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Washington Office of the Insurance Commissioner

Individual Health Insurance Market Stabilization Analyses

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Introduction

The Washington State Office of the Insurance Commissioner (OIC, the State, Washington) retained Wakely Consulting Group, LLC (Wakely) to analyze the Washington individual Affordable Care Act (ACA) market to determine if there are actions the State could take to improve market stability. Washington's individual health insurance market has shown symptoms of destabilization in recent years, including double digit premium increases and threats of areas with no or very low issuer participation. To address potential instability in the individual market, Wakely, on behalf of Washington, was tasked to analyze a variety of policies with a goal of improving affordability and access to coverage. This document will discuss the potential policies that were considered, the pros and cons of the approach, the effects of the different policies on the 2019 individual market, and the implications of the policies.

Throughout this report, many technical insurance terms and references to specific elements of the ACA are discussed. To assist the reader, Appendix B contains a glossary with definitions and additional detail.

This document has been prepared for the sole use of the management of Washington. Wakely understands that the report may be made public. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Executive Summary

Washington identified key goals that any policy would need to satisfy, including:

- Bending the premium cost curve downward to impact affordability,
- Improve access to health insurance coverage in rural counties, and
- Maximizing opportunity for federal pass-through funding.

Wakely investigated the potential effects of different reinsurance programs and state offered options to determine which policies best meet these goals.

Reinsurance Options

Reinsurance is a technique that protects issuers from catastrophic claims for the members they enroll. Typically, this risk is managed by insuring these members through the form of a reinsurance program. A reinsurance program can be structured in many different ways. Our analysis focuses on two types of reinsurance programs:

- A claims-based reinsurance program will reimburse an issuer for each member whose total claims in a calendar year hits a certain dollar amount.
- A condition-based program will only reimburse issuers for the claims of members who have certain conditions.

Table 1 summarizes the impacts of implementing a reinsurance program – either claims-based or condition-based – in order to reduce premiums by 10 percent. The analysis included the impact of potential federal pass-through funds that could be attained due to reduction in subsidies from a reinsurance program through a Section 1332 State Innovation Waiver[1] (1332 waiver). A variety of alternative scenarios were tested but the basic conclusions did not alter significantly from the best estimate scenarios in which a reinsurance program would reduce premiums, increase coverage, and provide federal savings, even if the projections vary from Wakely's best estimate.

[1] Per CMS's website, a Section 1332 State Innovation Waiver "permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA."

Table 1: Summary of Claims-Based and Condition-Based Reinsurance Programs

Impact Category	Metric	Description
Type	Program Name	Claims-Based / Condition-Based Reinsurance Program
Cost Impact	Estimated Annual Cost	$179 million - $232 million
Cost Impact	Estimated Pass Through	$42 million - $54 million, 22% - 27% of total costs (due to reduction in federal premium subsidy payments)
Cost Impact	Estimated Cost to State	$138 million - $181 million
Cost Impact	Administrative Costs (Borne by State)	Not calculated, but likely lower for claims-based than condition-based reinsurance program
Legislative Impact	1332 Waiver Required?	Not required for a reinsurance program, but recommended so the state can receive federal pass-through
Consumer Impact	What Consumers?	All individual market enrollees statewide, on and off the Exchange
Consumer Impact	Consumer Benefits	10% premium reduction for individual insurance market enrollees; 2.5% increase in individual market enrollment; Higher proportion of claim reduction in underserved counties[2]
Consumer Impact	Washingtonians Impacted	These programs have the potential to impact the entire individual market, which is an estimated 290,000 enrollees in 2019, prior to the implementation of reinsurance

To achieve these results, the following parameters are estimated for each program. Both programs targeted a decrease in overall individual market premium of 10%. Note that the impact of administrative costs related to running a reinsurance program are not included within this analysis. In addition, the results shown within the report reflect changes solely due to a reduction in paid claims and does not address how the program would be funded (i.e., we did not assume any assessment on individual market issuers).

- **Claims-Based Reinsurance** (for definitions of claim-based reinsurance parameters, see Appendix B).
    - Attachment Point: $66,000

[2] Underserved counties were defined by Washington as counties at risk of having no on the Exchange issuers in future years. These counties were defined as either those that were bare at some point for the 2018 benefit year or only have one issuer option for the 2018 benefit year. The counties include Chelan, Douglas, Ferry, Grays Harbor, Island, Klickitat, Pend Oreille, San Juan, Skagit, and Skamania. The definition of underserved county or the counties included in the definition may change in future analyses.

  - Coinsurance: 50%
  - Cap: $1 million

- **Condition-Based Reinsurance**. Wakely incorporated the set of conditions included in Alaska's condition-based reinsurance program[3] and targeted a percentage of claims to be removed from each condition on a percentage basis to reach the desired reduction in premium. The resulting percentage of claims removed for the selected conditions was 27.9 percent.

The claims-based and condition-based reinsurance programs have similar results on an aggregate level; however, their impact within the various market segments varies as is discussed within the report. For both programs, affordability will be improved for consumers and claim costs will be decreased for issuers, thus increasing the probability that issuers will offer coverage in rural areas.

State Offered Options

In addition to reinsurance programs, Wakely analyzed several state offered options. These include a state option to be offered in instances of a county not having an on the Exchange plan available (bare county), state funded cost-sharing reduction (CSR, see Appendix B for a definition) wraps, and state funded premium wraps.

In a state option, the State can either 1) incentivize participation from existing carriers in the State; 2) directly contract with providers and offer health plan choices; or 3) contract with an issuer to provide coverage (e.g., a third-party administrator (TPA)). However, in order for consumers to be eligible for components of ACA, such as subsidies, the entity offering plan choices must be deemed a qualified health plan (QHP). At least in the short-term, it may be most appropriate for the State to partner with entities that already comply with ACA requirements.

[3] The list of conditions in Alaska's reinsurance program can be found here https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/alaska-Application-with-Attachments-51117.pdf

The components of the State offered option are shown in Table 2.

Table 2: Summary of State Option in Bare / Underserved Counties

Impact Category	Metric	Description
Type	Program Name	State Offered Option
Cost Impact	Estimated Annual Cost	It is assumed that claim costs would be covered by collected premiums; however, the State would be liable for any administrative expenses of the program
Cost Impact	Estimated Pass Through	Dependent on type of state option selected and potential savings
Cost Impact	Estimated Cost to State	Administrative expenses
Cost Impact	Administrative Costs (Borne by State)	Not calculated
Legislative Impact	1332 Waiver Required?	OIC should receive legal counsel on this matter but potentially needed to waive certain QHP requirements
Consumer Impact	What Consumers?	All enrollees within bare / underserved counties, on and off the Exchange
Consumer Impact	Consumer Benefits	Addresses the access goal for consumers in rural areas, but they will likely have little impact on affordability (unless combined with other state actions)
Consumer Impact	Washingtonians Impacted	An estimated 20,000 enrollees are in the underserved counties in 2019

Finally, Wakely analyzed the impact of Washington providing additional subsidies so that enrollee premium costs or out of pocket expenses are lower for certain enrollees.

- Additional cost-sharing wraps would protect lower-income enrollees from high out of pocket expenses by reducing the portion of expenses they have to pay for medical care. However, this program is not anticipated to significantly increase enrollment or reduce premiums. A consumer's decision to enroll is primarily influenced by premium levels and consequently, cost-sharing levels are not expected to have a significant effect on overall levels of enrollment.
- Premium subsidy wraps provide additional premium assistance to certain enrollees. We have modeled the impact of applying the premium assistance to all unsubsidized enrollees since these are the enrollees that currently receive no subsidization and must absorb the full impact of the high premium increases. This policy option could improve the health of the risk pool, as lower net premiums should attract healthier enrollees.

The high-level impact of these programs is shown in Table 3. Wakely analyzed several potential premium wrap scenarios that would reduce premiums for the current unsubsidized population,

including both on and off the Exchange. In Table 3, we have included a similar level of state funding support and similar baseline assumptions as described above for the reinsurance program.

In general, wraps will make coverage more affordable to some consumers, but they will not lower total premiums unless the risk pool is "improved" through enrollment of healthier individuals (which is a possible outcome, especially for premium wraps).

Table 3: Summary of CSR and Premium Wrap Subsidies

Impact Category	Metric	Description	
Type	Program Name	CSR Wrap	Premium Wrap
Cost Impact	Estimated Annual Cost	$38 million statewide; $4 million underserved counties	$152 million statewide; $10 million underserved counties
Cost Impact	Estimated Pass Through	None	None estimated
Cost Impact	Estimated Cost to State	Total estimated annual cost	Total estimated annual cost
Cost Impact	Administrative Costs (Borne by State)	Not calculated	Not calculated
Legislative Impact	1332 Waiver Required?	No	No, but could result in some federal pass-through
Consumer Impact	What Consumers?	On the Exchange silver CSR variant enrollees (including member migration from other plans eligible for the CSRs)	Unsubsidized enrollees, on and off the Exchange (if off the Exchange consumers move on the Exchange)
Consumer Impact	Consumer Benefits	Enrollees in the lowest CSR tier (73%) will have cost-sharing reduced by approximately 14%; Enrollees in the second lowest CSR tier (87%) will have cost-sharing reduced by approximately 7%	Premium reduction of 14%; Unsubsidized enrollment may increase by an estimated 6.7%
Consumer Impact	Washingtonians Impacted	Approximately 55,000 enrollees (statewide)	Approximately 160,000 enrollees (statewide)

It is important to note that any of these analyses would need to be refined before implementation. The studies were done to inform the potential impacts of the programs, but additional analysis would be required to understand the full impact of any program.

Additionally, a change in the current legislative environment will have an impact on all analyses. This analysis did not include the impact of CSR payments being halted which may have a significant impact on results.

The remainder of the report will discuss these options and their impacts in additional detail.

Policy Options

Multiple policy options were examined in terms of their ability to improve market stabilization as well as increase affordability and accessibility to individual market plans. Beyond the main goals of stabilizing Washington's individual market, policy options were also examined in terms of their ability to achieve the secondary goals. These secondary goals included creating incentives to increase participation in rural or underserved counties, reducing premiums significantly in rural or underserved counties, and not adversely affecting the single risk pool. Two major policy options that could be used to improve affordability and accessibility in the individual market are reinsurance programs and state offered options. This section presents the results of Wakely's evaluation of different types of reinsurance programs and different types of state offered options, including their policy implications.

Reinsurance Options

Over the past few decades, there have been various types of reinsurance programs. This section will describe two different reinsurance mechanisms, including the benefits and drawbacks of the different approaches.

CLAIMS-BASED REINSURANCE

Claims-based reinsurance has been used over the years to reduce premiums. Claims-based reinsurance programs pay a portion of claim costs, based on a prescribed coinsurance rate, between an attachment point (the point at which the claims cost begin being paid) and a cap (the point at which the reinsurance payments stop). Policy makers traditionally trade-off between having a higher coinsurance, and thereby providing greater funding, and a lower coinsurance, which encourages insurers to maximize disease cost management.

From 2014 through 2016, the U.S. Department of Health and Human Services (HHS) implemented the ACA's transitional reinsurance program, which reimbursed individual market paid claims. For example, in 2014, HHS reimbursed 100 percent of claim costs between $45,000 and $250,000. It is estimated that, in 2014, premiums were 10-15 percent lower as a result of the federal reinsurance program. More recently, Oregon submitted a 1332 waiver that included a claims-based reinsurance program, to be implemented in 2018, that reimburses issuers. In addition, Minnesota recently had its 1332 waiver for a claims-based reinsurance program approved.

One of the benefits of a claims-based reinsurance program is that it reimburses a portion of all paid claims for members that reach the attachment point, not just a select few. As a result, acute events (e.g., neonatal babies) or conditions that are more expensive than initially realized (e.g., because of an introduction of a new drug) are included.

In addition, claims-based reinsurance programs are typically easier to operationalize and maintain than other types of reinsurance programs. Issuers are very familiar with claims-based reinsurance programs and can easily incorporate such programs into their premium rates. Intense analyses on which conditions should be selected for coverage is not needed. The ease of operational implementation is one of the reasons why HHS selected a claims-based reinsurance program rather than a condition-based reinsurance program when implementing the transitional reinsurance program. The transitional program was very successful as it reduced premiums more than 10 percent in 2014 (albeit reduced premiums less in 2015 and 2016).

Finally, claims-based reinsurance payments automatically adjust for higher unit costs. For example, if rural areas experience more high claims relative to the rest of the State, on a per-capita basis, rural areas will receive more funding.

The main drawback of a claims-based reinsurance program is that it may incentivize over-utilization. The larger the claim costs, the greater the reimbursement (up to the cap). Additionally, there have been concerns that provider contracts could be altered to provide incentives for reaching the reinsurance attachment point (i.e., gaming). As a result, unless the coinsurance rate is sufficiently low, claims-based reinsurance programs may result in greater spending than other reinsurance programs, which may negate some of the effectiveness of the program and reward inefficient plans. Finally, there may be some distortions as issuers may be over-compensated for high-risk enrollees as they would be reimbursed both with reinsurance claims and by risk adjustment payments (although this should be reflected in their premium rates). The Centers for Medicare and Medicaid (CMS), in their letter to Minnesota, noted that any adjustments a state might consider to risk adjustment methodology to avoid over-compensation would need to be operationalized by the State.

CONDITION-BASED REINSURANCE

In condition-based reinsurance, issuers transfer risk from themselves to an external state-sponsored entity for select conditions. For example, Maine instituted a condition-based reinsurance program that reimbursed issuers for enrollees with one of eight conditions (and also from issuer recommendations based on detailed medical questions). Alaska implemented a condition-based reinsurance program, through a 1332 waiver, in which an issuer will be reimbursed for any of 33 or more high cost conditions. For condition-based reinsurance programs, the State often times will reimburse all claims for individuals that are deemed to have these high risk conditions and not only those specific to the high risk condition, in exchange for ceding all premium and cost sharing reduction (CSR, see Appendix B for more details) funding to the State.

In a condition-based reinsurance program, an issuer would receive full reimbursement for select high cost conditions. These high cost conditions could be identified to meet the particular needs of a state. In Alaska, the condition-based reinsurance program has been effective at reducing the premium rates charged for the State's one issuer. Proposed rates in Alaska had double-digit

premium *decreases* as a result of the reinsurance program. The case of Alaska may not be applicable to other states as there currently is only one issuer and therefore issues like risk adjustment are non-applicable.

