Report to

The Vermont Legislature

Report on Health Insurance Affordability and Merged Markets

2019 Report to the Legislature

In Accordance with Secs. 9 and 12 of Act 63 of 2019

Submitted to:
House Committee on Health Care
House Committee on Appropriations
House Committee on Ways and Means
Senate Committee on Health and Welfare
Senate Committee on Appropriations
Senate Committee on Finance
Joint Fiscal Committee
Health Reform Oversight Committee

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Executive Summary

Act 63 of 2019 requires the Agency of Human Services (AHS) to evaluate Vermont's health insurance marketplace and to develop a strategy for making health insurance more affordable for all Vermont residents, including younger Vermonters and Vermonters who are not eligible for financial assistance. AHS approached these tasks in tandem since different marketplace configurations lend themselves differently to policy options for improving affordability. Relative to an affordability strategy, AHS was also asked to explore and consider the following:

1. The maximum amount of income that should be required for health insurance premiums and how to link the cost of health insurance to income so that no one pays more than the maximum identified
2. Requiring individuals between 100-138% of the Federal Poverty Level (FPL) enrolled in the Medicaid program to pay the maximum co-payments under federal law in order to repurpose state dollars for other low income individuals in need
3. The potential for establishing a regional, publicly financed, universal health care program in cooperation with other states

Marketplace Structure and Affordability

The AHS contracted with Wakely Consulting Group (Wakely) to evaluate the impact of moving from a merged market to an unmerged market where the risk pools and market reform rules would be separate for the small group and individual markets. In order to assess this impact, Wakely analyzed the performance of Vermont's current merged market structure. Vermont's market is relatively stable and the overall average premium paid by enrollees is likely less than or at the national average, all else equal. Nevertheless, premiums for unsubsidized members of the individual market can still be a significant portion of income.

Unmerging the markets and doing nothing else would result in a reduction in premiums for the small group at the expense of the individual market. However, an unmerged structure allows for additional policy flexibility and the potential for increasing federal pass-through amounts which could lead to reductions for the whole of the market. A partially unmerged market, where products and plan designs (and some plan costs) are the only elements differing between the two markets could promote policy flexibility without disadvantaging the individual market. AHS recommends that Vermont continue to explore the partially unmerged configuration, determine the full scope of operational considerations, and evaluate the feasibility and anticipated outcomes of implementing the option, in conjunction with stakeholders, in light of additional information.

Wakely analyzed policy options to address the affordability of health insurance premiums in the Exchange marketplace. These options rely on additional revenue sources, decreasing revenue for health care providers, or advantaging one segment of the market over another. As modeled, decreasing revenue for health care providers focuses exclusively on facility providers. Given the number of hospitals in Vermont that are operating below or near margin at current

provider rates, strong caution is necessary with regard to how access to care could be impacted by reference-based pricing. This is in addition to risks noted in the report associated with feasibility, operational complexity and cost, potential conflicts with the All-Payer Model and a relatively small population receiving benefit from referenced-based pricing. Given the considerable complexity and risk associated with the multiple options analyzed by Wakely, AHS recommends, for now, continued focus on and prioritization of the Vermont All-Payer Accountable Care Organization Model Agreement as it is a system-wide cost containment strategy intended to moderate the growth in health care spending and improve health care affordability. Nevertheless, if small group market enrollment continues to decline, premiums will escalate for the remaining purchasers relative to what they would have been with a larger, healthier risk pool. Again, a partially merged market configuration could position Vermont to better relieve pressure from changing marketplace dynamics by serving as a future platform for one or multiple of the options analyzed and delineated by Wakely.

At the time of this writing, the 2021 Notice of Benefit and Payment Parameters has not yet been published. Any potential policy changes included in that regulation have not been taken into consideration; we emphasize that analyses and recommendations offered herein are reliant on unpredictable federal policy.

Affordability Standard

Relative consensus exists that for individuals earning up to 400% FPL no more than 9.86% of income is reasonable to spend on health insurance premiums and a penalty for lack of health insurance would be unreasonable if health insurance costs exceeded 8.24% of income. Via the Affordable Care Act (ACA), federal subsidies for health care coverage are available to Vermonters based on their income level as verified through the tax system, with lower income earners receiving subsidies to limit the percentage of income for health care coverage to less than 9.86%. Additional subsidies are also available, based on income, from the State of Vermont. Those Vermonters whose income falls below the tax filing threshold have the opportunity to enroll in the Medicaid program to receive health care coverage. Vermont may want to engage in additional analyses to determine the number, incomes, and cost of living for persons purchasing health insurance coverage above 400% FPL for the purposes of evaluating the necessity and reasonableness of a 400% FPL plus subsidy structure.

Requiring Individuals Between 100-138% of FPL in the Medicaid Program to Pay Maximum Co-payments

Although increasing certain co-payment amounts may be allowable under federal regulations, there are significant operational barriers to doing so. The steps needed in order to change cost-sharing on a state level are likely to limit any potential state savings in doing so.

Regional, Publicly Financed, Universal Health Care Program in Cooperation with Other States

While efficiencies of scale may create some opportunities for reduction in administrative complexity and decreased costs, there are significant challenges in developing a regional program due to federal policies and potential policy changes, differences in state policies, and financing. Such challenges hindered and ultimately undermined multi-state programs created by the ACA.

Statutory Charge

Act 63 Sec. 12 of 2019 requires the Agency of Human Services to evaluate Vermont's health insurance markets to determine the potential advantages and disadvantages to individuals, small businesses, and large businesses, including the impacts on health insurance premiums and access to health care services, of maintaining the current health insurance market structure, moving to a fully merged market structure, or moving to a fully separated market structure.

On or before December 1, 2019, AHS shall submit its findings and any recommendations for modifications to the current market structure to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Act 63 Sec. 9 of 2019 also requires the Agency of Human Services (AHS) to develop a strategy for making health insurance affordable for all Vermont residents, including younger Vermonters and Vermonters who are not eligible for financial assistance. AHS was required to consider and accomplish the following:

1. The maximum percentage of an individual's or family's income that the individual or family should be required to pay for health insurance premiums and how to link the cost of health insurance to an individual's or family's income so that no individual or family pays more than the maximum percentage identified; and
2. Explore requiring individuals enrolled in the Medicaid program with income between 100 and 138% of the federal poverty level to pay the maximum allowable co-payment amounts in order to invest savings in assisting Vermonters who have lower incomes with obtaining access to affordable health insurance coverage;
3. Explore the potential for establishing a regional, publicly financed, universal health care program in cooperation with other states, including identifying the opportunities and challenges that would be presented by partnering with states to create such a program.

AHS shall submit its findings, recommendations, strategies, and estimates associated with the above and including any need for and feasibility of obtaining applicable federal waivers to the House Committees on Health Care, on Appropriations, and on Ways and Means; the Senate Committees on Health and Welfare, on Appropriations, and on Finance; the Joint Fiscal Committee; and the Health Reform Oversight Committee.

These efforts were conducted jointly with the Department of Vermont Health Access and the Department of Financial Regulation and in consultation with stakeholders from the Green Mountain Care Board, Blue Cross and Blue Shield of Vermont, MVP Health Care, The Vermont Medical Society, The Vermont Association of Hospitals and Health Systems, Bi-State Primary Care, The Office of the Health Care Advocate, The Vermont Chamber of Commerce, the Alliance of Health Care Sharing Ministries and with actuarial support from Wakely Consulting Group.

Introduction

Vermont has one of the lowest uninsured rates in the country, yet, like other states, small and large businesses, individuals and families often face challenges in regards to the affordability of health insurance.[1, 2] This report explores policy options and the associated potential impact on the cost of health insurance premiums and access to care. Vermont currently has a market structure in which the individual and small group markets are merged resulting in the sharing of risk across both markets. In response to Act 63 Sections 9 and 12, AHS considered the impacts of partially and fully unmerging the markets. It also considered additional policy strategies to offset potential resulting premium increases from unmerging the markets including a claims-based reinsurance program, a reference-based pricing plan offered off-Exchange, additional premium subsidies, and changing the age curve. Findings from this study and considerations for selecting a market structure are included in Appendix 1. Further consideration in regards to the maximum percentage of an individual's or family's income that an individual or family should be required to pay for health insurance premiums is explored in the Health Insurance Affordability Standards section. An analysis of the impact of fully merging the market was completed in 2016 and indicated that a fully merged market could have a negative impact on premiums for individuals, small business and large businesses.[3]

Also in response to Act 63 Section 9, AHS analyzed two specific policy options: investing savings generated from charging maximum allowable co-payment amounts to individuals in the Medicaid program with income between 100% and 138% of the federal policy level; and establishing a regional, publicly financed, universal health care program in cooperation with other states. These are discussed in the Act 63 Section 9 Policy Options section.

Health Insurance Affordability Standards

Federal and state policies use multiple standards to define health insurance affordability. These standards vary by definition purpose (e.g. for establishing subsidies or imposing penalties) and by factors such as household income and family size. The results of a scan of federal and state standards are below. These can be leveraged to evaluate policy options discussed in this report, including premium subsidies for individuals.

The Affordable Care Act (ACA) addresses issues of health insurance affordability through incentives and consequences designed to increase the purchase of health insurance such as by providing tax subsidies to eligible individuals, by limiting the amount of allowable cost-sharing imposed by health plans, and by imposing a tax penalty on individuals who can afford health insurance but do not purchase it. Within the ACA, the concept of "affordability" is defined according to purpose, such as for determining eligibility for tax subsidies, including premium tax

[1] In 2017, the national uninsured rate was 9% while Vermont's uninsured rate was 4%. Retrieved from: https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/

[2] The 2018 Vermont Household Health Insurance Survey reports a 3% uninsured rate: https://www.healthvermont.gov/sites/default/files/documents/pdf/VHHIS_Report_2018.pdf

[3] https://gmcboard.vermont.gov/sites/gmcb/files/documents/VT_LG_Study_LE_Final.pdf

credits and cost-sharing reductions, and determining if an individual is eligible for affordable employer-sponsored coverage and subject to tax penalties if coverage is not obtained. Affordability requirements are adjusted regularly. All requirements indicated below are for 2020.

Affordability: Eligibility for tax subsidies

Individuals earning between 100%[4] and 400% of the federal poverty level (FPL) and who purchase coverage through an exchange are eligible for premium tax credits to reduce the cost of coverage. Table 1 below indicates an individual's required contribution amount to the premium, which is calculated on a sliding scale based on the individual's estimated household income and the applicable percentage. This percentage table is adjusted annually to reflect the rates of premium growth and income growth during the preceding year.

Table 1. Applicable Percentage Table for 2020[5]

Household income percentage of Federal poverty line	Initial percentage	Final percentage
Less than 133%	2.06%	2.06%
At least 133% but less than 150%	3.09%	4.12%
At least 150% but less than 200%	4.12%	6.49%
At least 200% but less than 250%	6.49%	8.29%
At least 250% but less than 300%	8.29%	9.78%
At least 300% but not more than 400%	9.78%	9.78%

Affordability: Tax penalty definitions

Employer-sponsored minimum essential coverage is considered affordable if the employee's contribution for self-only coverage does not exceed 9.78% of the employee's projected household income.[6] Individuals who do not have access to affordable employer-sponsored insurance may be eligible for the premium tax credit, if they meet applicable criteria. Employers that do not offer affordable health insurance as defined above may be subject to penalties if full-time employees receive premium tax credits.

Individuals who do not have health insurance are subject to the individual mandate tax penalty unless they qualify for an exemption. An exemption from the individual mandate tax penalty is available to individuals who must pay more than 8.24% of their household income towards

[4] For Medicaid expansion states, such as Vermont, individuals up to 138% FPL are eligible for Medicaid.
[5] IRS Rev. Proc. 2019-29 Section 3.01
[6] IRS Rev. Proc. 2019-29 Section 3.02

health insurance for the 2020 benefit year.[7] Following passage of the Tax Cuts and Jobs Act, the current tax penalty is $0. However, this required contribution percentage is also used to determine whether an individual over the age of 30 may enroll in catastrophic coverage through an affordability exemption.

