are part of the single risk pool, catastrophic plan premiums are allowed to be adjusted to reflect the expected impact of catastrophic plan eligibility. In addition, catastrophic plans are treated separately in the risk adjustment program.

Adding a copper tier plan, with an actuarial value lower than that of the bronze tier plans, could result in increased enrollment among young and healthy individuals. However, the lower premiums associated with these plans mean that it would be more difficult to spread the risk of higher-cost enrollees in more generous plans. In addition, by their nature, both catastrophic plans and copper tier plans would have higher out-of-pocket cost-sharing requirements than other plans. This may be less of an issue for high-income individuals, but these types of plans are a less viable option for low- and perhaps even moderate-income individuals. (Individuals with incomes less than 250 percent FPL are eligible for cost sharing subsidies, but only if they purchase silver tier plans.)

- **Increased benefit design flexibility.** Designing benefit packages that would be more attractive to healthy enrollees could increase their participation. For instance, offering primary care visits or generic drugs with low copayments before the deductible could be a way to increase the value of benefits. Although insurers already have flexibility to vary plan designs within the actuarial value constraints, the HSA rules prohibit paying most non-preventive benefits prior to the deductible. Relaxing those rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits while also potentially reducing costs.

Make risk pools less susceptible to adverse selection

Even with provisions such as an individual mandate and premium subsidies that aim to reduce the adverse selection effects of prohibiting discrimination against individuals with pre-existing conditions, some degree of adverse selection will occur. In addition, many individuals enroll after the year begins, either later during the open enrollment period or during a special enrollment period. And many individuals drop coverage prior to the end of the year. Partial-year enrollment is not unexpected in the individual market, as individuals move between it and other sources of coverage, such as employer group coverage. Nevertheless, partial-year enrollment can be especially prone to adverse selection. Further mitigating adverse selection and encouraging full-year enrollment can improve the risk pool profile and market stability.

- **Modify the open enrollment period.** Shortening the open enrollment period or ending it prior to January 1 would increase the confirmed enrollment in January. As a comparison, the 2017 open enrollment period runs from November 1 to January 31 for ACA plans, but only from October 15 to December 7 for Medicare. Having an ACA open enrollment as short as that for Medicare might not be currently feasible—more time may be needed for outreach and enrollment efforts. In addition, individuals may need until December to know what their financial situation for the next year will be (e.g., whether they get a raise can affect enrollment decisions). Nevertheless, an enrollment period that ends prior to January 1 could reduce the potential for adverse selection, thus improving the average risk profile. In addition, it would help insurers understand their enrollee population sooner, direct members into care management programs earlier, provide more time to send welcome materials to enrollees, and better ensure enrollees access to insurance benefits closer to January 1.
- **Reduce the 90-day grace period.** Individuals receiving premium subsidies are allowed a 90-day grace period for premium payment. This can enable enrollees to select against the market by paying premiums retrospectively only if they use services during that time; those who don't use services can let their coverage lapse. This can destabilize the market and increase average costs per enrollee. Reducing the grace period so that it is the same as that for individuals not receiving subsidies, typically 30 days, could keep enrollees participating regardless of need, and for a longer duration. Concerns regarding premium affordability could be addressed through other mechanisms, such as increased or restructured premium subsidies.
- **Tighten SEP eligibility and enrollment verification.** Recent changes by CMS to eliminate some SEP categories and tighten the eligibility requirements for certain SEPs have been reported to have resulted in a 15 percent decline in SEP enrollment.⁵⁷ CMS has also announced plans to test procedures that would verify SEP eligibility.⁵⁸ Further limiting SEP eligibility and tightening enforcement could reduce any abuses of SEP eligibility that might be occurring. Although potentially difficult to implement, an additional option is to prohibit SEP enrollees from choosing richer plans than their prior coverage. Any requirements regarding SEP enrollment should not be so onerous as to reduce participation among those legitimately eligible, otherwise the consequence could be to reduce participation among healthy SEP eligibles, thus worsening the risk pool. Because higher claim costs among SEP enrollees likely reflects not only abuse of SEP eligibility, but also higher enrollment among high-cost SEP eligibles, consideration

should be made to increase outreach regarding SEP eligibility and the individual mandate (e.g., notices to employees losing group coverage). Doing so could reduce adverse selection by increasing participation among low-cost SEP eligibles. Nevertheless, late-year SEP enrollment among healthy eligibles could be low because deductibles aren't prorated.

- **Limit third-party premium and cost-sharing payments.** Adverse selection can occur when third parties pay an individual's insurance premiums and cost sharing, as these payments are more typically made on behalf of individuals with high health care needs. Payments from certain third parties may be appropriate. For instance, CMS requires insurers to accept third-party payments from federal, state, and local programs. However, it is less appropriate for providers who will receive payments for their services to be making payments on behalf of enrollees. CCIIO has expressed concerns that provider organizations could be steering Medicaid and Medicare patients to marketplace plans in order to obtain higher reimbursement rates.⁵⁹ Dialysis providers in particular appear to be benefiting from such steerage, even if it is not the best coverage option for patients. To address this issue, CMS issued rules to improve dialysis facility disclosure requirements and transparency around third-party premium payments.
- **Establish high-risk pools.** Rather than directly increasing the participation of healthy individuals, high-risk pools could be established to remove high-cost enrollees from the risk pool, reducing premiums for the remaining enrollment. If the issue and rating requirements were relaxed to allow insurers to deny coverage or charge higher premiums to individuals with pre-existing conditions, average standard premiums would be lower but high-risk individuals could have difficulty obtaining coverage. High-risk pools have been used to facilitate coverage for high-risk individuals, but enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss.⁶⁰ Substantial funding would be required for high-risk pools to be sustainable. In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums. As discussed above, an alternative is to use funding that would have been directed to external high-risk pools toward a program that reimburses plans the costs of high-risk enrollees.

Increase sources of potential individual market enrollment

Another approach to increasing enrollment in the individual market is expanding eligibility to other groups:

- **Incorporate Medicaid expansion population into the individual market.** The ACA expanded Medicaid eligibility to 138 percent of the FPL. Arkansas and New Hampshire received federal waivers to expand Medicaid by purchasing marketplace coverage for newly Medicaid-eligible adults; the Arkansas waiver began in 2014 and the New Hampshire waiver began in 2016. Iowa had implemented a similar program but subsequently terminated it when the remaining marketplace insurer would no longer accept Medicaid enrollees. Other states could pursue the approach of using Medicaid funds to purchase marketplace coverage. Incorporating the Medicaid expansion population into the individual market would increase marketplace enrollment, potentially increasing marketplace stability. But the impact on the risk profile and resulting premiums is unclear—having a lower income is often associated with having poorer health. In 2015, Arkansas had the highest average risk score in the individual market (but closer to the average risk score in the small group market), perhaps reflecting in part the Medicaid waiver. In addition, there is evidence that marketplace premiums are lower on average in states that expanded Medicaid compared to those that have not.⁶¹ These findings suggest that expanding traditional Medicaid could improve marketplace risk profiles, although marketplace enrollment would decline.
- **Merge the individual and small group markets.** Merging the individual and small group markets into a single risk pool would increase the size of the risk pool. Whether it would lead to greater market stability and lower premiums, at least compared to the individual market, would depend on the relative size and risk of the individual market compared to the small group market. For instance, if a state's small group market is relatively large and lower risk than its individual market, the small group market would more easily absorb the individual market, lowering premiums for those previously in the individual market without substantially increasing premiums for those previously in the small group market. In contrast, if the small group market in a state is relatively small compared to the individual market, merging the markets could increase small group premiums without a significant reduction in individual market premiums. Other factors that could impact outcomes are whether merged market premiums would be allowed to vary between individuals and groups and the extent to which a self-funding option is available for small groups with lower expected health care spending. Adverse

selection against the ACA market could occur if low-cost small groups pursue self-funding options. Currently, self-funding is relatively infrequent among small groups. Of establishments with fewer than 100 workers that offer health insurance, 14.2 percent offered a self-funded plan in 2015, up from 13.4 percent in 2014.⁶² Nevertheless, to limit additional adverse selection, rules might need to be considered to discourage further self-funding among small groups.