Condition-based reinsurance programs are inherently operationally more complex, since:

1.) Identifying which conditions should be reimbursed, often times annually, can be a large burden;
2.) Collecting condition-specific data is cumbersome and may have errors, and
3.) Auditing issuers to ensure proper and accurate medical coding may be difficult.

Beyond operational complexity, reimbursing all claims for a select number of conditions may result in issuers having less incentive to include proper medical cost management protocols. Finally, if the conditions selected are also conditions reimbursed by the federal risk adjustment program, it may result in over-compensation due to risk adjustment transfers. For example, if HIV were included in the condition-based reinsurance program, an issuer would be receiving compensation not only from the condition-based reinsurance program but also from the risk adjustment program, when the issuer actually maintains no risk for the enrollee with the HIV condition. This may produce distortions in the individual market. Alaska was not affected by this distortion as it only has one issuer.

Reference Pricing Reinsurance

Similar to condition-based reinsurance programs, reference pricing reinsurance programs pay issuers for enrollees with select conditions. It differs in that instead of paying for the total claim costs associated with that member, reference pricing programs instead reimburse with a preset amount. For example, issuers could be paid Medicare or some rate based on average costs, average contracts, etc. for enrollees with high cost conditions. This idea was considered as a way of stabilizing the individual market as part of the American Health Care Act of 2017.

Reference pricing provides some reimbursement to issuers with high cost conditions but, as opposed to condition-based reinsurance, it provides incentives to issuers to continue/improve medical cost management as the issuers will still be responsible for claims over the preset amount. Issuers will be able to achieve greater profitability if the claim costs they incur for an enrollee with a selected condition is lower than the preset amount. This is the opposite of condition-based type programs where greater issuer claim costs lead to greater reimbursement.

This type of program has never been attempted in a post-ACA setting. As with most programs, there may be some learning. For example, given that the rate is generally flat, it may under-compensate issuers for acute cases for certain conditions or issuers in areas with high average costs that may exceed the reference price. While it may be possible to have more complicated

condition categorization or adjust for regional variation, this would require additional analyses and operations that are far more complex.

Additionally, similar to condition-based programs, operations may be complex to begin with as proper intake of diagnoses or complex audits of medical conditions would be necessary to ensure that issuers are properly paid and reduce the incentive to game diagnosis codes. For example, operational details on which conditions would be included, how those conditions are defined, what payment level is assessed to that condition, how the conditions should be submitted, and what auditing is needed to ensure proper medical diagnosis are all components that need to be considered and decided upon. All of these decisions would need to be regularly revisited and updated given potential changes in the market or the cost of the condition. Many of the processes CMS uses to create a risk adjustment model would effectively need to be mimicked but instead of national data, Washington could rely on state-specific data.

Finally, while not as extreme as a condition-based program, the reference pricing program does have the potential for some issuers to be over-compensated for some conditions if the conditions selected for the reference pricing program match those compensated through risk adjustment. As previously noted, any adjustments to the risk adjustment methodology that the State would prefer would need to be operationalized by the State

INTERACTIONS WITH WSHIP PROGRAM

If Washington considers creating a program that reimburses issuers for high cost enrollees, one question that arises is if Washington State High Risk Pool (WSHIP) enrollees should be transferred to the individual market. Although many state high-risk pools ended after the implementation of the ACA in 2014, some remained due to state requirements or because some enrollees did not qualify to be enrolled in the Exchange. Washington's traditional high-risk pool continues to provide coverage to several hundred Washingtonians. It is our understanding that the majority of these individuals reside in urban areas and are provided coverage through third party payments of the WSHIP premiums. Although not all of the WSHIP members are eligible for individual ACA coverage, but, for those that can shift to the individual market, should efforts be made to do so?

Overall, high-risk pool costs would decrease for the State due to the lower aggregate claim cost and lower operational costs. Members who move to the individual market would incur lower premiums. However, premiums within the individual market will be increased since the average cost for those typically in high-risk pools is likely higher than the average of those in the individual market. Issuers will now need to manage these members, which could increase their administrative costs. If the impact of a reinsurance program is measured compared to the current baseline, inclusion of WSHIP enrollees will require greater reinsurance funds to achieve a preset reduction in premiums. Given the high costs WSHIP enrollees represent, we believe their transfer

to the individual market would decrease the effectiveness of any reinsurance program and, therefore, do not recommend incorporating them into the individual health insurance market.

There could be operational synergies if the WSHIP program has experience in the type of reinsurance program ultimately implemented. Any experience with claim costs or claims files, as well as the auditing that is necessary of that data, could aid in successful operational implementation.

State Offered Options

Another policy option that could be used to improve affordability and access to Washingtonians is a state offered option. This option could be used as a substitute for reinsurance or in conjunction with reinsurance. A state offered option is a program in which a state subsidizes, directly or indirectly, some portion of the liabilities associated with claims costs for enrollees or some of the out of pocket expenses that an enrollee may experience (i.e., premiums or cost-sharing payments). A state offered option has often been mentioned as a method for ensuring that all counties have coverage. A state can use it to guarantee an option is available or to increase the affordability of the coverage options.

STATE OFFERED OPTION – BARE COUNTY

While currently every county in the nation has some issuer coverage, there remains concern that some counties, specifically in rural areas, may lack coverage options in the individual market in 2019 and beyond. State offered options designed to guarantee access to coverage could take on various forms of creation such as changing legislation such that participation in a separate market (e.g. Medicaid managed care plan) is contingent upon offering coverage within the individual market, contracting with an existing QHP issuer, or contracting with an existing state agency or program. For example, allowing any individual to purchase coverage in Medicaid, a state employee program, a state high-risk pool, etc. could all be explored as ways to expand coverage. The State may also want to consider financial or other incentives for issuers to continue, or add, coverage within the underserved counties.

A state offered option achieves a policy goal of no bare counties[4], but may not lower premiums unless the program includes some type of lower provider reimbursement. If the provision of coverage is contingent on a bare county, it is likely to have minimal impact on the overall risk pool as it is likely to have a small number of enrollees and may not have lower premiums to attract healthier enrollees.

[4] A bare county is defined in this report as a county with no participation by a QHP issuer in the individual market.

Beyond ensuring enrollees have access to coverage, policy makers could have a goal of ensuring that that coverage is more affordable. To achieve this goal, policy makers could implement a state offered option with additional provisions that either limits provider reimbursement, incentivizes narrow networks, or provides additional cost-sharing or premium subsidies to enrollees. They could also use the State offered option to directly compete with private insurance companies. This may result, over time, with fewer options to consumers.

As an alternative to the State option explored above, policy makers could institute affordability provisions (e.g., premium or cost-sharing subsidy wraps or provider reimbursement requirement) without the creation of a state offered option. It should be noted that guaranteed coverage and affordability improvement can be countervailing forces. By adding additional contracting requirements or increased pressure on margins, issuers or providers may be more reluctant to participate, unless required by law.

COST-SHARING WRAP

The ACA included a key provision, known as CSR plans, that has had a substantial impact on protecting certain enrollees from high out of pocket expenses. Issuers are required to offer three silver plans with reduced cost-sharing (cost-sharing variant plans) for low-income enrollees meeting income thresholds. Cost-sharing subsidies have been found to influence plan choice[5] and have provided billions of dollars to reduce copays. For example, in 2016, while the median deductible in a non-cost-sharing variant silver plan for Healthcare.gov Marketplace enrollees was $3,000, those that enrolled in a cost-sharing variant had median deductibles between $500 and $3,000 less. Cost-sharing wraps will improve affordability for the subsidized population. However, the literature has frequently stressed that a consumer's decision to enroll is driven primarily by premiums rather than cost-sharing.[6] This is not to discount the positive effects that increased cost-sharing has for enrollees. For example, decreased cost-sharing has been shown to improve perceived affordability and decrease financial burden. Decreased cost-sharing has also been shown to improve drug adherence.[7] Finally, increased cost-sharing has been shown to affect

[5] Deliere, Thomas et al . 2017 "Do Individuals respond to Cost-Sharing Subsidies in their Selections of Marketplace Health Insurance Plans?" Journal of Health Economics

[6] Abaluck, Jason and Jonathan Gruber. (2011). "Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program." American Economic Review 101(June): 1180-1210

[7]https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/

enrollee decisions to enroll in Silver plans rather than Bronze plans, which may be financially beneficial to them.[8]

While cost-sharing wraps may increase affordability for enrollees, it is not likely to have a significant impact on enrollment. In fact, increased cost-sharing could also result in increased utilization, and, thus increased premiums. Higher utilization among those with reduced cost sharing, among subsidized enrollees, would likely increase premiums for all enrollees due to the single risk pool requirement. Consequently, while cost-sharing wraps would address a policy goal of improved affordability for subsidized enrollees, it is unlikely to reduce premiums, as higher utilization would put upward pressure on premiums. Cost-sharing wraps are also unlikely to produce federal savings, given the upward pressure on premiums, and, therefore, likely would not generate 1332 waiver related funding.

PREMIUM SUBSIDY WRAP

A final policy option that could improve the health of the risk pool are premium subsidy wraps. The American Academy of Actuaries noted that increased subsidies, specifically targeting younger enrollees, could have benefits to the risk pool.[9] However, programs that specifically target younger enrollees may have the risk of being seen as discriminatory. Lower premiums for families could be achieved by providing larger subsidy amounts for those currently receiving subsidies and providing subsidies to those not currently eligible for advanced premium tax credit (APTC). A premium wrap geared towards members that are not currently eligible for APTC will help to shelter those individuals from the large premium increases that may occur. This population is more vulnerable to the increase in premium rates compared to the individuals receiving APTC, since those receiving APTC receive a subsidy increase as the overall rates increase (based on the second lowest silver premium rate). One of the benefits of a subsidy wrap is that it could be targeted to specific vulnerable populations (i.e., those in underserved counties) or towards younger enrollees, whose enrollment may benefit the risk pool.

There are some downsides to a premium wrap. While it addresses premium affordability, it does not lower issuer claim costs (or premiums). Claim costs and the resulting potential liabilities for an issuer may have more salience in the short-term decision involving participation. Reinsurance programs lower premiums directly through lowering claims cost that issuers are liable for and

[8] Deliere, Thomas et al . 2017 “Do Individuals respond to Cost-Sharing Subsidies in their Selections of Marketplace Health Insurance Plans?” Journal of Health Economics

[9] http://www.actuary.org/files/publications/Sustainable_Health_Insurance_Marketplace_042417.pdf

indirectly by improving the risk pool. Premium wraps would only lower gross premiums (i.e., the second lowest cost silver plan) by improvements in the risk pool.

Approach

Within the multitude of policy options, Wakely prioritized analysis of a claims-based reinsurance program. This type of program can be relatively easier to operationalize than some of the other policy options and historically has had a significant positive effect on the individual market. However, Wakely also examined aspects of a reference pricing reinsurance model. While further research is needed, the analysis does demonstrate that there are both positives and negatives to a reference pricing reinsurance program. Finally, different state offered option policies were examined from a high-level.

Any of these analyses would need to be refined before implementation. The studies were done to inform the potential impacts of the programs, but additional analysis would be required to understand the full impact of any program.

Additionally, a change in the current legislative environment will have an impact on all analyses. This analysis did not include the impact of CSR payments being halted which may have a significant impact on results.

Data and Methodology

The methodology used in the analyses was complex and involved multiple components. The list below summarizes the key methodological elements used for the analyses, but Appendix A should be reviewed for complete information related to the analyses.

- **Base Period Data Collection**: Wakely collected 2015 and 2016 EDGE (see Appendix B for definition) and supplemental data from Washington issuers on behalf of the OIC, which included premiums, claims dollars, medical diagnoses, demographics such as age, gender, and geographic residence, enrollment dates, administrative expenses, and other member level characteristics. 2015 data was used primarily as a source of verification of stability between years. This is described in more detail in Appendix A.

  Note: All of Wakely's analysis is based on EDGE data. If data file formats used for Washington programs differ from the EDGE format, the estimates encapsulated herein may differ from actual results.

- **Base Period Data Analyses**: After compiling the 2016 base data, Wakely utilized a proprietary tool called Wakely Risk Insight (WRI) to estimate cost and profitability for every member in the data, based on certain data components (premiums, claims, risk adjustment transfers, administrative components). The member level detailed data was then rolled up into various sub-segments (such as metal level and geographic area by county) to perform analyses in order to assess whether any underlying sub-segments were the key drivers of the profitability variances. These results can be reviewed in Appendix A.

- **2019 Baseline Data**: Adjustments were made to the 2016 base data on a member level to generate an estimate of the 2019 baseline without any stabilization initiative. The 2019 baseline uses the 2016 data incorporating the most up to date information available at the time of modeling, using information from publicly available studies and 2018 individual ACA-compliant rate filings, provided to Wakely by the OIC on 9/13/2017. **These filings assumed that CSR plans will continue to be funded, which may be inconsistent with current practices. The defunding of CSR plans may have a significant impact on results.**

  The following describes the several adjustments made to the 2016 base data.

- **Allowed Trend.** The 2016 to 2018 allowed trend is derived from issuer-specific 2018 rate filings. The 2018 to 2019 trend is assumed to be 6.5 percent based on a publicly available

study.[10] The total factor from 2016 to 2019 is 1.278, which is equal to an approximate 8.5 percent annual trend.

- Although there is a possibility that trend may be higher than 6.5 percent from 2018 to 2019, as of the writing of this report, there is significant uncertainty as to what the market may look like at that time. The market should be monitored as new information becomes available that may inform this assumption. We note that recent financial data shows that in the first half of 2017, issuers, on average, achieved high profitability.[11] That data suggests that premium increases in the future should align with medical trend as future premiums would not need to account for previous underestimation of morbidity. Wakely completed this analysis before recent announcements on CSR defunding and did not account for that in this report.
- **Paid Trend.** The paid trend is derived from total allowed trend described above, adjusted by the differences in paid to allowed ratios from 2016 to 2018, based on information from issuer rate filings. The total factor from 2016 to 2019 is 1.207, which is equal to an approximate 6.5 percent annual trend.
- **Network Impact.** The network adjustment is derived from issuer-specific network changes from 2018 rate filings. This assumption represents the idea that issuers are moving from wide network to narrower network plans. This adjustment is equal to 0.994 in total (from 2016 to 2018 with no adjustment from 2018 to 2019), and it is applied to paid claims.
- **Premium.** The premium changes are derived from rate filings by issuer. The factor from 2016 to 2017 is equal to 1.137 (or 13.7 percent). The factor from 2017 to 2018 is equal to 1.265 (or 26.5 percent). The 2018 to 2019 premium change is assumed to follow with claim trend, which is a factor of 1.065 (or 6.5 percent). The total factor from 2016 to 2019 is 1.532 (or 53.2 percent).