Cost-sharing

Another mechanism for increasing the affordability of health insurance is to limit the ability of health plans to impose cost-sharing. The ACA set's annual limitations on cost-sharing. For 2020, the maximum annual limitation on cost-sharing for self-only coverage and other than self-only coverage is $8,150 and $16,300, respectively.[8] These are the maximum amounts than an individual or family may be required to pay on all cost-sharing charges, such as deductibles, co-payments, and coinsurance. For individuals at or below 250 percent of the FPL, annual limitations on cost-sharing is reduced, as indicated in Table 2 below.[9]

Table 2. Reduced Maximum Annual Limitation on Cost-Sharing for 2020

Eligibility Category	***Reduced Maximum Annual Limitation for Self-only***	***Reduced Maximum Annual Limitation for other than Self-only***
100[10]-150% FPL	*$2,700*	*$5,400*
151-200% FPL	*$2,700*	*$5,400*
201-250% FPL	*$6,500*	*$13,000*

State Standards

Several states have implemented or are implementing an individual health insurance mandate on the state level. California, District of Columbia, New Jersey, Rhode Island and Vermont enacted individual health insurance mandate legislation in response to the passage of the federal Tax Cuts and Jobs Act, which set the tax penalty to zero effective January 1, 2019. Massachusetts enacted an individual mandate in 2006 prior to the ACA. District of Columbia and all states that have a mandate, except for Vermont, require individuals who do not have health insurance to pay a penalty. These penalties are generally consistent with the penalty structure within the Affordable Care Act before the federal Tax Cuts and Jobs Act was enacted. Individuals who cannot afford health insurance may obtain an exemption. Definitions of affordability and the ability to obtain an exemption from the tax penalty for each state are further described below.

[7] PPACA; HHS Notice of Benefit and Payment Parameters for 2020, Final Rule, 45 CFR Parts 146, 147, 148, 153, 155, and 156, 84 Fed. Reg. 17454 (Apr. 25, 2019)
[8] Ibid.
[9] Ibid.

District of Columbia

The District of Columbia requires individuals and dependents to maintain minimum essential coverage. Exemptions from this requirement are modeled on the federal individual mandate as they were in effect on December 15, 2017. In addition, the District of Columbia provides hardship exemptions to the following individuals and dependents:

- Taxpayers ages 21 or older earning up to 222% FPL;
- Taxpayers ages 20 or younger earning up to 324% FPL;
- Dependents ages 21 or older who are claimed as dependents by taxpayers earning up to 222% FPL;
- Dependents ages 20 or younger who are claimed as dependents by taxpayers earning up to 324% FPL.[11]

Massachusetts

Massachusetts exempts individuals from the individual health insurance mandate and associated tax penalty if they are unable to afford minimum creditable coverage. The affordability standard varies by income. For 2019, it is 8% of income for individuals, couples and families above 400% FPL.[12] Affordability standards for individuals, couples and families below 400% FPL range from 0% to 7.6% of household income and are indicated in Tables 3 – 5 below.[13] Individuals may also file a hardship appeal due to special circumstances that made maintaining coverage unaffordable.[14]

Table 3. Calendar Year 2019 Affordability Schedule: Individuals

Income Bracket			Affordability Standard	Affordable Monthly Premium Ranges	
% FPL	Bottom	Top		Low	High
0-150%	$0	$18,210	0.00%		
150.1-200%	$18,211	$24,280	2.90%	$44	$59
200.1-250%	$24,281	$30,350	4.20%	$85	$106
250.1-300%	$30,351	$36,420	5.00%	$126	$152
300.1-350%	$36,421	$42,490	7.45%	$226	$264

[11] DC Code § 47–5102.

[12] Massachusetts Health Connector Calendar Year 2019 Affordability Schedule. Retrieved from: https://www.mahealthconnector.org/wp-content/uploads/Calendar-Year-2019-Affordability-Schedule.pdf

[13] Ibid.

[14] 956 CMR 6.07

350.1-400%	$42,491	$48,560	7.60%	$269	$308
above 400%	$48,561		8.00%	$324	

Table 4. Calendar Year 2019 Affordability Schedule: Couples (two people)

Income Bracket			**Affordability Standard**	**Affordable Monthly Premium Ranges**	
% FPL	Bottom	Top		Low	High
0-150%	$0	$24,690	0.00%		
150.1-200%	$24,691	$32,920	4.30%	$88	$118
200.1-250%	$32,921	$41,150	6.20%	$170	$213
250.1-300%	$41,151	$49,380	7.35%	$252	$302
300.1-350%	$49,381	$57,610	7.45%	$307	$358
350.1-400%	$57,611	$65,840	7.60%	$365	$417
above 400%	$65,841		8.00%	$439	

Table 5. Calendar Year 2019 Affordability Schedule: Families (three or more people)

Income Bracket			**Affordability Standard**	**Affordable Monthly Premium Ranges**	
% FPL	Bottom	Top		Low	High
0-150%	$0	$31,170	0.00%		
150.1-200%	$31,171	$41,560	3.40%	$88	$118
200.1-250%	$41,561	$51,950	4.90%	$170	$212
250.1-300%	$51,951	$62,340	5.85%	$253	$304
300.1-350%	$62,341	$72,730	7.45%	$387	$452
350.1-400%	$72,731	$83,120	7.60%	$461	$526

above 400%	$83,121		8.00%	$554	

New Jersey

New Jersey offers several exemptions from its individual health insurance mandate and associated tax penalty, three of which relate to affordability. Individuals who do not meet the New Jersey tax filing threshold are exempt. This threshold applies to those with gross income up to $20,000 for those filing as Married Filing Jointly, Head of Household, or Qualified Widower or gross income up to $10,000 for those filing as Single or Married Filing Separately. Individual market coverage is considered unaffordable if the premiums for the lowest cost Bronze-level plan available through the marketplace are more than 8.05% of an individual's household income. Employer-based coverage is considered unaffordable for an employee if the annual premium for the lowest cost self-only plan is more than 8.05% of household income. Similarly, employer-based coverage is considered unaffordable for an employee's family if the annual premium for the lowest cost family plan is more than 8.05% of household income.[15]

California

California is also implementing an individual health care mandate with tax penalties. Affordability hardship exemptions from the individual health insurance mandate are provided to: individuals whose premium contribution for the lowest-cost Bronze Plan, minus any premium assistance available or lowest cost employer-sponsored plan, employee-only plan exceeds 8.24% of household income; and households whose premium contribution for the lowest-cost employer-sponsored family plan is more than 8.24% of projected income. Additional exemptions include, but are not limited to, general hardship and income below the tax-filing threshold.[16]

Effective 2020, California is implementing a state-funded health insurance subsidy. These subsidies expand upon federal subsidies for individuals up to 400% FPL and include new subsidies for individuals earning greater than 400% and up to 600% FPL. Subsidies will be available for three years (2020-2022) and are subject to annual appropriations. Both the federal Premium Tax Credit and State Premium Assistance are calculated based on estimated income and family size and are provided to eligible individuals as lowered premiums at the time of purchase. The subsidies approved by the California Health Benefit Exchange Board for 2020 are included in Table 6 below.[17]

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[15] NJ Health Insurance Mandate Coverage Exemptions (New Jersey Department of the Treasury). Retrieved from: https://www1.state.nj.us/TYTR_RevTaxPortal/jsp/HealthInsuranceMandate/ExemptionMenu.jsp

[16] State of California Franchise Tax Board. Retrieved from: https://www.ftb.ca.gov/about-ftb/newsroom/news-articles/health-care-mandate.html?WT.ac=Healthcare

[17] California Health Benefit Exchange Board Resolution No. 2019-41. Retrieved from: https://board.coveredca.com/meetings/2019/06-26/State%20Subsidy%20Program%20Design%20for%20PY%202020%20(Resolution%202019-41).pdf

Table 6. California State Premium Assistance Applicable Percentage Table for 2020[18]

Household income	The initial premium percentage	The final premium percentage
At or below 138% FPL	0%	0%
Greater than 200% up to and including 250% FPL	6.24%	7.8%
Greater than 300% up to and including 400% FPL	8.90%	9.68%
Greater than 400% and up to and including 450% FPL	9.68%	14.00%
Greater than 450% and up to and including 500% FPL	14.00%	16.00%
Greater than 500% and up to and including 600% FPL	16.00%	18.00%

Rhode Island

Effective 2020, Rhode Island is implementing an individual health insurance mandate to maintain minimum essential coverage and an associated tax penalty. Individuals with household income below the tax filing threshold are not subject to the penalty. The exchange determines whether an individual is exempt from the tax penalty.[19] Exemptions are provided for reasons such as hardship or because no affordable plan was available. A plan is considered affordable if the employee-paid premium for the lowest-cost "self-only" employer-based health plan is 9.86% or less of an employee's household income.[20]

Discussion

Relative consensus exists that for individuals earning up to 400% FPL no more than 9.86% of income, consistent with RI and the 2019 federal standards, is reasonable to spend on health insurance premiums and a penalty for lack of health insurance would be unreasonable if health insurance costs exceeded 8.24% of income. Very few states have examined an affordability standard for persons over 400% FPL, but for those that have the affordability ranges from 8% of income in Massachusetts to a sliding scale in California up to 18% of income for persons at 600% FPL. Because California has a higher cost of living than Vermont, its program of subsidy up to 600% FPL is likely excessive for our state. Acknowledging the abrupt nature of the ACA "subsidy cliff" at 400% FPL, Vermont may want to engage in additional analyses to determine the number, incomes, and cost of living for persons purchasing health insurance coverage above 400% FPL for the purposes of evaluating a potential 400% FPL plus subsidy structure.

[18] 2020 State Premium Assistance Draft Program Design Document. Retrieved from: https://board.coveredca.com/meetings/2019/06-26/Program_Design_Document_Final.pdf

[19] RI Gen L § 42-157 (2018) as amended by 2019 H 5151

[20] HealthSource RI. Retrieved from: https://healthsourceri.com/mandate/

Act 63 Section 9 Policy Options

Strategies For Making Health Insurance Affordable

Specific strategies and considerations are included in Appendix A prepared by Wakely Consulting.

Investing Savings From Maximum Allowable Co-Payments

Act 63 directed AHS to explore requiring individuals enrolled in the Medicaid program with income between 100 and 138 percent of the federal poverty level to pay the maximum co-payment amounts for their health care services as are allowed under federal law and investing the State funds saved in assisting Vermonters who have lower incomes with obtaining access to affordable health insurance coverage.

For purposes of this report, AHS focused on the first level analysis of identifying existing Vermont Medicaid co-payments and the feasibility of changing them. Vermont Medicaid currently includes cost-sharing for outpatient services, dental, and prescription drugs. This is established in Health Care Administrative Rule 6.100.[21] These cost-sharing requirements are not delineated by income level. Rather, all Vermont Medicaid members are subject to cost-sharing unless they are exempt. Both state and federal law create a large number of exemptions from, as well as aggregate limits on, Medicaid cost-sharing.

AHS has identified the difference between permissible cost-sharing under state and federal law. Although increasing certain co-payment amounts may be allowable under federal regulations, there are significant operational barriers to doing so. The steps needed in order to change cost-sharing on a state level are likely to limit any potential state savings in doing so. These steps include issuing new administrative rules, seeking federal approval to amend the Medicaid State Plan, and updating provider materials. Perhaps most significantly, isolating the 100-138% FPL population—or any subpopulation—to model potential savings is not possible because of the way the member categories are captured in the Medicaid system. Cost-sharing is currently imposed across non-exempt membership and not by income level.

