Section 1332 State Innovation Waiver Actuarial Analyses and Certification and Economic Analyses

Maine Guaranteed Access Reinsurance Association

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EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been retained by the Maine Guaranteed Access Reinsurance Association (MGARA) to provide actuarial and consulting services related to the State of Maine's proposed Section 1332 State Innovation Waiver Application (Section 1332 Waiver). This Section 1332 Waiver seeks federal pass-through funding to support the re-start of MGARA beginning in calendar year 2019. This report provides the required actuarial analysis and certification, and economic analyses supporting the State's demonstration to CMS that MGARA meets the requirements for Federal pass-through funding.

Legislation authorizing the re-start of MGARA was signed on June 2, 2017 by Governor Paul LePage.[1] MGARA is a key component of the insurance market reforms originally instituted in May 2011, when the Maine State Legislature passed Public Law Chapter 90, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" (PL90). During its period of active operation (prior to suspension of operations due to the transitional reinsurance provided under the Affordable Care Act (ACA)), MGARA reduced insurance costs in Maine's individual health insurance market by providing reinsurance coverage for individual health insurance policies (subsidizing insurer paid claims for high cost members). For Maine's Section 1332 Waiver application, the State seeks to re-implement a state-based prospective reinsurance program for the individual market (also known as "non-group" coverage) beginning on January 1, 2019.

Under the re-activated MGARA, insurers offering comprehensive ACA-compliant individual market coverage will be eligible for reimbursement by submitting claims to MGARA through two mechanisms:

- 1) Automatic Ceding, whereby carriers are required to cede 90% of a non-group policy's contract premium[2] for any covered member having at least one of eight conditions specified by the MGARA Board of Directors.
- 2) Voluntary Ceding, whereby carriers may cede 90% of a non-group policy's contract premium to MGARA at the carrier's discretion.

In both cases, ceding occurs as members are identified with the qualifying conditions. MGARA then reimburses a portion of paid claims above the attachment point thresholds set by the MGARA Board of Directors. MGARA intends to fund its claim payments using assessments collected from group and non-group markets and through available Federal pass-through funding. Reimbursement for qualifying policyholders as defined by MGARA will be available regardless of whether the coverage is sold inside or outside the federally-facilitated insurance marketplace (FFM).

For MGARA to meet the Federal requirements for Section 1332 Waivers, it must be deficit neutral to the Federal government and meet the following standards:

- *Coverage*: The Section 1332 Waiver must provide health insurance to *at least* as many people as would be projected under the status-quo ACA (without waiver).
- *Affordability*: The Section 1332 Waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver.
- *Comprehensiveness*: The Section 1332 Waiver must provide coverage at least as comprehensive (as defined by the ACA's essential health benefits) as would be projected without the waiver.

It should be stressed that these requirements are in relation to coverage, affordability, and comprehensiveness without the waiver. For example, a Section 1332 Waiver is not required to result in more insured individuals relative to a period before its implementation. Rather, it must be estimated to insure at least as many during the projection period relative to if the Section 1332 Waiver was not implemented.

Our analysis indicates that all Federal requirements cited above are met by MGARA.

[1] http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280063452

[2] Contract premium is the sum of all member premiums paid under a single non-group medical contract

Coverage

During the course of the five-year initial waiver period and the ten-year projection period, we estimate MGARA will result in a lower number of uninsured Mainers each year than in the without MGARA scenario (also referred to as the baseline scenario). We estimate the reductions in the uninsured population attributable to MGARA will occur primarily in the population with income above 400% of the federal poverty level (FPL), as non-group (individual market) premium rates will be more affordable under MGARA.[3]

For the population with income between 100% and 400% FPL, who are eligible for Federal premium assistance, out-of-pocket premium rate changes have been limited since the ACA-reformed rating rules were implemented in January 2014. While premium rates for plans offered through the FFM have increased significantly from 2014, these increases have largely been borne by additional Federal premium assistance for the population with income between 100% and 400% FPL qualifying for premium assistance. Effective January 1, 2019, eligibility for Federal premium assistance will shrink to income ranges between 139% and 400% FPL due to the approval of Medicaid expansion by Maine residents on November 7, 2017.[4]

We estimate MGARA will not have any material impacts to the number of Mainers covered under employer-sponsored plans, traditional Medicaid, Medicare, or other public programs. We also assume the effective repeal[5] of the individual mandate and the approval of Medicaid expansion in Maine in 2019 will have impacts on the market independent of MGARA's operations. These anticipated changes are estimated to have large, one-time effects on the size of the non-group market and uninsured pool in 2019. Figure 1 illustrates changes in the number of Mainers uninsured and purchasing coverage in the non-group market under MGARA relative to the without MGARA scenario.

Figure 1
MGARA
Changes in Uninsured and Non-Group Market Resulting from MGARA Implementation
(in Thousands)

	Uninsured			Individuals Insured in Non-Group Market		
Calendar Year	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	92.2	92.2	0.0	78.1	78.1	0.0
2019	63.0	62.0	-1.1	61.0	62.1	1.1
2020	62.5	61.6	-0.9	60.5	61.3	0.9
2021	62.0	61.2	-0.8	59.9	60.7	0.8
2022	61.5	60.8	-0.7	59.4	60.1	0.7
2023	61.0	60.4	-0.6	58.9	59.6	0.6
2024	60.6	60.0	-0.5	58.4	59.0	0.5
2025	60.2	59.7	-0.5	57.8	58.3	0.5
2026	59.8	59.4	-0.4	57.3	57.7	0.4
2027	59.4	59.0	-0.4	56.7	57.1	0.4
2028	59.0	58.7	-0.3	56.2	56.5	0.3

Note: Values are shown in thousands. Numbers may not add due to rounding.

For the duration of the projection period, we estimate that approximately 300 to 1,100 additional annual non-group enrollees will enroll in the non-group market relative to the without MGARA scenario. This additional membership is assumed to come from previously uninsured members entering the market, as well as from reducing the annual lapse rate in the non-group market.

Modelling changes in individual enrollment involves a variety of competing influences including socio-economic status, social factors, political beliefs, health status, affordability, and other factors. The enrollment assumptions in this report are

[3] In 2018, the FPL is $12,140 for a single household and $25,100 for a family of four. 400% FPL would reflect income levels of $48,560 and $100,400, respectively. Please see https://aspe.hhs.gov/poverty-guidelines for more information.

[4] http://maine.gov/sos/cec/elec/results/2017/results1117.xlsx. Legal non-citizens with income up to 400% FPL will remain eligible for premium assistance.

[5] Legislators have eliminated the impact of the individual mandate by amending the penalty to $0. While not technically a repeal, this has the same effect.

point estimates within a range of reasonable values whose impacts were tested using economic and actuarial modeling; all tested enrollment scenarios were assumed to decrease Maine's uninsured pool and produced results satisfying the 1332 waiver guardrails. Based on this projected reduction in uninsured on an annual basis, we believe that MGARA meets the coverage requirement for approval of the Section 1332 Waiver.

With or without MGARA, we estimate a decline in non-group coverage over the course of the ten-year projection period. Most notably, in 2019 we expect a significant one-time reduction in non-group membership due to Medicaid expansion, which we estimate will result in a 19% contraction of the non-group market. We estimate Medicaid expansion will result in a modest reduction to individual market premium rates based on expected improvements to the morbidity of the non-group insurance pool; however, improvements in risk pool acuity are estimated to be offset by impacts of the effective repeal of the individual mandate penalty as signed into law on December 22, 2017 (effective January 1, 2019). The individual mandate repeal is estimated to further shrink the non-group market in 2019 and throughout the remainder of the ten year projection period. These estimates are assumptions based on professional judgment. It is certain that actual enrollment will vary from the estimates provided in this report by an unknown degree.

It is worth noting that while MGARA is estimated to reduce premiums in 2019, premiums are still estimated to increase over the course of the projection period at a rate greater than general inflation, resulting in higher costs for the population not qualifying for premium assistance. The MGARA-based premium reductions are expected to foster a non-group insurance market where existing enrollees are more likely to remain enrolled and where previously uninsured individuals are more likely to purchase insurance; as such, the with-waiver scenario complies with the 1332 Waiver coverage guardrail.

Affordability

MGARA is not estimated to materially impact premium rates for employer-sponsored insurance, nor change costs, eligibility parameters, or enrollment levels for public programs such as Medicaid and Medicare. A state-based assessment of $4 per member per month (PMPM) on commercial insurers and self-funded employers will be implemented to provide partial funding for MGARA. It is possible that this additional cost will be passed-through to employees in the form of slightly higher plan contributions or additional cost sharing requirements. However, we estimate the assessment for MGARA will be less than 1% of an average employer's premium costs.

For the non-group market, MGARA is estimated to reduce premium rates by 9.0% in 2019 (relative to without the waiver). This is achieved through a reinsurance mechanism that reduces insurers' paid claims expenses for certain high cost individuals insured in the ACA-compliant individual market. The program is funded through the $4 PMPM market-wide assessment and Federal pass-through funding.

During each year, the impact to consumers will vary significantly within the non-group market based on the consumer's household income and its interaction with the ACA's premium assistance program. Under the ACA's premium assistance program, qualifying households with income between 100% and 400% FPL (139% to 400% FPL after Medicaid expansion[6]) have out-of-pocket premium expenses capped to a specified percent of income. In 2018, we estimate approximately 78% of Mainers purchasing coverage in the ACA-compliant individual market will receive Federal premium assistance. We project that the vast majority of individuals receiving premium assistance without the waiver will also receive premium assistance under MGARA. For these individuals, the premium savings will accrue to the Federal government, as it reduces the amount of premium assistance necessary to ensure the out-of-pocket cost of coverage does not exceed the maximum specified by the ACA. It is possible that some young adults and other persons with income approaching 400% FPL receiving premium assistance without the waiver will see out-of-pocket premiums fall below the maximum specified by the ACA under MGARA. In these cases, only partial premium savings accrue to the Federal government, while the consumer also directly benefits from part of the premium reduction.

For households not eligible for premium assistance, the full amount of premium rate reduction will be realized under MGARA, with the Federal government not accruing any savings. As premium rates are estimated to be more affordable under MGARA, this should provide financial incentive for some of the uninsured individuals in the absence of the waiver to purchase health insurance. Figure 2 illustrates premium rate reductions for a 21-year old and a 64-year old for the second lowest cost silver plan (the benchmark plan that is used to determine available premium assistance).

[6] Legal aliens have and will continue to qualify for premium assistance in qualifying households with income up to 400% FPL.

Figure 2 MGARA Changes in Second Lowest Cost Silver Plan Monthly Premium from MGARA Implementation						
	21-Year Old Monthly Premium			64-Year Old Monthly Premium		
Calendar Year	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	$456	$456	$0	$1,367	$1,367	$0
2019	$463	$421	($42)	$1,388	$1,263	($125)
2020	$497	$451	($47)	$1,492	$1,352	($140)
2021	$525	$476	($49)	$1,574	$1,427	($147)
2022	$554	$503	($50)	$1,661	$1,510	($151)
2023	$581	$531	($50)	$1,744	$1,594	($150)
2024	$610	$560	($51)	$1,831	$1,679	($152)
2025	$641	$589	($52)	$1,923	$1,768	($155)
2026	$673	$623	($50)	$2,019	$1,869	($150)
2027	$703	$652	($51)	$2,110	$1,957	($153)
2028	$735	$686	($49)	$2,205	$2,058	($147)

Notes:
1. Values are rounded.
2. Values do not reflect available premium assistance for qualifying individuals.
3. Premiums are for non-tobacco user and assume Federal default 3:1 age rating.
4. The change in premium between 2018 and 2019 is primarily impacted by the lower risk patients being removed from the pool due to Medicaid Expansion, among other influences.