In addition to trending the data, Wakely applied a change to the enrollment and morbidity from 2016 to 2019. The targeted enrollment and morbidity assumptions were applied as follow:

- **Enrollment.** The enrollment target is derived based on 2016 EDGE data, 2017 data as of March 2017 provided by the OIC, and 2018 data estimated by an enrollment take-up function published by the Council of Economic Advisors (CEA)[12] using the 2018 premium increases. Subsidized enrollment is assumed to be flat from 2017 to 2018, with the

[10] https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[11] https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2017/

[12]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

enrollment decrease coming from the unsubsidized and off the Exchange populations. Enrollment in 2019 is estimated to be flat from 2018.

a. The resulting impact is 0.997 (or -0.3 percent) from 2016 to 2017, 0.945 (or -5.5 percent) from 2017 to 2018, and 1.000 (or 0.0 percent) from 2018 to 2019. The total impact from 2016 to 2019 is 0.942 (or -5.8 percent).
b. The enrollment was allocated separately for on and off the Exchange, since Wakely assumed that the subsidized portion of the Exchange enrollment would remain steady from 2017 to 2019. The resulting impact was a reduction of -3.5 percent of enrollment on the Exchange and -8.4 percent off the Exchange.

- **Morbidity.** The change in morbidity was developed based on statistics of the health status of those leaving the market compared to those staying and the estimated percentage of members assumed to be leaving. The health status statistics are from a study performed by the CEA (noted above). The estimated percentage of those assumed to be leaving uses the 2016 to 2019 change in enrollment estimates (described above). The resulting morbidity impact from 2016 to 2019 is 1.016 (or 1.6 percent).

Wakely determined the most appropriate methodology was to remove members from the 2016 data aligning with the overall estimated enrollment decrease from 2016 to 2019. The enrollment was removed assuming the healthier and younger members would be more likely to drop coverage between 2016 and 2019.

No additional adjustments were made to the 2016 detailed data to account for known changes that have already occurred in the emerging 2017 enrollment experience or that are believed to occur due to the 2018 rate filings.

- **Reinsurance Scenarios:** To estimate the effects of a reinsurance program, Wakely developed cost parameters and applied them on a member level such that the reinsurance funds would reduce premiums statewide by 10 percent. The amount of funds needed to achieve the premium savings was calculated based on the total estimated premiums in the individual market from the 2019 Baseline data. The results shown within the report reflect changes solely due to a reduction in paid claims and does not address how the program would be funded (i.e., we did not assume any assessment on individual market issuers). Enrollment was re-estimated with the lower post-reinsurance premium, using an enrollment function (described previously) to calculate a final individual market average enrollment. The increase in enrollment from the 2019 Baseline data, after a 10 percent reduction in statewide premiums due to reinsurance, is estimated to be 2.5 percent, which is made up of a 1.1 percent increase on the Exchange and a 4.3 percent increase off the Exchange. Detailed enrollment estimated by Exchange status and county were provided to the OIC.
    - **Claims-Based Reinsurance Program.** Wakely calculated claims-based reinsurance parameters (for definitions, please see Appendix B) to achieve a 10 percent reduction in premiums.

- **Condition-Based Reinsurance Program.** To illustrate the impact of a reference pricing program, Wakely used the set of conditions included in Alaska's reinsurance program[13] and targeted a 10 percent reduction in premiums, by removing a set percentage of claims across all covered conditions.

- **State Offered Option.** Wakely performed high-level analyses around the needed claim costs for a state offered option for the counties identified as underserved, as provided by the OIC. In addition, we discuss the possibility of premium and CSR subsidy wraps and include high-level analysis results for each program. For the CSR subsidy wrap, we analyze the impact to claim costs if enrollees in 73 percent variants were provided the same cost-sharing protection as those in 87 percent variants and all enrollees in 87 percent variants have the same cost-sharing protections as those enrolled in 94 percent variants. For the premium subsidy wrap, we estimate the impact of various premium wrap amounts on the unsubsidized population (both on and off the Exchange) since those are the enrollees that currently feel the full impact of premium increases. The analysis could be modified in future studies to also include additional premium wraps for the currently subsidized population.

[13] Additional analysis would be needed to construct a set of Washington-specific conditions. For example, conditions could be selected that are high cost, stable from year to year, and not gameable. Wakely would require significant input from the OIC in determining these conditions. However, the conditions selected typically only influence distributional outcomes (i.e. what issuers are paid at which amounts), and the overall effect on the risk pool is primarily dependent on the amount of funding.

Analysis Results

The following sections discuss the results of each portion of Wakely's analysis. For additional information regarding the data and methodology, see Appendix A.

Claims-Based Reinsurance

As discussed previously, Wakely targeted a 10 percent reduction in premiums using claims-based reinsurance parameters. The coinsurance was set at 50 percent in order to ensure that issuers are still at risk for a portion of the costs and continue to manage the care of the enrollee. The cap was set at $1 million in order to not have any overlap with the pooling mechanism that will be part of the 2018 risk adjustment model (which begins at $1 million). Wakely then calculated the necessary attachment point in order to achieve a 10 percent reduction in premiums. The resulting attachment point was $66,000.

Wakely then summarized the data by various market segments to compare the resulting reduction in premiums and paid claim amounts. It is important to keep in mind that the premium reduction is applied at the State level, even though there are variations in the reduction in claims at the various market sub-segments. Wakely incorporated the premium reduction equally to all members due to our understanding that any reinsurance initiative would need to be applied to the entire market equally (or index rate) in any issuer rate filing, due to ACA rating requirements. Wakely can vary the resulting premium by various market segments, but we understand the process of applying it in such a way would likely require a 1332 waiver.

Table 4 includes the claims-based reinsurance results for the underserved counties, urban counties which are defined as those with the five largest cities in the State (see Appendix A for full listing), and other, which are the remaining counties. A small portion of members are excluded due to county mappings that are out of state or an inability to map to a county due to data errors. They are not included as a data breakout, but are included within the total. The tables include both per member per month (PMPM) metrics and a comparison of the reinsurance program to the 2019 baseline data.

When analyzing the impact of the reinsurance program by geographic area, Table 4 shows that the program would help those living in the underserved areas the most, reducing claims by nearly 15 percent on average in those counties. Since the premium reduction is applied to everyone equally, it will not lower premiums in the underserved counties, but it will improve the profitability relative to the other areas, which may improve the attractiveness to issuers in offering coverage in these areas. As discussed, the reduction in premium will be 10 percent in all segments of the market.

Table 4: Claims-based Reinsurance Results by Geographic Area

Area	Premium PMPM	Paid Claims PMPM	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
Urban	$494.90	$371.32	-10.0%	-11.2%
Underserved	$578.09	$441.66	-10.0%	-14.9%
Other	$544.07	$408.60	-10.0%	-13.7%
Total	**$511.28**	**$389.44**	**-10.0%**	**-12.2%**

Table 5 shows the impact of applying the reinsurance parameters on versus off the Exchange. The reduction in off the Exchange claims would be 13.1 percent compared to 11.5 percent on the Exchange.

Table 5: Claims-based Reinsurance Results by Exchange Status

Exchange Status	Premium PMPM	Paid Claims PMPM	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
On The Exchange	$519.64	$398.84	-10.0%	-11.5%
Off The Exchange	$501.44	$378.39	-10.0%	-13.1%
Total	**$511.28**	**$389.44**	**-10.0%**	**-12.2%**

As can be seen in Table 6, the reinsurance parameters would reduce claims most in the bronze metal level and would have only an average impact of reducing claims in the gold metal level. Historically, the bronze metal levels have been significantly more profitable than the gold metal levels. However, it is difficult to say whether this will continue to be the case with any revisions in the 2018 and 2019 risk adjustment programs.

Table 6: Claims-based Reinsurance Results by Metal

Metal Level	Premium PMPM	Paid Claims PMPM	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
Catastrophic	$212.20	$54.28	-10.0%	0.0%
Bronze	$459.76	$200.38	-10.0%	-14.3%
Silver 70%	$523.61	$389.58	-10.0%	-11.5%
Silver 73%	$566.37	$388.32	-10.0%	-11.7%
Silver 87%	$534.63	$473.88	-10.0%	-10.6%
Silver 94%	$489.82	$430.08	-10.0%	-9.2%
Silver Total	*$526.66*	*$416.96*	*-10.0%*	*-10.9%*
Gold	$612.86	$823.05	-10.0%	-12.7%
Total	**$511.28**	**$389.44**	**-10.0%**	**-12.2%**

POSSIBLE ADDITIONAL ANALYSES

The same parameters were applied equally to all areas of the State. Wakely could vary the parameters for certain market segments (such as the underserved counties) such that they would receive more favorable parameters. In addition, Wakely could model other types of parameters (such as higher coinsurance and higher attachment points) for Washington to understand impacts of various reinsurance parameters.

These analyses, or other variations on claims-based reinsurance, could be undertaken as part of Phase II. Phase II was discussed in the Request for Proposal for this project in which a possible 1332 waiver would be pursued or other analysis could be completed. Throughout the report, we mention that several components could be further analyzed as part of Phase II of the analysis if Washington decides that is the best course of action.

Condition-Based Reinsurance

CONSIDERATIONS FOR REFERENCE PRICING

Wakely provided information to Washington to begin understanding the process in which to implement a reference pricing insurance program, including the following questions to consider:

- What metrics should be used to choose the list of conditions? Will you receive input from advocacy groups? How can you avoid the potential for gaming? Is it more important to have a bigger list and smaller cap rates or vice versa? Would issuers have concerns on level of complexity?
- How will you consider the variation within each condition, and how that would impact the capitation rate? Would the rate be a certain percentage of average annual claims for each condition that would not vary by condition?
- Should the rates vary by adults and children and/or by region?
- Should the list contain comorbidities? How would the State want to handle comorbidities or differing levels of severity?
- Would any risk adjustment program adjustments be needed?
- What operations are needed for diagnosis validation/audit?
- How often would the program need to be updated?

SIMPLIFIED REFERENCE PRICING EXAMPLE

Then, Wakely calculated a simplified example reference pricing reinsurance program to illustrate a potential option. Wakely targeted a 10 percent reduction in premiums using the set of conditions included in Alaska's condition-based reinsurance program, and targeted the percentage of claims to be removed from each condition included such that a 10 percent reduction was achieved. The

resulting percentage of claims removed was 27.9 percent. Note, this is not exactly how a reference pricing program would be developed, but it is to illustrate what a variation of a condition-based program may look like.

Wakely then summarized the data by various market segments to compare the resulting reduction in premiums and paid claim amounts. As noted above within the transitional reinsurance program, the premium reduction is applied at the State level, even though there are variations in the reduction in claims at the various market sub-segments. Wakely incorporated the premium reduction equally to all members due to our understanding that any reinsurance initiative would need to be applied to the entire market equally (or index rate) in any issuer rate filing.

When analyzing the impact of the reference pricing reinsurance program by geographic area, it can be seen in Table 7 that the program would help those living in the underserved areas the most, reducing claims by approximately 13.3 percent. Since the premium reduction is applied to everyone equally, it will not lower premiums in these areas, but it will improve the profitability of these areas relative to the other areas, which may improve the attractiveness to issuers in offering coverage in the underserved counties. However, it is important to note that the reduction in claims was more significant for the underserved counties in the claims-based reinsurance program. As discussed, the reduction in premium will be 10 percent in all segments of the market.

Table 7: Simplified Reference Pricing Reinsurance Results by Geographic Area

Area	Premium PMPM	Paid Claims PMPM	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
Urban	$494.90	$367.42	-10.0%	-12.1%
Underserved	$578.09	$450.36	-10.0%	-13.3%
Other	$544.07	$415.46	-10.0%	-12.3%
Total	**$511.28**	**$389.35**	**-10.0%**	**-12.3%**

Table 8 shows the impact of applying the reinsurance parameters on and off the Exchange. The reduction in both segments of the market is nearly equal.

Table 8: Simplified Reference Pricing Reinsurance Results by Exchange Status

Exchange Status	Premium PMPM	Paid Claims PMPM	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
On The Exchange	$519.64	$394.99	-10.0%	-12.4%
Off The Exchange	$501.44	$382.71	-10.0%	-12.1%
Total	**$511.28**	**$389.35**	**-10.0%**	**-12.3%**

As shown in Table 9, the reinsurance parameters would reduce claims most in the gold metal level, which may be more desirable since historically, the gold metal level has been less profitable than the other metal levels. However, it is difficult to say whether this will continue to be the case with any revisions in the 2018 and 2019 risk adjustment programs.

Table 9: Simplified Reference Pricing Reinsurance Results by Metal Level

Metal Level	Premium PMPM	Paid Claims PMPM	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
Catastrophic	$212.20	$53.58	-10.0%	-1.3%
Bronze	$459.76	$205.65	-10.0%	-12.0%
Silver 70%	$523.61	$389.88	-10.0%	-11.4%
Silver 73%	$566.37	$386.70	-10.0%	-12.1%
Silver 87%	$534.63	$470.51	-10.0%	-11.3%
Silver 94%	$489.82	$423.66	-10.0%	-10.6%
Silver Total	*$526.66*	*$415.12*	*-10.0%*	*-11.3%*
Gold	$612.86	$813.62	-10.0%	-13.7%
Total	**$511.28**	**$389.35**	**-10.0%**	**-12.3%**

POSSIBLE ADDITIONAL ANALYSES

In these analyses, the same parameters were applied equally to all areas of the State. Wakely could vary the parameters for certain market segments such that they would receive more favorable parameters. In addition, Wakely could begin discussions around implementing a true reference pricing reinsurance program.

In order to pursue a true reference pricing analysis, the first step would be to choose a list of conditions in which to include in the program. This could take significant time and require input from various entities, but it is necessary if Washington would like to consider a list of conditions that is most reflective of the Washington population. From this list, Wakely would work with the OIC to identify the other parameters that should be taken into account in the program, which

would include answering many of the items in the “Considerations for Reference Pricing” section above.

State Offered Option – Bare County

One potential type of a state offered option is a publically sponsored plan that provides coverage in the event that no QHP issuer provides coverage in a certain county. If additional state provided incentives are not sufficient to promote issuer participation or the State wishes to ensure some coverage option, the State could choose to directly offer coverage options or contract with entities who would in turn provide coverage.