While AHS is willing to explore this further, it may be more fruitful to focus on other investment options including the potential reforms described elsewhere in this report to address affordability in the individual health insurance market.

Regional, Publicly Financed, Universal Health Care Program

To explore the potential for establishing a regional, publicly financed, universal health care program in cooperation with other states, AHS staff pursued meetings with key contacts, such as leadership from State Insurance Exchanges, in states within the Northeastern United States. For the purposes of this report and discussions with other states, it is assumed that a universal health care program can be structured and funded in many ways, including public and private

[21] https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules

payers, and achieves the outcome of universal coverage of the population. Leadership in other states noted the complexity of a variety of features within each state's health care landscape that could be challenging to overcome in a multi-state program, such as variation in eligibility categories, state-level subsidies available in some but not all states, differences between merged and unmerged markets across states, and how states utilize community and age rating policy options. Further examples are provided in the challenges section below. It was noted that there could be multi-state partnership opportunities to purchase or develop new technologies and platforms for state insurance marketplaces, however, shared governance and ongoing collaboration can be challenging and time intensive. It was noted that a multi-state program may provide states with greater ability to negotiate prices and attract larger, national carriers but this also could impact local providers, especially for states with home grown and state-specific carriers.

In addition to learnings from these discussions, AHS identified additional opportunities and challenges. While efficiencies of scale may create some opportunities for reduction in administrative complexity, increased competition in the market, and decreased costs, there are also significant challenges in developing a regional program due to uncertainty regarding policy changes at the federal level, differences in state policies, and financing.

Opportunities

Partnering with nearby states could achieve some efficiencies of scale for both payers and insurers, where policy alignment across states allows. Depending on the program design, a regional, publicly financed, universal health care program that includes private insurance options could potentially increase competition in the insurance market resulting in greater affordability through decreased premiums and cost-sharing. Studies have indicated that competition through increased numbers of insurers results in lower premiums within a state.[22,23] Study results have also indicated that, within state borders, smaller and more rural counties bundled with larger areas benefit from more insurers and lower premiums.[24] It is unclear if the results of these studies would apply to a multi-state program.

There could be additional opportunities associated with increasing the size of the risk pool by covering an expanded population and increasing numbers of enrollees. These opportunities include long-term stabilization, lower per-enrollee administrative costs, and improved bargaining power. However, since risk pools are fairly established in states today, it could be

[22] Abraham, J.M., Drake, C., McCullough, J.S. et al. (2017) What drives insurer participation and premiums in the Federally-Facilitated Marketplace? *International Journal of Health Economics and Management.* 17:4, 395-412.
[23] Dafny, L., Gruber, J., Ody, C. (2015). More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. *American Journal of Health Economics.* 1:1, 53-81.

[24] Dickstein, M.J., Duggan, M., Orsini, J., Tebaldi, P. (2015). The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act. *American Economic Review*, 105(5): 120-125.

politically challenging to integrate risk pools across states because some populations would benefit from lower costs, and some would experience cost increases.

Challenges

Given recent policy changes at the federal level such as decisions to cease making cost-sharing reduction payments to insurers and cease imposing an individual mandate tax penalty on individuals as well as uncertainty about future changes, states are actively exploring policy options for maintaining high rates of insurance and reducing health care costs. A regional program could reduce the state's ability to make swift and local policy decisions in response to these types of changes and potentially have negative consequences. Entering into agreements with other states could impact the types and timeliness of available policy changes.

New administrative challenges could arise from developing a regional program. For example, it could hinder or add administrative complexity to the state's ability to independently select a benchmark plan and state-based essential health benefits package. If a regional program were to be designed as a Medicaid buy-in, there would be differences in Medicaid benefits, payment and care delivery models, and operations that would need to be reconciled among partners. States in the Northeast have adopted various exchange structures. While many states (CT, MA, NY, RI and VT) use state-based exchanges, NH and ME utilize federal and partnership exchanges, respectively. Changes to exchange design may be needed because potential partnering states currently have variation.

Financing of a regional program could be a challenge since each state would likely need to appropriate funds which would be subject to annual appropriations. Financial challenges in a single state could impact other states participating in an agreement. In addition, since uninsured rates are already low in the Northeast, there may be less interest in investing in a program that could be complex to implement or operationalize. Uninsured rates in the Northeast range from 2.8% (MA) to 5.8% (NH) as of 2017, with the exception of ME which has a higher rate of uninsured individuals (8.1).[25]

The ACA includes opportunities for insurers to offer products in more than one state such as the Multi-State Plan (MSP) Program option and Health Care Choice Compact. The MSP Program is now being discontinued due to a contraction from offering coverage in thirty-five states to one state. A reason cited for the lack of success for this option is the absence of authority for the implementing agency to set national standards and the resulting high administrative complexity for insurers to receive approval from and comply with state regulations and oversight in each state.[26] The ACA also allows states to develop a Health Care Choice Compact to allow insurers to sell qualified health plans across state lines that are subject to the laws and regulations of the issuing state. To date, although several states have passed legislation related

[25] https://www.census.gov/library/visualizations/interactive/uninsured-rate.html

[26] "For Policy Makers Looking to Expand Coverage, Lessons from the Demise of the ACA's Multi-State Plan Program," Health Affairs Blog, September 30, 2019.

to selling insurance across state lines, no states have entered compacts. While proponents have argued that selling products across state lines allows for a larger risk pool and variation in products offered, critics have noted high costs in developing provider networks in new markets, noted the burden of developing interstate compacts and seeking federal approval of sales, and expressed concerns that lower-cost individuals would purchase lightly regulated and less expensive products from other states impacting premiums within the state due to changes within the risk pool.[27]

[27] Jennson, J., Riley, T. "Selling Health Insurance Across State Lines: Lessons for States and Questions for Policymakers"National Academy for State Health Policy, February 2017.

Appendix 1: Actuarial Analyses to Satisfy Act 63

www.wakely.com

State of Vermont, Agency of Human Services

Actuarial Analyses to Satisfy Act 63

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Introduction

The State of Vermont has been on the forefront of health care reform. At the start of the Affordable Care Act (ACA) Vermont implemented a number initiatives and regulations designed to stabilize the individual and small group markets, including merging the two markets. Since 2014, Vermont has had a stable market with the same issuers and stable rate increases compared to national averages. However, premiums are still high, especially for unsubsidized individuals and families. As a result, the State of Vermont's Agency of Human Services (AHS or Vermont or the State) retained Wakely Consulting Group, LLC (Wakely) in response to the legislative charge of Act 63[1] of 2019.

The State of Vermont passed Act 63 in part to determine the potential advantages and disadvantages to maintaining or changing its current merged market structure. In particular, the Act required an evaluation of: 1) maintaining the current merged market structure, 2) moving to a market structure that merged the individual, small and large groups[2], and 3) moving to a market structure in which all three markets were unmerged and separate.

A prior report[3] completed in 2016 addressed the second task in Act 63, which analyzed the impact of large group being a part of the merged market structure. Thus, Wakely's focus is to analyze Vermont's individual and small group Affordable Care Act (ACA) market to accomplish two tasks:

- Evaluate the impact on health insurance premiums and access from going from the current structure with a fully merged individual and small group market to two fully separated markets, and

- Analyze the best marketplace structure and policy options to maximize federal resources through potential 1332 waivers and for addressing insurance premium prices for unsubsidized purchasers and younger Vermonters.

This document will discuss the potential policies that were considered, the pros and cons of each, the effects of the different policies on the 2021 markets, and the implications of the policies. This analysis was completed before the release of the 2021 Notice of Benefit and Payment Parameters and therefore does not include any potential policy changes that may be included in that regulation. For example, it does not include potential changes to silver-loading, which would have a large impact on the analyses and estimates in this report. This report also does not include

[1] https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT063/ACT063%20As%20Enacted.pdf

[2] Note Act 63 requested an analysis of merging individual, small, and large group markets together. Previous analysis by Lewis and Ellis had found such a proposal would be disadvantageous for both markets. See https://gmcboard.vermont.gov/sites/gmcb/files/documents/VT_LG_Study_LE_Final.pdf for the details of this 2016 analysis.

[3] https://gmcboard.vermont.gov/sites/gmcb/files/documents/VT_LG_Study_LE_Final.pdf

changes that may result due to recent changes regarding health reimbursement arrangements. Changes in Federal policy that affect the ACA markets would produce different estimates. Given these limitations, as well as the high-level nature of some of the analyses, further detailed analyses are necessary for more refined impacts of the policy options. The appendices include a full summary of limitations and assumptions.

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

Executive Summary

In 2018, Vermont's individual ACA market averaged around 33,000 members, of which 64% receive some level of Advanced Premium Tax Credits (APTC). The small group ACA market averaged around 44,700 members in 2018. To date in 2019, individual market enrollment has been stable. To date in 2019, small group market enrollment has decreased around 10%. While premium increases varied by issuer and specific plan, the overall average premium increases in the ACA merged market averaged under 6% in 2019 (higher for the individual subsidized members and lower for individual unsubsidized and small group) and are expected to be approximately 11% in 2020 based on 2020 rate filings.

Vermont's ACA market is unique both in structure and in composition. Vermont has a merged market, which means all risk (i.e., a single risk pool for both markets) and applicable market reform rules (i.e. guaranteed availability) for the individual and small group markets are merged. Vermont is the only state to have a fully merged market as defined under CFR 156.80(c).[4] Additionally, Vermont is one of two states to have no age rating (i.e., community rating), with New York being the other. No age rating means that an individual's premium is the same regardless of age. Vermont also has an average age in its individual market that is higher relative to the individual market national average, likely driven by the higher average age of the population, community rating resulting in higher premiums for younger adults, and CHIP eligibility rules that cover children at higher income levels relative to the national average. Finally, Vermont has one of the lowest uninsured rates in the country. All of these factors combined make Vermont a unique state in terms of health coverage for individuals and small employers.

[4] The rules governing the merged market was finalized in the Market Reform rules regulation found here https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28428.pdf

It is typically believed that Vermont has higher premiums than most states since a common comparison is the premium rates for a 40 year-old. Given Vermont's community rating[5] and the higher average age of enrollees, Vermont's 40 year-old rate is notably higher than most states and the national average. Based on information provided by Kaiser Family Foundation and the age factors used for each state, Table 1 shows how Vermont's rates compare to nearby states for a non-smoking 21, 40 and 60 year-old. The table shows that Vermont has the highest premiums for both a 21 and 40 year-old. However, the premiums for a 60 year-old are much more competitive. Only New York, which also has community rating, and Massachusetts, which uses different age factors than the Federal factors, have lower premiums at age 60 (New York varies based on metal level). Roughly half of Vermont's individual market enrollees are aged 50 and above, where the premiums are most competitive compared to other states.

Table 1: 2019 Premiums On-Exchange by Selected Age and State[6]

	Lowest Cost Bronze Before Tax Credit			2nd Lowest Cost Silver Before Tax Credit			Lowest Cost Gold Before Tax Credit		
State, Major City	21 Year Old	40 Year Old	60 Year Old	21 Year Old	40 Year Old	60 Year Old	21 Year Old	40 Year Old	60 Year Old
Maine, Portland	$262	$335	$711	$379	$485	$1,030	$455	$582	$1,236
Massachusetts, Boston	$213	$251	$426	$273	$321	$545	$284	$334	$567
New York, New York	$421	$421	$421	$587	$587	$587	$697	$697	$697
New Hampshire, Manchester	$237	$303	$643	$315	$402	$854	$347	$444	$943
Vermont, Burlington	$426	$426	$426	$622	$622	$622	$584	$584	$584

Similarly, when comparing Vermont's 2019 overall average premium paid by enrollees on-Exchange against the national average monthly premium of $594.17, Vermont's average monthly premium of $571.94[7] is actually less. While this comparison can be influenced by other factors (for example, the mix of metal level plans that enrollees select), it is reasonable to assume that Vermont's average rate is likely less or around the national average, all else equal. Appendix C

[5] Vermont also does not distinguish between smokers and non-smokers in its community rating, which may also result in its premiums appearing higher.