Based on the above summary of our analysis, we believe MGARA meets the affordability requirement for approval of a Section 1332 Waiver.

Comprehensiveness

As MGARA makes no change to insurer benefit requirements for plans offered in Maine's health insurance markets, MGARA meets the comprehensiveness requirements required for a Section 1332 Waiver. MGARA makes no changes to essential health benefit (EHB) or state-mandated benefit requirements in the individual market. Therefore, the focus of the actuarial analysis was related to coverage and affordability requirements for this Section 1332 Waiver, as presented above and discussed in greater detail later in this report.

Economic Analyses

A Section 1332 waiver application must demonstrate that it will not increase the Federal deficit. By reducing non-group premiums, MGARA is estimated to result in Federal savings on premium assistance provided through the FFM. We also evaluated changes in Federal revenue related to FFM user fees and the health insurance providers fee (HIF). Note, we do not estimate changes to Federal cost-sharing reduction (CSR) payments, because CSR payments from the Federal government were halted in late 2017.

- *FFM user fees*: As a result of reducing premiums in the individual market, we estimate the Federal government will collect a decreased amount of revenue related to the FFM user fee (assumed to be 3.5% of FFM premium).

- *HIF*: National collected revenue amounts for the HIF are prescribed in 2018 (premium volume changes that year do not impact the collected amount). In 2019, the HIF has a one year suspension signed into law on January 22, 2018 as part of a continuing appropriations act.[7] Thereafter, the national HIF collection amount is estimated to be indexed by changes in per capita employer-sponsored insurance premiums. As MGARA does not materially impact employer-sponsored insurance, we do not estimate any impacts to the national HIF amounts during the ten-year projection period from 2019 through 2028.

It is possible that MGARA may impact other Federal revenue items, such as Federal income taxes paid by insurers. However, quantifying these items is beyond the scope of our analysis. The combination of Federal premium assistance savings plus the sum of revenue changes from the other described Federal revenue sources comprise the estimated Federal pass-through funding available to Maine under Section 1332 Waiver regulations. Figure 3 illustrates the division of state and Federal funding for the ten-year projection period and the state-based assessment amount.

Figure 3
MGARA
Estimated Available Pass-Through Funding and State-Based Assessment

Calendar Year	State-Based Assessment ($ Millions)	Federal Pass-through Funding ($ Millions)	Ceded Premiums ($ Millions)	Total Revenue ($ Millions)	Estimated Assessment Enrollment Base (Thousands)	State-Based Assessment PMPM	Ceded Lives
2019	$22.6	$33.4	$37.0	$93.0	471	$4.00	5,500
2020	22.4	37.5	39.7	99.6	467	4.00	5,600
2021	22.2	38.9	41.2	102.3	462	4.00	5,500
2022	22.0	39.8	42.6	104.4	457	4.00	5,400
2023	21.7	38.9	43.6	104.2	453	4.00	5,200
2019-2023	$110.9	$188.6	$204.1	$503.6	2,310		27,200
2024	21.5	39.2	44.6	105.3	449	$4.00	5,100
2025	21.3	39.1	46.1	106.5	444	4.00	5,000
2026	21.1	37.5	47.5	106.1	440	4.00	4,900
2027	20.9	37.5	48.9	107.3	436	4.00	4,800
2028	20.7	35.7	49.9	106.3	432	4.00	4,700

Notes:
1. State-based assessment PMPM does not include cost of administering MGARA. The $4.00 PMPM assessment generates an estimated $20 to $22 million in state-based revenue per year.
2. Federal Pass-through Funding is shown net of FFM Exchange Fees
3. Actual Federal pass-through funding will be determined based on premium rates filed for each year and is shown net of exchange fees.

[7] https://www.congress.gov/bill/115th-congress/house-bill/195/text

4. Estimated values are rounded.
5. The 2019 assessment base may be lower than the values illustrated to the extent employer-sponsored plans do not begin paying the assessment until the beginning of their plan year in 2019 (which may be on a non-calendar year basis).

For the state-based assessment amount, the State of Maine will assess a $4 PMPM fee on health insurance coverage for all insured persons in the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees). Premiums ceded by insurers will be (and are modeled as being) netted out of the premium reductions applied to non-group rates under MGARA.

Sensitivity of Results

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health insurance programs, particularly within the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. *As final Federal pass-through funding will be based on actual premiums filed by insurers offering coverage in Maine's non-group market, final funding amounts may differ significantly from the estimates provided in this report. It is our assumption that insurers will file rates to reflect the estimated impact of MGARA in 2019.*

The actuarial and economic analyses presented in this report solely reflect the estimated incremental impact of MGARA. Other state or Federal policy changes may impact actual amounts presented in this report.

We specifically note that our projections of enrollment and premium rates in the individual market assume direct Federal funding of CSR subsidies is not re-instated, Medicaid expansion occurs in Maine starting in 2019, and insurer pricing assumptions and resulting enrollment behaviors do not materially deviate from 2018 assumptions and behaviors. The changes occurring in 2019 relative to Medicaid expansion and the effective repeal of the individual mandate are expected to be highly impactful to Maine's insurance markets and as such create significant uncertainties in projecting future market enrollment and premium rates. Additionally, to the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted to a significant degree.

SECTION I. ACTUARIAL ANALYSIS

This section provides the required actuarial analysis for Maine's Section 1332 Waiver application. Appendix 1 contains the actuarial certification for the Section 1332 Waiver.

A description of the actuarial analysis meeting the requirements under 45 CFR 155.1308(f)(4)(i) and other applicable information as requested in the Checklist for Section 1332 Innovation Waiver Applications has been provided in this section. For purposes of this analysis, calendar year 2018 serves as the baseline year for the ten-year required projections.

As discussed in the Assumptions and Methodology section of this report, we utilized a combination of U.S. Census Bureau data, population growth projections from Maine's Office of Policy and Management, publicly available health insurance enrollment and premium data, modeling of the ACA's premium assistance structure, a survey developed by Milliman and administered to Maine carriers through MGARA requesting multiple years of claims, premiums, and enrollment data, and proprietary insurer data provided by the Maine Bureau of Insurance (BOI), to model the estimated impact of MGARA during the ten-year projection period. Our analysis reflects Maine's estimated demographics during the projection period and models insurance purchasing behavior based on changes in premium rates and Federal premium subsidies. Our modeling allows for the summarization of projected enrollment and premium information by age, gender, health status, household income, and insurance market.

Prior to performing any projections, we calibrated our projection model's census, premium, claims expense, and other assumptions to reflect Maine's insurance markets. As MGARA is estimated to primarily impact Maine's individual health insurance market and uninsured population, the focus of our modeling efforts was on the interaction between these populations under both the status-quo ACA and the Section 1332 Waiver.

1. REINSURANCE PARAMETERS

MGARA was established in 2011 under Maine Law[8] as a private, nonprofit association and shares the goal of the Federal transitional reinsurance program operated under the ACA of providing premium relief to the individual health insurance market. MGARA actively operated between July 1, 2012 and December 31, 2013. The Maine individual market consisted of approximately 34,000 in-force lives during this period, after which the ACA facilitated the creation of a three-year transitional reinsurance program, which led to the eventual suspension of MGARA operations. The State of Maine intends to reinstate MGARA beginning January 1, 2019.[9]

Similar to the federal transitional reinsurance plan, MGARA is intended to subsidize insurers' claim expenses for high cost claimants, while maintaining an insurer's incentive to manage the costs associated with these claimants. The basic prospective model, scheduled to be reinstated January 1, 2019, is anticipated to be configured as follows:

- MGARA Funding
    - A $4.00 PMPM market assessment on nearly 500,000 lives. A supplemental assessment of $2.00 may be made under conditions of adverse experience.
    - 90% of contract (subscriber and dependents) premium for ceded members and their dependents.
    - Federal pass-through funding granted from the 1332 Waiver application.
- MGARA Parameters and Reinsurance Payments
    - Medical and Pharmacy plan paid claims expenses for ceded members. Ceded members are identified as having any of eight conditions MGARA defines as mandatory for ceding to the reinsurance pool. The eight mandatory ceded conditions are: Uterine Cancer; Metastatic Cancer; Prostate Cancer; Chronic Obstructive Pulmonary Disease (COPD); Congestive heart Failure; HIV Infection; Renal Failure; and Rheumatoid Arthritis. Claims for the entire contract (subscriber and dependents) are ceded to the reinsurance pool. MGARA is responsible for claims according to the threshold formula described below.

[8] 24-A M.R.S. § 3858(1).

[9] Note that the parameters proposed for the 2019 and future MGARA operations are not identical to the parameters used in MGARA's 2012 operations.

- Carriers also have the option of voluntarily ceding members along with their dependents. MGARA is responsible for claims according to the threshold formulas described below.
- Reinsurance Thresholds: MGARA makes payments to an insurer when an eligible claimant's accumulated claims incurred during the calendar year exceed the initial attachment point. The initial attachment point during early operations (i.e., in 2012-13) was set at $7,500. The proposed initial attachment point for operations starting in 2019 is $47,000. For claimants with annual paid claim expenses not exceeding $47,000, insurers will not receive any payments from the reinsurance fund. To the extent a claimant's paid medical[10] expenses exceed $47,000, the insurer will receive a payment from the reinsurance fund based on the parameters outlined in Figure I-1A.
- MGARA expenses include $8.00 per ceded person per month for administrative costs and an additional $150,000 per year cost in overhead. These expenses are funded by the MGARA funding items.
- MGARA set the final ceding premium rate at 90% of the policy premium.

Figure I-1A illustrates the assumed reinsurance parameters for the program.

Figure I-1A
MGARA
Calendar Year 2019 Reinsurance Parameters

Parameter	Parameter Value
Initial Attachment Point	$47,000
Reinsurance Threshold 2	$77,000
Coinsurance Percentage 1 (between Initial Attachment Point and Reinsurance Threshold 2)	90%
Coinsurance Percentage 2 (above Reinsurance Threshold 2)	100%

$$\begin{aligned} &Reinsurance\ Payment \\ &= Maximum[0, [\ Minimum\ (Annual\ Paid\ Claim\ Expense - Initial\ Attachment\ Point, \\ &Reinsurance\ Threshold\ 2 - Initial\ Attachment\ Point)] \times Coinsurance\ Percentage\ 1 \\ &+\ Maximum(0, Annual\ Paid\ Claims\ Expense -\ Reinsurance\ Threshold\ 2) x\ Coinsurance\ Pecentage\ 2 \end{aligned}$$

The reinsurance attachment point parameters displayed above were selected to keep MGARA solvent and to preserve a target level of surplus over the course of the projection period based on the modeled outcomes. In practice, the MGARA board will set the reinsurance parameters. The Initial Attachment Point and Reinsurance Threshold 2 parameter values shown in Figure I-1A are appropriate for the non-group enrollment, premium, and claims assumptions underlying a singular set of with-MGARA and without-MGARA scenarios; these parameters may need to be revised if the underlying assumptions are changed.

Figure I-1B provides several examples of reinsurance payments in 2019 for claimants with varying annual medical expenses, based on the parameter values in Figure I-1A.

[10] Includes amounts for all services and materials covered under the health care plans, including medical services, prescription drugs, and medical equipment and supplies.