The following list outlines certain items the State should consider in determining whether a state option is needed and what form it should take:

- What needs to be accomplished in order to offer a state option (e.g. QHP status)?
- What costs will the State face?
- What are the costs to consumers (i.e. premiums, subsidies. etc.)?
- How easily can it be implemented?
- How quickly can it be implemented?

Some options the State may want to consider include:

1. Require participation in bare counties in the individual market as a condition for Medicaid managed care contracting.
2. Provide financial or other incentives for existing issuers to offer plans in bare counties.
3. Offer coverage through an existing state agency or program, such as WSHIP.
4. Conduct a procurement process to choose an existing issuer, with QHP status, from which to contract to provide all plan functions (i.e. contract with a selected issuer on an Administrative Services Only (ASO) basis).

The following discusses each of the potential state options in more detail.

1. Require participation in bare counties in the individual market as a condition for Medicaid managed care contracting.

This option has been considered in states like Nevada. In this option, as part of a requirement for a Medicaid managed care organization to participate in Medicaid, the company would also be required to offer individual market coverage. The incentive is that Medicaid participation may be enough to induce coverage options in the individual market. However, it is possible that tying the two together may result in exits from both programs.

2. Provide financial or other incentives for existing issuers to offer plans in bare counties.

This option would provide incentives to issuers that offer plans in bare counties. The following are some examples of potential incentives.

- All reinsurance payments could be contingent on an issuer offering coverage in an underserved county (or counties) and, therefore, enhance issuer profitability. By having reinsurance dollars available to issuers that offer coverage in underserved areas, there is a greater incentive to offer coverage in these counties. However, by having the payments available based solely on whether coverage is offered in certain rural or underserved counties, regional issuers that lack an ability to contract in those areas would be at a disadvantage.
- Provide greater reinsurance payments for enrollees within underserved counties through adjustments to parameters, such as increasing the coinsurance rates for enrollees in select counties.
- Provide extra “points” in a future Medicaid managed care procurement in the Exchange for offering coverage in underserved counties.
- Provide some type of loss protection (reimbursement of losses) or risk corridor for issuers that offer plans in such counties.

3. Offer coverage through an existing state agency, such as WSHIP.

The State could consider providing coverage through an existing state agency. A downside of this approach is that existing state agencies may not currently possess all the necessary administrative functionality required for the ACA individual marketplace, including the complex and expensive functionality required for individual market participation. For example, in order to participate in ACA individual market risk adjustment, the agency would need to set up (directly or through a vendor) an EDGE server. It is our understanding that none of the existing state agencies have this capacity. The administrative burdens that are required to offer and manage a plan under the ACA could require high upfront costs and be time consuming to implement and continue to administer. Such functionality would have to be purchased from outside vendors and can be expensive. The Washington Exchange (HBE) assists with some of the administrative tasks for enrollees on the Exchange such as outreach, marketing, enrollment, and eligibility, which may ease some of the administrative burden.

Also note, without a section 1332 wavier, the entity would need to be deemed a QHP in order to offer coverage through the Exchange so that enrollees can receive premium tax credits and enroll in cost-sharing reduction plans. In this option, the State would bear that financial risk.

4. Conduct a procurement process to choose an existing issuer, with QHP status, from which to contract to provide all plan functions (i.e. contract with a selected issuer on an Administrative Services Only (ASO) basis).

An alternative approach would be for the State to contract with an existing ACA issuer with QHP status. While further legal analysis is needed, having the arrangement deemed a QHP would likely be needed so that enrollees would be eligible for premium tax credits. An operational arrangement for the entity to receive subsidy payments and transfer enrollment data would likely be necessary (albeit current issuers would have experience on successfully achieving this). Being deemed a QHP would also be needed to ensure enrollees are considered part of the single risk pool for purposes of rate setting and individual market risk adjustment transfers.

The issuer would provide all plan functions, including finance, administration, enrollment, member services, provider contracting, care management, claims payment, actuarial, and required operations to administer EDGE data transfers (e.g. risk adjustment requirements), and other ACA requirements. Such issuers could only be considered acceptable for contracting if they are already effectively operating in the ACA individual market, and, thus, have proven capabilities. It is likely that the overall arrangement would require some financial costs to the State.

The State could contract with the selected issuer on an ASO basis, reimbursing the selected issuer for all claims as well as paying a set per enrollee fee to the issuer. The set fee or alternative financial arrangement is likely necessary to achieve participation in the arrangement. The State would bear financial risk in this option.

Once the arrangement is implemented, an additional policy consideration is the duration of the program. This will be impacted by changes in the extent of issuer participation in the individual insurance market.

BARE COUNTY STATE OFFERED OPTION ANALYSES

As part of its high-level analysis, Wakely estimated the potential claim costs that would occur if a state offered option was offered in a bare county. Washington provided a list of ten counties that potentially could be underserved, as described previously. Using the 2019 Baseline data (i.e., without reinsurance), and assumptions and methodology contained therein, Wakely estimated the claims for the potential underserved counties.

Table 10: 2019 Baseline Projections for Underserved Counties

Underserved Counties	Paid Claims PMPM	Paid Claims PMPM + 10%	Paid Claims PMPM - 10%	Paid Claims PMPM + 20%	Paid Claims PMPM - 20%
Ferry	$664.48	$730.92	$598.03	$797.37	$531.58
Pend Oreille	$477.04	$524.75	$429.34	$572.45	$381.63
Grays Harbor	$606.02	$666.62	$545.42	$727.22	$484.82
Island	$519.69	$571.66	$467.72	$623.63	$415.75
Chelan	$449.08	$493.99	$404.17	$538.89	$359.26
San Juan	$442.82	$487.10	$398.54	$531.38	$354.25
Klickitat	$674.36	$741.79	$606.92	$809.23	$539.48
Skagit	$517.28	$569.01	$465.56	$620.74	$413.83
Douglas	$545.97	$600.57	$491.38	$655.17	$436.78
Skamania	$569.83	$626.81	$512.85	$683.80	$455.87
Underserved Total	**$519.15**	**$571.07**	**$467.24**	**$622.98**	**$415.32**
WA Market Total	**$443.75**				

On average, if baseline individual market claim costs occur, these underserved counties would have claims of approximately $519 PMPM if there were no changes in the current mix of age, metal level, etc. in the plans. This is higher than the projected state average claim cost of $444 PMPM, which may indicate higher than average claim costs in underserved areas (however, it could also be attributable to differences in mix of enrollees between the underserved counties and the entire state).

Wakely analyzed a potential range of claims costs in the event that there is an increase or decrease of 10 percent or 20 percent in current commercial claim costs. This results in claim costs for the underserved counties in 2019 ranging from $415 PMPM to $623 PMPM. The estimated claims would have an impact on the resulting premium charged to members and, therefore, impact enrollment in the market. Factors that could influence the cost of the State offered option chosen include provider contract rates, efficiency of administrative functions, and use of care management and utilization management programs. A shift in membership mix, unit cost, or plan design will impact the overall claims.

If all of the projected number of enrollees living in underserved counties were enrolled in the State option, we estimate this would yield a total of approximately $126 million in claim costs (this does not include cost-sharing reduction payments which could reimburse some of those claims costs) for which Washington or the contracted entity would be liable.

However, for illustrative purposes, if the State or its contracted entity were able to obtain contracting agreements at 10 percent less than the current commercial market, the State or its contracting entity could be liable for approximately $113 million in claim costs. If Washington or

its contracted entity were able to obtain contracting agreements with provider reimbursement levels at 10 percent higher than the current commercial market, the State or its contracting entity could be liable for up to approximately $138 million in claim costs. Please note these estimates are based on the baseline assumptions as described in Appendix A. The extent to which enrollment or claims cost differ from the estimates, the amounts would also differ.

Possible Additional Analyses

Additional analyses could include adjustments to enrollment assumptions or claim cost assumptions. Claim costs could differ due to changes in morbidity shifts in the risk pool or differences in unit costs. For example, this analysis focused on a flat percentage range applied to the commercial market. If the contracted entity is able to have rates more similar to Medicare or Medicaid, those results could look much different than what is presented here, and Wakely could update the analysis to account for these differences. However, this may be a much more in-depth analysis involving repricing the current data to a different fee schedule. However, if the contracted entity is able to achieve lower costs than what is currently offered in the individual market, then actual costs or premiums charged could be lower as well.

Cost-Sharing Reduction Wrap

Beyond a state offered option to cover enrollees in underserved counties, another policy option would be to provide cost-sharing wraps to assist in covering member out of pocket costs. In another words, the State would cover a portion of the cost that a member must pay for care. By the State paying for a portion of consumer costs, individuals may have greater access to services needed or may avoid forgoing medical care.

Wakely, under direction by Washington, estimated a scenario in which a state funded cost-sharing wrap is applied to individuals in 87 percent or 73 percent actuarial value[14] silver metal level CSR variants. To be eligible for these CSR variant plans, a member must have a FPL (federal poverty level) between 150 percent and 250 percent.

[14] An actuarial value is the portion of health care costs that the carrier pays after accounting for the portion that a member is responsible for. For example, if the total cost of coverage is $100 and a member pays $20 in cost sharing, the carrier pays $80 and the actuarial value is 80% ($80/$100). Carriers are required to classify their plan offerings into one of several coverage tiers (or metal levels) based on the expected portion of costs, or actuarial value, that will be paid by the carrier for a standard population. The HHS regulations requirements define around what actuarial value ranges are allowed for each metal level.

In this scenario, enrollees in 73 percent variants would be provided an additional cost wrap of 14 percent (i.e., create a plan where the average consumer would be responsible for 13 percent of claims costs). In addition, enrollees in 87 percent CSR variants would have, on average, a 7 percent wrap (i.e., enrollees would be responsible, on average, of 6 percent of costs). Table 11 estimates the amount of wrap funds needed by the State for this scenario in each geographical area.

Table 11: Claim Cost of CSR Wrap by Geographical Area

Geographical Area	CSR Wrap Claim Costs
Underserved	3,820,000
Other Rural	12,410,000
Urban	21,940,000
Total	**38,170,000**

We have assumed that the lowered cost-sharing due to the wrap would increase utilization in the 73 percent CSR variant plan by 12 percent, consistent with the load included in the federal risk adjustment model, as the actuarial value increases to 87 percent. We also estimate that both wraps would likely increase enrollment in those plans (i.e. individuals previously selecting bronze plans with FPLs between 150 percent and 250 percent may shift to silver CSR plans due to the additional cost sharing paid for by the State).

POSSIBLE ADDITIONAL ANALYSES

Additional scenario testing is possible. This can be completed for different enrollment or morbidity assumptions, including changes to the number of people or the risk mix of those members, which would alter the estimates. Wakely could additionally do analyses on provision of wraps for other populations (for example, provision of wraps for enrollees with incomes between 250-400 percent FPL). Given the time frame for completion of this report and current data limitations (for example limited utilization data by FPL), Wakely was unable to estimate additional cost-sharing wraps. In the event that the Federal Government no longer reimburses issuers for member cost-sharing within the CSR variant plans, another analysis could be performed in which the State could focus on back-filling CSR funding that has been withdrawn.

Premium Wrap

Premium wraps are an additional policy that could be considered that would improve affordability for consumers and potentially improve the health of the overall risk pool. A key consideration would be which population to target. For example, should the policy focus on moderate and middle-income families, specific geographical areas, younger enrollees, those already receiving premium subsidies from the Federal Government, those not receiving premium subsidies from the Federal Government, etc.

The focus of our analysis is for the policy to provide premium subsidies to enrollees that currently do not receive any assistance from the Federal Government (i.e., unsubsidized – for example, they have an FPL above 400 percent). The current subsidy structure provides for those with FPLs between 139 percent and 400 percent, mitigating the impact of premium increases to these enrollees. Despite large premium increases, individuals receiving subsidies can have the ability to spend approximately similar levels on premiums from year to year. Individuals not eligible for subsidies are not protected from premium increases. Instead, they will experience the full premium increase and could be at greater risk for exiting the market, especially those enrollees that are healthy. Subsidizing this population could lead to a healthier risk pool and more stable market.

Within the 2019 Baseline scenario, we have estimated that 40 percent of the individual market would receive subsidies in 2019 and 60 percent of the individual market would not receive subsidies in 2019. One premium wrap policy option would be to provide a fixed dollar or percentage amount to the unsubsidized enrollees to increase affordability and increase enrollment take-up.[15] As mentioned earlier, increased enrollment could improve the risk pool and increase affordability.

Using the baseline assumptions, we estimated the impact of a premium wrap for individuals not currently receiving APTC. Targeting an overall cost to the State of $150 million, which is a similar amount of funding needed for a reinsurance program, would result in the following:

- A premium reduction of 45 percent for unsubsidized members on the Exchange, or
- A premium reduction of 15 percent for all unsubsidized members (both on and off the Exchange, assuming there may be large incentives for off the Exchange members to migrate to the Exchange).

After incorporating additional enrollment expected due to the additional subsidies, which is an estimated 6.7 percent increase in unsubsidized enrollment, premiums would decrease by 14 percent in total (for unsubsidized enrollees both on and off the Exchange).

The table below illustrates the percent reduction in premiums, cost of the option, and reduction to member monthly costs, by geographical area.

[15] For operational reasons, Exchange enrollment may be needed for hypothetical eligibility for premium wraps. If such a requirement was included, it would incentivize enrollment from the off the Exchange to on the Exchange.

Table 12: Claim Cost of Premium Wrap by Geographical Area

Impact of Wrap		On Exchange, Unsubsidized Population	Total Unsubsidized Population	Total Unsubsidized Population, Increased Enrollment
Premium Percent Reduction		45.0%	15.0%	14.0%
Cost of Premium Reduction	Total	$151,445,000	$152,831,000	$152,223,000
	Underserved	$8,958,000	$10,029,000	$9,989,000
	Other Rural	$32,231,000	$34,045,000	$33,909,000
	Urban	$110,255,000	$108,758,000	$108,325,000
Dollar Value, Per Member Per Month	Total	$219	$80	$75
	Underserved	$235	$88	$82
	Other Rural	$235	$82	$76
	Urban	$213	$79	$73

Various scenarios were run to target different premium reductions and potential variances in baseline premium rates in 2019 and enrollment changes. All of these scenarios targeted only the current unsubsidized population.