[6] Data from https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/ and Federal or state age factors applied as appropriate.

[7] https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf

includes additional details on Vermont's historical experience and how it compares to national benchmarks.

Despite Vermont's premiums being similar to or less than the national average, the premiums can still cost significantly more than 10% of a family's income for some unsubsidized members in the individual market. Affordability of health care is a concern that most states share with Vermont. Despite Vermont being among the leaders in the United States at having a low uninsured rate, there remains a number of uninsured. The most common characteristic of the remaining uninsured are younger individuals (ages 25 to 44), poorer individuals and families (below 250% of the Federal Poverty Level, or FPL), and individuals and families that do not qualify for subsidies (above 400% FPL).

The following discusses how a change in the merged market structure may affect the premiums in the various markets. In addition, various policy options under different market structures were analyzed to understand the overall impact to premiums different policies would have on the various markets and sub-populations within the markets, specifically targeting the unsubsidized individual market members. None of the policy options analyzed are expected to encourage underinsurance. Underinsurance is where individuals enroll in plans that do not provide adequate coverage and the cost-sharing requirements are burdensome to the point of being unaffordable.

Merged Market Structure

A merged market, as defined under CFR 156.80, treats the individual and small group markets as a single merged risk pool. That means that all risk is shared across both markets. It further means that any product developed for either market must be available to all enrollees in either market. A larger risk pool through merger does have advantages, as it can be more stable and be less susceptible to smaller events impacting premiums. However, it also typically has distributional implications (one market can have higher premiums than it otherwise would have) and product differentiation limitations (products designed only for individuals or only for small employers are more difficult to create).

Wakely evaluated different market configurations in order to analyze how each could impact Vermont's enrollees and how they may interact with additional policy options the State could pursue. In particular, Wakely analyzed the impact of unmerging the markets. This could be accomplished either by fully unmerging the markets (in which case risk adjustment would not occur between the markets) or partially unmerging the markets (in which case risk adjustment would occur between the markets). The key differences between a partially unmerged market and a fully merged market is that in a partially unmerged market, products and plan designs (and some plan costs) could differ between the two markets.

The following highlights the key considerations for unmerging the markets, compared to the fully merged market. Table 2 summarizes the impact under each merged market structure compared

to the current merged market, each of which is described in greater detail later in the report. The impact to the various market segments is color-coded on a comparative scale to indicate which measures are most positively affected and which are least positively affected under each structure. Green components are the most positively affected, yellow is generally unaffected, and red components are the likely negatively affected. The darker the shade the stronger the effect. Since a primary AHS goal is to decrease premiums for the unsubsidized and younger adults in the individual market, the individual market has been split by adult ages and subsidized and unsubsidized members. Individual market members who are children are not represented in the table, as they represent a small portion (8%) of the market and the impact of most of the policies is similar to the impact on adults.

Table 2: Impact Based on Merged Market Structure

	Individual Market				Small Group
	Younger Adults (21-44)		Older Adults (45+)		
	Subsidized	Unsubsidized	Subsidized	Unsubsidized	
Current Market Distribution	25%	8%	36%	22%	100%
Fully Unmerged					
Partially Unmerged					

Likely Positive Impact
Mixed/No Impact/Contingent
Likely Negative Impact

The following outlines more specific considerations for the State on whether to change the merged market structure.

- **State Costs:** Neither of the policy options would require ongoing state costs. The only potential costs are if CMS would require actuarial justification in the decision to change the current merged market structure.

- **Federal Approval:** Both fully unmerging the markets and a partially unmerged market would need Federal approval. Discussions with CMS would be needed as to the exact requirements needed to obtain permission. If the State would partially unmerge the markets, permission would be needed from CMS both to unmerge the markets and to continue operating risk adjustment between the two markets.

- **Operational Complexities:** While both market structures are operationally feasible, the partially unmerged market would be operationally more complex than a fully unmerged market given the additional approval needed from CMS and the additional decisions that

will be needed. The additional flexibility offered in a partially unmerged market creates more options as to how the policy options can be structured and how each market is impacted.

- **Consumer Impact**:
    - Fully unmerging the markets would result in a shift in premiums, since risk adjustment would no longer occur between the markets. In addition, the financial results (measured based on loss ratio) of the two markets currently varies. Assuming similar target loss ratios in an unmerged market, Wakely estimates that unsubsidized individual market premiums could increase by 7.0% and small group premiums would decrease by 5.8%. For individual subsidized members, their premiums would remain the same or could potentially decrease depending on the plan in which they are enrolled. These impacts are estimates and will vary based on specific issuer assumptions. These impacts are also not the actual premium change but relative change compared to what the premium changes would otherwise be in 2021.
    - Wakely estimates that there would be no premium impact to either market if the markets were only partially unmerged, assuming no other policy changes, since the risk pools would still be combined.
- **Alignment with State Goals:** A primary goal is premium reduction for the unsubsidized individual market, specifically younger enrollees, and small group employers. There is an additional goal of potentially maximizing Federal pass-through dollars in the event of a 1332 waiver[8]. Fully unmerging the market, while it does have the advantage of increasing policy flexibility and potentially increasing Federal pass-through amounts (for example, for a reinsurance program), would decrease small group premiums at the expense of unsubsidized individual market premiums. Partially unmerging the market achieves the goal of increasing policy flexibility, including increasing the potential for Federal pass-through dollars, but does not alter current premiums for either unsubsidized enrollees or small group enrollees. Both options have an advantage over the current structure in regards to a 1332 waiver pass-through,[9] however the fully unmerged option has policy trade-offs between two groups of enrollees.

[8] Section 1332 of the ACA allows states to apply for waivers that alter certain ACA requirements for the individual and small group markets. States can use implement innovative changes to their markets if they, at minimum, meet certain guardrails, such as increasing coverage and not increasing the federal deficit. See Appendix D for more detail.

[9] Federal pass-through amounts are generally calculated as the savings a state can achieve for the Federal government. To date the majority of savings to the Federal government have come from a reduction in Premium Tax

While Wakely did not evaluate merging the individual, small, and large groups together, previous analysis by Lewis and Ellis[10] estimated the impact of merging all three markets under two different scenarios, with the two scenarios varying based on if government employees would be included in the fully merged markets. While there are other factors to consider, the analysis indicated the individual and small group market premiums would increase by 6% to 9% compared to the current merged market. It also indicated the change could be unfavorable to a significant number of large groups.

Additional Policy Options

Wakely also, analyzed various policy options to understand their impact on premium affordability. Some of the policy options analyzed would be most effective under an unmerged or partially unmerged market, while others can be equally effective under any of the merged market structures. Specifically, a claims-based reinsurance program and a reference-based pricing plan will be most effective if implemented in an unmerged or partially unmerged market structure. Premium subsidy changes and creating age-rated premiums can be implemented under any of the market structures, although the impacts may be different based on the market structure in place.

The policy options analyzed were modeled in conjunction with either fully unmerged or partially unmerged markets to understand the overall impact of the combined policy changes. Changing the market structure changes premium costs for enrollees and could change how issuers incorporate policy changes into their rates. Given that the market structure influences the impact of different policies, Wakely modeled the different policies in different market structures. It is important to note that given Vermont's current merged market structure, policies (i.e., reinsurance) could have very different impacts in Vermont compared to other states. The policy options analyzed include:

- A claims-based reinsurance program with a 1332 waiver was modeled under both an unmerged and partially unmerged structure. A claims-based reinsurance program is a program in which the state reimburses a portion of high cost-claims in the market, thereby reducing premiums.

- A reference-based pricing plan offered off-Exchange was modeled under a partially unmerged structure. A reference-based pricing plan is a plan whose provider reimbursements are set by the state, with the policy goal of having lower reimbursement rates than the current market, which in turn would lower premiums for the specific plan.

Credit spending. The easier and cheaper it is to influence the second-lowest cost silver plan in the individual market, the easier and cheaper it is to achieve Federal savings and therefore Federal pass-through amounts.

[10] https://gmcboard.vermont.gov/sites/gmcb/files/documents/VT_LG_Study_LE_Final.pdf

- Additional premium subsidies were modeled under a partially unmerged structure. Premium subsidies are state directed subsidies designed to reduce an enrollee's out of pocket premium costs.

- Implementing Age Rating was modeled under a partially unmerged structure. The age curve or age factor is the rate at which premiums change due to age differences. Currently, Vermont's premiums do not change based on age, i.e., a flat age curve.

The policy options analyzed can be very different in how they would operate. Some would require state funding while others have trade-offs where premiums decrease for one segment of the market and increase for another. In order to more easily compare each of the premium options, a similar policy goal was established. In particular, a 10% premium reduction, was targeted for at least a portion of the individual market, as a result of each policy option. The specifics for each policy option are discussed later in the report.

Each of the policy options provided different effects, which is summarized in the chart below. The chart captures the combined effects of the specific policy option and the noted market structure. Table 3 summarizes the key considerations for each program, each of which is described in greater detail later in the report. Each component is color-coded on a comparative scale to indicate which measures are most positively affected and which are least positively affected under each program. The darker the shade the stronger the effect. For example, the darker green indicates an option that is more favorable than one with a lighter green shading. A few policies are shaded gray for small group since the policies would not apply to that market. Similar to Table 2, the individual market has been split by adult ages and subsidized and unsubsidized members.

Table 3: Impact on Markets for each Policy Option

Policy	Market Structure	Individual Market				Small Group
		Younger Adults (21-44)		Older Adults (45+)		
		Subsidized	Unsubsidized	Subsidized	Unsubsidized	
Reinsurance	Unmerged					
Reinsurance	Partially Unmerged					
Additional Premium Subsidies	Partially Unmerged					
Reference-Based Pricing Plan	Partially Unmerged					
Age Rating	Partially Unmerged					

	Likely Positive Impact
	Mixed/No Impact/Contingent
	Likely Negative Impact

The following outlines more specific considerations for the State on how the various policy options could impact the individual and small group markets.

- **State Costs**: Some of the policy options, such as reinsurance or additional premium subsidies, would require the state to raise funds to cover all or a part of the cost of the program. The higher the state investment, the larger the premium reduction to consumers. For illustrative purposes, Wakely determined state costs that would be needed to lower premiums by 10% on select segments of the individual market. The range in estimated 2021 state costs for this level of premium impact is $10.2 to $19.5 million for reinsurance. For additional premiums subsidies, $2.2 million would be needed to lower premiums for enrollees between 400% to 500% FPL while $9.3 million would be needed to lower premiums 10% for all unsubsidized above 400% FPL. For the reference-based pricing plan, there are likely no direct state costs but it is important to note that the cost of the program would be incurred by facilities who would take lower reimbursement rates (roughly 20% lower) so that the individual market premiums could be 10% lower. The state could incur significant additional operational costs to administer and monitor the reference-based pricing plan program. There would be minimal one-time state costs for age rating changes.

- **Federal Funding:** The reinsurance program is the only program that would require a 1332 waiver, with the expectation that Federal funding would be available to pay a portion of the program.

- **Federal Approval:** The reinsurance program and implementation of age rating would require Federal approval.

- **Operational Complexities:** The reference-based pricing plan would likely be the most difficult to accurately and appropriately implement, while the reinsurance program would likely be the easiest. Additional premium subsidies and age rating have moderate operational complexities.