- **Remove option for adult children up to age 26 to remain on a parent's insurance plan.** The ACA allows adult children to remain on a parent's plan up to age 26. This likely suppresses young adult enrollment in the individual market. Eliminating that provision could increase young adult enrollment in the individual market, but could also lead to an increase in uninsured rates among young adults. The potential impact on the individual market risk pool profile depends on the extent of adverse selection among younger adults, with healthy young adults opting to forgo coverage.

Increasing Insurer Participation and Improving the Regulatory Environment

Options to level the playing field

It is important for competing plans to operate under the same rules. For the most part, the ACA applies the same rules to all plans in the individual market. However, there are some instances in which plans are treated differently. Options to address these inconsistencies include:

- **Reduce the grace period for subsidized enrollees.** As noted above, reducing the grace period for subsidized enrollees could improve the risk pool profile. It would also increase consistency between individuals with premium subsidies and those without, including those purchasing coverage off the marketplace.
- **Consistent SEP enforcement mechanisms.** Stricter SEP enforcement mechanisms have the potential to improve the risk profile. In addition, more consistent SEP verification processes between plans on and off the marketplace could reduce any related disadvantages for on-marketplace plans.

- **Modifying marketplace fee assessments.** Marketplace fees should be assessed in a manner that does not disadvantage insurers participating in the marketplace. Currently, marketplace fees are assessed only on insurers selling coverage on the marketplace, but these insurers are required to spread the fee to both their on- and off-marketplace enrollees. Insurers selling off marketplace only avoid these fees. Potential solutions include allowing insurers to vary their administrative charges for on-marketplace and off-marketplace members, with the marketplace business being charged the entire marketplace fee. Another option would be to charge the marketplace fee to all insurers operating in the market, even those operating exclusively off marketplace. This would spread the costs of the marketplace over a broader base and allow the charge to be a lower percentage of premium. Even off-marketplace-only insurers benefit from marketplace functions that increase enrollment, because they can improve the overall market's risk profile.

Prohibit off-marketplace plans

Another option that would create a level playing field is to require all insurers and plans to be offered only through the marketplace. This would prevent insurers from choosing to market only off marketplace to avoid some of the fees and additional marketplace rules and may help with some risk selection problems to the extent that risk adjustment does not fully compensate for risk differences between on- and off-marketplace plans. In general, a wider array of insurance plans is available off the marketplace than on the marketplace. Prohibiting off-marketplace plans could potentially increase the options available to enrollees receiving premium subsidies. On the other hand, insurers may choose to continue offering only the narrower set of on-marketplace options, thus reducing plan choice among individuals previously purchasing off-marketplace plans. Also, some insurers may decide not to participate in the market at all.

Continue to improve the risk adjustment program

The risk adjustment program should fairly compensate insurers for the risk of their enrollees so that insurers do not have incentives to avoid any particular type of potential enrollee. CCIIO has indicated plans to modify the risk adjustment program so that it better reflects differences in the underlying risk among participating insurers. These modifications include the incorporation of prescription drug data, the incorporation of preventive services, and better accounting for partial-year enrollees. In addition, CCIIO will begin using data collected from the ACA-compliant individual and small group markets for purposes of calculating risk scores and making risk adjustment transfers to also calibrate the

model. This will improve the model's accuracy for these markets compared to the current calibration method that uses experience from large employer plans. CCIIO is also exploring the incorporation of a high-risk enrollee pool to improve risk adjustment for extremely high-cost enrollees. The risk adjustment program should continue to be monitored. If experience suggests that the risk model systematically over- or under-compensates for certain enrollee subgroups, the model should be revised as appropriate. Except under exceptional circumstances, changes should be made on a prospective basis only. In addition, CCIIO should continue to provide and improve interim reports to help reduce uncertainty for insurers.

Conduct effective rate review

A sustainable insurance market requires that premiums be adequate but not excessive. Although much focus is often given to ensuring that rates are not too high, it is equally important that rates not be approved if they are too low. Low rates may help an insurer attract a large membership, but rates that are too low have numerous adverse consequences, including:

- **Higher risk of insurer insolvency.** Insurer insolvencies not only cause coverage disruption for enrollees, but the cost can be borne by other insurers through state guaranty funds or special assessments that increase premiums.
- **Inadequate premium subsidies.** If premium subsidies are based on the second-lowest silver tier plan with a premium that is set too low, those subsidies will be insufficient to purchase a more adequately priced plan.
- **Insufficient risk adjustment transfers.** The risk adjustment program bases transfers on market average premiums. If those averages are understated due to an insurer having rates that are too low, the risk adjustment transfers will be too low to adequately adjust for risk profile differences among insurers.

Another issue with the rate review process is the availability of insurer premiums and pricing assumptions to competing insurers. The ACA requires rate filing transparency and an opportunity to allow for consumer feedback, although the level of detail required varies by state. Because there are multiple rate filing rounds, this transparency means that rates could be publically available, even before they are approved. As a result, insurers would be able to mimic another's pricing strategy, sometimes referred to as shadow pricing. In other words, premiums can go up or down relative to initially filed rates for reasons other than the adequacy of rates. This further emphasizes the need for an effective rate review that considers not only whether premiums are excessive, but also whether they are inadequate.

Allow insurance sales across state lines

Under this option, insurers licensed to sell insurance in any particular state would be allowed to sell insurance under that state's rules in other states. The intention is to spur more competition, which could increase consumer choice, lower premiums, and improve services. For instance, an insurer could choose to follow the rules of a state with less restrictive benefit requirements in order to offer lower-cost coverage in another state. Although states currently have the ability to permit the sale of insurance across state lines, few have done so to date and no out-of-state insurers have entered the market in those states.⁶³

Health insurance is licensed and regulated primarily by state authority. Prior to the ACA, the rules regarding insurance issue, premium rating, and benefit requirements varied considerably by state. The ACA narrowed state differences in these rules by imposing more standardized requirements. Premium rate review and approvals continue to be conducted primarily at the state level, as are other consumer protections such as network adequacy requirements.

Allowing insurance licensed in one state to be sold in another would raise concerns regarding how insurers would set up local provider networks and how consumer protections would be enforced. In addition, with many of the rules currently harmonized across states, there is less ability for insurers to take advantage of differences in rules in order to lower premiums by avoiding certain requirements.

If the ACA issue, rating, and benefit requirements were relaxed and the state variation in rules returned, there would be more opportunity for insurers to take advantage of these differences. However, this could create an unlevel playing field, with plans in a single market competing under different market rules. Less-healthy individuals would purchase plans licensed in states with stricter regulations (e.g., guaranteed issue, community rating, comprehensive benefit requirements), and healthier people would purchase plans licensed in states with looser regulations. Such a result could lead to healthier people benefiting from less-expensive insurance, but those who are older and have more health issues would face higher premiums. Premiums for the plans licensed in states with stricter regulations would increase accordingly. Such a situation could threaten the viability of the insurance market in states with more restrictive rules and create a situation in which states would have incentives to reduce insurance regulations and consumer protections. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.