- One set of scenarios targeted a reduction of $100 per member per month for the unsubsidized population.
    - For only on the Exchange, premiums decreased between 19 percent and 21 percent, depending on the geographic area.
    - For both on and off the Exchange, premiums decreased between 17 percent and 19 percent, depending on the geographic area.
- If premiums in the baseline scenario increase by 20 percent,
    - The cost of the wrap for the underserved population will increase to a range of $10,750,000 to $12,035,000, depending on eligibility criteria (only on the Exchange and both on and off the Exchange, respectively).
    - The dollar value per member per month increases to $281 for on the Exchange members and $105 for both on and off the Exchange.
- If premiums in the baseline scenario are increased by 20 percent in the underserved areas and premium wraps are implemented to decrease premiums by 30 percent in the underserved counties and 10 percent in the rest of the State, the resulting cost to the State and value per member per month is shown within the Table 13 below.

Table 13: Claim Cost of Premium Wrap by Geographical Area
Scenario: Underserved Counties - Baseline Premiums Increase 20 Percent, 30 Percent Premium Reduction; All Other Counties - 10 Percent Premium Reduction

Impact of Wrap		On Exchange, Unsubsidized Population	Total Unsubsidized Population
Premium Percent Reduction		30% Underserved, 10% All Others	30% Underserved, 10% All Others
Cost of Premium Reduction	Total	$38,830,000	$119,271,000
	Underserved	$7,167,000	$24,069,000
	Other Rural	$7,162,000	$22,696,000
	Urban	$24,501,000	$72,505,000
Dollar Value, Per Member Per Month	Total	$56	$62
	Underserved	$188	$211
	Other Rural	$52	$54
	Urban	$47	$52

POSSIBLE ADDITIONAL ANALYSES

Wakely, to date, has primarily focused its efforts on reinsurance analysis and the EDGE data. Deeper analysis of premium and cost-sharing wraps, specifically inclusion of breakdowns by FPL and of those currently with APTC, would require additional data elements. The additional elements would be needed to include, at minimum, policy level data broken down by FPL, metal level, applied APTC, allocated APTC, and county. Wakely acknowledges that we have data from the HBE containing some of these elements; however, our analysis has focused thus far on using the EDGE data and not thoroughly vetting all of the components contained within the HBE dataset (and we believe the dataset is missing some of the components previously listed). We'd also need to refine our analysis of off the Exchange and uninsured FPL distributions. Finally, we may also need to create an appropriate mapping between any new data elements and the existing EDGE data. Given the level of additional data complexity and additional modeling, it was not possible to complete in time for this report, but it could be considered for Phase II or another future analysis.

Combination of Proposals

It is possible for Washington to enact a combination of policies. For example, they could have a combination of claims-based reinsurance and a state offered option in the case of any potential bare counties. If the claims-based reinsurance program described above was enacted alongside a state option, then the claims cost the State would be responsible for would be less than it would be without the reinsurance program. For example, assuming that all enrollees in underserved counties were enrolled in a state option, the total claims cost the State would be responsible for would be approximately 15 percent less than they would have been otherwise (see Table 14). State revenue from premiums would be approximately 10 percent less as premiums are estimated

to be similarly lower due to reinsurance. Since reinsurance reduces claims costs in underserved counties more than the rest of the State, it is likely that the probability of an underserved county not having private coverage would be reduced.

Table 14: Impact of Claims-based Reinsurance in Underserved Counties

County	Reduction in Premium from Baseline	Reduction in Paid Claims from Baseline
Ferry	-10.0%	-12.9%
Pend Oreille	-10.0%	-8.9%
Grays Harbor	-10.0%	-14.1%
Island	-10.0%	-14.9%
Chelan	-10.0%	-13.8%
San Juan	-10.0%	-14.3%
Klickitat	-10.0%	-18.7%
Skagit	-10.0%	-15.6%
Douglas	-10.0%	-15.8%
Skamania	-10.0%	-13.1%
Underserved Total	**-10.0%**	**-14.9%**
WA Total	**-10.0%**	**-12.2%**

If Washington were to pursue implementing any of these initiatives, additional analyses, including scenario and sensitivity testing, would need to be done in order to have a thorough understanding of the implications of any initiative. This testing may be done as part of any Phase II of the analysis.

1332 Waiver Implications

The ACA permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the State must complete an application in which it demonstrates that it has met the regulatory requirements.

In order for a 1332 waiver to be approved, the State must demonstrate that the waiver does not interfere with the four "guard rails". The four guard rails are defined as:

- Coverage (there must be at least a comparable number of individuals with coverage under the waiver);
- Affordability (waiver must not increase out of pocket spending including premiums and cost sharing);
- Comprehensiveness (the waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark); and
- Deficit neutrality (the waiver should not increase the federal deficit).

States may receive funds from the Federal Government commiserate with the federal savings the State waiver achieves.

Reinsurance Options

CALCULATING FUNDING TARGETS

The reinsurance program will lower premium amounts for the entire market. Since APTC is tied to the second lowest cost silver plan (SLCSP) in each county, any reduction in SLCSP premiums will lead to a decrease in the amount of APTC for which the Federal Government is liable. Through a 1332 waiver, a state can request that the Federal Government return this amount of net federal savings, or "pass-through" savings, back to the State to help fund the reinsurance program costs.

In order to estimate the potential amount of a reinsurance program that may be funded through net federal savings (through a 1332 waiver), Wakely completed a high-level calculation of the funds needed for a 10 percent reduction in premiums. In addition, Wakely calculated the amount that the State might be able to achieve from the Federal Government as pass-through, due to savings in cost from subsidies from the implementation of the reinsurance program. These baseline scenario results can be seen in Table 15. Note, Washington could use federal funding to pay for administrative costs. In such an event, the effects of reinsurance on premiums would be reduced, unless state increased funding for reinsurance. Wakely is not able to estimate costs of administering a reinsurance program.

Table 15: High-Level Results of Baseline Scenario

Metric	Amount
Initial 2019 Enrollment	290,000
Enrollment Post-Reinsurance	297,000
Total Premiums	$1,976,700,000
Approximate Reinsurance Dollars Needed	$197,700,000
Approximate State Dollars Needed[16]	$147,500,000
Approximate Net Federal Savings	$50,200,000
Pass-Through Savings Percent	24%

To estimate the average 2019 APTC amounts, Wakely used the most recently available information from CMS on effectuated enrollment and average APTC payments in 2017[17] and trended it based on the change in the SLCSP from 2017 to 2018 based on rate filing information. The trend impact from 2018 to 2019 is 6.5 percent similar to the overall premium trend applied from 2018 to 2019. The amounts were also adjusted for changes in the risk pool.

Enrollment was re-estimated with the lower post-reinsurance premium, using an enrollment function (for further information, see Appendix A), to calculate a final individual market average enrollment. The increase from the 2019 baseline is estimated to be 2.5 percent, which is made up of a 1.1 percent increase on the Exchange and a 4.3 percent increase off the Exchange. Detailed enrollment estimated by the Exchange status and county were provided to the OIC.

The enrollment with the reinsurance program is estimated to be higher than without the reinsurance program. Wakely did not estimate the impact to the morbidity of the market due to the implementation of the reinsurance program, as was discussed with the State, but this analysis can be performed in Phase II if the State pursues implementing a reinsurance program.

Please note, this calculation above is shown as an estimate of what may be achieved as pass-through savings. The calculation was completed from a high-level, and it does not match exactly results produced in the detailed analyses described previously. The analysis would be done at a more detailed level if the State were to pursue a 1332 waiver to acquire the net federal savings.

[16] State funds needed do not include any administrative expenses that would be required to operate the reinsurance program.

[17] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

LEVERS OF FUNDING AND PASS-THROUGH SAVINGS

Several factors can vary the impact of funding needed for a reinsurance program as well as the pass-through savings that may be achieved. The following are the factors (all in the individual market) that have the biggest impact:

- **Average Premium PMPM and Total Market Enrollment.** The overall estimated market premium amount (defined as average premium PMPM multiplied by total individual market enrollment) is the total premium expected for the market. The amount of funding required to lower premiums by a certain percent is that percent multiplied by the total premium expected for the market.
    - An increase in either the average premium PMPM or the total individual market enrollment would increase the total funding needed to reduce premiums by a set percentage.
- **Second Lowest Cost Silver Plan (SLCSP) Premium.** As previously discussed, since APTCs are tied to the SLCSP, and savings in APTCs are a driving impact of the amount of federal pass-through funds possible, the SLCSP premium impacts the amount of federal pass-through funds the State can receive. In particular, the relationship between the SLCSP premium and the overall market premium impacts the possible amount of federal pass-through funds.
    - A larger, in an absolute sense, decrease in the SLCSP premium due to any program initiative that meets 1332 requirements can increase the total pass-through funding a state can receive. If the reduction in the SLCSP relative to the overall premium reduction is larger, the State can expect a relatively higher federal pass-through amount.
- **Proportion of Individual Market Receiving APTC.** Related to the SLCSP, the proportion of the population that receives APTC has an impact on the pass-through funds that can be expected.
    - In the baseline, the higher the proportion of the market that receive APTC, the relatively higher the potential pass-through savings, since a reduction in subsidy amounts will have a greater impact if there are more enrollees receiving subsidies.
- **Change in Morbidity of the Market from Reinsurance**. This is a smaller factor than those previously mentioned. However, with a reduction of premiums, it is expected that there will be an increase in healthier enrollees entering the market. This may cause the premiums to be reduced by a slightly larger amount than what is driven solely by the dollar amount removed from the reinsurance program.

The impact of the reinsurance program will vary by market segment, including in the underserved counties, depending on several factors, including the amount of enrollees within each market segment that would be eligible for the reinsurance parameters. However, Wakely's analysis assumed that the premium reduction would be felt equally by all areas of the State.

REINSURANCE FUNDING SCENARIO TESTING

Wakely performed scenarios around the funding and pass-through amounts, which involved changing the enrollment, premium, and proportion of enrollees receiving APTC assumptions. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis as described previously.

First, we tested for scenarios in which enrollment was higher and lower than the enrollment contained in the baseline. The definitions of each scenario are discussed more in depth in Appendix A. These results can be seen in Table 16. The general takeaways are:

- All scenarios aim to increase premium by 10%, but an increase in enrollment leads to a larger amount of funding needed for that decrease (with opposite results for lower enrollment).
- The high scenario has a lower proportion of enrollment receiving APTC which causes the lower pass-through percentage compared to the other scenarios.

Table 16: Reinsurance Funding Scenarios – Variations in Enrollment

Metric	Baseline	High	Low
Initial 2019 Enrollment	290,000	307,000	255,000
Enrollment Post-Reinsurance	297,000	315,000	261,000
APTC Enrollment	117,000	117,000	101,000
Total Premiums	$1,976,700,000	$2,060,000,000	$1,793,100,000
Approximate Reinsurance Dollars Needed	$197,700,000	$206,000,000	$179,300,000
Approximate State Dollars Needed[18]	$151,200,000	$160,300,000	$137,700,000
Approximate Net Federal Savings	$46,500,000	$45,700,000	$41,600,000
Pass-through Percent	24%	22%	23%

In addition, Wakely tested scenarios in which the 2018 to 2019 premium increase is larger than in the baseline. Instead of a 6.5% premium increase from 2018 to 2019, the premiums increase by the average of the premium increases from 2016 to 2017 and 2017 to 2018, which is approximately 20%. The enrollment was held constant from the results in Table 10 to pinpoint the impact of the increase in premium; however, it is likely that enrollment would decrease from Table 10 due to the higher increase in premiums assumed from 2018 to 2019. The results can be seen in Table 17. The key takeaway is that the pass-through funding levels as a percent are similar to

[18] State funds needed does not include any administrative expenses that would be required to operate the reinsurance program.

Table 16, but the amount of funding needed for the program increased due to the increase in premiums.

Table 17: Reinsurance Funding Scenarios – Variations in Enrollment, Premium High

Metric	Baseline	High	Low
Total Premiums	$2,229,200,000	$2,323,100,000	$2,022,100,000
Approximate Reinsurance Dollars Needed	$222,900,000	$232,300,000	$202,200,000
Approximate State Dollars Needed	$170,400,000	$180,600,000	$155,200,000
Approximate Net Federal Savings	$52,600,000	$51,700,000	$47,000,000
Pass-through Percent	24%	22%	23%

In addition, Wakely analyzed a scenario using the "Low" enrollment scenario shown in Table 16, the "High" premium scenario (approximately 20 percent premium trend from 2018 to 2019), but that the proportion of enrollment receiving APTCs was higher (i.e. stayed steady from 2016 levels), to show the impact on the pass-through funding level with a higher proportion of APTC enrollees. The results are shown in Table 18.

Table 18: Reinsurance Funding Scenarios – High Pass-Through Percent Scenario

Metric	Baseline
Initial 2019 Enrollment	255,000
APTC Enrollment	117,000
Total Premiums	$2,022,100,000
Approximate Reinsurance Dollars Needed	$202,200,000
Approximate State Dollars Needed	$147,800,000
Approximate Net Federal Savings	$54,400,000
Pass-through Percent	27%

Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenario. These results imply that Washington's reinsurance program would reduce premiums, increase coverage, and provide federal savings, even if the projections vary from Wakely's best estimate. It should be noted that our required funding estimates do not include any state costs for administering the program(s).

OTHER REINSURANCE ANALYSIS

As can be seen above, the federal savings accrue by the extent to which the SLCSP is reduced. For condition-based reinsurance or reference pricing reinsurance, to the extent to which the programs achieve similar reductions in premiums as claims-based reinsurance, Washington should expect similar state funds needed and federal pass-through. For example, if a condition-based reinsurance program were constructed to reduce premiums by 10 percent, then the approximate state needs and expected 1332 waiver federal pass-through should be

approximately the same as the above tables. To the extent other reinsurance program differs in the level of premium reduced, the expected funds needed would commensurately change.

If a reinsurance program is ultimately pursued by Washington, Wakely would recommend a 1332 waiver. A reinsurance program would generate federal savings to which Washington could be entitled.

State Offered Options

State options are expected to provide less 1332 waiver-related federal funding relative to reinsurance options. Reinsurance programs decrease premiums both by direct reimbursement of claims and improved morbidity of the risk pool. Premium wraps, while improving affordability for consumers, only have an impact on gross premiums to the extent which they improve the overall morbidity of the risk pool (reflected in the second lowest cost silver premium). This reduces the potential federal funds albeit does not eliminate it. The extent to which a premium wrap program does improve morbidity for the risk pool could be grounds for the State to receive federal pass through amounts. Cost-sharing wraps, while they improve affordability, are not expected to necessarily improve the morbidity of the risk pool and in fact, may increase premiums due to increased utilization. Wakely believes that a 1332 waiver would be not needed to implement either program.