- **Consumer Savings**: As noted, the impact to premiums for some policy options will depend on the investment from the State. For the reinsurance programs, a 10% premium reduction for unsubsidized members was assumed. Under reinsurance with an unmerged market, the small group premiums also are estimated to decrease by 5.8%, which comes at a higher cost to the state. The premiums subsidies looked at reducing premiums by 10% for all unsubsidized and only for the unsubsidized between 400% and 500% FPL. Age rating is budget neutral so there are members who will see both premium increases and decreases. In particular, a 21 year-old would see relative premium decreases of 10% but that decrease would get gradually less and become a relative premium increase around age 45. Those aged 65 could see premium increases around 9%. Finally, the reference-based pricing plan would decrease premiums by 10% for unsubsidized consumers.

- **Consumers Impacted:** The primary target for premium reduction is the unsubsidized individual market, specifically the younger enrollees, since the value proposition is less, relative to other state's individual market, for these individuals given community rating. There is also a secondary goal to lower premiums for small group enrollees. While each of the policy options targeted lowering premiums by 10% for some portion of the unsubsidized individual market, the impact on other segments of the individual market and small group vary. In particular, for the small group market, the impact of age rating will vary based on the composition of each small group. For subsidized enrollee, the impact will vary based on plan and age. For example, younger subsidized enrollees in bronze plans may face premium increases, while older subsidized enrollees in bronze may face premium decreases.

- **Alignment with State Goals:** The main AHS goals of lower premiums for unsubsidized younger enrollees and small group members could be met by any of the policy options. However all of the options include trade-offs. Several of the options require external funding (for example reinsurance or subsidies). Other options may result in higher premiums for some sub-segment of the population. For example, reinsurance could

increase premiums for subsidized enrollees, or implementing age rating could increase premiums for older enrollees or families.

Merged Market Considerations in Conjunction with Policy Options

The ideal market structure for the State ultimately depends on many other factors. While the most important factor is the State's policy priorities, there are other factors, including but not limited to:

- **Availability of State funds.** The amount of funds, if any, that may be available for select policy options could determine the most appropriate market structure. For example, if having lower premiums in both the individual and small group markets are priorities, then unmerging the markets may make sense only if funds are available to offset the premium increases the individual market would experience as a result of unmerging the markets.

- **Needed flexibility.** If the State has a known policy preference, then the policy preference may determine the best market structure. However, if there is uncertainty, a partially unmerged market may be the most ideal structure since it provides the State with greater flexibility to implement a future policy, as it can more easily target the policy impact to just the individual or small group market.

- **Operational considerations.** To unmerge the markets, either partially or fully, would require permission from CMS. Discussions with CMS would be needed as to the exact requirements needed to obtain permission.

It is important to note that the policy options analyzed focus on the financing of health insurance premiums and are mostly short-term solutions to lower premiums for targeted populations. These programs will most likely not address the longer-term issue of overall health care costs. There is a trend at the state-level (and supported at the Federal level) to ensure policy efforts and 1332 waivers include cost containments strategies. Such a model could reduce costs to the states or further reduce premiums. Vermont has a long history of implementing various programs statewide to address cost containment. For example, Vermont's All-Payer Accountable Care Organization Model is a statewide initiative designed to move costs away from fee for service payments to a value-based, pre-paid Accountable Care Organization (ACO) with a goal of limiting health care cost growth to no more than 3.5% in aggregate across all payers, while increasing access to primary care providers, and improving health outcomes.

Results of the Analyses

Unmerging the Market

Currently, Vermont has a merged market. While multiple states considered merging their markets as part of the implementation of the ACA, ultimately only Vermont implemented a fully merged market. Most states have an unmerged market, although at least one state (Massachusetts) has a partially unmerged market.

FULLY MERGED

In a fully merged market, guaranteed issue, rate setting, and risk adjustment occur across both markets (individual and small group) such that premiums for the individual and small group markets are the same. In order to ensure “merged rates”, the rate development (“index rate”) and risk adjustment occurs across both markets, and all products are available to both markets (guaranteed issue). The result is that any changes in either market (for example changes in morbidity) is spread across the entire market. This results in a larger risk pool which is better able to absorb negative changes to the market and potentially allows for portability between the individual market and small employers.

However, since the markets are joined, it is harder to create policy solutions targeted to either market. For example, issuers have a harder time of targeting products to segments of the population. Furthermore, policies designed to reduce premiums for unsubsidized enrollees in the individual market, such as reinsurance, have a harder time targeting only the individual market. Consequently, it would take greater funding to decrease premiums for the unsubsidized individual market since the impact of reinsurance would need to be spread across both markets. Consequently, while the merged market has some policy advantages in terms of stability, it reduces options in regards to policy flexibility.

FULLY UNMERGED

In a fully unmerged market, guaranteed issue, rate setting, and risk adjustment occur within each market (individual and small group) separately. In addition, products can be developed specifically for one market. Table 4 shows the expected impact to each market if a fully unmerged market was implemented in Vermont.

Table 4: Estimated 2021 Impact of Fully Unmerging the Markets

Market	Average Members	Impact of Separate Risk Adjustment	Premium Adjustment to even out Experience in the Markets	Premium Impact by Market
Individual	33,040	4.3%	2.5%	7.0%
Small Group	40,358	-3.6%	-2.3%	-5.8%

If unmerging was enacted in 2021, Wakely estimates this would increase premiums by 7.0% in the individual market and decrease premiums by 5.8% in the small group. These are not absolute premium changes for 2021, but rather the change in premiums solely attributed to unmerging the markets. These impacts are driven primarily by small group plans which, on average, transfer risk adjustment funds to individual market plans. Additionally, the individual market performs worse than the small group market even with the risk adjustment transfers. Assuming the same loss ratio would be targeted in both markets further increases the individual premiums and further lowers the small group premiums.

Because of APTCs, the entire individual market would not experience a premium impact of 7.0%. While unsubsidized enrollees will experience the premium increase, subsidized enrollees will not experience the premium increase and in certain circumstances, may experience a premium decrease.[11]

While unmerging the markets will increase individual market premiums, it will also allow the state to implement policy options that affect only the individual market. Consequently, enrollees in the small group would see premium decreases and unsubsidized enrollees in the individual market would see a premium increase, which could be offset by other policy options targeted at the unsubsidized individual market. Subsidized enrollees would either have no impact (especially those who purchase the second lowest cost-silver plan) or have some benefit (the construction of the subsidy often means that a greater of amount of subsidy is available with a premium increase for those that purchase certain non-benchmark plans, for example a bronze plan).

[11] In certain situations, the amount of subsidies an enrollee has increases faster than premiums resulting in subsidized enrollees (such as those enrolled in bronze plans) to potentially have lower net premiums.

PARTIALLY UNMERGED

While Act 63 did not specifically speak to this option, another potential option is a partially unmerged market. In an unmerged market, states have flexibility in that there are options between a fully merged and fully unmerged market. In a partially unmerged market, rate setting and risk adjustment generally occurs across markets but issuers can create plans targeted to each market, as guaranteed issue is not applicable.[12] Massachusetts currently operates a partially unmerged market.

In this scenario, since risk adjustment is unaffected, premiums are not impacted. However, similar to a fully unmerged market, Vermont would be able to implement policy options that affect only the individual market, which may be able to garner more pass-through funds through a 1332 waiver, since the state could more easily direct reinsurance payments to individual market plans, for example. Vermont would need to get CMS approval to operate a partially unmerged market such that risk adjustment still occurs across both markets.[13] CMS may require analysis to justify changes to merged market and risk adjustment.

Additional Policies

Given that fully unmerging the markets is estimated to increase the premiums in the individual market, Wakely further analyzed additional policies that could potentially offset these premium increases. In a partially unmerged market, these additional policy options could make premiums more affordable to unsubsidized and younger Vermonters. Listed below are some of the policies explored:

- Reinsurance, under both a fully unmerged and partially unmerged market
- Reference-Based Pricing Plan
- Premium Subsidies
- Implementing Age Rating

The remainder of the report will discuss these options and their impacts on premiums for the markets and various sub-populations. The policy options will be split by those that would be most efficient under a fully unmerged or partially unmerged market (reinsurance and reference-based

[12] Please note that under ACA requirements, a partially unmerged market is considered unmerged but CMS does allow risk adjustment to occur across individual and small groups (i.e., merged) even if the state does not have a legally merged market in certain circumstances.

[13] In a partially unmerged market, CMS may default to not having risk adjustment across both markets, unless CMS approves of Vermont's policy position to continue risk adjustment across both markets.

pricing plan) and those that could be offered under any merged market structure (additional premium subsidies and age rating).

Additional Policies – Fully Unmerged or Partially Unmerged Market

The two policies that would be most efficient under a fully unmerged market or a partially unmerged market are the reinsurance program and the reference-based pricing plan. For reinsurance, the benefit of these structures is that the impact of the reinsurance program could be applied only to the individual market instead of spreading the payments to the small group market as well. Also, federal funding would be substantially lower under the current market structure. For the reference-based pricing plan, this product would likely be limited to only the unsubsidized individual market in order to limit the number of members who enroll in a plan where facilities receive lower reimbursement rates. Under the current structure, this plan would have to be offered to both the individual and small group markets.

STATE-BASED REINSURANCE PROGRAM – FULLY UNMERGED AND PARTIALLY UNMERGED MARKET

Reinsurance is a technique that protects issuers from catastrophic claims for the members they enroll. Typically, this risk is managed by insuring these members through the form of a reinsurance program. A reinsurance program can be structured in many different ways. Our analysis focuses on a claims-based reinsurance program, which pay a portion of claim costs, based on a prescribed coinsurance rate, between an attachment point (the point at which the claims cost begin being paid) and a cap (the point at which the reinsurance payments stop). Policy makers traditionally trade-off between having a higher coinsurance, which provides more protection for the issuers, and a lower coinsurance, which encourages insurers to maximize disease cost management.

The reinsurance program that was modeled includes a successful 1332 waiver. In this model, CMS will provide Federal pass-through funds to assist the state in its reinsurance program.[14] Wakely estimated the costs and impact associated with a 10% premium reduction compared to the current market (merged and no reinsurance). Under a fully unmerged market where individual market premiums would increase by 7%, a reinsurance impact of approximately -16% is needed to arrive at a net 10% premium reduction. For the partially unmerged market, the reinsurance program only needs a -10% premium impact.

Below are the key results of the analysis:

[14] Please see the Appendix D for more details on 1332 waivers.

- **State Costs:** In an unmerged market, the State would need to fund approximately $19.5 million to arrive at a 10% premium impact. In a partially unmerged market the State would need to fund approximately $10.2 million to arrive at a 10% premium impact.

- **Federal Funds:** Wakely estimates the Federal pass-through (or amount of the program that the Federal government will pay) is around 60% but varies by scenario. This results in approximately $16.4 to $27.7 million in Federal pass-through dollars under the partially unmerged and unmerged markets, respectively. Federal approval, through the 1332 waiver, would be required.

- **Consumer Savings:** Unsubsidized enrollees would experience a 10% relative decrease in premiums. In the fully unmerged market, the small group members would experience a 5.8% premium decrease due to the unmerging (the reinsurance program would not apply to small group).

- **Consumers Impacted**: The small group market would not be impacted by the reinsurance program directly albeit would experience a premium decrease if the markets were fully unmerged. The major beneficiary of the reinsurance program would be unsubsidized enrollees in the individual market, which represent 36% of the market. Uninsured individuals who are not eligible for subsidies could also potentially benefit if the lower premiums encourage them to take-up coverage. Finally, subsidized members in the individual market (64% of the market) are mostly unaffected by premium changes since their out of pocket (net) premiums are based on income. However, if a subsidized member purchases a plan other than the second lowest cost silver plan, it is possible their net premiums would increase since their premium subsidy would be lower as a result of the second lowest cost silver plan premium decreasing.

- **Alignment with State Goals**: In both models the States' primary goals are met as unsubsidized enrollees' premiums would be lower than the baseline (merged market, no reinsurance configuration). In a fully unmerged market with a reinsurance program, the small group market premiums will also be lower (but more state funding is needed under that scenario).