Include a public plan option

In order to increase plan availability and consumer choice, a public plan option could be offered as a marketplace competitor. This could be structured as a fallback option in areas with no or few participating insurers or could be offered more broadly. In order to compete on a comparable basis with private plans, a public plan would need to follow the same rules as those governing private plans and set premiums that are self-supporting. These rules could include the establishment of a premium stabilization fund that would function similarly to private plan surplus and cover any unexpected differences between plan expenditures and premiums, rather than relying on general government funds.

A public plan could provide consumers with an additional option, especially in areas with no or few other participating insurers. Nevertheless, a public plan would face the same underlying issues as private plans, such as low enrollment and sole community providers, which make it difficult for insurers to cover costs and earn a reasonable return. A public plan could potentially support lower premiums than traditional health plans, especially if such plans are able to use the federal government's clout with providers to negotiate payment rates at, or somewhat above, Medicare rates. Such an approach could lead to a more affordable coverage option, but would create an unlevel playing field relative to other competing private plans. If a public plan can achieve much lower provider payment rates than other plans, thereby allowing it to offer lower premiums, the effect could be to eliminate competition, making the public plan the sole option. In addition, there could be concerns regarding health care access if providers opt to not participate at the lower payment rates.

A variant of the public plan option is to allow older adults, (e.g., 50 or 55 and older), to buy into Medicare. There are many design considerations involved, such as whether the benefits would be structured similarly to current Medicare benefits, how the premium would be determined, and whether subsidies would be available. A Medicare buy-in could have a large impact on the individual marketplace. In 2016, 26 percent of individuals enrolling during the open enrollment period were age 55–64.⁶⁴ If a large portion of these individuals were to move to a Medicare buy-in, it could lower average premiums in the individual market. However, by reducing the size of the individual market pools, the financing of the marketplaces and the predictability of experience could be affected.

Allowing consumers a choice between the individual market and a Medicare buy-in could create opportunities for adverse selection for both markets, depending on the plan generosity and premium differences between the two options. For instance, because Medicare does not cap out-of-pocket costs, individuals with high expected health care costs could be more likely to opt for individual market coverage rather than Medicare. This selection against the individual market would at least partially offset any premium reductions resulting from a younger average enrollment age.

Offering a Medicare buy-in option would also have implications for employer coverage. Employers are concerned about health care costs for workers and covered retirees in the very age group that a Medicare buy-in program would target. Their support for early retiree coverage has already diminished in the past 25 years. A Medicare buy-in option could be seen as a potential replacement for remaining early retiree coverage, depending on benefit and premium levels. If federal premium subsidies are available for Medicare buy-in coverage, such a shift would increase the costs of federal premium subsidies.

CONCLUSION

To be sustainable, the individual market under the ACA requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings. Experience from the first three years of the ACA varies, with the markets in some states faring relatively well. More typically however, the results thus far indicate the need for improvement along most of these measures.

Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has generally been lower than expected and enrollees have been sicker than expected. Both of these factors have contributed to substantial premium increases in many, but not all, states. For the most part, competing plans face the same rules; however, some rules might be disadvantaging insurers participating in the marketplaces compared to off the marketplaces. The uncertain and changing regulatory environment, including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments, contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.

Many options have been put forward to improve the short- and long-term sustainability of the individual market, either through changes to the ACA or by replacing the ACA with a different approach. If as part of this a goal is to provide coverage to people with pre-existing conditions at standard premiums, it is vital to enroll enough healthy people to spread the costs of those who are sick. The ACA's individual mandate, annual open enrollment period, and premium subsidies aim to achieve a balanced risk profile. Increased penalties for non-enrollment could help improve the risk profile, as could improving premium affordability, for instance through increased premium subsidies or additional funding for high-risk enrollees. Weakening the incentives for participation, however, could further exacerbate adverse selection issues and lead to higher premiums and more uninsured.

Achieving a balanced enrollee risk profile, along with providing consistent rules in a timely fashion to insurers, could lead to a more stable and sustainable market. Insurer participation could increase as a result, leading to more consumer choice.

Individual market experience varies by state. The ACA's section 1332 waivers could be used by states to pursue different approaches to improving the individual market. These approaches could reflect the particular situations of each state.

Finally, it's important not to overlook the need for a continued focus on controlling health care spending. Most premium dollars go toward paying medical claims. Therefore, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires keeping health spending in check. Moderating health spending growth is a key to the sustainability of not only the individual market, but also the health care system as a whole.

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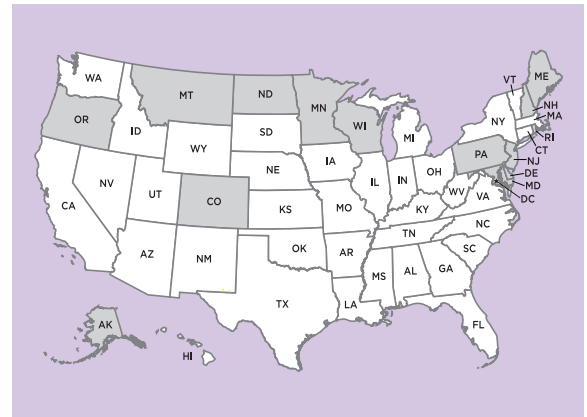
CCIIO DATA BRIEF SERIES

State Innovation Waivers: State-Based Reinsurance Programs

AUGUST 2021

BACKGROUND

Section 1332 of the Affordable Care Act (ACA) permits states to apply for waivers from certain ACA requirements to pursue innovative and individualized state strategies that provide their residents with access to affordable, quality health care, subject to approval by the Department of Health and Human Services (HHS) and the Department of the Treasury (collectively, the Departments). In order for a section 1332 waiver to be approved, the Departments must determine that the waiver will provide coverage that is at least as comprehensive as the coverage provided without the waiver; will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; will provide coverage to at least a comparable number of residents as without the waiver; and will not increase the federal deficit. States were first able to apply for section 1332 waivers beginning on January 1, 2017, and to date, the Departments have approved 16 states' waivers.



As of Plan Year (PY) 2021, 14 states with approved section 1332 waivers operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.ⁱ

The data presented below provide an overview of the state-based reinsurance programs implemented as of PY 2021 under currently approved section 1332 waivers (referred to throughout this report as section 1332 state-based reinsurance waivers), including relevant information about premiums, issuer participation, plan offerings, and enrollment.ⁱⁱ

CURRENTLY APPROVED SECTION 1332 STATE-BASED REINSURANCE WAIVERS

Funding Sources and Program Design Elements

Tables 1 and 2 summarize state funding sources and programmatic elements for currently operating section 1332 state-based reinsurance waivers.ⁱⁱⁱ Through section 1332 waivers, states have designed and implemented different reinsurance models, including: a claims cost-based model, where issuers are reimbursed for a portion of the costs of enrollees whose claims exceed an attachment point (CO, DE, MD, MN, MT, ND, NH, NJ, OR, PA, RI, WI); a conditions-based model, where insurers are reimbursed for costs of individuals with one or more of pre-determined high-cost conditions (AK); or a hybrid conditions and claims cost-based model (ME).

ⁱ State-based reinsurance programs are distinct from the temporary federal reinsurance program that was effective for the 2014 through 2016 benefit years, the latter having been established via section 1341 of the ACA. The goal of the ACA's temporary reinsurance program was to stabilize individual market premiums during the early years of the federal market reforms that took effect beginning in 2014.

ⁱⁱ The information contained in this report does not reflect the American Rescue Plan Act of 2021, or other factors that may have led the states to update their PY 2021 parameters since submitting rate filings for the 2021 plan year (e.g., the Departments' 2021 pass-through estimates).

ⁱⁱⁱ State legislation authorizing states' funding sources are listed in the endnotes.