If a cost-sharing wrap program is selected, Wakely would not recommend a 1332 waiver. The savings, if any, generated to the Federal Government are not likely to be significant. No waiver authority would be needed to implement such a program. A premium wrap, unless sufficient funds are appropriated, is also not likely to generate sufficient federal saving, however, further analysis is needed.

While further legal counsel is recommended, a state offered option, as described above, would likely not be eligible for significant federal funds as the premiums charged would be aligned with what would have been expected to be charged. The second-lowest cost silver plan would remain constant between the two environments by the current construction.

A state offered option may not generate federal funds but in order for it to participate as part of the single risk pool or have enrollees be eligible for subsidies, a 1332 waiver may be necessary. Further legal analysis would be needed to verify this. However, if the determination is made that a 1332 waiver is necessary for the State offered option to be deemed a QHP and part of the single risk pool, Wakely would recommend that a 1332 waiver be obtained, as current CMS requirements include being a licensed issuer in good standing. Some federal saving may be possible using a state offered option but further details are necessary to determine that.

Feasibility Recommendation

Each of the options evaluated has the potential to lower premiums, improve affordability, or improve consumer choice.

- Any of the reinsurance programs would reduce premiums through the reduction of claims cost. Reinsurance programs are expected to reduce claims cost for issuers, and therefore, increase the probability that an issuer will cover a particular area.
- A premium wrap would reduce the net premiums for enrollees albeit not affect gross premiums. The benefit of premium wraps is that it is easier to target socio-economic population (i.e., those currently ineligible for subsidies) than a reinsurance program.
- Cost-sharing wraps or state coverage options are not expected to lower premiums. To the extent to which counties do not have coverage, a state coverage option would increase consumer choice.

Funding requirements differ for each of the options.

- Among the reinsurance options, it is Wakely's opinion that a claims-based reinsurance program would be least complicated and likely least expensive, in the short-run, to operate on an ongoing basis.
- The additional verification and ongoing analytic needs of a condition-based or reference pricing program would be higher than a claims based program, in the short term, as we expect operational costs to be higher than for the other programs.
- Premium or cost-sharing wraps appear to be feasible as other states have implemented them. Wakely was unable to ascertain potential administrative costs of such programs.
- A state offered option funding requirement would include both variable expenses (dependent on the number of enrollees and amount of claims for those people) as well as fixed costs for administrating that program. Wakely did not estimate the likelihood of a bare county for which a state offered option in Washington was necessary. Wakely assumed that the primary method of funding the program would be through premiums collected by enrollees in the State offered option. If fixed costs for the program are high and likelihood of bare counties is low, then funding needs beyond premiums would increase.

We are unable to comment on the feasibility of each option in terms of the funding mechanisms.

Assumptions and Reliances

Wakely has utilized data provided by Washington issuers in the analyses described in this report. A data request was sent to all issuers that contained a full description of the EDGE server files (see Appendix B for definition) and supplemental data needed. The analyses were performed using the following data provided from the issuers:

- A complete set of 2015 and 2016 EDGE Server XML data were collected from each issuer. This data includes:
    - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each issuer to the EDGE Server.
    - The corresponding response files that apply an accept/reject status to the claims in the inbound files.
    - The final outbound files that were produced in May 2016 for 2015 data and May 2017 for 2016 data. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports.
- TPIR files (the risk adjustment payment transfer reports – see Appendix B for further description) that contain the values that CMS used to calculate the issuer-specific risk adjustment transfer amounts for 2015 and 2016 by plan identifier and rating area.
- Supplemental information was collected to provide administrative expense, CSR information, and member level county information that is not available in the EDGE data.

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and should be reviewed by the OIC for reasonability.

Enrollment, medical, pharmacy, and supplemental records that were rejected by the EDGE server were removed from the analyses. Wakely utilizes independent logic per the guidance of the EDGE Server Business Rules to identify records that are accepted but not valid for use in the EDGE Server. Medical, pharmacy, and supplemental records that were orphaned, voided, or replaced were removed from the analyses. The extent to which Washington would implement a program that differs from EDGE specifications, the results may differ as well. For example, historically, claim costs in medical-loss ratios reporting exceeds that in EDGE files.

The enrollment (including premiums) and paid claim PMPM information provided in the EDGE Server was assumed to be accurate and complete for all Washington issuers. Wakely was not able to collect the complete detailed EDGE data for one small issuer in the 2016 market. Due to the issuer's size, Wakely was able to manually incorporate the data using what the issuer had provided. In doing this, Wakely assumed that the claims of the enrollees in that issuer were

weighted evenly on enrollment for those members that switched plans. Due to the infrequency in which members switched plans and the size of the issuer, Wakely does not anticipate this will have a significant impact on the analysis.

Administrative components were collected in this study on a PMPM basis from all issuers. Wakely allocated the administrative components such that 70 percent of the administrative PMPM was a fixed PMPM charged to each enrollee equally and 30 percent of the administrative PMPM was variable, such that it would change based on each enrollee's premium. We have reduced the administrative PMPM from each issuer by $2.25 PMPM to reflect the expiration of the 2016 transitional reinsurance program fee. In addition, pharmacy rebates were collected on a PMPM based and allocated based on membership. All pharmacy rebates were assumed to be negative even if they were submitted as positive to Wakely.

The CSR adjustments were applied only to enrollees in plans with variants 02 to 06 (which are the plan variants that receive cost-sharing adjustments). Enrollees with high cost claims were given a maximum CSR adjustment equal to the "MOOP CSR Adjustment", which is a field in the EDGE data that indicates the difference in a CSR member's plan MOOP and the MOOP of the standard plan. The remaining CSR enrollees received an equal percentage CSR adjustment based on the remaining dollars in that CSR variant as provided by the issuers in the supplemental data. Any negative CSR adjustments provided by issuers were removed from the analysis. Any CSR amounts provided by issuers that were allocated to members in plans with variants 00 and 01 (which are the standard plans, on and off the Exchange) were excluded. These were not significant adjustment amounts.

Wakely mapped on the member-county mapping provided by the issuers to the EDGE data. Wakely reviewed the issuer submissions of member to county mapping and found that only a negligible amount contained invalid entries. In addition, two issuers were only able to provide the last known county of each member in their submission. Based on our review, we do not expect this to have a significant impact on the analysis. After using the mapping methodology described in Appendix A, less than 3 percent of records were not mapped to a county. Of those 3 percent of records, Wakely reviewed that they were random and distributed proportionally to membership, so that they would not significantly impact the results of the analysis. This methodology would not capture members that stayed within the same rating area but moved counties. Wakely reviewed the data for the percent of people that switched counties but stayed within the same rating area and plan. Wakely found this to be a negligible issue impacting less than 1 percent of enrollment. It is not believed to impact the results of the analysis. In addition, some counties outside of Washington were provided. These records were excluded in any county level results.

Wakely made certain assumptions about the application of the final 2017 risk adjustment methodology, which is incorporated in 2016 base period data results in Appendix A. For example, there is no example of how the enrollment component of the risk adjustment methodology is implemented. In addition, Wakely utilizes an independent method from the "Do It Yourself" (DIY)

software provided by CMS to risk score members. Wakely updates and maintains the Wakely Risk Assessment (WRA) model that risk scores members based upon CMS's published guidance (Notice of Benefit and Payment Parameters and the DIY files). Wakely performs member and condition level checks to confirm that the overall application of the model is consistent. Some negligible differences exist, but generally, Wakely is in line CMS's application.

Wakely relies on these (and other proprietary assumptions, which are implicit and built into the WRI tool) when assigning member level relative profitability.

Wakely made additional assumptions in this analysis, including:

- Our assumption regarding the percentage of retention components that are paid on a PMPM versus percent of premium basis may not hold true for all issuers.
- Relative profitability is shown in the 2016 results and is adjusted such that 2017 risk adjustment methodology is incorporated and 2016 federal transitional reinsurance fees are removed. The relative profitability is updated with these components and is equal to member premium less claim components (claims, risk adjustment transfer, pharmacy rebates, and CSR receivables) less retention components.
- Relative profitability does not include the impact of the transitional federal reinsurance program, which was in effect during the 2016 plan year but expired as of January 1, 2017. Additionally, the final 2017 risk adjustment methodology was incorporated within this calculation instead of the 2016 risk adjustment methodology. In addition, the risk adjustment transfers were reduced by the 14 percent administrative adjustment in effect as of 2018 to account for fixed administrative expenses not being impacted by risk adjustment. As a result, the amounts do not reflect true 2016 profitability.
- The downstream impacts of implementing a reinsurance program, including the impact of an assessment on premiums or other funding mechanisms and the impact of improved morbidity in the resulting risk pool, were not considered for purposes of these analyses.
- The impact of private commercial reinsurance was not reflected in the analyses.

Any errors in the EDGE server data, TPIR files, supplement data, and other source data could have an impact on the results of these analyses.

The analysis assumes that the 2016 data is indicative of the future market at the sub-segment level (Exchange status, county, metal level, etc.). To the extent that the sub-segments have changed significantly since 2016 in ways that Wakely has not accounted for, the analyses may not be accurate, such as enrollment shifts from off the Exchange to on the Exchange or any migration in enrollment from one metal level to another.

Wakely did not include adjusted claims or relative profitability in years beyond 2016, since there is significant uncertainty as to the impact that the 2018 and 2019 risk adjustment models will have on the market, particularly at the market segment level. In addition, this analysis does not include

the update to the 2018 federal age curve, which will impact both premiums and risk adjustment transfers.

Wakely relied on data provided to Wakely by the Washington HBE, including the 2018 SLCSP premiums and data for the on the Exchange unsubsidized market (including enrollment and average premium) as of April 2017, as well as other publicly available studies.

Wakely relied on data provided by the OIC, including 2017 off the Exchange enrollment data by county and the 2018 issuer rate filings supplied as of 9/13/2017. Wakely understands that the on Exchange rate filings were final as of this date, but the off the Exchange rate filings were still under review. Any large changes in any of the rate filing data may have an impact on the results of this analysis.

In addition, Wakely used rate filing assumptions assuming that CSRs will continue to be funded, per instruction from Washington. Changes to the funding status of CSRs (or any other changes in the current legislative environment) may have significant impact on the results of this analysis.

Wakely has not considered any change to the geographical rating area analysis that is occurring concurrently with this analysis. Any changes to the geographical rating areas or the rating band restrictions in Washington may impact this analysis. Before any initiatives are implemented, Washington should consider the impact of including any changes to the geographic rating area analysis.

It is important to note that any of these analyses would need to be refined before implementation. The studies were done to inform the potential impacts of the programs, but additional analysis would be required to understand the full impact of any program.

Disclosures and Limitations

Responsible Actuary. Danielle Hilson is the actuary responsible for this communication. Al Bingham provided support and peer review. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michelle Anderson, an Associate of the Society of Actuaries and Member of the American Academy of Actuaries, and Michael Cohen, a policy consultant and Ph.D., managed much of the modeling and analyses.

Intended Users. This information has been prepared for the sole use of the management of Washington and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that Washington will provide this report to Washington legislators and potentially Washington issuers. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the model are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that the State of Washington issuers will attain the projected values included in the report. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Washington.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the ‘Assumptions and Reliances’ section identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change**, including that CSRs will continue to be funded.** Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. There are no other known

relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

Appendix A: Detailed Data and Methodology

Base Period Data

Wakely worked with Washington issuers on behalf of the OIC to collect 2015 and 2016 EDGE server data, risk adjustment transfer payment files (also known as TPIR files), and supplemental data. These data sets contained detailed member level information such as premiums, claims dollars, information to calculate risk score transfer amounts, and enrollment specifications. The data also included higher-level summaries such as administrative expenses for each issuer and a mapping of each member to the county in which they live. Wakely reviewed the supplemental data provided by the issuers for reasonability. In addition, Wakely followed up with the issuers to ensure we understood the data that was provided and that it was consistent and relevant to the study. The analysis focused on using the 2016 data; the 2015 data was used mainly for high-level reasonability checks and to assess the stability in data from year to year.

Wakely was not able to collect the detailed EDGE files from one issuer. However, Wakely was able to collect sufficient information from the issuer to incorporate the data into the analysis by performing manual adjustments to the received data. This was possible because of the issuer has a very small portion of the market in 2016. Wakely does not expect the manual adjustments to have an impact on the analysis performed.

The data that was then processed through the Wakely Risk Insight (WRI) tool. WRI is a tool that was designed to assist in identifying the drivers of profit and loss in a risk-adjusted environment at the enrollee level. Wakely used EDGE server logic when determining which records should be included in or rejected from the analyses. To perform the analyses, WRI calculates, estimates, and allocates important financial quantities (e.g. risk adjustment transfers, taxes, fees, etc.) at the member level. The data components, including premiums, claims, risk adjustment transfers, cost-share reduction amounts, and administrative components, were allocated to each member to find relative profitability by member.

Relative profitability is derived from the calculation of profitability, which is equal to member revenue less adjusted claim costs (defined as claims costs adjusted for pharmacy rebates, risk adjustment transfers, and CSRs) less administrative components. The metric is intended to measure the relative profitability relationships between sub-segments within the individual market. The relative profitability is shown such that the total calculated profitability from the data, for the individual market, is set to zero and all other cohorts are shown in relation to the total.

In addition, Wakely collected a member level county mapping. Since the EDGE data does not contain county, and Washington is particularly interested in counties that may be at risk of not having any on the Exchange plans, Wakely collected member level county data and mapped it on to the EDGE data. Wakely reviewed the issuer submissions of member to county mapping and

found that only a negligible amount contained invalid entries. The county was then mapped on to the EDGE data using the existing EDGE enrollment spans. Wakely first applied a perfect match, such that the supplied enrollment spans in the county mapping matched the enrollment spans in the EDGE data perfectly. Then a second map was applied such that the enrollment start date in the county mapping was within the enrollment span in the EDGE data. After applying these two steps, only 3 percent of EDGE record did not contain a valid county map. Wakely reviewed that these 3 percent of records were random and distributed proportionally to membership, to ensure likelihood of minimal impact to the results of the analysis. It should be noted that this methodology does not capture members that stayed within the same plan and rating area but moved counties. Wakely reviewed the data for the percent of people that switched counties but stayed within the same rating area and plan and found that this was a negligible issue impacting less than 1 percent of enrollment.