- **Key Benefits:** This type of program has been successful in reducing premiums in other states and there is ability to leverage Federal funds through a 1332 waiver to create a larger program than one solely funded by state-funds. A reinsurance program is typically easier to operate compared to other analyzed programs.

- **Key Risks:** Federal funding amounts have a high degree of uncertainty. Also, the program could hurt some subsidized members in the market if their federal premium assistance subsidies are reduced. There are limitations in the ability to target certain populations' premiums through a reinsurance program. The ability to implement this would be

contingent on the availability of state funds. Reinsurance is a short-term fix. In order to avoid large premium increases in future years, increasing state funding for the program would be necessary.

REFERENCE-BASED PRICING PLAN – PARTIALLY UNMERGED MARKET

Another option is a reference-based pricing plan. In this model both of Vermont's issuers would offer non-QHP (albeit ACA compliant) plans whose provider payment rates are lower than what currently exists in the individual market. While the specifications of a reference-based priced plan would need to be refined, the reason to offer only off-Exchange in a partially unmerged market is so the plan could be limited to the individual market, target unsubsidized enrollees, and not impact subsidized enrollees. The less take up in the product, the less impact to the providers.

The specific plan that Wakely modeled would only be offered off-Exchange in the individual market. While this product could be implemented under a different market configuration, the product was analyzed assuming a partially unmerged market. A 10% reduction in premiums was targeted as an illustrative example and to compare this option with the other policy options analyzed. Based on the target premium reduction, the needed change in provider reimbursement rates for facilities only was calculated. Wakely did not make estimates targeting a specific reduction in provider payment rates or by reducing payments for non-facility services (such as professional). The impact to the facility providers is roughly twice what the premium impact is, because the portion of claims that are facility based are only a portion of claims costs and most administrative costs will not change as claims costs are reduced. Consequently, Wakely estimated for a 10% relative reduction in premiums, the facility reimbursements[15] would need to decrease approximately 20%. While this analysis only considered changing the reimbursement rate for facilities, the State could consider expanding the providers who would be impacted, which could either decrease the impact on the facilities and/or increase the premium impact.

Below are the key results of creating an off-Exchange reference-based pricing plan in a partially unmerged market.

- **State Costs**: The State would incur operational and analytic costs. The state would need to engage in significant analysis to identify the appropriate reference-based price (percent of Medicare) and which services would be included in the benchmark. Furthermore, the State may incur operational costs to operate, contract, or provide oversight on the reference-based pricing plans.

- **Federal Funds:** None and no Federal approval is needed.

[15] For purposes of the analysis, Wakely relied on EDGE data and defined facility to include all institutional claims. For further information, please see the Appendix A.

- **Consumer Savings**: Unsubsidized enrollees are estimated to have a 10% premium decrease.

- **Consumers Impacted**: 36% of the current individual market would have a lower premium option due to this product. It is not likely that the premium reduction would be large enough to make the product attractive to the 64% of the individual market that is currently subsidized. It may also be attractive to uninsured members although with only a 10% premium reduction, it is not likely to result in significant enrollment increases (enrollment retention is the more likely benefit).

- **Alignment with State Goals**: Lower premiums for unsubsidized individuals. Subsidized enrollees would not be negatively impacted by the policy.

- **Key Benefits**: Lower premiums could be achieved for the targeted populations.

- **Key Risks:** This policy option may not be feasible for Vermont. Additional analysis would be needed to understand how lower provider payments would interact with Vermont's All-Payer (APM) model, including if this policy could potentially conflict with the initiatives set forth under the APM or other goals of the State. Also, it may be extremely difficult to operationalize and implement a reference-based pricing plan given the complexities of provider payment rates and how the plan could impact the reimbursement levels. The product would only be available to a very small portion of the health insurance market, so the State would need to balance the additional complexity with the number of Vermonters helped by the product. This may result in a negative reaction from the provider community. In addition, costs for oversight of the program may be needed. Finally, this product would likely not be viable under the current market structure since it would also need to be provided to the small group market, which would decrease provider reimbursement for a significantly higher number of enrollees.

Additional Policies – Any Merged Market Structure

ADDITIONAL PREMIUM SUBSIDIES – FULLY MERGED OR PARTIALLY UNMERGED

Additional premium subsidies, i.e., in addition to the Federal APTCs, provide premium assistance to a subset of enrollees. One of the benefits of additional subsidies is that it could be targeted to specific vulnerable populations which may in turn benefit the risk pool.

While there are an infinite number of ways a subsidy program can be structured, for comparison purposes Wakely modeled the impact of providing a premium wrap assistance to both all unsubsidized individual market enrollees and also to just the unsubsidized between 400% to 500% FPL. In both scenarios, a 10% average premium reduction was targeted (although the reduction could vary by income/FPL level). While an average percent of premium was targeted

for comparison purposes, premium subsidy structures could be allocated on a per member per month amount or based on the income of the member, similar to the Federal APTC program. Roughly 35% of the 2021 individual market is expected to be over 400% FPL, of which around 8% is between 400% and 500% FPL. Income levels of the unsubsidized is less reliable than income levels for the subsidized individuals.

Since the baseline premiums are the same under the current fully merged market and under a partially unmerged market, the impact of a premium subsidy program would be the similar under both market structures. Below are the key results if the State created in an additional premium subsidy program in a partially unmerged market.

- **State Costs:** If the subsidies result in an average premium reduction of 10% for only those between 400% and 500% FPL, approximately $2.2 million in funding would be necessary. This increases to $9.3 million if the 10% average reduction applies to all members over 400% FPL. Note that the $9.3 million is less than the amount needed for the same impact to unsubsidized members under the reinsurance program.

- **Federal Funds**: None needed and no Federal approval is needed.

- **Consumer Savings:** The 10% reduction translates to around $800 in savings per member per year, on average, based on estimated 2021 premiums.

- **Consumers Impacted**: As modeled, only unsubsidized individuals would be impacted. This program does not apply to the small group market. While the current modeling does not assume additional premium subsidies for those with current Federal subsidies, the State could consider an additional subsidy for those under 400% FPL. The subsidies may also make the premiums more attractive to uninsured members although with only a 10% premium reduction, it is not likely to result in significant enrollment increases (enrollment retention and affordability is the more likely benefit).

- **Alignment with State Goals:** The program would result in lower premiums for unsubsidized individuals. If the State chose to do so, it could provide additional subsidies to younger members to encourage younger members to enroll in coverage, given healthy, younger individuals have less incentive to enroll given community rating. Subsidized enrollees would not be negatively impacted by the policy.

- **Key Benefits:** Targeting members who are not currently eligible for APTCs, or the unsubsidized over 400 percent FPL population, will help to shelter those individuals from bearing large premium increases that may potentially occur. Another benefit of offering a premium wrap is the program is completely funded by the State, therefore, there is less risk due to reliance on Federal funds. Given that only State funds would be used, there is also more flexibility that can be done under the program. For example, the State could

modify the amount and the beneficiaries of the premium subsidies every year if needed. There is also potential to decrease premiums more for the targeted unsubsidized enrollees compared to the impact from implementing a reinsurance program.

- **Key Risks**: There are some downsides to a premium wrap. The key challenge is the need to raise State funds to pay for the program. While the program addresses premium affordability, it does not lower overall claim costs or premiums at the single risk-pool level, except for circumstances where take-up due to the wrap lowers morbidity. Additionally, Vermont will need to discuss how to operationalize and structure the program. For example, it may be operationally easier to offer subsidies to on-Exchange enrollees only. However, this may be problematic as unsubsidized members are currently encouraged to enroll off-Exchange in order to avoid silver-loading. The premium available to the targeted population will need to be marketed in such a way to avoid member confusion and encourage enrollment, i.e. the added benefit needs to be understood by all parties. There is also some risk due to higher take-up than expected which may cause the program to cost more than originally budgeted or for enrollment caps to be implemented.

As noted, there are a limitless number of ways a premium wrap program can be structured. The structure modeled was high level for an easier comparison against other policy options. Any structure should consider the "cliff" (400% FPL, at which subsidies drop off making the net premium significantly different for those slightly under and slightly over 400% FPL), target population, income of the member, available funding, and the State goals. A couple of additional options that could be considered by the State include:

1. Provide a fixed dollar amount per month to all or a subset of unsubsidized enrollees to increase affordability and enrollment take-up.

2. Provide a percentage of premium (based on member premium or benchmark premium) or varying by age or region. Both California and Washington are in the process of implementing an ACA like subsidy structure (i.e., net premiums are capped at a percentage of income). In particular, the California structure limits the premium for those 400% to 450% FPL to 9.68% to 14% of income, premiums limited to 14% to 16% for those who are 450 to 500% FPL, and limited to 16% to 18% of income for those who are 500% to 600% FPL. California's program is also providing additional subsidies for those 200% to 400% FPL with the subsidies for this population also linked to income.

IMPLEMENTING AGE RATING – FULLY MERGED OR PARTIALLY UNMERGED

Currently, Vermont has a fully community rated market. Most states follow the Federal standard age factors, which sets a 3:1 age ratio for premiums. This means that for unsubsidized enrollees currently in Vermont, younger enrollees pay more and older enrollees tend to pay less relative to if the state implements age rating. Vermont could institute age rating such that younger

unsubsidized enrollees would pay less. This age rating could go to 3:1 or could be something less (e.g. 2:1).

This option, unlike most of the other policy options, was modeled to apply to both the individual and small group markets. While age rating could be implemented in any of the merged market structures, the specific impact to premiums would vary based on the structure since the distribution of members by age varies in the individual and small group markets. For this analysis, it was assumed that the markets would be fully merged or partially unmerged, such that the combined distribution of the members was used to determine the impact.

For comparison purposes to the other policy options, Wakely developed age rating rules that resulted in a 10% relative premium reduction for the youngest adult age group (21-24 year olds). Assuming the program was revenue neutral and that the percent difference in premiums by age group would be the same for all age groups resulted in age rating rules with a 1.2:1.0 ratio, compared to the Federal 3:1 ratio. That is, the premiums for a 65 year old in this scenario would be 20% higher than the premiums of a 21 year old, all else equal. It should be noted that a change in the age factors would impact risk adjustment transfers. Further analysis would be needed to understand how risk adjustment transfers would impact the markets and issuers.

It is also possible that the State would want more or less variation in the premiums by age. The age factor could be adjusted as needed. The age factors could also be phased in over time to limit the impact from occurring all at once.

Table 5 below shows the relative premium change by age group, as well as the portion of individual and small group members who fall into the age group. The Federal age factors adjust each year after age 24. Vermont could have factors that vary by age or by age groups. Children are not included in this analysis. While Vermont is community rated, there are set family tier ratios which results in child premiums being less than adult premiums. Vermont would likely also need to change the family tier structure, which creates additional complexities. For the high-level analysis only adult age factors were adjusted.

Table 5: Relative Impact on Premiums for a 1.2:1.0 Age Factors

Age Group	Estimated 2021 Market Distribution (Adults Only)	Relative Premium Impact
21-24	6.3%	-10.0%
25-29	8.4%	-8.0%
30-34	8.4%	-6.0%
35-39	8.3%	-4.0%
40-44	8.5%	-1.9%
45-49	10.4%	0.2%
50-54	12.5%	2.4%
55-59	15.5%	4.7%
60-64	18.6%	6.9%
65+	3.1%	9.3%

Below are the key results if the State implements age rating in a fully merged or partially unmerged market.