Figure I-1B MGARA Individual Health Insurance Market Calendar Year 2019 Reinsurance Payment Examples[11]				
Person	**Annual Medical Expense**	**Reinsurance Eligible Medical Expense**	**Coinsurance Percentage**	**Reinsurance Payment**
A	$20,000	$0	90%	$0
B	$48,500	$1,500	90%	$1,350
C	$250,000	$203,000	90% between 47k and 77k, then 100%	$27,000 + $173,000 = $200,000

We believe insurers continue to have a financial incentive to manage health care costs and utilization for insured individuals meeting the payment criteria for the reinsurance program because the carrier must cover the claim amounts up to the attachment point while ceding 90% of the total premium to MGARA. After the member is ceded to MGARA, the insurers recognize that efficient claims management translates into lower individual market rates albeit indirectly. Annual MGARA funds are fixed pools of money and are not retrospectively adjusted to cover the total claim costs incurred by ceded members. If MGARA's subsidization of carrier liability leads to ineffective management of ceded member costs, the program may require adjustments to MGARA's plan design parameters. From the consumer and provider perspective, the reinsurance program is not expected to have a material impact on incentives to manage health care costs and utilization relative to the ACA's current structure.

2. PROJECTED REINSURANCE FUNDING LEVELS

For calendar year 2019, in addition to receiving Federal pass-through payments granted by the 1332 Waiver application, the State intends to collect a $4 PMPM assessment across Maine's commercial insurance markets (excluding state and Federal employees). The $4 PMPM assessment is constant for each year of operation and, with the other sources of MGARA funding, covers costs associated with administering and operationalizing MGARA. The parameters displayed in the "Reinsurance Parameters" section are estimated to ensure high probabilities of program solvency based on the projected payments into and out of MGARA over the 10-year projection period.

Our modeling has assumed that the full annual value of the $4 PMPM assessment (i.e., $48 per member per year [PMPY]) charged to the assessed markets is paid by all assessable lives. In practice, depending on the timing associated with the re-instatement of MGARA, the actual assessment collections may be affected by durational effects including policy lapses and mid-year renewals; for 2019 in particular, the $48 annual assessment may only be partially paid by policies priced prior to the reinstatement of MGARA and/or renewed after January 1, 2019. Depending on timing of assessments relative to approval data from the BOI, the modelling may need to reflect a partial year assessment for MGARA's first year of operation, or an alternative delay for the first year of operation.

Please note that all modeling results displayed henceforth in this report assume the $48 PMPY MGARA assessment is collected across all assessable lives.

Using 2015 incurred claims data from the Maine All Payer Database, which includes de-identified individuals in the individual market and their associated medical costs, we summarized costs associated with individuals who would be subject to mandatory ceding as well as high cost individuals that carriers would likely cede to the reinsurance pool voluntarily. The costs were adjusted to 2019 dollars using historical trends for the Maine non-group market between 2015 and 2017, and a projected trend from 2017 to 2019.

The aggregate dollar amount of the reinsurance fund will be distributed to qualifying insurers offering coverage in the non-group market. To the extent the initial reinsurance parameters for the year result in a shortage of payments to insurers relative to the aggregate fund amount, the reinsurance threshold parameters will be adjusted to increase insurer payments

[11] Initial Attachment Point = 47,000; Reinsurance Threshold #2 = 77,000. Coinsurance Percentage #1 = 90%; Coinsurance Percentage #2 = 100%

to the aggregate fund amount on a retrospective basis. Conversely, MGARA's Board will monitor payments and adjust the reinsurance parameters as necessary to avoid a funding deficit.

Figure I-2A illustrates the estimated aggregate reinsurance funding, insurer paid claim expenses (prior to reinsurance), and reinsurance funding as a percent of ceded member paid claim expenses during the ten-year projection period. On an annual basis, MGARA will evaluate the reinsurance parameters and estimated impact to Maine's individual health insurance market. As illustrated in Figure I-2A, due to health care inflation greater than the modeled inflation of MGARA attachment points and the flat MGARA assessments that reduce in value over time, the reinsurance recoveries decrease as a percentage of the total ceded member paid claims over time, going from an estimated 24% of insurer paid claims expense in 2019 to an estimated 18% in 2028.

Figure I-2A
MGARA
Section 1332 Waiver Application
Estimated Reinsurance Payments and Aggregate Insurer Paid Claims Expenses

Calendar Year	Reinsurance Payments ($ Millions)	Insurer Paid Claims Expenses for Ceded Members Prior to Reinsurance ($ Millions)	Ratio: Reinsurance Payments to Paid Claims Expense
2019	89.7	399.4	22%
2020	97.7	417.8	23%
2021	100.9	438.1	23%
2022	103.3	459.3	22%
2023	102.9	478.6	22%
2024	104.2	498.8	21%
2025	105.7	518.1	20%
2026	104.6	538.4	19%
2027	106.0	556.5	19%
2028	104.2	575.3	18%

Note: Reinsurance payments funded through a combination of Federal and state dollars and ceded premiums. Insurer paid claims reflect estimated enrollment changes. Values are rounded.

3. ESTIMATED PREMIUM IMPACT FROM REINSURANCE PROGRAM

In modeling the impact of MGARA, we have assumed MGARA reinsurance payments (net of costs to insurers from the $4 PMPM assessments and ceded premiums) will produce dollar-for-dollar reductions in individual market insurer paid claims expense. Additionally, our analysis is based on the scenario whereby carriers take full credit for the modeled MGARA reinsurance claims recoveries; in other words, we assume that carriers reduce their projected claim amounts (and, in result, premium rates) by the total projected reinsurance recoveries per member per month (PMPM) estimated by our actuarial modeling, less ceded premiums. Should carriers apply less than full credit for MGARA reinsurance recoveries in reducing paid claim costs, a smaller premium impact for the reinsurance program would result.

Under the ACA, qualifying households not eligible for Medicaid with incomes between 100%[12] and 400% of the FPL (between 139% and 400% FPL with Medicaid expansion) are eligible for an Advance Premium Tax Credit (APTC) that may be used to lessen the cost of health insurance coverage in the ACA marketplaces. APTC amounts are funded as subsidies issued by the Federal Government. These subsidies are determined based on the second lowest cost silver plan in a rating region (i.e., the subsidy benchmark plan); all else being equal, a reduction in the cost of the subsidy benchmark plan produces a reduction in Federal expenditures associated with APTCs. Our modeling assumes that MGARA reinsurance recoveries are applied to all on- and off-FFM non-group plans as a constant percent of premium.

[12] Legal aliens with income below 100% FPL may also receive a premium tax credit.

4. COVERAGE REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(C), the State's proposed waiver must provide coverage to at least a comparable number of its residents as the provisions of Title I of the ACA. Under MGARA, we expect that an additional number of individuals will have health insurance. This is a result of MGARA reducing premiums in the individual market, which we estimate will incentivize additional individuals to purchase health insurance relative to without the waiver.

By making premium rates more affordable, we estimate the average member persistency (number of months during the year coverage is maintained/in force) under the Section 1332 Waiver may improve, reducing the potential for gaps in insurance coverage. As discussed throughout this report, we estimate individuals not qualifying for the Advanced Premium Tax Credit (APTC) in absence of the waiver will see the greatest reduction in out-of-pocket premiums, and therefore may have more significant changes in coverage relative to the population qualifying for APTCs.

Funding for MGARA will be through a combination of federal pass-through funding (as a result of reducing the federal government's expenditures on premium tax credits) and a state-based assessment on comprehensive commercial health plan coverage. Insurers, third-party administrators, and other self-funded employer plans will be assessed a PMPM amount to generate the targeted state-based revenue needed for the reinsurance fund. We estimate that the cost of the assessment will be less than 1% of an average employer's total health insurance costs (including employee contributions). While a new assessment for MGARA may marginally increase the cost of offering employer-sponsored insurance, we do not estimate the assessment amounts are large enough to result in a material change in the likelihood of employers offering health insurance coverage relative to current law. As observed in the Agency for Health Care Quality & Research's Medical Expenditure Panel Survey (MEPS), the percentage of private sector establishments with fifty or more employees offering coverage has remained at approximately 96% since the late 1990's, despite significant cost increases for employer-sponsored insurance during that timeframe.[13] While more significant changes have occurred for establishments with fewer than fifty employees, we do not estimate the assessment, by itself, will result in a material change in the likelihood of such an employer offering health insurance to its employees; this is supported by experience with MGARA during its operations in 2012 through 2013.

The following paragraphs detail 2018 (baseline year) health insurance coverage in the non-group market, as well as estimated coverage changes during the ten-year projection period, 2019 through 2028.

A. NON-GROUP MARKET ENROLLEES BY HOUSEHOLD INCOME

Figure I-4A(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028 by household income, as measured as a percentage of the federal poverty level (FPL). Enrollment figures include comprehensive non-group coverage; we note that based on a survey provided to Maine's individual market carriers (see Market Calibration segment of Section III – Assumptions and Methodology), Maine was reported to have no transitional or grandfathered plans in 2017.

[13] Agency for Healthcare Research and Quality. *Percent of private-sector establishments that offer health insurance by firm size and selected characteristics* (Table I.A.2), year 1996-2015. Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. (July 11, 2017)

Figure I-4A(i) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Household Income: 2018 through 2028 (Thousands) Without Waiver											
Income Level % of FPL	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
0% - 99%	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>=100% to <=150%	18.1	4.2	4.1	4.1	4.1	4.1	4.0	4.0	4.0	3.9	3.9
>150% to <=200%	15.2	15.2	15.1	15.0	14.8	14.7	14.6	14.5	14.4	14.3	14.1
>200% to <=250%	11.8	11.7	11.7	11.6	11.5	11.4	11.3	11.2	11.1	11.1	11.0
>250% to <=300%	7.5	7.4	7.4	7.3	7.3	7.2	7.2	7.1	7.0	7.0	6.9
>300% to <=400%	8.4	8.3	8.3	8.2	8.2	8.1	8.1	8.0	7.9	7.8	7.8
>400%	16.0	14.2	13.9	13.7	13.5	13.4	13.2	13.0	12.8	12.6	12.5
Total	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Total values are rounded separately.

As shown in Figure I-4A(i), the greatest concentration of non-group market enrollment in the 2018 baseline year and ten-year projection period has household income ranging from 100% to 250% FPL, representing nearly 51% of market enrollment in each year of the projection period (after Medicaid expansion is assumed to occur). It is assumed that the vast majority of these households are receiving federal premium assistance to purchase health insurance coverage in the FFM. The structure of the ACA's premium subsidy is expected to result in minimal out-of-pocket premium rate increases for households purchasing coverage with federal premium assistance in the FFM.

The population with household income above 400% FPL or below 100% FPL is not eligible for premium assistance under the ACA.[14] As a result of additional premium rate increases, we estimate the number of individuals purchasing coverage in the non-group market declines during the ten-year projection period. From 2020 through the end of the projection period, we estimate a slow erosion of enrollment from the population not qualifying for premium assistance. Note that this long-term erosion differs from the short-term, one-time enrollment reduction between 2018 and 2019, where we assume that all non-group market enrollees with income below 139% FPL exit the individual marketplace and instead received coverage from Maine's Medicaid Expansion program; this corresponds with the projected reduction of the >=100% to <=150% FPL cohort by approximately 77% between 2018 and 2019. An additional one-time reduction in members >400% FPL (i.e., non-subsidized individual market members) is assumed to occur in 2019 coinciding with the effective date of the elimination of the individual mandate penalty. We assume no material change in membership from enrollees with income <400% FPL in response to the effective individual mandate repeal – such enrollees have been more likely to qualify for individual mandate affordability exemptions[15] and have been subject to lesser individual mandate penalties than members with incomes >400% FPL. We therefore expect an insignificant amount of low-income, non-group enrollment to have been driven by the force of the individual mandate penalty.