TABLE 1
State Funding Sources for Section 1332 State-Based Reinsurance Waivers

State	First Year of Operation Under a Waiver	State Funding Sources ^{iv}
Alaska	2018	Alaska funds the state portion of its section 1332 state-based reinsurance waiver through a separate fund called the Alaska Comprehensive Health Insurance Fund. This fund is established within Alaska's general fund and financed by the state's premium tax that applies to all lines of insurance (not just health insurers) in Alaska. ¹ Premium tax rates vary from 0.75% to 6% depending on insurer type.
Colorado	2020	Colorado funds the state portion of its section 1332 state-based reinsurance waiver through the Colorado Health Insurance Affordability Enterprise (Enterprise). The Enterprise was established under Colorado Senate Bill 20-215 in June 2020. ² The main source of funding for the Enterprise is drawn from a fee on health insurers who would otherwise be subject to the now repealed federal Health Insurance Provider Fee under Section 9010 of the ACA. For PYs 2022 and 2023 only, Colorado will administer a special assessment on hospitals. A portion of the state's health insurance premium tax revenue will also go to the Enterprise. Money from the state's general fund is available for section 1332 state-based reinsurance waiver administration only.
Delaware	2020	Delaware funds the state portion of its section 1332 state-based reinsurance waiver through an assessment on carriers and any person or entity subject to state regulation that provides either 1) products that would otherwise be subject to the federal Health Insurance Providers Fee under Section 9010 of the ACA; or 2) products subject to a state assessment. The state assessment is 2.75% of premium annually in years that the Health Insurance Providers Fee is waived, and 1% of premium annually in years that the Health Insurance Providers Fee is assessed. ³
Maine	2019	Maine funds the state portion of its section 1332 state-based reinsurance waiver through 1) a market-wide assessment (\$4 per member/per month), and 2) a ceding premium equal to 90% of premiums received from consumers for all policies ceded, whether on a mandatory or discretionary basis. ⁴
Maryland	2019	In PY 2019, Maryland funded the state portion of its section 1332 state-based reinsurance waiver through a 2.75% state assessment on certain health insurance carriers. ⁵ The assessment equals the amount carriers otherwise would have been subject to under the now-repealed federal Health Insurance Providers Fee of Section 9010 of the ACA. Maryland extended and reduced the assessment to 1% for PYs 2020-2023. ⁶
Minnesota	2018	Minnesota funds the state portion of its section 1332 state-based reinsurance waiver through its general fund and a portion of past accumulations of the state's 2% provider tax, which applies to hospitals and other providers. ⁷
Montana	2020	Montana funds the state portion of its section 1332 state-based reinsurance waiver through a 1.2% annual state assessment on major medical health insurance premiums. ⁸
New Hampshire	2021	New Hampshire funds the state portion of its section 1332 state-based reinsurance waiver through a premium assessment of 0.6% of the previous year's second lowest cost silver plan without waiver rate across all licensed health insurance issuers in the state's individual and group health insurance markets with some exceptions. ^{9,10}
New Jersey	2019	New Jersey funds the state portion of its section 1332 state-based reinsurance waiver from revenue raised by shared responsibility payments per the state individual mandate, ¹¹ and if necessary, the state general fund.
North Dakota	2020	North Dakota funds the state portion of its section 1332 state-based reinsurance waiver through a state assessment on insurers writing in the small and large group health insurance markets. North Dakota allows insurers to deduct the assessment from the state premium tax. ¹² The PY 2020 assessment on the insurers was approximately \$22M. Assessments were suspended in the third quarter of PY 2020 and the suspension is expected to continue through PY 2021.
Oregon	2018	For PYs 2018 through 2019, Oregon funded the state portion of its section 1332 state-based reinsurance waiver through a phased-in 1.5% state premium assessment levied on major medical premiums and, for PY 2018 only, Oregon also used excess fund balances held in two state programs, the Oregon Health Insurance Marketplace (OHIM) fund and the Oregon Medical Insurance Pool (OMIP) account. ¹³ Starting in PY 2020, Oregon made two changes to the assessments: 1) increased the premium assessment to 2%, and 2) expanded the assessment to apply to premiums derived from "insurance described in ORS 742.065" (stop loss insurance). ^{14,15}
Pennsylvania	2021	Pennsylvania funds the state portion of its section 1332 state-based reinsurance waiver through a portion of a user fee that is 3.0% of premiums and assessed on issuers participating in the Pennsylvania Health Insurance Exchange and other available state sources. This fee only affects individual market issuers, as there are currently no participating SHOP issuers. ¹⁶
Rhode Island	2020	Rhode Island funds the state portion of its section 1332 state-based reinsurance waiver through a state appropriation for the Health Insurance Market Integrity Fund to support operation and administration of the program, and from penalties collected from the state individual mandate. ^{17,18}
Wisconsin	2019	Wisconsin funds the state portion of its section 1332 state-based reinsurance waiver through state general purpose revenue (GPR), which consists of general taxes, miscellaneous receipts, and revenues collected by the state. The state is able to appropriate GPR for the Wisconsin Healthcare Stability Plan (WIHSP) through a sum sufficient appropriation. ¹⁹

^{iv} Unless otherwise indicated, the state funding sources presented reflect all active years to date of a given state's reinsurance program.

TABLE 2, cont.
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters		
Maryland	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: \$462M*/\$352.8M (2019) \$416.8M* (2021) \$400M* (2020)		
		Attachment point: \$20,000 (2019-2021)	Coinsurance rate: 80% (2019-2021)	Cap: \$250,000 (2019-2021)
Minnesota	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: Up to \$271M** (2018/2019) \$165.8M* (2020) \$136.1M (2018) \$204.5M* (2021) \$149.7M (2019)		
		Attachment point: \$50,000 (2018-2021)	Coinsurance rate: 80% (2018-2021)	Cap: \$250,000 (2018-2021)
Montana	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$32.9M* (2020) \$39.5M* (2021)		
		Attachment point: \$40,000 (2020/2021)	Coinsurance rate: 60% (2020/2021)	Cap: \$101,750 (2020/2021)
New Hampshire	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$45.5M* (2021)		
		Attachment point: \$60,000 (2021)	Coinsurance rate: 74% (2021)	Cap: \$400,000 (2021)
New Jersey	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: \$295M*/\$267.7M (2019) \$397.5M* (2021) \$320M* (2020)		
		Attachment point: \$40,000 (2019/2020) \$35,000 (2021)	Coinsurance rate: 60% (2019/2020) 50% (2021)	Cap: \$215,000 (2019/2020) \$245,000 (2021)
North Dakota	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$47.3M* (2020) \$24.7M* (2021)		
		Attachment point: \$100,000 (2020/2021)	Coinsurance rate: 75% (2020/2021)	Cap: \$1M (2020/2021)
Oregon	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: \$90M*/\$90M (2018) \$101.8M* (2020) \$95.4M*/\$94.5M (2019) \$104.3M* (2021)		
		Attachment point: \$95,000 (2018) \$90,000 (2019/2020) \$83,000 (2021)	Coinsurance rate: 59.2% (2018) 50% (2019-2021)	Cap: \$1M (2018-2021)
Pennsylvania	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$133.9M* (2021)		
		Attachment point: \$60,000 (2021)	Coinsurance rate: 60% (2021)	Cap: \$100,000 (2021)

TABLE 2, cont.
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters		
Rhode Island	Claims Cost Based	Total Amount of Reinsurance Payments Planned*:		
		\$14.7M* (2020) \$19.3M* (2021)		
		Attachment point:	Coinsurance rate:	Cap:
		\$40,000 (2020) \$30,000 (2021)	50% (2020) 50% (2021)	\$97,000 (2020) \$72,000 (2021)
Wisconsin	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid:		
		\$200M*/\$174.3M (2019) \$200M* (2020/2021)		
		Attachment point:	Coinsurance rate:	Cap:
		\$50,000 (2019) \$40,000 (2020/2021)	50% (2019/2020) 48% (2021)	\$250,000 (2019) \$175,000 (2020/2021)

^v In Table 2 for **Total Amount of Reinsurance Payments**, values marked with one asterisk (*) indicate the total planned cost of the reinsurance payments for eligible claims, which is the state's estimated total reinsurance reimbursements for a given reporting year for eligible claims expected to be incurred in the individual market.