- **State Costs**: There are expected to be minimal explicit State costs beyond initial costs to determine the appropriate age rating and implementation costs.
- **Federal Funds:** None needed but Federal approval would be required. The factors do not necessarily have to follow the Federal standard and could be crafted to follow State policy preferences (within ACA legal limits).
- **Consumer Savings:** As noted in the table above, there would be notably lower premiums for the youngest adults with more moderate decreases for members around age 44.
- **Consumers Impacted:** The implementation of age rating would decrease premiums for younger unsubsidized enrollees and small group firms with relatively younger enrollees. It is also possible that the effect would have negligible, if not positive, impact to subsidized older enrollees. However, changing to age rating could increase premiums for older unsubsidized enrollees or firms that employ relatively older employees. Additionally, some subsidized younger enrollees may have premium increases (e.g., younger subsidized enrollees that buy bronze plans).
- **Alignment with State Goals:** This would align with the primary AHS goal of lowering premiums for unsubsidized and younger members. However, there are trade-offs since some members will see their premiums increase.

- **Key Benefits:** The key benefit is that minimal funds would be needed to implement this policy change and it does meet the state goals. Decreasing premiums for the younger population is increasingly important as alternative insurance options are available that do not have community rating (e.g. self-funding, large groups with health reimbursement account options, etc.). Limiting the migration due to the new insurance options will limit enrollment and risk changes in the current Vermont markets.

- **Key Risks:** Vermont has a long history of community rating so this change may not be viewed favorably. In addition, a change in age factors will impact risk transfers. This should be analyzed further to ensure that there are no unintended consequences of an age rating change to the markets and/or issuers.

Combining Policy Options

While each of the policy options was analyzed in isolation, with a specific merged market structure, some of the policy options could be combined to optimize the impacts and/or eliminate the negative impacts that some options create for specific market segments. Following are a few examples, albeit not complete list, of potential combinations:

- Implementing age rating could be combined with other policy options (e.g. reinsurance, premium subsidies, etc.) that decrease premiums in the individual market. This could partially or fully offset the premium increases for older members due to the age factors while significantly increasing the decrease in premiums for younger unsubsidized members.

- Policy options could be combined to limit the needed state funds and/or to limit the impact on other stakeholders (i.e. facility providers). For example, if a 10% premium reduction is targeted, a reference-based pricing plan could be developed that results in a 5% premium reduction and the State could also provide premium subsidies for an additional 5% reduction.

Additional Policies Considered

Wakely worked with the State to determine the specific policies to model. However, additional policies were considered that were not ultimately modeled due to data or time constraints. Each of these is briefly discussed below.

PREMIUM SUBSIDY REALLOCATION

There was interest in Vermont restructuring the current Federal subsidy program. It would be possible, through a 1332 waiver, to re-allocate subsidies as the State believes best. In this model, assuming Federal approval of the waiver, Vermont would receive the Treasury's estimate of

Premium Tax Credits (PTCs) that Vermont would have otherwise received absent the waiver. Vermont would allocate the PTCs by a different formula that the current ACA subsidy structure (for example, greater amount of subsidies to younger enrollees or including subsidies for those between 400% and 500% FPL).

This has a benefit of Vermont being able to better align the subsidy structure to the State policy goals. A major challenge is that it may be difficult to achieve an approved 1332 waiver. Vermont would also need to combine current PTCs and the Vermont Premium Assistance (VPA) program to understand the details of what the current net premiums are by income level. Furthermore, re-allocation of subsides may result in some currently subsidized enrollees from having net premium increases. Finally, the state is at risk if unforeseen changes to the state market occurs. The amount of pass-through would not alter if, for example, subsidized enrollment was higher than expected. In such a scenario, the state would need to either reduce the amount of subsidies enrollees receive, lock out additional enrollees for receiving subsidies, or allocate state funds to mitigate the short-fall.

BASIC HEALTH PLAN

A couple of states, New York and Minnesota, have implemented Section 1331 of the ACA in the form of a Basic Health Plan (BHP). The Basic Health plan is eligible for enrollees with incomes between 138% and 200% FPL. A BHP would allow the state to create a transition program for enrollees shifting out of Medicaid or out of the individual market. Also by removing enrollees below 200% FPL the merged market may experience an improvement in morbidity as enrollees below 200% tend to have higher claims cost. A significant challenge to this program is that it may be disruptive to enrollees currently in the individual market, who otherwise would lose subsidy eligibility. Finally, BHP funding is calculated by CMS, so changes in CMS regulations or funding calculations, may result in funding short-falls.

VERMONT PREMIUM ASSISTANCE RE-ALLOCATION

Vermont currently has a premium subsidy program that supplements Federal APTCs for lower income enrollees in the individual market. While it may be possible to use this funding and reallocate it to other target populations, due to the potential for increased premiums for the current beneficiaries it was determined that this was not a change worth analyzing.

GEOGRAPHIC RATING AREAS

Given the goals of the State to lower premiums for unsubsidized and younger members, Wakely reviewed the 2018 data to see if creating rating areas in Vermont would support the State goals. Based on the historical data, Chittenden and surrounding counties have both a higher number of younger adults and a lower portion of members receiving premium subsidies in the individual market, compared to the statewide average. It is possible that premiums could be lowered in

these counties, which would help the younger unsubsidized members in the individual market. However, this would result in premium increases to other areas of the state where the percent of unsubsidized is still significant. Due to this and Vermont's history of having a single rating area, no further analysis was done on this option.

COST-SHARING WRAP

The ACA included a key provision, known as CSR plans, that has had a substantial impact on protecting certain enrollees from high out of pocket expenses. The Federal government requires Issuers to offer three silver plans with reduced cost-sharing (cost-sharing variant plans) for low-income enrollees meeting income thresholds. Vermont added a fourth reduced cost-sharing plan. Vermont would have the option for additional cost-sharing wraps or to reallocate the current funds for its cost-sharing wrap.

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

Appendix A: Data and Methodology

The analyses in this report utilized multiple data sources and methodologies. This section describes the key elements of the methodology and assumptions used for various calculations and analyses. Data reliance and assumptions were discussed within Appendix B.

Data Collection

Wakely worked with Vermont carriers on behalf of Vermont to collect 2018 EDGE server data, risk adjustment transfer payment files (or TPIR files), and 2018 and emerging 2019 supplemental data for all carriers participating in the individual and small group ACA Vermont markets during those years. These data sets contained detailed member level information such as premiums, claims dollars, information to calculate risk score transfer amounts, and enrollment specifications. The data also included additional information, such as county to member mappings and APTC information. Wakely reviewed the supplemental data provided by the carriers for reasonability.

Risk Adjustment Methodology

The calculation of risk adjustment was utilized for recalculating risk transfers under the merged and unmerged scenarios for both 2018 and 2021. Wakely's processing tools first used the 2018 HHS-HCC risk adjustment methodology and transfer process to be consistent with the data provided by the Vermont carriers in order to provide a historical view of the 2018 market. The transfers were then recalculated under an unmerged scenario to provide insight into how premium amounts may be impacted by unmerging risk transfers. The 2021 risk transfers were calculated using the trended statewide premium values and the 2018 HHS-HCC risk adjustment methodology. Adjustments were made in the individual market for members switching metals for their risk scores to more accurately reflect the risk scores of the metal to which they transferred. In the 2021 risk transfer calculation the members that were removed from the small group market were not included.

Wakely did not adjustment the claim data for the risk adjustment high cost risk pooling, which reimburses claims above $1,000,000 million dollars at 60%. While there were no claims in 2018 that were eligible for high cost risk pooling payments, it is possible that in 2021 claims could be reimbursed under this program.

Federal Poverty Level Assignment

FPL at the subscriber level was required for structuring benefits of the wrap programs and also for evaluating many of the program impacts on the 2021 individual market. As mentioned, this information is not included within the collected EDGE data. Therefore, Wakely used FPL assignment logic to group subscribers into FPL categories based on carrier supplied APTC

information, 2018 U.S. Census data, and CMS Open Enrollment files. FPL was assigned at 50 percent increments from 100 percent to 500 percent, for both on and off the Exchange enrollees.

FPL assignment for APTC eligible subscribers' on-Exchange: The APTC subsidy is calculated by subtracting a certain percentage of the household's income from the cost of the second lowest cost silver plan available to that household. While APTC is calculated at the tax household level for purposes of these analyses, Wakely assumed subscriber and dependents on a policy was equal to a tax household. APTC provided by the carriers was used to infer subscriber annual income levels based on the Federal formula. This calculation utilizes the maximum payable amount a subscriber can spend on premiums and the second lowest cost silver plan in the county the subscriber is enrolled in, to estimate a household income and FPL percentage. The resulting FPL was compared to known FPL based on plan eligibility, such as CSR silver variant enrollees who would fall within their respective 138 percent to 250 percent FPL range, and APTC members who would fall under 400 percent FPL.

FPL assignment for non-eligible APTC subscribers' on-Exchange: 2018 U.S. Census data and 2018 CMS Public Use Files (PUF) were used to determine the distribution of on-Exchange enrollment by FPL range above 400 percent FPL. Subscribers were then randomly assigned to FPL categories to match the estimated on-Exchange distribution. The resulting FPL estimates were compared to the known threshold that non-APTC on-Exchange subscribers have income levels higher than 400 percent FPL to ensure reasonability of results.

While Wakely does not have access to individual level income data, the summary findings were compared to both Census data and CMS Open Enrollment Reports for reasonability.

2021 Baseline Development

The 2018 EDGE server data that Wakely received was processed through the Wakely Risk Insight (WRI) tool. WRI is a tool that was designed to assist in identifying the drivers of relative experience in a risk-adjusted environment. Wakely used EDGE server logic when determining which records should be included in or rejected from the analysis. To perform the analysis, WRI calculates, estimates, and allocates important financial quantities (e.g. risk adjustment transfers, premiums, claims, etc.) at the member level. The data components, including premiums, claims, and risk adjustment transfers components were allocated to each member.

In order to calculate the impact of the program changes, Wakely then developed a Baseline database to best estimate the environment in 2021. Assumptions were developed based on Wakely internal modeling, emerging 2019 experience, conversations with Vermont carriers and the State, and public source information to project the 2018 carrier data to the 2021 time period.

Adjustments were made to the 2018 base data at a member level basis to generate an estimate of the 2021 Baseline.

1. **Paid Trend.** The paid trend is derived from the carrier's 2019 and 2020 rate filings. Trend was split between medical and pharmacy separately. Wakely used an approximate trend of around 7% for each year across medical and pharmacy. Wakely assumed the same factors for 2020 to 2021 as the 2019 to 2020 factors. The overall increase to paid claims for 2018 to 2021 is 24.8% for individual and 25.5% for small group.

2. **Premium.** The premium changes from 2018 to 2019 and from 2019 to 2020 were derived from the rate filings. The premium increases were applied at the 14-digit plan identifier level for each carrier. Wakely assumed the same factor for 2020 to 2021 as the 2019 to 2020 factor for each plan. The overall increase to premiums for 2018 to 2021 is 33.9% for individual and 30.0% for small group.

In addition to trending the data, Wakely applied a change to the enrollment and morbidity from 2018 to 2021. The targeted enrollment and morbidity assumptions were applied as follows:

- **Enrollment.** Individual enrollment on aggregate was assumed to be stable from 2018 to 2021. Small group enrollment was decreased by 10% to account for association health plans and other factors.

- **Metal Level.** Individual market enrollment metal level mix was adjusted to match the estimated metal level mix in 2019 to account for the significant shifting that occurred due to CSR silver loading. For members who switched metal level, premiums were adjusted to align with the new metal level. Claims were adjusted so that the original ratio between premiums and claims remained constant. Small group enrollment was also adjusted for changes in metal level shifts.

- **Morbidity.** Individual market morbidity was assumed to have no change given no enrollment changes. Small group morbidity was adjusted with a small increase in claims (approximately 2.2%) to account for the enrollment loss.

- **APTC**. To estimate the average 2021 APTC amounts, Wakely used the 2018 and emerging 2019 APTC information from Vermont's insurers including APTC amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We then inflated gross premiums for APTC enrollees in 2021 by the average market premium increases. This new 2021 gross premium amount is then reduced by the 2021 net premium values to calculate the 2021 APTC PMPM amounts. The 2021 net premiums were the 2018 net premiums adjusted by 2019 net premium data to account for indexing.