Figure I-4A(ii) illustrates estimated non-group market enrollment in thousands under MGARA (with waiver) during the baseline year (2018), and from 2019 through 2028.

[14] With the exception of legal aliens within income below 100% FPL.

[15] http://www.milliman.com/insight/2018/The-individual-mandate-repeal-Will-it-matter/

Figure I-4A(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Household Income: 2018 through 2028 (Thousands) With Waiver											
Income Level % of FPL	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
0% - 99%	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>=100% to <=150%	18.1	4.2	4.1	4.1	4.1	4.1	4.0	4.0	4.0	3.9	3.9
>150% to <=200%	15.2	15.2	15.1	15.0	14.8	14.7	14.6	14.5	14.4	14.3	14.1
>200% to <=250%	11.8	11.7	11.7	11.6	11.5	11.4	11.3	11.2	11.1	11.1	11.0
>250% to <=300%	7.5	7.4	7.4	7.3	7.3	7.2	7.2	7.1	7.0	7.0	6.9
>300% to <=400%	8.4	8.6	8.5	8.4	8.3	8.2	8.2	8.1	8.0	7.9	7.9
>400%	16.0	15.0	14.6	14.4	14.1	13.9	13.6	13.3	13.1	12.9	12.7
Total	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Total values are rounded separately.

Figure I-4A(iii) illustrates the estimated net non-group market enrollment change resulting from the implementation of MGARA from 2019 through 2028 (note that values in this table are not rounded to thousands). For 2018, the baseline year, no change occurs since MGARA begins in 2019. Enrollment figures reflect comprehensive non-group coverage (Maine is estimated to have a trivial number of transitional and grandfathered coverage in 2018 and none thereafter).

Figure I-4A(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Household Income: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
Income Level % of FPL	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
0% - 99%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>=100% to <=150%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>150% to <=200%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>200% to <=250%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>250% to <=300%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>300% to <=400%	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
>400%	0.0	0.8	0.7	0.6	0.6	0.5	0.4	0.4	0.3	0.3	0.2
Total	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Total values are rounded separately.

As observed in Figure I-4A(iii), enrollment increases resulting from MGARA are estimated to come primarily from the population not eligible for premium assistance and not eligible for the ACA's Medicaid expansion (i.e., those with household income greater than 400% FPL). As this population is not eligible for premium assistance under the ACA, these households realize the full impact of MGARA's premium reduction (rather than all or a portion of the savings accruing to the Federal government). Out-of-pocket premium costs for the vast majority of the population eligible for premium assistance are not estimated to be reduced by MGARA. For young adults with income approaching 400% FPL, we estimate the premium savings achieved through MGARA may result in persons no longer being eligible for premium assistance (as the cost of the second lowest cost silver plan decreases below the maximum permitted under the ACA), while still decreasing out-of-pocket premiums. Therefore, we estimate individual market enrollment increases may also occur for persons with household income between 300% and 400% FPL under the waiver.

The net enrollment changes above represent point estimates from a range of reasonable enrollment responses. Due to the high uncertainty in non-group market enrollment behavior, we tested the impact of assuming that enrollment by previously uninsured members in the non-group market more than doubled in 2019 from 1,100 to 2,300. This enrollment increase resulted in the following outcomes:

- **Reduced Pass-Through Funding:** We assume that a percentage of the previously uninsured members enrolling in the 2019 non-group market are eligible for modest premium subsidies (i.e., members with incomes between 300% and 400% FPL). The increased volume of these members decreases the level of pass-through funding available to fund MGARA.
- **Lower Average Non-Group Market Premium Rate**: We assume that members transitioning from being uninsured to having non-group market insurance have income above 300% FPL; on average, it is estimated that these members have a lower health risk than the average continuously-enrolled non-group market member. Increasing the enrollment from these lower morbidity, previously uninsured members reduces the average non-group market premium rate.
- **Increased Reinsurance Attachment Points:** Because of the reduction to the Federal pass-through funding and to the average non-group market premium rate, both of which are used to fund MGARA, the reinsurance attachment points must increase to meet MGARA's solvency and target surplus requirements. When the previously uninsured member migration increased from 1,100 to 2,300, all else equal, the MGARA attachment points rose by $5,000 from $47,000 and 77,000 to $52,000 and $82,000
- **Smaller Non-Group Premium Reduction:** Based on the increased reinsurance attachment points and because of the larger non-group market membership, MGARA produces a small change in non-group market premium rates when the previously uninsured member migration into the non-group market is increased.

B. NON-GROUP MARKET ENROLLMENT BY PREMIUM TAX CREDIT ELIGIBILITY

The next series of figures illustrates the impact to non-group market enrollment resulting from MGARA based on enrollee advance premium tax credit (APTC) eligibility status. Under the ACA, qualifying households with income between 100%[16] and 400% of the FPL are eligible for an APTC that may be used to purchase health insurance coverage in the FFM. Figure I-4B(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028, while Figure I-4B(ii) illustrates the same information under MGARA (with waiver). Figure I-4B(iii) illustrates the net change in enrollment by APTC status resulting from MGARA (note that values in this table are not rounded to thousands). Enrollment figures include comprehensive non-group coverage (Maine is estimated to have trivial transitional or grandfathered coverage in 2018 and thereafter).

Figure I-4B(i)
MGARA
Individual Health Insurance Market
Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2018 through 2028 (Thousands)
Without Waiver

APTC Status	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Eligible	61.0	46.9	46.5	46.2	45.9	45.6	45.2	44.8	44.5	44.1	43.7
Not Eligible	17.1	14.2	13.9	13.7	13.5	13.4	13.2	13.0	12.8	12.6	12.5
Composite	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Composite values are rounded separately.

As shown in Figure I-4B(i), approximately 78% of individual market enrollees are estimated to receive an APTC to purchase health insurance coverage during the 2018 baseline year. During the ten-year projection period, the percentage of market enrollees estimated to receive an APTC is relatively flat, remaining at about 78% in 2028. Note that from 2018 to 2019, the APTC eligible population is projected to decrease by approximately 23% in both scenarios due to the availability of expanded Medicaid coverage. The non-APTC eligible cohort is projected to decrease by around 17% between 2018 and 2019 due to a combination of persons with income below 100% FPL now being eligible for Medicaid and the individual mandate repeal. Under MGARA, this enrollment reduction is mitigated by members assumed to enter the market to take advantage of lower premiums.

[16] Legal aliens with income below 100% FPL may also receive a premium tax credit.

Figure I-4B(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2018 through 2028 (Thousands) With Waiver											
APTC Status	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Eligible	61.0	47.1	46.7	46.4	46.0	45.7	45.4	45.0	44.6	44.2	43.8
Not Eligible	17.1	15.0	14.6	14.4	14.1	13.9	13.6	13.3	13.1	12.9	12.7
Composite	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Composite values are rounded separately.

Figure I-4B(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
APTC Status	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Eligible	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Not Eligible	0.0	0.8	0.7	0.6	0.6	0.5	0.4	0.4	0.3	0.3	0.2
Composite	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Composite values are rounded separately.

As MGARA is estimated to have the greatest consumer premium impact to the population not eligible for Federal premium assistance (APTC), the majority of coverage gains in the individual market are estimated to occur from persons not eligible for APTC. Under the waiver, it is possible that a small number of APTC-enrollees without the waiver may no longer qualify for APTC upon MGARA implementation. As MGARA is estimated to reduce the cost of the second lowest cost silver plan, young adults with income near 400% FPL may have the value of available premium assistance reach $0. However, to the extent that healthcare inflation assumptions outstrip income growth, over time, some of these persons are modeled to regain APTC-eligibility during the course of the projection period.

C. NON-GROUP MARKET ENROLLMENT BY PLAN

This section provides the estimated impact to non-group market enrollment by plan level resulting from MGARA. Under the ACA, households may purchase a non-group plan in one of four metallic tiers: bronze, silver, gold, or platinum.[17] However, insurers participating in Maine's non-group market do not currently offer platinum level coverage. For individuals under age 30 or persons qualifying for an unaffordability or hardship exemption, a catastrophic plan may also be purchased.

Figure I-4C(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028, while Figure I-4C(ii) illustrates the same information under MGARA (with waiver). Figure I-4C(iii) illustrates the net change in enrollment by plan level resulting from MGARA.

[17] Please see https://www.healthcare.gov/choose-a-plan/plans-categories/ for more information.

Figure I-4C(i) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Plan Level: 2018 through 2028 (Thousands) Without Waiver											
Plan Level	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Catastrophic	1.0	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.8
Bronze	34.6	31.1	30.8	30.5	30.2	29.9	29.7	29.4	29.1	28.8	28.5
Silver	39.5	26.3	26.1	25.9	25.7	25.6	25.4	25.1	24.9	24.7	24.5
Gold	3.0	2.7	2.7	2.6	2.6	2.6	2.6	2.5	2.5	2.5	2.4
Platinum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Composite	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Composite values are rounded separately.

Figure I-4C(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Plan Level: 2018 through 2028 (Thousands) With Waiver											
Plan Level	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Catastrophic	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8
Bronze	34.6	31.8	31.3	31.0	30.7	30.3	30.0	29.7	29.3	29.0	28.7
Silver	39.5	26.5	26.3	26.1	25.9	25.7	25.5	25.2	25.0	24.7	24.5
Gold	3.0	2.8	2.8	2.7	2.7	2.7	2.6	2.6	2.5	2.5	2.5
Platinum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Composite	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Composite values are rounded separately.

Figure I-4C(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Plan Level: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
Plan Level	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Catastrophic	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Bronze	0.0	0.7	0.6	0.5	0.5	0.4	0.3	0.3	0.3	0.2	0.2
Silver	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Gold	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0
Platinum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Composite	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Composite values are rounded separately.

As shown in Figure I-4C(iii), the majority of enrollment increases resulting from MGARA are estimated to occur in the Bronze metallic tier.. As MGARA has the greatest premium effect on consumers not eligible for premium assistance, we estimate Bronze coverage will experience the greatest enrollment increase as a result of the waiver. We note that for both scenarios in 2019, the silver plan enrollment is projected to decrease by one-third due to the availability of expanded Medicaid coverage, which impacts individuals with incomes of 100%-138% FPL who enroll largely in on-exchange silver cost-sharing reduction plans.

D. NON-GROUP MARKET ENROLLMENT BY AGE

This section provides the estimated impact to non-group market enrollment by age group from MGARA. Figure I-4D(i) illustrates the estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028, while Figure I-4D(ii) illustrates the same information under MGARA (with waiver). Figure I-4D(iii) illustrates the net change in enrollment by plan level resulting from MGARA (note that values in this table are not rounded to thousands).

Figure I-4D(i)
MGARA
Individual Health Insurance Market
Estimated Non-Group Market Enrollees by Age Group: 2018 through 2028 (Thousands)
Without Waiver

Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
17 and Under	9.8	7.6	7.5	7.4	7.3	7.3	7.2	7.2	7.1	7.1	7.0
18 to 25	10.7	8.3	8.3	8.3	8.3	8.3	8.2	8.2	8.1	8.0	7.9
26 to 34	10.7	8.4	8.3	8.2	8.1	8.0	7.9	7.9	7.9	8.0	8.0
35 to 44	12.7	9.8	9.9	10.0	10.1	10.1	10.2	10.2	10.2	10.1	10.1
45 to 54	9.8	7.5	7.3	7.1	6.9	6.8	6.6	6.6	6.5	6.5	6.4
55 to 64	21.5	17.1	16.7	16.4	16.1	15.8	15.5	15.0	14.6	14.2	13.8
65 and Over	2.9	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.8	2.9	2.9
Total	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Total values are rounded separately.