Values marked with two asterisks (**), in the case of Minnesota, indicate the maximum program size (\$271M) for PYs 2018 and 2019, such that the actual program size will fully cover reimbursements to carriers for 80% of the costs between \$50,000 and \$250,000 for individual claims. However, there is general agreement between the state's model and carriers' models that an approximate 20% reduction in premiums is the result of the state's program parameters (i.e., attachment point, coinsurance rate, and cap), which are the most relevant information the carriers need and use to develop rates.

Values without any asterisks indicate the total actual amount paid out by the state for reinsurance payments in the individual market for a given reporting year where known. The final total amount paid out by the state for a given reporting year is typically available in the following PY. Furthermore, the total actual amount does not include the expected operational costs associated with running the state-based reinsurance program.

The average premium reduction rates in the with waiver scenario compared to the without waiver scenario for a given PY (as seen in Table 3) reflect the total planned cost of the reinsurance payments for eligible claims. Note that the total planned costs for PYs 2020 and 2021 do not yet reflect potential cost changes due to COVID-19 or the American Rescue Plan Act of 2021. States may update their program budgets and payment parameters as more claims and enrollment data are received.

Premiums

Table 3 presents the actual impact of the section 1332 state-based reinsurance waiver on statewide average premiums each year of the waiver's operation compared to the estimated impact on statewide average premiums in the first year of the waiver (i.e., as estimated in the original state waiver application). From PYs 2018 to 2021, states that have implemented section 1332 state-based reinsurance waivers for the individual market have reduced statewide average second-lowest-cost silver plan premiums by a range of 3.75% to 41.17% relative to premiums absent the waiver, as shown in Table 3.

TABLE 3
Statewide Average Premium Impact of Section 1332 State-Based Reinsurance Waivers^{vi}

State	First Year of Operation Under a Waiver	Estimated Statewide Average Premium Reduction in First Year of Waiver ^{vii}	Actual Statewide Premium Reduction from Waiver Compared to No Waiver ^{viii}			
			2018	2019	2020	2021
Alaska	2018	Up to a 20% reduction	30.18%	33.95%	37.12%	41.17%
Minnesota	2018	Up to a 20% reduction	16.78%	20.16%	21.29%	21.31%
Oregon	2018	Up to a 7.5% reduction	7.15%	6.71%	8.00%	8.05%
Maine	2019	Up to a 9% reduction		13.86%	7.24%	9.11%
Maryland	2019	Up to a 30% reduction		39.63%	35.83%	34.0%
New Jersey	2019	Up to a 15% reduction		15.49%	16.93%	16.02%
Wisconsin	2019	Up to an 11% reduction		9.92%	11.04%	13.04%
Colorado	2020	Up to a 16% reduction			22.44%	18.47%
Delaware	2020	Up to a 20% reduction ^{ix}			13.78%	15.80%
Montana	2020	Up to an 8% reduction			8.89%	9.38%
North Dakota	2020	Up to a 20% reduction			20.03%	12.14%
Rhode Island	2020	Up to a 5.9% reduction			3.75%	6.40%
Pennsylvania	2021	Up to a 4.6% reduction				4.92%
New Hampshire	2021	Up to a 16% reduction				13.90%
Overall State Average Premium Reduction Among States with Approved Section 1332 State-Based Reinsurance Waivers^x			12.73%	17.84%	17.65%	14.13%

^{vi} The statewide average premium is an average of premiums among rating areas in the state, with each rating area given an equal weight. Enrollment data by rating area are unavailable.

^{vii} The estimated statewide average premium reduction for the first year of the waiver is provided by each state as part of its waiver application.

^{viii} The actual statewide average premium reductions are calculated using per person per month premium information submitted by each state for pass-through calculations pertaining to each year of the approved waiver. Consistent with the specific terms and conditions of its waiver, each state provides to the Departments: (1) the final second lowest cost silver plan (SLCSP) rates for a representative individual (e.g., a 21-year-old nonsmoker) in each rating area with the approved waiver; and (2) the state's estimate of what the final SLCSP rates for a representative individual in each rating area would have been absent approval of the waiver for each year of the approved waiver.

^{ix} Delaware estimated a 13%-20% average premium reduction, depending on the level of funding expected to be available for each plan year, plus any additional assumed morbidity improvement, as explained in its application.

^x Overall average premium reduction uses 2018 risk adjustment premium to weight each state's premium reduction and estimate an overall premium reduction across states with approved section 1332 state-based reinsurance waivers.

Issuer Participation

Table 4 shows changes in individual market Exchange issuer participation among states with section 1332 state-based reinsurance waivers. Figures 1 and 2 illustrate the change in individual market Exchange issuer participation in these states comparing PYs 2017 (before any reinsurance waivers were operational)^{xi} and 2021 on national maps. Table 5 presents a summary of the percentage of enrollees with access to 1, 2, or 3+ individual market Exchange issuers in states with operational section 1332 state-based reinsurance waivers, compared to the percentage of individual market Exchange enrollees in all states across the U.S.

TABLE 4
Individual Market Issuer Exchange Participation in States with
Section 1332 State-Based Reinsurance Waivers^{xii}

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation ^{xiii}				
		2017	2018	2019	2020	2021
Alaska	2018	1	1	1	2 [^] Re-entry: Moda	2
Minnesota	2018	4	4	4	4	5 [^] Entry: Quartz Health Solutions
Oregon	2018	6	5 Exit: ATRIO Health Plans	5	5	6 [^] Entry: Cambia Health Solutions (additional HIOS ID)
Maine	2019	3	2 Exit: Anthem	3 [^] Re-entry: Anthem	3	3
Maryland ^{xiv}	2019	3	2 Exit: Cigna	2	2	3 [^] Re-entry: UnitedHealth Group
New Jersey	2019	3	4 [^] Entry: Mulberry Health (Oscar)	4	4	4
Wisconsin	2019	15	11 Exits: Anthem, Franciscan Health Solutions, Gundersen Health System, Molina Healthcare	12 [^] Re-entry: Molina	13 [^] Re-entry: WPS Health Plan, Inc.	14 [^] Re-entry: Anthem
Colorado	2020	7	7	7	8 [^] Entry: Oscar Health	8
Delaware	2020	3	1 Exits: Aetna (two separate HIOS IDs)	1	1	1
Montana	2020	3	3	3	3	3
North Dakota	2020	3	2 Exit: Medica	3 [^] Re-entry: Medica	3	3
Rhode Island	2020	2	2	2	2	2

TABLE 4, cont.
**Individual Market Issuer Exchange Participation in States with
Section 1332 State-Based Reinsurance Waivers^{xii}**

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation ^{xiii}				
		2017	2018	2019	2020	2021
Pennsylvania	2021	8	9 [^] Entry: Highmark (additional HIOS ID)	11 [^] Entry: Centene Re-entry: Geisinger Health (additional HIOS ID)	12 [^] Entry: Mulberry Health (Oscar)	12
New Hampshire	2021	4	3 Exit: Minuteman Health	3	3	3

TABLE 5
**Percent of Enrollees with Access to 1, 2, 3+ Individual Market Exchange Issuers,
Compared to Overall U.S.^{xv}**

Section 1332 State-Based Reinsurance Waiver States	1 Issuer		2 Issuers		3+ Issuers	
	2020	2021	2020	2021	2020	2021
	4%	3%	14%	9%	82%	88%
Overall U.S.	9%	3%	18%	15%	73%	82%

^{xi} Note that Alaska began operating a state reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.