2016 Base Period Data Summary

The 2016 data was summarized to show enrollment, premiums, paid claim amounts, adjusted paid claims, and relative profitability (see Appendix B for definitions) at a high-level for various sub-segments of the market. These tables are intended to show a historical look of the market. They contain 2016 data, adjusted for 2017 changes in the risk adjustment model and removing the impact of the Federal transitional reinsurance program $2.25 PMPM fee, since that program ended after 2016. If the experience remained relatively constant from 2016 to 2017, these tables indicate the relative profitability of various segments incorporating the 2017 risk adjustment model. To the extent there was high membership churn and migration across the various segments of the market, the relativities may differ in future years.

Table 19 shows the above described data segmented by Exchange status. In 2016, the on the Exchange market had slightly higher enrollment as well as premium and paid claims. However, the table shows that the adjusted paid claims are lower than the off the Exchange, and the relative profitability for the on the Exchange market is higher than off the Exchange.

Table 19: 2016 Data, Adjusted for 2017 Risk Adjustment Transfers, by Exchange Status

Exchange Status	Average Enrollees	Member Months	Premium PMPM	Paid Claims PMPM	Adjusted Paid Claims PMPM	Relative Profitability
On The Exchange	165,020	1,980,236	$376.29	$369.54	$337.31	$9.68
Off The Exchange	147,753	1,773,041	$365.10	$357.97	$347.61	($10.81)
Total	**312,773**	**3,753,277**	**$371.00**	**$364.07**	**$342.18**	**$0.00**

Similar metrics are shown in Table 20 by metal level. The relative profitability is highest for the catastrophic and bronze metal levels and for the CSR variants of the silver metal level. These results have been seen consistently nationwide, with the higher-level metal tiers having worse

experience. These results could change with the updated 2018 and 2019 risk adjustment models.

Table 20: 2016 Data, Adjusted for 2017 Risk Adjustment Transfers, by Metal Level

Metal Level	Average Enrollees	Member Months	Premium PMPM	Paid Claims PMPM	Adjusted Claims PMPM	Relative Profitability
Catastrophic	1,336	16,030	$156.11	$43.90	$42.72	$100.24
Bronze	128,295	1,539,546	$333.42	$190.26	$274.77	$30.65
Silver 70%	65,380	784,559	$380.74	$362.15	$364.49	($13.26)
Silver 73%	15,592	187,107	$409.61	$359.48	$359.42	$20.84
Silver 87%	34,164	409,965	$386.43	$431.82	$321.82	$36.54
Silver 94%	19,110	229,316	$354.03	$387.42	$290.03	$38.53
Silver Total	*134,246*	*1,610,946*	*$381.74*	*$383.17*	*$342.44*	*$10.74*
Gold	48,896	586,755	$446.00	$776.44	$526.50	($112.65)
Total	**312,773**	**3,753,277**	**$371.00**	**$364.07**	**$342.18**	**$0.00**

Washington was particularly interested in counties that are defined as “underserved”, or at risk of having no on the Exchange issuers in future years. These counties were defined as either those that were bare at some point for the 2018 benefit year or only have one issuer option for the 2018 benefit year. The counties include Chelan, Douglas, Ferry, Grays Harbor, Island, Klickitat, Pend Oreille, San Juan, Skagit, and Skamania. In addition, Wakely identified the “Urban” counties as those with the five largest cities in the State. These counties include Clark, King, Pierce, Snohomish, and Spokane. All remaining counties were included in the “Other” category. In addition, there is the “Excluded” category, which included the records that could not be mapped to a county or they were mapped to a county that was outside of the State of Washington.

Table 21 shows that the underserved counties were the least profitable for issuers in the 2016 benefit year, after adjusting for the 2017 risk adjustment model, and the urban areas were the most profitable.

Table 21: 2016 Data, Adjusted for 2017 Risk Adjustment Transfers, by Geographic Area

Area	Average Enrollees	Member Months	Premium PMPM	Paid Claims PMPM	Adjusted Claims PMPM	Relative Profitability
Urban	208,701	2,504,416	$359.44	$344.00	$319.85	$12.09
Underserved	21,198	254,378	$418.51	$425.11	$416.79	($30.58)
Other	73,373	880,474	$394.32	$387.25	$373.15	($10.02)
Excluded	9,501	114,009	$339.00	$489.89	$426.94	($120.00)
Total	**312,773**	**3,753,277**	**$371.00**	**$364.07**	**$342.18**	**$0.00**

Baseline Data (2019)

After reviewing the 2016 data, Wakely had to estimate the 2019 individual market in order to evaluate the market stabilization initiatives. To do this, Wakely applied assumptions to the 2016 EDGE data derived from public sources and from 2018 issuer rate filings as of 9/13/2017. Wakely relied on the filings assuming that CSRs will continue to be funded, as directed by Washington. Only the on the Exchange 2018 rate filings were finalized as of the time of the analysis; the off Exchange filings were not yet completed. However, Wakely does not believe there have been significant changes in any of the rate filings as of writing of this report.

The assumptions that were applied to the 2016 EDGE data (at the member level) are as follows:

- **Allowed Trend.** The 2016 to 2018 allowed trend is derived from issuer-specific 2018 rate filings. The 2018 to 2019 trend is assumed to be 6.5 percent based on a publicly available study.[19] Note that other factors beyond trend influence premium increases (see Morbidity). The total three-year trend is weighted by issuer-specific 2016 enrollment. The total factor from 2016 to 2019 is 1.278, which is equal to an approximate 8.5 percent annual trend.
    i. Although there is a possibility that trend may be higher than 6.5 percent from 2018 to 2019, as of the writing of this report, there is significant uncertainty as to what the market may look like at that time. The market should be monitored as new information becomes available that may inform this assumption. We note that recent financial data shows that in the first half of 2017, issuers, on average, achieved high profitability.[20] That data suggests that premium increases in the future should align with medical trend as future premiums would not need to account for previous

[19] https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[20] https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2017/

underestimation of morbidity. Wakely completed this analysis before recent announcements on CSR defunding and did not account for that in this report.

- **Paid Trend.** The paid trend is derived from total allowed trend described above, adjusted by the differences in paid to allowed ratios from 2016 to 2018, based on information from issuer rate filings. The paid trend is weighted on issuer-specific 2016 enrollment. The total factor from 2016 to 2019 is 1.207, which is equal to an approximate 6.5 percent annual trend.
- **High Claim Trend.** Wakely reviewed the high claims from 2015 to 2016 to identify whether the high claims had trended at a higher rate than the overall trend rate; however, Wakely found no evidence that this was occurring. No adjustment was required.
- **Network Impact.** The network adjustment is derived from issuer-specific network changes from 2018 rate filings and weighted on 2016 enrollment. This assumption represents the idea that issuers are moving from wide network to narrower network plans. This adjustment is equal to 0.994 in total (from 2016 to 2018 with no adjustment from 2018 to 2019), and it is applied to paid claims.
- **Administrative Expenses**. Administrative expenses are assumed to be 70 percent fixed and 30 percent variable. The 70 percent of administrative expenses that is on a fixed PMPM basis is assumed to stay constant from 2016 to 2019. The remaining 30 percent of administrative expenses will vary depending on the estimated 2019 premium.
- **Premium.** The 2016 to 2017 premium change is derived from rate filings by issuer and weighted on 2016 membership. The factor is equal to 1.137 (or 13.7 percent). The 2017 to 2018 premium change is derived from the rate filings and weighted on 2017 membership as of 3/31/17. The factor is equal to 1.265 (or 26.5 percent). The 2018 to 2019 premium change is assumed to follow with claim trend, which is a factor of 1.065 (or 6.5 percent). The total factor from 2016 to 2019 is 1.532 (or 53.2 percent).

In addition to trending the data, Wakely applied a change to the enrollment and morbidity (estimated by a change in paid claims) from 2016 to 2019. The targeted enrollment and morbidity assumptions were applied as follow:

- **Enrollment.** The enrollment target is derived based on 2016 EDGE data, 2017 data as of March 2017 provided by the OIC (adjusted to account for attrition throughout the year, estimated using an internal Washington Health Benefit Exchange analysis), and 2018 data

estimated by a take-up function published by the Council of Economic Advisors (CEA)[21] using the 2018 premium increases. Subsidized enrollment is assumed to be flat from 2017 to 2018, with the enrollment decrease coming from the unsubsidized and off the Exchange populations. Enrollment in 2019 is expected to be flat from 2018. The resulting impact is 0.997 (or -0.3 percent) from 2016 to 2017, 0.945 (or -5.5 percent) from 2017 to 2018, and 1.000 (or 0.0 percent) from 2018 to 2019. The total impact from 2016 to 2019 is 0.942 (or -5.8 percent). The enrollment was allocated separately for on and off the Exchange, since Wakely assumed that the subsidized portion of the Exchange enrollment would remain steady from 2017 to 2019. The resulting impact was a reduction of -3.5 percent of enrollment on the Exchange and -8.4 percent off the Exchange.

- **Morbidity.** The change in morbidity was developed based on statistics of the health status of those leaving the market compared to those staying and the estimated percentage of the portion of members assumed to be leaving. The health status statistics are from a study performed by the CEA (noted above). The estimated percentage of those assumed to be leaving uses the 2016 to 2019 change in enrollment estimates (described above). The resulting morbidity impact from 2016 to 2019 is 1.016 (or 1.6 percent).

Wakely determined the most appropriate methodology was to remove members from the 2016 data aligning with the overall estimated enrollment decrease from 2016 to 2019. The enrollment was removed assuming the healthier and younger members would be more likely to drop coverage between 2016 and 2019.

In order to remove enrollment while targeting an increase in morbidity (i.e., claims PMPM) from 2016 to 2019, Wakely assigned probabilities to members based on their health (estimated by annual claims) and age status. Members were grouped by decile of annual claim amounts (and the top 0.5 percent of annual claimants) and age bands (with a separate age band for children and thereafter 10-year age bands). Using these two indicators, Wakely assigned a factor of likelihood that a member would leave the market. For example, a member between the ages of 19-29 that is in the 30th percentile of claims will be more likely to leave the market than a member that is between the ages of 40-49 that is within the 80th percentile of claims. Each individual's probability of remaining in or leaving the market was then multiplied by a random factor to select a random population upon each time of running the model. Several iterations were performed to ensure that a consistent impact to the market was occurring for each set of parameters used.

No additional adjustments were made to the 2016 detailed data to account for known changes that have already occurred in the emerging 2017 enrollment experience or that are believed to

[21]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

occur due to the 2018 rate filings, but these adjustments can be made to the analysis if preferred by the OIC.

Claims-Based reinsurance

The resulting 2019 estimated data was used to perform the reinsurance analyses at the member level. Washington is interested in a stabilization initiative that markedly reduces premiums. To estimate the effects of a claims-based reinsurance program, Wakely assumed that the reinsurance funds would reduce premiums statewide by 10 percent. The amount of funds needed to achieve the premium savings was calculated based on the total estimated premiums in the individual market. A portion of the total estimated funds needed would come through a reduction in administrative costs (from the portion of administrative costs that is assumed to be variable as discussed previously). The remaining portion of dollars was removed from the claim costs. The result is a higher than 10 percent reduction in claim costs is needed (as is seen in the results section).

In this analysis, the paid claims covered by the reinsurance parameters have simply been removed from the baseline. No cost of administering the program has been taken into consideration and how the program would be funded was not a consideration. However, as noted, since the goal of a state-based reinsurance program is to reduce premiums, the funding for the program would need to be found outside of only the individual market.

In general, the methodology used to apply the claims-based reinsurance parameters parallels the methodology used for the Federal transitional reinsurance program under the ACA. Members are grouped by issuer but are allowed to accumulate claims if they change plans or rating areas within an issuer. The exception is that CSR Maximum Out of Pocket (MOOP) adjustments were not considered in developing these assumptions, consistently with how they were applied by the Federal transitional reinsurance program. In the transitional program, the total paid claims necessary to hit the attachment point is increased by the difference between the MOOP from the CSR plan compared to the standard silver base plan. The purpose of this adjustment is to not double count money paid to the issuer for the difference in cost-sharing benefits that are afforded to CSR eligible members. Wakely can incorporate this adjustment if Washington prefers in Phase II of the analysis.

Using this methodology, Wakely determined the reinsurance parameters assuming a $1 million cap amount and 50 percent coinsurance and solved for the attachment point targeting the 10 percent reduction in premium amounts. The attachment point was found to be approximately $66,000 to reduce the premiums (ignoring any funding impact) by 10 percent. These parameters were applied at the member level. Wakely is not recommending that Washington implement this version of the program necessarily, but it is used to show Washington an example of what this type of program may look like for the State of Washington.

The results by various segments of the market are found in the body of the report.

Condition-Based Reinsurance

Washington was additionally interested in the impact of a condition-based reinsurance program.

Wakely provided Washington with a summary of condition data derived from the 2016 Washington EDGE data. The summary contains various metrics, including member months, minimum, maximum, and average allowed claim costs, and risk weights (for adults in the silver metal level plan) for each condition that is contained within the Federal risk adjustment model. In addition, information is included for single conditions as well as for combinations of conditions, which illustrates the impact of comorbidities, was included. Washington will have to consider this data, along with the discussion included previously in the report, when deciding whether to further pursue a condition-based reinsurance model. In addition, any analyses would have to be refined to account for credibility issues contained within the Washington-specific data. Wakely can additionally analyze the 2015 Washington data and national benchmarks to incorporate parameters where the 2016 Washington data may be lacking.

To illustrate the impact of a potential condition-based reinsurance program, Wakely performed a high-level analysis on the Washington data, using the conditions from the approved Alaska condition reinsurance program,[22] and removed an equal percentage of claims for all applicable conditions such that the 10 percent reduction in premiums was attained. The percentage of claim results removed for the applicable conditions was found to be 27.9 percent. The results were summarized at the same level as the claims-based reinsurance results. Wakely is not recommending that Washington implement this version of the program; rather, this is shown as an illustrative example of what a condition-based reinsurance program may look like in Washington.

Calculating Funding Targets

In order to estimate the potential amount that may be funded through net Federal savings (through a 1332 waiver), Wakely completed a high-level calculation of the funds needed for a 10 percent reduction in premiums. In addition, Wakely calculated the amount that the State might be able to achieve from the Federal Government as pass through due to savings in costs in subsidies from the implementation of the reinsurance program. The results of this analysis can be seen in Table 22.