As shown in Figure I-4D(i), approximately 44% of individual market enrollees are estimated to be 45 years or older during the 2018 baseline year.

Figure I-4D(ii)
MGARA
Individual Health Insurance Market
Estimated Non-Group Market Enrollees by Age Group: 2018 through 2028 (Thousands)
With Waiver

Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
17 and Under	9.8	7.8	7.7	7.6	7.5	7.4	7.3	7.3	7.2	7.2	7.1
18 to 25	10.7	8.5	8.4	8.4	8.4	8.4	8.3	8.2	8.2	8.1	8.0
26 to 34	10.7	8.5	8.4	8.3	8.2	8.1	8.0	8.0	8.0	8.0	8.0
35 to 44	12.7	10.0	10.0	10.1	10.2	10.2	10.3	10.3	10.2	10.2	10.2
45 to 54	9.8	7.7	7.5	7.3	7.1	6.9	6.7	6.6	6.6	6.5	6.5
55 to 64	21.5	17.2	16.8	16.5	16.2	15.8	15.5	15.1	14.6	14.2	13.8
65 and Over	2.9	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.8	2.9	2.9
Total	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Total values are rounded separately.

Figure I-4D(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Age Group: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
17 and Under	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
18 to 25	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
26 to 34	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
35 to 44	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
45 to 54	0.0	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1
55 to 64	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
65 and Over	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Total values are rounded separately.

As shown in Figure I-4D(iii), additional incremental non-group enrollment is estimated to occur across each age group due to MGARA.

5. AFFORDABILITY REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(B), a State's proposed waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application.[18] Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to "vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues".

Under MGARA, we estimate premium rates in the non-group market will be reduced. For the majority of the APTC-eligible population, this will not impact out-of-pocket premium costs for the second-lowest cost Silver plan (subsidy benchmark plan). These households will continue to pay up to a maximum percentage of their household income for the subsidy benchmark plan. A portion of consumers receiving an APTC in the absence of MGARA will no longer be eligible for the subsidy after the reinsurance program is implemented due to the premium expense not exceeding the maximum percentage of household income as defined under the ACA. These consumers will realize out-of-pocket premium savings as a result of MGARA. Finally, for consumers purchasing coverage in the FFM without an APTC or outside the FFM, premium savings will be realized from MGARA. Consumers not receiving an APTC under current law will realize the greatest savings from MGARA, as they accrue 100% of premium savings, whereas for APTC consumers, a large portion of savings are retained by the Federal government (which will be re-distributed in the form of pass-through funding).

For persons qualifying for APTC that are purchasing Bronze level coverage, it is possible that out-of-pocket premiums may increase as a result of MGARA. As MGARA is estimated to reduce the dollar amount of the APTC for qualifying individuals, the available financial assistance that can be applied to the purchase of Bronze level coverage is reduced. However, we estimate the impact to low income persons is limited for the following reasons:

- Because members with household income under 250% of FPL and purchasing bronze level coverage qualify for cost sharing reductions if a Silver plan is purchased[19], there is a strong financial incentive to purchase Silver coverage.

[18] https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf

[19] Native Americans qualify for a zero cost sharing plan if income is between 100% and 300% FPL, regardless of metal level purchased.

- For certain low income individuals, the ACA's subsidy structure has created the availability of a $0 out-of-pocket premium for Bronze coverage.[20]

    - As MGARA is estimated to reduce premiums, it is likely the number of marketplace enrollees qualifying for a $0 Bronze plan will decrease to some degree.
    - We do not anticipate that the magnitude of the premium reductions produced by MGARA will have a large impact on the cost of subsidized premiums for members eligible for a $0 Bronze plan in the without waiver scenario.
    - Rating loads applied to silver plans in 2018 to account for the termination of CSR subsidies have further reduced the likelihood of enrollees losing $0 Bronze plan eligibility due to MGARA.

Premium savings from MGARA will vary by allowable rating factors under the ACA and the APTC structure: age, tobacco-usage, geographic location, plan metallic level, and household income. Vulnerable residents will realize out-of-pocket premium savings consistent with their demographics as they relate to these factors. MGARA does not make any changes to required insurer plan design, cost sharing limitations, or cost sharing assistance in the non-group market. For persons not eligible for APTC, it may be possible that MGARA allows the consumer to purchase a richer benefit plan (e.g., a Silver instead of a Bronze plan), which may result in lower out-of-pocket cost sharing expenses. As discussed previously, funding for MGARA will be through a combination of federal pass-through funding (as a result of reducing the federal government's expenditures on premium tax credits) and a state-based assessment on comprehensive commercial health insurance coverage. Individual, Small Group, Large Group, and Self-Funded plans will be assessed a PMPM amount to generate the state-based revenue for the reinsurance fund.

As the cost of the MGARA assessment is estimated to be less than 1% of the total cost of employer-sponsored insurance in Maine, we do not estimate a material change in employee contributions or cost sharing requirements resulting from MGARA.

Sections A through D below provide estimates of changes in market premiums and APTC amounts resulting from MGARA.

A. NON-GROUP MARKET PER MEMBER PER MONTH PREMIUM

The following tables illustrate estimated non-group PMPM premium for 2018 and the ten-year projection period without the waiver, under the waiver, and the net change in per member per month premium. We have illustrated premiums for ACA-compliant coverage (ACA), which reflects premiums attributable to coverage purchased in the FFM, as well as coverage outside the FFM that is compliant with ACA rating rules. Note, drivers of premium rate changes resulting from the waiver include the reinsurance program, as well as age and plan mix changes.

Figure I-5A(i)
MGARA
Individual Health Insurance Market
Estimated Non-Group Premium PMPM by Plan Type: 2018 through 2028
Without Waiver

Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	$681	$683	$732	$771	$812	$852	$893	$935	$979	$1,020	$1,063

Note: Values are rounded to the nearest whole dollar.

2018 premium rate changes are based on the current rate filings submitted by the carriers actively selling ACA products in Maine. Premium rates for ACA-compliant coverage are estimated to increase from 2019 through 2028 due to assumed marketplace premium trend ranging from at 4.5% to 5.5% per year. In 2019, we model Medicaid expansion as producing a modest reduction to individual market rates based on expected morbidity improvements to the non-group insurance pool; additionally, we assume a 2% reduction in 2019 premiums due to the one-year suspension of the Health Insurer Fee using our best estimate produced in a Milliman analysis.[21] We assume these rate reductions are partially offset by impacts of the effective repeal of the individual mandate penalty. We do not apply an explicit rate adjustment to reflect the effective

[20] https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/

[21] http://www.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf

individual mandate penalty repeal in 2019, as Maine carriers made consideration for a weakly enforced individual mandate in pricing 2018 policies.[22]

Figure I-5A(ii)
MGARA
Individual Health Insurance Market
Estimated Non-Group Premium PMPM by Plan Type: 2018 through 2028
With Waiver

Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	$681	$618	$661	$697	$736	$777	$817	$858	$904	$944	$990

Note: Values are rounded to the nearest whole dollar.

Figure I-5A(iii)
MGARA
Individual Health Insurance Market
Estimated Non-Group Premium PMPM by Plan Type: 2018 through 2028
Net PMPM Dollar Change

Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	$0	($64)	($71)	($74)	($76)	($75)	($76)	($77)	($74)	($75)	($72)

Note: Values are rounded to the nearest whole dollar.

As observed in the above figures, MGARA is estimated to result in a PMPM premium decrease for ACA compliant coverage that ranges from about $65 to almost $80 PMPM during the ten year projection period relative to estimated premium levels without the waiver. MGARA is estimated to result in a premium decrease in 2019 relative to the prior year rates; however, premium rates are estimated to increase thereafter under both scenarios due primarily to healthcare expense inflation, while still being lower than if the waiver was not implemented.

Under MGARA, premium rates are estimated to trend higher during 2021 through 2028 relative to the status-quo scenario. As MGARA funding is assumed to be held constant at a flat $4 PMPM assessment, there is a leveraging impact on premium rates, resulting in average annual premium increases ranging from 4.5% to 5.6% during that portion of the projection period relative to 4.2% to 5.3% without the waiver (including impact of plan selections).

B. NON-GROUP MARKET AGGREGATE PREMIUM

The following tables illustrate estimated non-group aggregate annual premiums during the ten-year projection period without the waiver, under the waiver, and the net change in aggregate annual premiums. We have illustrated premiums for ACA-compliant coverage (ACA). ACA coverage reflects premiums attributable to coverage purchased in the FFM, as well as coverage outside the FFM that is compliant with ACA rating rules.

Figure I-5B(i)
MGARA
Individual Health Insurance Market
Estimated Non-Group Aggregate Annual Premiums by Plan Type: 2018 through 2028 ($ Millions)
Without Waiver

Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	$ 638	$ 500	$ 531	$ 555	$ 579	$ 602	$ 626	$ 649	$ 672	$ 694	$ 716

Note: Dollar amounts are rounded to the nearest million.

[22] https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/

As illustrated in Figure I-5B(i), aggregate ACA-compliant annual premiums in 2018 are estimated to be approximately $638 million. During the projection period, individual market annual premium volume is estimated to increase to approximately $716 million.

Figure I-5B(ii)
MGARA
Individual Health Insurance Market
Estimated Non-Group Aggregate Annual Premiums by Plan Type: 2018 through 2028 ($ Millions)
With Waiver

Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	$ 638	$ 461	$ 487	$ 508	$ 531	$ 555	$ 578	$ 600	$ 626	$ 647	$ 671

Note: Dollar amounts are rounded to the nearest million.

Figure I-5B(iii)
MGARA
Individual Health Insurance Market
Estimated Non-Group Aggregate Annual Premiums by Plan Type: 2018 through 2028 ($ Millions)
Net Change

Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	$ 0	$ (39)	$ (45)	$ (47)	$ (48)	$ (47)	$ (48)	$ (48)	$ (47)	$ (47)	$ (45)

Note: Dollar amounts are rounded to the nearest million.

The above figures illustrate a significant decrease to aggregate annual ACA premiums resulting from the implementation of MGARA in 2019, even with the migration of some uninsured people to the non-group market under MGARA.

C. SECOND-LOWEST-COST SILVER PLAN PREMIUM – 40 YEAR OLD

The following tables illustrate the estimated second-lowest-cost silver plan PMPM premium (also referred to as the "subsidy benchmark plan") for a single, 40 year old, non-tobacco user by Maine's four rating areas.[23] The majority of enrollment is estimated to be in Rating Areas 1 and 3, together representing 65% of statewide individual marketplace enrollment. We have assumed the member distribution by rating area during the projection period is consistent with the observed member distribution in the baseline year. As shown in Figure-5C(i), Rating Areas 2, 3, and 4 have premium rates that are approximately 2%, 7% to 49% higher than the statewide average, while Rating Area 1 has premium rates approximately 5.5% lower than the statewide average.