^{xii} For states with a Federally-facilitated Exchange (FFE), CMS issuer counts are based upon the number of unique Health Insurance Oversight System (HIOS) IDs. Issuers represent the organization within an insurance company that is responsible for insurance offerings in a given state. Registering an entity as an Issuer within HIOS will generate a unique Issuer ID. FFE 2021 data reflected in this table are point in time as of October 2, 2020. State-Based Exchange (SBE) 2021 data reflected in this table are self-reported from the Exchanges to CMS. These data are point in time as of October 30, 2020 for the following 1332 waiver states: Colorado, Maryland, Minnesota, New Jersey, and Rhode Island, and August 30, 2020 for Pennsylvania. Note that New Jersey and Pennsylvania transitioned from FFEs to SBEs in PY 2021. Issuers offering partial county coverage are considered participating in a county and are included in the total number of issuers in a county. Issuers that partially cover counties do not cover every zip code in the county.

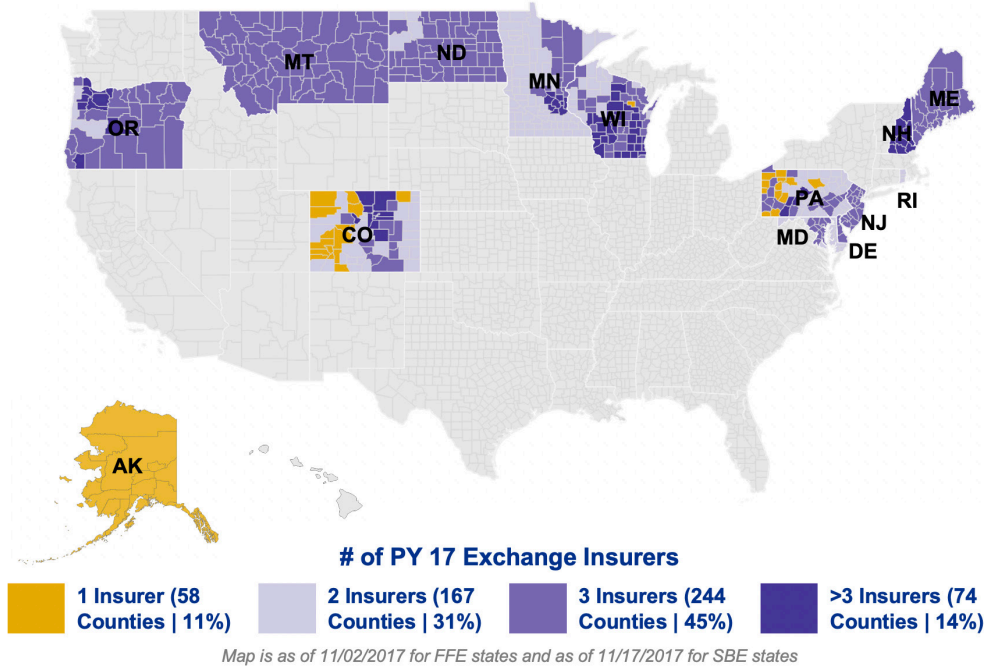
^{xiii} [^]Denotes a new issuer participating (entry or re-entry) in the individual market from the previous year.

^{xiv} To ensure that the total counts of issuers within a state or county are consistent with SBE reporting BlueChoice (HIOS 28137), CFMI (HIOS 45532), and GHMSI (HIOS 94084) in Maryland have been aggregated to the parent company level (CareFirst BlueCross BlueShield).

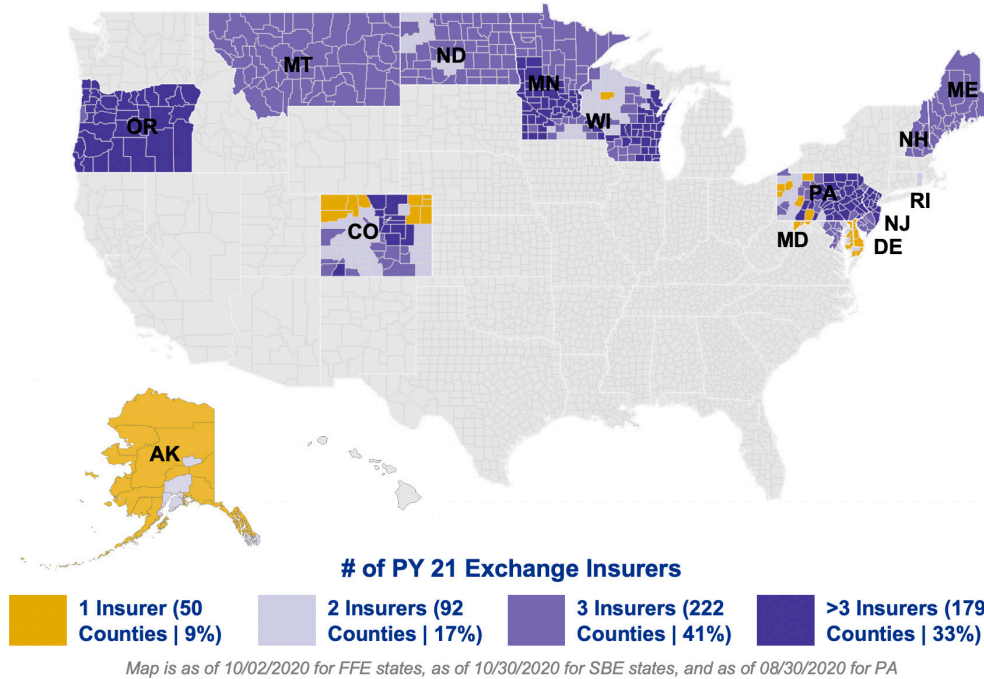
^{xv} Methodology note for Table 5: The number of issuers in each county was counted and weighted by the county enrollment. That weighted issuer count was then divided by the total enrollment. Because data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019), only PYs 2020 and 2021 are shown, which account for all states with operational section 1332 state-based reinsurance waivers for those particular years. To calculate national trends, Los Angeles County, California has two rating areas where issuers could possibly participate on the State's Exchange in the individual market. Since Los Angeles County has a very large number of enrollees, the two rating areas in the county are treated as separated counties for purposes of these calculations.

FIGURES 1 and 2
Individual Market Issuer Participation on the Exchanges in States with
Section 1332 State-Based Reinsurance Waivers^{xvi}

2017



2021



^{xvi} For illustrative purposes, PY 2017 is provided as a comparison year to PY 2021 because section 1332 waivers were not yet operational in PY 2017, and the first waivers went into effect in PY 2018. Note that for some states, issuers exited the state’s individual marketplace prior to the state’s implementation of a section 1332 state-based reinsurance waiver, and some states’ waivers began operating as recently as PY 2021. For each state’s first year of operation and issuer count across Pys 2017 through 2021, please refer to Table 4 above.

Plan Offerings

Table 6 shows the average number of qualified health plans (QHPs) by metal level per county, weighted by enrollment in states with section 1332 state-based reinsurance waivers. Table 7 summarizes the average number of QHPs weighted by enrollment available in states with section 1332 state-based reinsurance waivers, compared to the average number of QHPs available in all states across the U.S.