[22] The list of conditions in Alaska's reinsurance program can be found here https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/alaska-Application-with-Attachments-51117.pdf

Table 22: High-Level Results of Baseline Scenario

Scenario	Baseline
Initial 2019 Enrollment	290,000
Enrollment Post-Reinsurance	297,000
Total Premiums	$1,976,700,000
Total Reinsurance Dollars Needed	$197,700,000
Approximate State Dollars Needed[23]	$147,500,000
Approximate Net Federal Savings	$50,200,000

Please note, this calculation above is shown as an estimate of what may be achieved as pass through savings. The calculation was completed from a high-level, and it does not match exactly that produced in the detailed analyses described previously. The analysis would be done at a more detailed level if the State were to pursue a 1332 waiver to acquire the net Federal savings.

To estimate the average 2019 APTC amounts, Wakely used the most recently available information from CMS on effectuated enrollment in 2017[24] and trended it based on 2018 rate filing information and estimated changes in medical trend from 2018 to 2019. This methodology matches how the paid claims were adjusted. The amounts were also adjusted for estimated changes in morbidity from 2016 to 2019.

The enrollment with the reinsurance program is estimated to be higher than without the reinsurance program. Wakely did not estimate the impact to the morbidity of the market due to the implementation of the reinsurance program, but this analysis can be performed in Phase II of the project.

Enrollment was re-estimated with the lower post-reinsurance premium, using the CEA enrollment function discussed previously, to calculate a final individual market average enrollment.

Reinsurance Funding Scenario Testing

Wakely performed scenario testing which involved changing the assumptions around enrollment, premiums, and proportion of the population receiving APTC for 2019. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis. We tested

[23] State funds needed do not include any administrative expenses that would be required to operate the reinsurance program.

[24] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

for scenarios in which enrollment was higher and lower than the enrollment contained in the baseline.

- The low enrollment scenario was based on lower enrollment due to ongoing uncertainty and cutbacks in outreach and enforcement at the Federal level.
- The high scenario corresponds to approximately similar enrollment patterns that existed in 2017, similar to the CBO projections about the 2019 benefit year (i.e., the individual market in 2019 is approximately the same size as it was in 2017).[25]

Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios. These results imply that Washington's reinsurance program would reduce premiums, increase coverage, and provide Federal savings, even if the projections vary from Wakely's best estimate. Our estimates of needed funding do not include any cost of administering the program. The results can be seen in Table 23 and several other scenarios are shown in the body of the report.

Table 23: Reinsurance Funding Scenarios – Variations in Enrollment

Metric	Baseline	High	Low
Initial 2019 Enrollment	290,000	307,000	255,000
Enrollment Post-Reinsurance	297,000	315,000	261,000
APTC Enrollment	117,000	117,000	101,000
Total Premiums	$1,976,700,000	$2,060,000,000	$1,793,100,000
Approximate Reinsurance Dollars Needed	$197,700,000	$206,000,000	$179,300,000
Approximate State Dollars Needed[26]	$151,200,000	$160,300,000	$137,700,000
Approximate Net Federal Savings	$46,500,000	$45,700,000	$41,600,000
Pass-through Percent	24%	22%	23%

[25] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf

[26] State funds needed does not include any administrative expenses that would be required to operate the reinsurance program.

State Offered Option – Bare County

The State offered option for bare counties was calculated using the same 2019 Baseline data, including enrollment and claim costs, as the reinsurance programs were based on. Underserved counties were identified by Washington as described previously. Wakely assumed that claims charged by the State in a state offered option would align with commercial rates layering on percentage ranges of 10 percent and 20 percent. The extent to which Washington could negotiate different provider rates would affect claims cost. Wakely also assumed that enrollment take-up would be similar between a state offered option and what historically has occurred for private options. If enrollees are ineligible for APTCs or CSRs through the State option, this would affect enrollment, premiums, and claims amounts presented.

Cost-Sharing Reduction Wrap

The CSR wrap results were calculated using the 2016 enrollment data of enrollees in 73 percent and 87 percent CSR variant plans. The 2016 enrollment was used since we have assumed the subsidized population (especially those in CSRs since they are among the lowest FPL enrollees) will remain steady from 2016 to 2019 and not drop coverage. The claim costs were projected from 2016 to 2019 using the baseline allowed claim assumptions discussed previously. Additional adjustments were made to account for increased utilization and for increased selection of cost-sharing variants among eligible bronze plan enrollees.

The remaining methodology in calculating the CSR wraps is discussed within the body of the report.

Premium Wrap

The following were the steps used to calculate the premium wrap:

1. **Off the Exchange Enrollment.** Wakely used the 2016 off the Exchange EDGE enrollment, adjusting for actual enrollment changes from 2016 to 2017 using county-level data provided from the OIC. The data was then trended to 2018 based on the take-up function previously described incorporating the premium trend by county (described below) from 2017 to 2018. Enrollment was estimated to be flat from 2018 to 2019.
2. **On the Exchange Unsubsidized Enrollment**. Wakely used on the Exchange unsubsidized enrollment by county as of April 2017 provided by the Washington HBE. This data was adjusted to account for expected attrition throughout the year, and then was trended to 2018 based on the take-up function previously described incorporating the premium trend by county (described below) from 2017 to 2018. Enrollment was estimated to be flat from 2018 to 2019.
3. **Off the Exchange Premiums.** The off the Exchange premiums were trended to 2019 based on 2016 premiums from the EDGE data, adjusted for rate filings premium trends

from 2016 to 2018, adjusted for county-level variance based on variances in county-level SLCSP trend from the total SLCSP trend in years 2016 to 2017 and 2017 to 2018. The premiums were adjusted from 2018 to 2019 using 6.5% trend as described previously.

4. **On the Exchange Unsubsidized Premiums.** The on the Exchange unsubsidized premiums were trended to 2019 based on 2017 premiums provided by the Washington HBE, adjusted for rate filings premium trends from 2017 to 2018, adjusted for county-level variance based on variances in county-level SLCSP trend from the total SLCSP trend from 2017 to 2018. The premiums were adjusted from 2018 to 2019 using 6.5% trend as described previously.

From here, Wakely calculated the impact of applying different premium wraps to the unsubsidized population. We also estimated increased unsubsidized enrollment as a result of lower premiums due to the premium wrap. Additional enrollment was estimated using the take-up function, as described previously.

Please note that the final enrollment totals do not align with the high-level baseline enrollment totals described elsewhere in the report. This is primarily due to incongruities in data received from the Washington HBE. This portion of the analysis relied on the most recently available data provided by HBE.

Appendix B: Glossary of Key Terms

Actuarial Value (AV) – An actuarial value is the portion of health care costs that the carrier pays. For example, if the total cost of coverage is $100 and a member pays $20 in cost sharing, the carrier pays $80 and the actuarial value is 80 percent ($80/$100). Carriers are required to classify their plan offerings into one of several coverage tiers (or metal levels) based on the expected portion of costs, or actuarial value, that will be paid by the carrier for a standard population. HHS regulations set the requirements around what actuarial value ranges are allowed for each metal level (as described more in metal level below).

Adjusted Paid Claims – This metric is equal to paid claims net of pharmacy rebates, cost sharing reduction (CSR) amounts, and risk adjustment transfers.

Advanced Premium Tax Credits – A type of Federal subsidy that reduces the amount eligible individuals pay for their monthly health insurance premiums.

Allowed Claims – Allowed claims represent the overall cost of health care services paid to providers. The amount is net of the provider discounts that are negotiated by the insurance issuer. Allowed claims are the total of the issuer payment portion (called paid claims) and the member cost-sharing portion, which includes deductibles, copayments and coinsurance.

Average Enrollees – Average enrollees is defined as Member Months divided by 12. It indicates the average number of enrollees in a segment of the market in any given month.

Issuer – This term refers to the licensed insurance company selling insurance plans in the State of Washington. Other commonly used and inter-changeable terms are health plan, issuer, and insurer.

Claims-Based Reinsurance Parameters – Parameters for claims-based reinsurance programs determine the reimbursement amount that an issuer will receive for claims subject to the program. Reinsurance programs apply to paid claims accumulated at the member level over a period of time, typically a calendar year. The **attachment point** is the amount that must be accumulated before reinsurance begins. The **reinsurance cap** is the maximum claim amount that will be removed. The claim dollars accumulated in between the attachment point and the cap are applied to the **coinsurance** percentage to determine the amount of reimbursement from a reinsurance program. For example, an individual with $500,000 of claims with an attachment point of $50,000, a reinsurance cap of $250,000, and 50 percent coinsurance would result in a reinsurance payment of $100,000 = ($250,000 - $50,000) * 50 percent.

Condition-Based Reinsurance Parameters – In condition-based reinsurance, issuers transfer risk from themselves to external entities for enrollees with pre-specified select conditions. Reimbursement for selected conditions could range from paying all claims associated with a

person with a set condition or paying only a portion of the costs associated with an enrollee with a pre-specified condition. If in addition to the condition being pre-specified, a set payment amount is also defined, such as a coinsurance percentage or a defined contribution amount, we refer to that type of reinsurance as **reference pricing reinsurance**.

Cost Sharing Reduction plans (CSRs) – Cost sharing reduction plans are subsidized plans with reduced enrollee cost sharing (lower deductibles, copays, coinsurance, and out of pocket expenses) for lower income members. A member who is eligible for CSR, and who purchases a silver plan, will be placed in a CSR plan based on their income level. There are three CSR plan variations for each standard silver plan based on three different income level tiers. The CSR plan variations are significantly richer than the standard silver plan such that members have less cost sharing (lower deductibles, copays, coinsurance, and out of pocket expenses). As a result, the CSR plans have higher AVs than the standard silver plans. The three CSR plan variation AVs are 94 percent, 87 percent, and 73 percent (compared to 70 percent for the standard silver plan). The Silver 94 percent AV CSR plan has the richest coverage of all ACA plans, with an AV above platinum plans, and is offered to members with income levels under 150 percent of the Federal Poverty Level (FPL). The Silver 87 percent AV CSR plan has a benefit richness between platinum and gold plans and is offered to members with income levels between 151-200 percent of the FPL. Finally, the Silver 73 percent AV CSR plan is slightly richer than a standard silver plan in which members qualify if their income levels fall between 201-250 percent of the FPL. If a member earns more income than 250 percent of the FPL, they are not eligible for CSR subsidies. CSR plans are only applicable to the individual on the Exchange market.

Credibility – Credibility refers to the measure of predictive value that is attributable to a set of data. Actuaries and researchers use historical data to estimate what might happen in the future so it is important to understand the validity of the historical data before it is used. The credibility is determined by the size and consistency of the historical data set along with the similarity of the historical data to the expected future environment the actuary or researcher is trying to predict. Small amounts of data are not considered credible at predicting the impact of a change. For example, in these analyses, some sub-segments of the market had very few enrollees so using that data to estimate the impact of implementing a state reinsurance program would not be reliable.

EDGE Server – The EDGE Server system was developed as part of the ACA for Qualified Health Plans enrolling on the Exchange. It is a secure data sharing platform that allows HHS to receive member health data from all issuers in a specified format. The data is used by HHS to estimate certain financial payments (such as risk adjustment transfers).

Exchange – The Exchange refers to the Washington Health Benefit Exchange, the online purchasing marketplace where individuals and small employers can purchase ACA state certified benefit plans based on income.

Metal Level – Metal level refers to the categorization of plans based on the portion of the total expected claim costs the issuer pays, or actuarial value, versus what the member pays in cost sharing (deductibles, copays, and coinsurance). The metal levels measure the richness of the benefit plan. All ACA plans must be designed to fall under one of four metal levels (excluding catastrophic). The table below shows the average portion the issuer is expected to pay, average portion the Federal Government is expected to pay for CSR plan variations, and average portion the member is expected to pay for each metal level. CMS regulations allows the plans to have a di minimis plus 2 or minus 4 percent. For example, a silver plan would need to be assigned an actuarial value of 66 percent to 72 percent. The di minimis for CSR plans is plus or minus 1 percent. For 2018, the bronze di minimis is expanded for bronze plans that meet certain requirements.

Table 24: Metal Level Categorization

	Issuer Pays	Federal Government Pays	Member Pays	Price Tag for Members
Bronze	60%	0%	40%	Low
Silver	70%	0%	30%	Medium
Silver CSR 73%	70%	3%	27%	Subsidized
Silver CSR 87%	70%	17%	13%	Subsidized
Silver CSR 94%	70%	24%	6%	Subsidized
Gold	80%	0%	20%	High
Platinum	90%	0%	10%	Highest

Paid Claims – This metric represents the amount that an insurance issuer pays providers for services rendered to members. Paid claims do not include the member cost sharing portion (deductibles, copays, and coinsurance).

Rating Area – Rating area refers to the combination of counties within a state where premium rating factors for each area must all be the same. The rating area is determined based on the county where an enrollee lives.

Relative Profitability – Relative profitability is not representative of “true” profitability. Profitability may vary due to the impact of other sources outside these analyses including the 2016 Federal transitional reinsurance program (which provided claim reimbursements not included within these analyses), commercial reinsurance, and differences as to how issuers measure profitability, such as allocation of administrative expenses, which may vary from the methodology used in these analyses. These analyses measure relative profitability, or profitability relationships between sub-segments of the market, to identify sub-segments where the variance is largest and might be contributing to market instability. The relative profitability is shown for each market separately such that the total calculated profitability from the data, for the individual and small group markets,

is set to zero and all other sub-segments, are shown in relation to the total. For example, if the bronze relative profitability in the individual market is $30 PMPM it does not imply that the bronze profit is $30 PMPM but rather that the profitability for bronze plans is $30 PMPM higher than the average profitability for the entire individual market. This report will use the term “relative profitability” as the measurement of the profitability being analyzed.

Risk Adjustment Program – The ACA’s risk adjustment methodology is intended to reinforce market rules that prohibit risk selection by issuers. Risk adjustment accomplishes this by transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees. The goal of the risk adjustment program is to encourage issuers to compete based on the value and efficiency of their plans rather than by attracting healthier enrollees. The program redistributes funds, within each state and for the individual and small group market separately (unless merged markets), from plans with lower-risk enrollees to plans with higher-risk enrollees, based on a **Risk Adjustment Methodology and Risk Adjustment Transfer Formula** (referred to often throughout the report) produced by the U.S. Department of Health and Human Services (HHS). The methodology underlying the risk adjustment program includes calculation of risk scores for each enrollee, a method by which enrollees are weighted together for each issuer, and a calculation, called the payment transfer formula, that combines the weighted risk scores at the issuer level with other factors and determines the payment transfer between issuers within each market separately.

TPIR Files – TPIR Files are reports issued by CMS, on June 30 of each year, to all issuers included within the risk adjustment payment transfer calculation for the prior benefit year. The report includes information regarding risk adjustment transfer results at granular levels.