Figure I-5C(i)
MGARA
Individual Health Insurance Market
Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old:
2018 through 2028 Without Waiver

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
1	$513	$523	$561	$591	$622	$652	$684	$715	$749	$780	$813
2	$554	$565	$606	$638	$672	$704	$738	$772	$808	$842	$878
3	$581	$592	$635	$669	$705	$738	$774	$810	$848	$884	$921
4	$810	$825	$885	$932	$981	$1,028	$1,078	$1,128	$1,181	$1,230	$1,282
Composite	$582	$591	$636	$671	$708	$743	$780	$819	$860	$899	$939

Notes:
1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

Figure I-5C(ii)
MGARA
Individual Health Insurance Market
Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2018 through 2028
With Waiver

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
1	$513	$476	$508	$536	$566	$596	$627	$658	$693	$724	$759
2	$554	$514	$549	$578	$610	$644	$676	$710	$748	$781	$819
3	$581	$539	$576	$607	$640	$675	$710	$745	$785	$820	$859
4	$810	$750	$802	$845	$892	$940	$988	$1,037	$1,093	$1,141	$1,196
Composite	$582	$538	$576	$608	$643	$679	$715	$753	$796	$834	$877

Notes:
1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

[23] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/me-gra.html

Figure I-5C(iii) MGARA Individual Health Insurance Market Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2018 through 2028 Net Change											
Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
1	$0	-$47	-$53	-$55	-$56	-$56	-$57	-$57	-$56	-$56	-$54
2	$0	-$51	-$57	-$60	-$62	-$60	-$62	-$62	-$60	-$61	-$59
3	$0	-$53	-$59	-$62	-$65	-$63	-$64	-$65	-$63	-$64	-$62
4	$0	-$75	-$83	-$87	-$89	-$88	-$90	-$91	-$88	-$89	-$86
Composite	$0	-$53	-$60	-$63	-$65	-$64	-$65	-$66	-$64	-$65	-$62

Notes:
1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

As shown in Figure I-5C(iii), each rating area is estimated to experience a reduction in the premium amount for the subsidy benchmark plan under the "with waiver" scenario. We have assumed the baseline premium rates accurately reflect the underlying insured population in each rating region. Therefore, on a PMPM basis, rating areas with higher baseline premiums are estimated to have a greater PMPM reduction relative to rating areas with lower premiums.

We note that while we expect fewer silver 94% CSR plan enrollees to be in the market in 2019 and future years due to Medicaid expansion, we do not explicitly reduce the second lowest cost silver plan (2LCSP) premiums for this scenario. The rate reduction to the 2LCSP (and all other) non-group market premiums in Maine due to the shift of these 94% CSR plan members is partly dependent on how the excess cost of CSR plans is allocated to plans on and off the exchange. Because we do not have clear guidance at this time on what allocation strategies the Maine BOI will allow in 2019 for covering excess costs associated with CSR plans, which would impact the rate level of the 2LCSP in 2019, we do not make an adjustment to premiums for this component of the membership change. The ultimate CSR allocation methodologies permitted by the Maine BOI would impact both the with- and without-waiver scenario premium rates; therefore, the impact of the allowed rating methodologies would have minimal impact on the projected Federal pass-through funding.

D. ADVANCED PREMIUM TAX CREDIT

The following tables illustrate the estimated number of average enrollees per month receiving an APTC through the FFM, the average APTC PMPM amount, and aggregate annual APTC expenditures for 2018 and the ten-year projection period without the waiver, under the waiver, and the net change for these values resulting from waiver implementation. Without the waiver, aggregate annual APTC expenditures are estimated to increase to over $475 million by 2028.

Figure I-5D(i) MGARA Individual Health Insurance Market Estimated Premium Tax Credit Enrollment and Expenditures: 2018 through 2028 Without Waiver											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC Enrollees[1]	61	47	47	46	46	46	45	45	44	44	44
APTC PMPM[2]	$584	$565	$608	$644	$682	$718	$755	$793	$832	$868	$906
Aggregate APTC[3]	$427	$318	$340	$357	$376	$393	$410	$426	$444	$459	$475

Notes:
1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC represent annual values and have been rounded to the nearest million.

Figure I-5D(ii) MGARA Individual Health Insurance Market Estimated Premium Tax Credit Enrollment and Expenditures: 2018 through 2028 With Waiver											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC Enrollees[1]	61	47	47	46	46	46	45	45	45	44	44
APTC PMPM[2]	$584	$500	$536	$568	$605	$642	$678	$715	$757	$792	$834
Aggregate APTC[3]	$427	$283	$301	$316	$334	$352	$369	$386	$405	$420	$438

Notes:
1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC represent annual values and have been rounded to the nearest million.

Figure I-5D(iii) MGARA Individual Health Insurance Market Estimated Premium Tax Credit Enrollment and Expenditures: 2018 through 2028 Net Change											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC Enrollees[1]	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
APTC PMPM[2]	$0	-$65	-$72	-$76	-$78	-$76	-$77	-$78	-$75	-$76	-$73
Aggregate APTC[3]	$0	-$35	-$39	-$41	-$42	-$41	-$41	-$41	-$39	-$39	-$37

Notes:
1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC represent annual values and have been rounded to the nearest million.

As shown in Figure I-5D(iii), MGARA is estimated to cause a slight increase in the number of APTC enrollees by inducing enrollees with incomes between 300% FPL to 400% FPL (i.e., lightly subsidized members) to enter the market. MGARA is also estimated to have an effect on the per capita APTC amount, decreasing it by nearly 11% in 2019 relative to the baseline scenario. The per capita APTC savings translate to significant aggregate savings on APTC expenditures. These savings, net of other applicable Federal revenue changes, are estimated to become available pass-through funding for MGARA.

6. COMPREHENSIVENESS REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(A), a State's proposed waiver must provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) of the ACA. As described in CMS-9936-N, comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs). MGARA makes no changes to EHB requirements in the individual market, nor is it estimated to have any effect on other health insurance programs and populations within the State of Maine. Additionally, MGARA makes no changes to state-mandated benefits. As MGARA is estimated to increase enrollment in the non-group market relative to projections absent the waiver, it increases the number of Mainers with insurance coverage that meets the EHB requirements, fulfilling the comprehensiveness requirements of 45 CFR 155.1308(f)(4)(iv)(A).

SECTION II. ECONOMIC ANALYSIS

45 CFR 155.1308(f)(4)(ii) requires the Section 1332 waiver application to provide economic analyses to support the State's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement and the Federal deficit requirement. Analyses related to the estimated impact of MGARA to health insurance coverage in Maine have been provided within the actuarial certification. This section addresses the deficit neutrality requirements of the waiver application, providing a ten-year budget plan that includes all costs under the waiver, including administrative and other costs to the Federal government.

As shown in the actuarial analysis, Figure I-4D(iii), MGARA is estimated to have a material impact on the Federal government APTC expenditures for Mainers purchasing health insurance coverage through the FFM. As permissible under Section 1332 of the ACA, Maine seeks to apply the Federal savings on APTC expenditures to support MGARA. To fulfill the Section 1332 Waiver budget neutrality requirements, Maine seeks Federal pass-through funding equal to Federal APTC savings, less other changes to Federal government expenses. Figure II-1 provides a summary of estimated Federal expenditure changes during the ten-year projection period.

Figure II-1
MGARA
Individual Health Insurance Market
Estimated Federal Government Expenditures Changes: 2019 through 2028 (in Millions)

Revenue / (Expense) Item	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Federal APTC Expenditures	$35	$39	$41	$42	$41	$41	$41	$39	$39	$37
Aggregate Shared Responsibility Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Exchange User Fee	($1)	($2)	($2)	($2)	($2)	($2)	($2)	($2)	($2)	($2)
Health Insurer Fee	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Reduction in Federal Expenditures	$33	$37	$39	$40	$39	$39	$39	$38	$38	$36

Note: Values are on an annual basis.

Federal APTC Expenditures: As MGARA is estimated to reduce the cost of the second lowest cost silver plan (subsidy benchmark plan) during the projection period, the federal government's expenditures on APTC for Mainers is estimated to be reduced. Further detail on APTC savings is provided in Section I-5D of the actuarial certification.

Aggregate Shared Responsibility Payments: On December 22, 2017, President Trump signed into law "H.R.1 - An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018." Section 11081 of that Act repeals the Shared Responsibility Payments for individuals established by the Affordable Care Act. The repeal becomes effective January 1, 2019; therefore, we project no change to Federal Expenditures based on changes to Aggregate Shared Responsibility Payments in the 2019 to 2028 projection period.

Exchange User Fee: For states electing to use the FFM, the federal government requires a 3.5% assessment on insurance marketplace coverage to support the operation of the FFM. As MGARA is estimated to reduce premium rates for non-group coverage purchased both on and off the marketplace, it is also estimated to reduce the revenue generated by the 3.5% premium assessment on insurance purchased through the FFM.

Health Insurer Fee: Section 9010 of the ACA mandates a national assessment on health insurers of $14.3 billion in 2018; that assessment has been suspended for 2019. Thereafter, the national assessment amount is indexed based on the "premium growth rate" as defined under the ACA. As the premium growth rate is calculated based on changes per capita costs for employer-sponsored insurance, we do not believe MGARA materially impacts the premium growth rate calculation. Therefore, MGARA is not estimated to result in any changes to Federal revenue from the HIF.

The remainder of this section provides more detailed discussion on the components of Federal revenue changes, excluding APTC expenditures, which are discussed in detail within the actuarial certification.

1. EXCHANGE USER FEE

Section 1311(d)(5)(A) of the ACA allows an Exchange (also referred to as a marketplace) to charge assessments or user fees to participating health insurers to generate funding to support the operation of the Exchange. In the proposed 2019 Notice of Benefit and Payments parameters, the Federal government set the 2019 user fee for insurers offering coverage in the FFM at 3.5% of charged premium.[24] For purposes of our ten-year projection, we have assumed that Maine will continue to utilize the FFM and the 3.5% user fee will continue through the course of the projection period.

FFM user fee revenue may change as a result of the following impacts under MGARA:

- MGARA is estimated to result in a decrease in per capita premiums charged by insurers in the ACA-compliant non-group market, both within the FFM and in the outside market.

- To the extent persons receive an APTC without MGARA, but no longer receive an APTC under the waiver (as a result of premium rate decreases rendering the APTC worth $0), the financial incentive to purchase coverage through the FFM is removed. FFM data through 2017 indicate that about 86% of Mainers purchasing coverage in FFM qualify for an APTC.[25] Therefore, it is possible that a small portion of the APTC population in the absence of the waiver will shift to purchasing coverage outside of the FFM as a result of MGARA. These households are most likely to consist of young adults, with income above 300% FPL, as these persons receive a lower amount of APTC relative to older and/or lower income households.

- Additional persons entering the non-group market as a result of MGARA are more likely to not qualify for an APTC, as MGARA's premium reduction will primarily accrue to consumers with income above 400% FPL who do not qualify for APTC.

Figure II-2A illustrates the estimated change in premium revenue during the projection period, as well as the corresponding change in the collected FFM user fee, based on 3.5% of premium revenue. The On-Exchange premiums for 2019 and beyond were estimated based on the split of non-group market premiums by on-exchange and off-exchange markets from a survey administered to Maine Carriers by Milliman through MGARA.

Figure II-2
MGARA
Individual Health Insurance Market
Estimated Change in Insurer Assessment Revenue 2019 through 2028
3.5% Premium Assessment Assumed (in Millions)

Calendar Year	Change in On-Exchange Premium Revenue	Change in Federal Assessment from Exchange Fee
2019	$42.2	$1.5
2020	$46.2	$1.6
2021	$47.7	$1.7
2022	$48.5	$1.7
2023	$47.3	$1.7
2024	$47.4	$1.7
2025	$47.4	$1.7
2026	$45.4	$1.6
2027	$45.5	$1.6
2028	$43.2	$1.5

Note: Values are rounded to the nearest hundred thousand and are on an annual basis.