TABLE 6
Average Number of QHPs per County Weighted by Enrollment in States with
Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
AK	2018	All	5	5	7.7	8.3	0	2.7	0.6	3.3
		Bronze	2	2	3.4	3.6	0	1.4	0.2	1.6
		Silver	2	2	2.7	2.8	0	0.7	0.1	0.8
		Gold	1	1	1.7	1.8	0	0.7	0.1	0.8
		Platinum	0	0	0	0	0	0	0	0
CO	2020	All	N/A	39	47.2	60.8	N/A	8.2	13.6	N/A
		Bronze	N/A	14.6	17.8	24.1	N/A	3.2	6.3	N/A
		Silver	N/A	15.7	20.2	25.6	N/A	4.5	5.4	N/A
		Gold	N/A	8.7	9.2	11.1	N/A	0.5	1.9	N/A
		Platinum	N/A	0	0	0	N/A	0	0	N/A
DE	2020	All	6	7	8	11	1	1	3	5
		Bronze	2	2	3	3	0	1	0	1
		Silver	3	3	2	3	0	-1	1	0
		Gold	1	1	2	3	0	1	1	2
		Platinum	0	1	1	2	1	0	1	2
MD	2019	All	15.5	13.6	16.6	25.4	-1.9	3	8.8	9.9
		Bronze	4.6	3.7	5.7	8.3	-0.9	2	2.6	3.7
		Silver	5.4	4.5	4.5	8.1	-0.9	0	3.6	2.7
		Gold	4.6	4.5	5.5	8.2	-0.1	1	2.7	3.6
		Platinum	0.9	0.8	0.8	0.9	-0.1	0	0.1	0
ME	2019	All	15.2	25.5	29.2	31	10.3	3.7	1.8	15.8
		Bronze	6	10	12	13	4	2	1	7
		Silver	7.2	12.5	14.2	14.2	5.3	1.7	0	7
		Gold	2	3	3	3.7	1	0	0.7	1.7
		Platinum	0	0	0	0	0	0	0	0
MN	2018	All	N/A	N/A	28.1	44.7	N/A	N/A	16.6	N/A
		Bronze	N/A	N/A	12.5	17.6	N/A	N/A	5.1	N/A
		Silver	N/A	N/A	10.2	18.5	N/A	N/A	8.3	N/A
		Gold	N/A	N/A	5.3	8.5	N/A	N/A	3.2	N/A
		Platinum	N/A	N/A	0	0	N/A	N/A	0	N/A

TABLE 6, cont.
**Average Number of QHPs per County Weighted by Enrollment in States with
Section 1332 State-Based Reinsurance Waivers^{xvii}**

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
MT	2020	All	15.8	17.8	20.9	20.9	2	3.1	0	5.1
		Bronze	7.5	8.5	9.3	9.3	1	0.8	0	1.8
		Silver	4.7	5.7	7.3	7.3	1	1.6	0	2.6
		Gold	3.7	3.7	4.3	4.3	0	0.6	0	0.6
		Platinum	0	0	0	0	0	0	0	0
ND	2020	All	8.2	20.6	20.7	21.9	12.4	0.1	1.2	13.7
		Bronze	2.6	9.3	9.3	9.9	6.7	0	0.6	7.3
		Silver	3.2	7	7.1	6.9	3.8	0.1	-0.2	3.7
		Gold	2.3	4.3	4.3	5.1	2	0	0.8	2.8
		Platinum	0	0	0	0	0	0	0	0
NH	2021	All	13.7	14.8	23.4	32.4	1.1	8.6	9	18.7
		Bronze	3	4	9.8	10.8	1	5.8	1	7.8
		Silver	7.9	7.9	10.7	16.6	0	2.8	5.9	8.7
		Gold	2.9	2.9	2.9	4.9	0	0	2	2
		Platinum	0	0	0	0	0	0	0	0
NJ	2019	All	18.6	19.4	20.4	23.4	0.8	1	3	4.8
		Bronze	4.5	4.5	4.5	6.6	0	0	2.1	2.1
		Silver	10.3	10.3	11.3	12.2	0	1	0.9	1.9
		Gold	3.8	4.6	4.6	4.7	0.8	0	0.1	0.9
		Platinum	0	0	0	0	0	0	0	0
OR	2018	All	20.5	25.5	30.4	49.1	5	4.9	18.7	28.6
		Bronze	7	9.8	12.1	20.3	2.8	2.3	8.2	13.3
		Silver	7.2	8.6	10.1	16.3	1.4	1.5	6.2	9.1
		Gold	6.2	7.1	8.2	12.5	0.9	1.1	4.3	6.3
		Platinum	0	0	0	0	0	0	0	0
PA	2021	All	13.5	16.1	26.3	34.7	2.6	10.2	8.4	21.2
		Bronze	3	3.9	8.3	10.5	0.9	4.4	2.2	7.5
		Silver	5.4	6.7	10.7	15.1	1.3	4	4.4	9.7
		Gold	3.7	4	6.5	9	0.3	2.5	2.5	5.3
		Platinum	1.4	1.4	0.7	0	0	-0.7	-0.7	-1.4

TABLE 6, cont.
Average Number of QHPs per County Weighted by Enrollment in States with Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
RI	2020	All	18	18	19	20	0	1	1	2
		Bronze	4	4	4	4	0	0	0	0
		Silver	7	7	7	7	0	0	0	0
		Gold	7	7	7	7	0	0	0	0
		Platinum	0	0	1	2	0	1	1	2
WI	2019	All	31.2	27.6	35.4	49.7	-3.6	7.8	14.3	18.5
		Bronze	9.4	9.2	12.8	19.9	-0.2	3.6	7.1	10.5
		Silver	12.6	11.3	13.8	18.8	-1.3	2.5	5	6.2
		Gold	8.2	6.6	8.3	10.5	-1.6	1.7	2.2	2.3
		Platinum	1.1	0.5	0.5	0.5	-0.6	0	0	-0.6

TABLE 7
Average Number of QHPs Weighted by Enrollment Available in States with Section 1332 State-Based Reinsurance Waivers Compared to Overall U.S.^{xviii}

Section 1332 State-Based Reinsurance Waiver States	Bronze		Silver		Gold		Platinum		TOTAL	
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
	10.0	13.2	11.3	15.0	6.3	8.2	0.2	0.2	27.8	36.6
Overall U.S.	12.3	19.3	15.0	22.9	7.0	9.1	2.2	2.3	36.6	53.6

^{xvii} Methodology note for Table 6: The number of plans in each county and metal level was counted and weighted by the county enrollment. That weighted plan count was then divided by the total enrollment. Data only reflects states with operational section 1332 state-based reinsurance waivers for that year, with some exceptions where state data was unavailable. Data are only available going back to 2018, and data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019, so their values are set to N/A for those years). Highlighted cells indicate years when a state's section 1332 state-based reinsurance waiver is operational.

^{xviii} Methodology note for Table 7: The number of plans in each county and metal level was counted and weighted by the county enrollment. That weighted plan count was then divided by the total enrollment. Because data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019), only PYs 2020 and 2021 are shown, which account for all states with operational section 1332 state-based reinsurance waivers for those particular years. To calculate the national trends, Los Angeles County, California has two ratings areas where issuers could possibly offer a different number of plans. Since Los Angeles County has a very large number of enrollees, the two rating areas in the county are treated as separated counties for the purposes of these calculations.

Enrollment

Table 8 displays individual market enrollment both on and off-Exchange for states that began implementing section 1332 state-based reinsurance waivers in PYs 2018 and 2019.