[24] https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf, page 51054.

[25] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2017_OEP_State-Level_Public_Use_File.zip, worksheet (5) by Premium and FA

2. HEALTH INSURANCE PROVIDERS FEE

The Health Insurer Providers Fee (HIF), mandated by Section 9010 of the ACA is applicable to qualifying health insurance premiums earned by for-profit and a portion of non-profit insurers. The annual fee amount required for an insurer is based on its premium volume in proportion to the premium volume of other health insurers subject to the HIF during the prior year. Nonprofit insurers who receive more than 80% of their premium revenue from Medicare, Medicaid, CHIP, and dual eligible plans are exempted from the fee. Other nonprofit insurers will be able to exclude 50% of their premium revenue from the health insurer fee calculation. In 2018, the national HIF charge is $14.3 billion. In 2019, there is a moratorium on the collection of the HIF; thereafter, the HIF charge is increased by the rate of premium growth relative to the preceding year (as defined in Section 36B(b)(3)(A)(ii) by the IRS).[26]

As MGARA is not estimated to materially change employer-sponsored insurance premiums in Maine, we do not estimate MGARA will impact CMS' projection of per enrollee employer-sponsored insurance premiums. In the absence of other information and based on current regulations, we assume that CMS will continue to calculate the premium growth rate based on projected changes in employer-sponsored insurance premiums.

Since the ACA's implementation, the Centers for Medicare & Medicaid Services (CMS) has used a methodology based on the most recent National Health Expenditures Accounts projection of per capita employer-sponsored insurance premiums to develop the above referenced premium growth percentage.[27] It is uncertain to what degree (if any) changes would be made to this calculation in the future.

Based on this set of assumptions, we do not estimate MGARA will have any material impact on HIF charges during the ten-year projection period. To the extent the state-based assessments supporting MGARA result in higher per capita employer-sponsored insurance premiums in Maine, MGARA would actually result in greater HIF revenue for the Federal government based on the current indexing methodology.

It is possible that the share of HIF payments made attributable to Maine health insurance premiums may vary as a result of MGARA. As MGARA is estimated to reduce insurer premium volume, it may result in a slight increase in required payments from insurers not participating in Maine's individual health insurance market (as well as APTC expenditures in other states). This may change the amount of HIF revenue collected from Maine insurers, but will not change the national assessment amount.

[26] Please see https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010 for more information related to the HIF.

[27] https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-12-16.html, see paragraph entitled "Premium Adjustment Percentage".

SECTION III. ASSUMPTIONS AND METHODOLOGY

1. MARKET CALIBRATION

A key aspect of modeling healthcare reform proposals is establishing a status quo set of assumptions for the population being modeled. For the State of Maine insurance markets, we developed estimates for the number of individuals insured in Maine through the non-group insurance market (or uninsured) in the baseline year (2018) by age, gender, household income, health status, metallic level and premium rates (if applicable), and other factors to establish baseline assumptions for Maine's population. We did not perform these estimates for Maine's transitional policies as, based on proprietary data provided in a survey to Maine's individual market carriers, no transitional policy enrollment was reported for 2017. We calibrated the total 2018 individual market enrollment to actual on- and off-exchange open enrollment figures known as of mid-January 2018; this calibration was based on proprietary data that we received from Maine insurers and Maine's Bureau of Insurance (BOI). We developed our starting census and premium rate assumptions for the non-group insurance market from a number of publicly available data sources. The assumptions in the model related to insurance take-up rates and market migration specific to Maine have been informed by studies on the impact of key changes to the regulations and composition of the non-group market (e.g., individual mandate repeal, Medicaid expansion, etc.) and by actuarial judgment. Data from insurers included estimated 2017 enrollment by income level. Proprietary data received from Maine's BOI included aggregate open enrollment figures by metal level and by on-exchange/off-exchange. Additional detail on data sources used in our census and assumption calibration process is provided below:

- **2018 Open Enrollment data** – The Maine BOI provided proprietary data by carriers operating in Maine's non-group insurance markets, which was used along with 2017 Marketplace Enrollment Reports to determine the 2018 on-exchange and off-exchange enrollment by plan metal level and income level.

- **2017 Marketplace Enrollment Reports** – We utilized publicly available data provided by Centers for Medicare and Medicaid Services (CMS) to estimate the split of 2018 Individual Health Insurance Marketplace enrollment by income level.

- **U.S. Census Bureau data** – The U.S. Census Bureau contains state-by-state counts which identify population cohorts by gender, age, income level, and insurance type. This information was used to estimate the size of Maine's uninsured population, as well as to calibrate income levels for non-group market enrollees who were not already tagged with income indicators.

- **Maine Carriers 2015 to 2017 Survey Data** – This survey was developed by Milliman and administered to Maine carriers through MGARA requesting claims, premiums, and enrollment data from 2015 through 2017. This source was used to evaluate the need to model transitional and grandfathered policies, as well as to estimate the split of On-Exchange and Off-Exchange premiums as a percentage of total non-group market premiums for 2019 and beyond.

- **2018 Filed Premium Rates** –The 2018 rates used were those filed by the two major carriers active in the Maine individual market in 2018 (i.e., Community Health Options and Harvard Pilgrim). We applied adjustments to age-specific and area-specific rates to normalize them to a state-wide basis before applying to the model; Federal age curve factors were applied to the rates to restate premiums on the appropriate age basis for each projection cohort.

- **CPI** – We used CPI-U projections from the Congressional Budget Office (CBO) June 2017 report, "An Update to the Budget and Economic Outlook: 2017 to 2027" to project changes in the Federal Poverty Level through 2028. Our modeling assumes that the rate of wage inflation in Maine does not differ materially from the inflation rate indicated by the CPI-U.

- **Long-Term Marketplace Premium Trends –** We referred to the CBO report, "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2017 to 2027," as a source for our long-term marketplace trend estimates, which range from 5.5% to 4.5% over the course of the projection period (averaging to a 5% overall trend during the projection period).[28]

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

- **Enrollment Changes due to Individual Mandate Repeal –** To estimate the impact of the repeal of the individual mandate penalty on Maine's non-group market enrollment, we reviewed studies published by the CBO and by S&P Global to determine a range of estimated Individual insurance market contraction; we then selected within that range using actuarial judgment. We applied adjustments based on the 2017 Marketplace Enrollment Reports to reflect the size of Maine's insurance market as a proportion of the national market, Maine's prevalence of unsubsidized non-group insurance market enrollees compared to the national average prevalence (subsidies – and the lack thereof – impact willingness to remain insured), and the expected duration of members who exit the individual insurance market due to the individual mandate penalty repeal.

- **Medicaid Expansion –** Our modeling assumes that Medicaid expansion is effective in 2019 and that eligible individuals enroll in Medicaid-sponsored insurance rather than through the Marketplace. Beginning in 2019, we therefore reduce the estimated non-group enrollment to exclude individuals with income levels <138% of the FPL. We apply an adjustment to the 2019 rates to reflect changes to the market-wide morbidity level following the Medicaid expansion population shift; that adjustment was determined using a 2016 issue brief published by ASPE with judgment-based modifications to produce results consistent with Maine's population characteristics.

Based on actual insurance enrollment from insurer eligibility reports and public programs, we estimated 2018 counts for the non-group insurance market. The demographic distributions were used to allocate enrollment by age, gender, and income level.

2. POPULATION MODELING

Based on the Maine census projections, we estimated enrollment in each insurance market from 2019 through 2028 by assuming the distribution of insurance market enrollment by age, gender, and income level would remain constant relative to 2017. Changes in insurance market enrollment during the projection period are a result of changes in Maine's estimated population by age and gender in the census projections. For example, the census projections estimate the Maine population age 65 and over will increase from approximately 286,000 in 2019 to 358,000 by 2029. This results in a corresponding increase in the number of estimated Medicare enrollees during the same time period.

For the uninsured and non-group market, further adjustments were made to enrollment projections based on the census projections. We have observed a significant increase in the individual market enrollment in Maine from 2013 through 2015, and some volatility from 2015 through 2017. Maine enrolled approximately 34,000 individual members in individual coverage in 2012, while the individual market reached more than 90,000 by 2017.

In our projections, we have estimated immaterial changes in non-group coverage for the population eligible for APTC over the 10 year projections. As the structure of the APTC calculation caps a consumer's out-of-pocket premium, we have assumed little enrollment changes (other than those driven by census projections), for the population eligible for APTC. This assumption is supported by the stability in APTC enrollment between 2016 and 2017, despite significant premium rate increases occurring in the market. As discussed in this report, MGARA is not estimated to have a material impact on out-of-pocket premiums for the population eligible for the APTC. Therefore, under both the without waiver and waiver scenarios, we projected similar APTC enrollment.

For the uninsured and non-group markets, we divided enrollment into risk quintiles. Individuals in high risk quintiles were assumed to have a greater likelihood of maintaining insurance (current non-group) or entering the market (current uninsured) relative to enrollees in lower risk quintiles.

For the population not eligible for APTC, mostly Maine individuals with income above 400% FPL, we have assumed further attrition in market enrollment will occur if premium rate growth exceeds income growth. As a result of MGARA, we estimate enrollment attrition is halted for several years for Mainers currently purchasing coverage in the non-group market. Additionally, the decrease in premiums is estimated to incent a small number of currently uninsured individuals to purchase coverage in the projection period.

3. PREMIUM PROJECTIONS

Premiums estimated in the non-group market for 2019 are based on estimated healthcare inflation (assuming no change in benefit levels or insured demographics), the estimated premium reduction due to the one-year suspension of the Health Insurer Fee, and on changes in market-wide morbidity due to Medicaid expansion.

Federal premium assistance was estimated based on premium rate changes for the second-lowest cost Silver plan available in the FFM, projected household income by FPL, and the indexing of the premium tax credit expenditures. For each enrollee

cohort, a rating factor corresponding to the default Federal age curve was assigned.[29] We confirmed that our model produced an estimated, aggregate, Federal premium assistance amount that closely corresponds to the average APTC per month for qualifying enrollees published by CMS ($413) using results from the June 2017 Enrollment Snapshot Report to calibrate the pre-baseline year of our economic model.[30]

4. REINSURANCE PAYMENT MODELING

For our reinsurance modeling we used medical and prescription drug claim and eligibility data from the Maine All Payer Database as the source of the model's experience data. Members in the individual market who were not covered by Medicare Part C or by supplemental plans and who had sufficient months of eligibility were included along with their incurred allowed claims. Allowed claims were trended to the projection period using trend consistent with the long-term premium trends in the economic model. Paid claims were determined by multiplying allowed claims by the average paid-to-allowed ratio from carriers' 2018 URRT.

Eligibility for MGARA is determined either by auto-ceding conditions defined by MGARA or by voluntary ceding by non-group insurers. The following conditions for auto-ceding members into MGARA are used: Chronic Obstructive Pulmonary Disease (COPD); Cancer – Corpus Uterus (Endometrial Carcinoma); Cancer – Metastatic; Rheumatoid Arthritis; Cancer – Prostate Gland; Congestive Heart Failure; Renal Failure; HIV Infection.

The financial projection model assigns expected claims to each insured person based on their assumed medical conditions and, for in-force business, their historical claims experience. Rounded output from the actuarial modeling of MGARA operations is displayed in Appendix II: Actuarial Modeling Summary.