TABLE 8
Individual Health Insurance Market Subsidized^{xix} and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Waivers, Compared to Overall U.S.^{xx}

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment
Alaska ^{xxi}	2018	Total	17,596	15,898	16,761	16,533
		<i>Percent Change^{xxii}</i>		<i>-10%</i>	<i>+5%</i>	<i>-1%</i>
		Subsidized	14,065	13,442	14,125	13,254
		<i>Percent Change</i>		<i>-4%</i>	<i>+5%</i>	<i>-6%</i>
		Unsubsidized	3,531	2,456	2,636	3,279
		<i>Percent Change</i>		<i>-30%</i>	<i>+7%</i>	<i>24%</i>
Minnesota	2018	Total	240,312	155,471	148,943	150,950
		<i>Percent Change</i>		<i>-35%</i>	<i>-4%</i>	<i>1%</i>
		Subsidized	42,631	61,932	62,832	59,219
		<i>Percent Change</i>		<i>+45%</i>	<i>+1%</i>	<i>-6%</i>
		Unsubsidized	197,681	92,539	86,111	91,731
		<i>Percent Change</i>		<i>-53%</i>	<i>-7%</i>	<i>7%</i>
Oregon	2018	Total	224,670	210,384	190,899	177,715
		<i>Percent Change</i>		<i>-6%</i>	<i>-9%</i>	<i>-7%</i>
		Subsidized	87,436	95,919	98,489	95,106
		<i>Percent Change</i>		<i>+10%</i>	<i>+3%</i>	<i>-3%</i>
		Unsubsidized	137,234	114,465	92,410	82,609
		<i>Percent Change</i>		<i>-17%</i>	<i>-19%</i>	<i>-11%</i>
Maine	2019	Total	82,158	77,897	72,801	67,260
		<i>Percent Change</i>		<i>-5%</i>	<i>-7%</i>	<i>-8%</i>
		Subsidized	63,402	57,984	57,883	52,589
		<i>Percent Change</i>		<i>-9%</i>	<i>-0.2%</i>	<i>-9%</i>
		Unsubsidized	18,756	19,913	14,918	14,671
		<i>Percent Change</i>		<i>6%</i>	<i>-25%</i>	<i>-2%</i>
Maryland	2019	Total	255,560	227,207	193,227	191,824
		<i>Percent Change</i>		<i>-11%</i>	<i>-15%</i>	<i>-1%</i>
		Subsidized	95,084	98,261	110,632	114,189
		<i>Percent Change</i>		<i>3%</i>	<i>13%</i>	<i>3%</i>
		Unsubsidized	160,476	128,946	82,595	77,635
		<i>Percent Change</i>		<i>-20%</i>	<i>-36%</i>	<i>-6%</i>

TABLE 8, cont.

Individual Health Insurance Market Subsidized^{xix} and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Waivers, Compared to Overall U.S.^{xx}

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment
New Jersey	2019	Total	336,605	342,903	312,923	303,808
		<i>Percent Change</i>		2%	-9%	-3%
		Subsidized	186,444	185,258	178,312	162,892
		<i>Percent Change</i>		-1%	-4%	-9%
		Unsubsidized	150,161	157,645	134,611	140,916
		<i>Percent Change</i>		5%	-15%	5%
Wisconsin	2019	Total	246,712	299,302	206,934	197,421
		<i>Percent Change</i>		-7%	-10%	-5%
		Subsidized	174,641	166,310	164,999	157,413
		<i>Percent Change</i>		-5%	-1%	-5%
		Unsubsidized	72,071	62,992	41,935	40,008
		<i>Percent Change</i>		-13%	-33%	-5%
Total U.S. ^{xxiii}		Total	14,517,542	13,018,351	12,128,447	11,718,848
		<i>Percent Change</i>		-10%	-7%	-3%
		Subsidized	8,248,839	8,025,959	8,356,247	8,272,321
		<i>Percent Change</i>		-3%	+4%	-1%
		Unsubsidized	6,268,703	4,992,392	3,772,200	3,446,527
		<i>Percent Change</i>		-20%	-24%	-9%

^{xix}Subsidized and unsubsidized in terms of eligibility for Advance Payments of the Premium Tax Credit (APTC).

^{xx} Enrollment data for 2016, 2017, 2018, and 2019 sourced from: Trends in Subsidized and Unsubsidized Enrollment October 9, 2020. Data includes average monthly enrollment in the ACA individual market (on and off-Exchange), and does not include enrollment in grandfathered or transitional (“grandmothered”) plans. Available online at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf>.

^{xxi} Alaska began operating its reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.

^{xxii} Percent changes in enrollment are for 2016 to 2017, 2017 to 2018, and 2018 to 2019.

^{xxiii} Total U.S. enrollment excludes data on plans from Massachusetts and Vermont, because both states have merged their individual and small group markets.

TABLE 1 ENDNOTES:
**Legislation Authorizing State Funding Sources for States
with Section 1332 State-Based Reinsurance Waivers**

Alaska

¹ SB 165 was signed into law on June 29, 2018. (Chapter 46 SLA 18). Available online at <http://www.akleg.gov/basis/Bill/Detail/30?Root=SB%20165>

Colorado

² SB20-215 was signed into law on June 30, 2020. Available online at https://leg.colorado.gov/sites/default/files/2020a_215_signed.pdf

Delaware

³ HB 193 was signed into law on June 20, 2019. Available online at <http://legis.delaware.gov/BillDetail/47632>

Maine

⁴ SP 221 LD 659 was signed into law on June 2, 2017. Available online at <https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0221&item=3&snum=128>

Maryland

⁵ SB 387 was signed into law on April 10, 2018. Available online at https://www.marylandhbe.com/wp-content/uploads/2018/04/Ch_38_sb0387E.pdf

⁶ HB 258 was signed into law on May 25, 2019. Available online at http://mgaleg.maryland.gov/2019RS/Chapters_noln/CH_597_hb0258t.pdf

Minnesota

⁷ HF No.5 was signed into law on April 3, 2017. Available online at https://www.revisor.mn.gov/bills/text.php?number=HF5&version=0&session=ls90&session_year=2017&session_number=0&type=ccr&format=pdf

Montana

⁸ SB 125 was signed into law on April 30, 2019. Available online at <https://leg.mt.gov/bills/2019/BillPdf/SB0125.pdf>

New Hampshire

⁹ HB 4 (Chaptered Law 346 of 2019) was signed into law on October 2, 2019. Available online at http://gencourt.state.nh.us/bill_status/billText.aspx?id=1336&txtFormat=html&sy=2019

¹⁰ RSA 404-G:3. Available online at <http://www.gencourt.state.nh.us/rsa/html/xxxvii/404-g/404-g-mrg.htm>

New Jersey

¹¹ A3380 was signed into law on May 30, 2018. Available online at https://www.njleg.state.nj.us/2018/Bills/A3500/3380_R1.PDF

North Dakota

¹² HB 1106 was signed into law on April 18, 2019. Available online at <https://www.legis.nd.gov/assembly/66-2019/documents/19-8068-05000.pdf>

Oregon

¹³ HB 2391 was signed into law on July 5, 2017. Available online at <https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/HB2391>

¹⁴ Oregon Revised Statutes, 743B.800 (2019). Available online at https://www.oregonlegislature.gov/bills_laws/ors/ors743b.html

¹⁵ HB 2010 was signed into law on March 13, 2019. Available online at <https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/HB2010/Enrolled>

Pennsylvania

¹⁶ Act 42 was signed into law on July 2, 2019. Available online at <https://www.insurance.pa.gov/Documents/Act%2042%20Codified.pdf>

Rhode Island

¹⁷ S 2934 was signed into law on July 3, 2018. Available online at <http://webserver.rilin.state.ri.us/BillText/BillText18/SenateText18/S2934A.pdf>

¹⁸ H 8351 was signed into law on July 3, 2018. Available online at <http://webserver.rilin.state.ri.us/BillText/BillText18/HouseText18/H8351.pdf>

Wisconsin

¹⁹ 2017 Wisconsin Act 138 was signed into law on February 27, 2018. Available online at <https://docs.legis.wisconsin.gov/2017/related/acts/138>