5. ALTERNATE SCENARIOS

In addition to modeling with- and without-MGARA scenarios under the assumption that Maine Medicaid expansion is implemented in 2019, we modeled with- and without-MGARA scenarios under conditions having no Maine Medicaid expansion in 2019 or future years. Figure II-4 summarizes enrollment assumptions based on the no Medicaid expansion scenario.

[29] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf, page 4.

[30] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf, Average Advanced Premium Tax Credit by State, February 2017, page 6

Figure II-4 MGARA No Medicaid Expansion Changes in Uninsured and Non-Group Market Resulting from MGARA Implementation (in Thousands)						
	Uninsured			Individuals Insured in Non-Group Market		
Calendar Year	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	92.2	92.2	0.0	78.1	78.1	0.0
2019	93.2	92.4	-0.8	75.9	76.7	0.8
2020	92.4	91.7	-0.7	75.2	75.9	0.7
2021	91.6	91.0	-0.6	74.6	75.3	0.6
2022	90.9	90.3	-0.6	74.0	74.6	0.6
2023	90.2	89.7	-0.5	73.4	73.9	0.5
2024	89.5	89.1	-0.4	72.8	73.2	0.4
2025	88.9	88.5	-0.4	72.1	72.4	0.4
2026	88.3	88.0	-0.3	71.4	71.7	0.3
2027	87.7	87.5	-0.3	70.7	70.9	0.3
2028	87.2	87.0	-0.2	70.0	70.2	0.2

Medicaid expansion is estimated to reduce the non-group market by about 19% - without Maine's Medicaid expansion the projected size of the non-group market in 2019 shifts from 61.0K to 75.9K under the without MGARA scenario and from 62.1K to 76.7K under the with MGARA conditions. The 0.8K difference in membership between the with- and without-MGARA scenarios under no Medicaid expansion is less than the 1.1K difference for the Medicaid expansion scenarios, meaning MGARA is estimated to have a smaller impact on enrollment if Medicaid expansion does not take place. This is due primarily to the following factors:

- Under the no Medicaid expansion scenario, while the nearly 500,000 member assessable pool (and therefore the collected MGARA assessments) increases slightly by retaining the would-be Medicaid expansion enrollees in the non-group market, the 70,000 member non-group market increases at a rate much greater than the assessable market. This dynamic means that each dollar of MGARA assessment funding must be spread over an increased number of non-group market claimants in the no Medicaid expansion scenario, reducing the impact of the MGARA recoveries on premiums. The reduced impact on premiums leads to a reduction in the estimated enrollment changes.
- The average non-group market premiums are higher in the no Medicaid expansion scenario because members with income ranges <138% FPL, a group having average morbidity, remain in the non-group risk pool; this relative premium increase reduces expected enrollment into the non-group market.

As discussed above, the MGARA assessments must cover an increased claimant population in the no Medicaid expansion scenario, and in result the MGARA attachment points are raised to ensure program solvency.

Figures II-5 through II-7 illustrate the average premiums, reinsurance attachment points, and MGARA cash flow assumptions under the no Medicaid expansion scenario.

Figure II-5 MGARA No Medicaid Expansion Changes in Second Lowest Cost Silver Plan Monthly Premium from MGARA Implementation						
	21-Year Old Monthly Premium			64-Year Old Monthly Premium		
Calendar Year	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	$456	$456	$0	$1,367	$1,367	$0
2019	$472	$439	($33)	$1,415	$1,317	($98)
2020	$507	$470	($37)	$1,521	$1,410	($112)
2021	$535	$492	($43)	$1,605	$1,476	($128)
2022	$564	$520	($44)	$1,693	$1,560	($133)
2023	$593	$549	($44)	$1,778	$1,646	($131)
2024	$622	$578	($44)	$1,867	$1,734	($133)
2025	$653	$609	($44)	$1,960	$1,827	($133)
2026	$686	$643	($43)	$2,058	$1,928	($130)
2027	$717	$673	($43)	$2,151	$2,020	($130)
2028	$749	$705	($45)	$2,247	$2,114	($134)

Figure II-6 MGARA No Medicaid Expansion Calendar Year 2019 Reinsurance Parameters	
Parameter	Parameter Value
Initial Attachment Point	$55,000
Reinsurance Threshold 2	$85,000
Coinsurance Percentage 1 (between Initial Attachment Point and Reinsurance Threshold 2)	90%
Coinsurance Percentage 2 (above Reinsurance Threshold 2)	100%

Figure II-7 MGARA No Medicaid Expansion Estimated Available Pass-Through Funding and State-Based Assessment							
Calendar Year	State-Based Assessment ($ Millions)	Federal Pass-through Funding ($ Millions)	Ceded Premiums ($ Millions)	Total Revenue ($ Millions)	Estimated Assessment Enrollment Base (Thousands)	State-Based Assessment PMPM	Ceded Lives
2019	$23.3	$34.7	$46.7	$104.7	486	$4.00	6,500
2020	23.1	39.2	49.9	112.2	481	$4.00	6,500
2021	22.9	44.6	52.6	120.1	476	$4.00	6,600
2022	22.6	45.6	54.6	122.8	472	$4.00	6,500
2023	22.4	44.6	56.0	123.0	467	$4.00	6,300
2019-2023	$114.3	$208.7	$259.8	$582.8	2,382		32,400
2024	22.2	44.7	58.0	124.9	462	$4.00	6,200
2025	22.0	44.1	59.7	125.8	458	$4.00	6,100
2026	21.8	42.4	61.3	125.5	453	$4.00	6,000
2027	21.6	42.0	62.9	126.5	449	$4.00	5,900
2028	21.3	42.6	64.6	128.5	445	$4.00	5,800

LIMITATIONS

The services provided for this project were performed under the contract between Milliman and MGARA dated July 31, 2017.

The information contained in this report has been prepared for MGARA to provide actuarial certification and economic analyses related to the State of Maine's Section 1332 Waiver application that seeks Federal funding for MGARA. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for MGARA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has relied upon the accuracy and completeness of data and information provided by MGARA, the Maine Bureau of Insurance (BOI), and Maine insurance carriers; data sources underlying the analysis include Federal government reports related to insurance marketplace enrollment and premiums, proprietary insurer financial data, and Federal economic and healthcare expenditure forecasts. Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted there is significant uncertainty surrounding future enrollment, premiums, and claims in health insurance programs, particularly within the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We specifically note our projections of enrollment and premium rates in the individual market assume no direct Federal funding of CSR subsidies, Medicaid expansion effective January 1, 2019, insurer pricing assumptions do not materially deviate from 2018 assumptions, and there are no material changes to the ACA and its associated regulations following the completion date of the supporting analyses. It is certain that values presented in this report will deviate from actual amounts. However, to the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree. Actual insurer premiums in 2019 and beyond may contain additional margin related to these contingencies to provide financial protection for these occurrences.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Several of the authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX I: ACTUARIAL CERTIFICATION

Maine Bureau of Insurance
Section 1332 Waiver Application
Maine Guaranteed Access Reinsurance Association
Actuarial Certification

I, Kathleen E. Ely, am a Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been engaged by the Maine Guaranteed Access Reinsurance Association (MGARA) to perform an actuarial analysis and certification regarding the State's Section 1332 Innovation Waiver proposal that seeks Federal funding for implementation of MGARA. I am generally familiar with the federal requirements for Section 1332 waiver proposals, commercial health insurance rating rules, insurance exchanges, the Affordable Care Act's premium assistance structure, rules surrounding individual shared responsibility payments, and other components of the Affordable Care Act relevant to this Section 1332 State Innovation Waiver proposal.

As required under 45 CFR 155.1308 (f)(4)(i), this certification provides documentation that the actuarial analyses support the State of Maine's finding that MGARA complies with the following requirements for Section 1332 waivers as defined under 45 CFR 155.1308 (f)(3)(iv)(a)-(c):

- The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
- the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; and,
- the proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver

The assumptions and methodology used in the development of the actuarial certification has been documented in my report provided to the State of Maine. The actuarial certification provided with this report is for the period from January 1, 2019 through December 31, 2023. To the extent state or federal regulations are modified through the end of the waiver period, it may be necessary for this actuarial certification and corresponding analyses to be amended.

The actuarial analyses presented with this certification is based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the analyses.

In developing the actuarial certification, I have relied upon data and information provided by the State of Maine, publicly available Federal government data sets and reports, and insurer enrollment and financial data. I have relied upon these third parties for audit of the data. However, I did review the data for reasonableness and consistency.

Kathleen E. Ely, FSA
Member, American Academy of Actuaries
2018

APPENDIX II: ACTUARIAL MODELING SUMMARY

MGARA Operation Financial Projections

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Commercial Market for Assessment	471,000	467,000	462,000	457,000	453,000	449,000	444,000	440,000	436,000	432,000
Assessment PMPM	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00
Market Premium	$683	$732	$771	$812	$852	$893	$935	$979	$1,020	$1,063
Premium with Waiver	$618	$661	$697	$736	$777	$817	$858	$904	$944	$990
Premium Change Percentage	-9.4%	-9.7%	-9.6%	-9.4%	-8.8%	-8.5%	-8.2%	-7.6%	-7.4%	-6.8%
Individual Enrollment	62,100	61,300	60,700	60,100	59,600	59,000	58,300	57,700	57,100	56,500
Number of Auto Cedes	4,300	4,300	4,200	4,200	4,200	4,100	4,100	4,000	4,000	3,900
Number of Voluntary Cedes	1,200	1,300	1,200	1,200	1,000	1,000	900	800	800	700
Initial Attachment Point	$47,000	$47,000	$51,000	$56,000	$63,000	$69,000	$75,000	$84,000	$90,000	$100,000
Reinsurance Threshold 2	$77,000	$77,000	$81,000	$86,000	$93,000	$99,000	$105,000	$114,000	$120,000	$130,000
Revenue (millions)										
Estimated Passthrough Dollars from Waiver	$33.4	$37.5	$38.9	$39.8	$38.9	$39.2	$39.1	$37.5	$37.5	$35.7
Market Assessment at $4.00 PMPM	$22.6	$22.4	$22.2	$22.0	$21.7	$21.5	$21.3	$21.1	$20.9	$20.7
Autocede Premium	$28.9	$30.5	$31.9	$33.3	$34.8	$36.2	$37.6	$39.2	$40.6	$42.1
Voluntary Cedes Premium	$8.1	$9.2	$9.3	$9.3	$8.8	$8.4	$8.5	$8.3	$8.3	$7.8
Total Revenue	$93.0	$99.6	$102.3	$104.4	$104.2	$105.3	$106.5	$106.1	$107.3	$106.3
Expenses (millions)										
Autocede Claims	$60.2	$64.8	$67.2	$69.3	$70.0	$71.4	$72.9	$73.1	$74.5	$74.2
Voluntary Cede Claims	$29.5	$32.9	$33.6	$33.9	$32.9	$32.8	$32.8	$31.5	$31.6	$30.1
MGARA Admin	$0.7	$0.7	$0.7	$0.7	$0.6	$0.6	$0.6	$0.6	$0.6	$0.6
Total Expenses	$90.4	$98.4	$101.5	$103.9	$103.5	$104.8	$106.3	$105.2	$106.7	$104.9
Net Gain/Loss	$2.6	$1.2	$0.8	$0.5	$0.7	$0.5	$0.2	$0.9	$0.6	$1.4
Ending Surplus (1)	$8.0	$9.1	$9.7	$9.9	$10.3	$10.6	$10.7	$11.6	$12.0	$13.3

Notes
(1) MGARA Operational Surplus is currently $5.4m