  The resulting 2021 APTC and net premium amounts were reviewed for reasonability by FPL and metal level.

The regulatory environment, both at the federal and state level, does impact enrollment, premiums, and morbidity. The assumed regulatory environment in 2021 reflects the status quo, as follows:

- We assumed silver loading on-Exchange would continue. Based on the 2020 proposed National Benefit and Payment Parameters, this may be disallowed beginning in 2021.
- No other proposed regulatory changes were included within the 2021 Baseline.

2021 Policy Methodology

The following are assumptions that applied to all of the merged market structure and policy options evaluated.

- **Enrollment.** No change in enrollment was assumed due to premium increases or decreases as a result of market structure or policy options. While this was done to provider easier comparisons, particularly since different combinations of market structure and policy options were evaluated, it is not expected that enrollment changes would be large. The Vermont market has remained relatively stable despite years of 10% rate increases. Also, the uninsured rate is low in Vermont so any take-up of insurance due to lower premiums is likely to be small. Enrollment changes should be considered for more detailed analysis for any policy option the State is considering.
- **Morbidity.** No change in morbidity was assumed as a result of policy changes since no enrollment changes were assumed.

REINSURANCE METHODOLOGY

The starting impact of a 10% premium decrease as a result of reinsurance was used to estimate the total and state funding needed by taking the reduction in premiums and dividing the total reinsurance funding amount by the total estimated 2021 baseline individual market premium.

Some of the key assumptions in the calculations include:

- Assumes no premium assessment would be used to raise the needed external funds. If there is a premium assessment or impact of the SLCSP is lower than market average, pass-through will be less and more state funds will be needed for the same premium impact. Based on preliminary analysis, it may not be viable to fund the state portion of the funds only through an assessment of the fully insured market as the individual market represents a significant portion of total premiums in the fully insured market (generally, the larger the assessment on the individual market the smaller the Federal pass-through).

- Assumes the impact of reinsurance is the same for the SLCSP issuer as the market average. If the impact of reinsurance is less for the SLCSP issuer, pass-through will be less and more state funds will be needed for the same premium impact.

- Enrollment and morbidity of the market is not expected to change as a result of the reinsurance. While it is likely that there may be a small increase in enrollment as a result of the program, the impact is likely to be small and would not impact the relative results.

Federal pass-through amounts were calculated in the following manner, consistent with the methodology outlined by the Office of Tax Analysis (OTA). First, the aggregate amount of advanced-premium tax credits in the baseline scenario were compared to the aggregate amount of advanced premium tax credits in the waiver scenario. The difference in advanced premium tax credits is then adjusted to calculate the total premium tax credit subsidy. To do that Wakely relied on discussions with OTA and CMS to estimate the PTC ratio as well as using publicly available IRS tax statistics from the 2016 benefit year. The actual data used by OTA for the 2021 calculations will be from 2018 as well as from 1095-A data, which are currently not public at the time of Wakely completing this report. The ratio of total PTC subsidy after reconciliation to APTC based on tax data for benefit year 2016 (or 91.7%) was multiplied by the APTC savings. This total PTC savings are then reduced by potential differences in the Federal Exchange user fee. This new aggregate amount is the total net Federal savings.

Additionally, we note that a different methodological approach to the application of the premium tax credit adjustment could result in a different pass-through. According to the OTA methodology, the adjustment to advanced premium tax credits to calculate premium tax credits is handled at the last step via a ratio multiplied by APTC savings. However, if a different methodology were applied, such as PTC ratio applied directly to APTC amounts at the baseline, the result would increase the pass-through of the best estimate, thus increasing total funding and the premium impact. Changing how the PTC adjustment is applied could increase the pass-through which would require less state funding.

REFERENCE-BASED PRICING PLAN METHODOLOGY

For the reference-based pricing plan, the following steps were taken:

- Using a Rand report[16], we estimated the current facility reimbursement in the commercial market as a percent of Medicare. This equaled 217% of Medicare but varied by inpatient and outpatient.

[16] https://www.rand.org/pubs/research_reports/RR3033.html

- Using the 2018 Vermont EDGE data provided by the issuers, it was determined that facility costs represented approximately 57% of the total claims costs. To define which claim amounts are “facility”, Wakely first identified professional and institutional claims from the EDGE data, which contains a form type code field that identifies all medical claims as “professional” or “institutional”. Wakely also used the bill type code field in the EDGE medical data to further distinguish between outpatient and inpatient institutional claims. The form type code and bill type code fields are populated by the issuers in the medical files that are being submitted to the EDGE server. All institutional claims, both inpatient and outpatient, were considered facility claims for purposes of the analysis. This definition would likely be refined by the State if a reference-based pricing product was further analyzed.

- Based on 2020 Vermont rate filings, we assumed a non-benefit expense load of 10% and that this load would not change as claims change.

- Given all of these assumptions and a target premium reduction of 10%, we were able to calculate the needed decrease in provider reimbursement rates for facilities and the resulting % of Medicare.

ADDITIONAL PREMIUM SUBSIDIES

For the additional premium subsidies, the following steps were taken:

- Wakely estimated the number of 2021 member months from 400% to 500% FPL and also 400%+ FPL. This was based on APTC data and census information, as noted prior.

- Using the estimated 2021 premiums for this population, we calculated what a 10% reduction in premiums would require for each of the populations, which becomes the needed state funding.

AGE FACTOR CHANGES

For changes to the age factors, the following steps were taken:

- The estimated 2021 distribution of premiums (member months times premium) by age grouping was developed using the baseline data.

- For adults aged 21 and over, new age factors were developed that met the following parameters: resulting in a 10% premium reduction for a 21 year-old, was budget neutral, and the age factors increased the same percent for each age grouping.

Appendix B: Assumptions and Reliances

Wakely has utilized data provided by Vermont carriers in the analyses described in this report. A data request was sent to all carriers that contained a full description of the EDGE server files (see Appendix 1 for definition) and supplemental data needed. The analyses were performed using the following data.

- A complete set of 2018 EDGE Server XML data were collected from each carrier. This data includes:
    - The inbound enrollment, medical, pharmacy, and supplemental files that were submitted by each carrier to the EDGE Server.
    - The corresponding response files that apply an accept/reject status to the claims in the inbound files.
    - The final outbound files that were produced in May 2019. These files include the risk adjustment, high cost risk pooling, and enrollee claims detail/enrollee claims summary reports.
- TPIR files (the risk adjustment payment transfer reports – see Appendix 1 for further description) that contain the values that Centers for Medicare and Medicaid Services (CMS) used to calculate the issuer-specific risk adjustment transfer amounts by plan identifier and rating area.
- 2018 and 2019 supplemental information was also collected including:
    - January through August 2019 premium and membership experience by Exchange status and county, as well as Exchange status and metal level for both the individual and small group markets.
    - Annual 2018 premium, enrollment, and claim cost experience by Exchange status and metal level for both individual and small group markets.
    - Annual 2018 and January through August 2019 individual market membership and premium experience for APTC eligible subscribers including APTCs, gross premium, and net premiums by metal level.
- 2019 subscriber level information was also collected:
    - For each small group subscriber span the employer county, subscriber state, and subscriber county.
    - For each individual subscriber span the subscriber county, gross premium, household premium, and APTC amount. The Vermont Premium Assistance amount for each subscriber span was also requested, however, the issuers were

unable to provide this value at the subscriber span level to Wakely and thus was not included in the analysis.

The enrollment, premiums, and paid claim PMPM information provided in the EDGE Server was assumed to be accurate and complete for both of the Vermont carriers.

Enrollment, medical, pharmacy, and supplemental records that were rejected by the 2018 EDGE server were removed from the analyses. Wakely utilizes independent logic per the guidance of the 2018 EDGE Server Business Rules to identify records that are accepted but not valid for use in the 2018 EDGE Server. Medical, pharmacy, and supplemental records that were orphaned, voided, or replaced were removed from the analyses. Any errors in the EDGE server data, TPIR files, supplement data, enrollment data and other source data could have an impact on the results of these analyses.

Wakely utilizes a proprietary risk scoring model called Wakely Risk Assessment (WRA) using the HHS-HCC model based on CMS's published guidance such as the Notice of Benefit and Payment Parameters and "Do It Yourself" (DIY) software. Wakely applied the 2018 CMS HHS-HCC risk adjustment methodologies, as utilized within the relative experience analyses. Wakely relies on the above and other proprietary assumptions implicit in the WRI tool when assigning member level relative experience.

Additional assumptions were made within the models used in the analyses.

- Wakely estimated FPL at the subscriber level based on APTC information, 2018 U.S. Census data, and assignment logic. On-Exchange breakouts were also reviewed against CMS Open Enrollment statistics, over various years.

- The high cost risk pool program that began in 2018 reimburse claims in excess of $1 million at 60 percent coinsurance rate. No claims passed the $1 million threshold in 2018, and therefore no adjustment was made. No adjustment was made for 2021 although it is possible that there will be claims above $1 million in 2021.

- The mechanism of funding the analyzed programs was not incorporated into the analyses. No assessment was assumed on the individual market and all operational and administrative costs that the state may incur, were not included.

- Overall Individual market enrollment in 2021 was assumed to be stable relative to 2018. Furthermore, Wakely assumed that the small group enrollment in 2021 was assumed to similar to the enrollment experience to date in 2019. Differences in enrollment for either market, for example due to changes in the HRA policy, could have material effects on the estimates in this report.

- Wakely did not did not adjust the portion of members on/off Exchange when migrated members for the individual market. This result in the estimates having too many members in silver-plans. Wakely estimates this likely results in overstating the individual premiums from 2018 to 2019 by approximately 1%.

- Expectations for the 2021 individual and small group markets environment, particularly around enrollment, morbidity, trend, and premium changes were discussed with insurers in the Vermont market.

- Wakely did include any enrollment changes due to the policy options. In reality, enrollment would be expected to change due to the policies, however to provide a more equal comparison of policy effects, Wakely did not include enrollment impacts or related morbidity impacts of the potential policy changes.

In addition to the data described above, Wakely relied on the following public data sources to inform the assumptions used in the analyses:

- The 2018 and 2019 Open Enrollment Report PUF produced by HHS[17]

- Effectuated Enrollment Reports released by CMS[18]

- 2017 and 2018 U.S. Census data[19]

- 2019 and 2020 Vermont Rate Filings[20]

[17] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html

[18] https://www.cms.gov/newsroom/fact-sheets/early-2019-effectuated-enrollment-snapshot

[19] https://www.census.gov/cps/data/cpstablecreator.html

[20] https://ratereview.vermont.gov/

Appendix C: Historical Experience and Benchmarks

Before estimating the impact of the various merged market structures and policy options on the individual and small group markets, we first looked at the historical data to better understand the market. This was critical to better to understand which policy options might work best in Vermont's markets.

The following shows key highlights of the historical data (2018 and 2019 to date) as well as comparisons to national data.

Historical Data

The following highlights the Vermont individual and small group market enrollment distributions for various segments of the market. The portion of member months that are subsidized is also included for the individual market to better understand which segments of the market are paying full premiums.

The table below shows the distribution of member months by age grouping.

Table 6: 2018 Age Distribution by Market

Age Group	Individual Market Distribution	% Individual Market Subsidized	Small Group Market Distribution
00-01	0.3%	32.9%	1.0%
02-20	8.0%	33.8%	16.5%
21-24	5.2%	66.2%	5.7%
25-29	7.2%	78.3%	7.4%
30-34	6.8%	81.7%	7.7%
35-39	6.8%	77.9%	7.6%
40-44	7.1%	72.9%	7.6%
45-49	9.0%	70.4%	9.0%
50-54	10.9%	65.3%	10.8%
55-59	15.2%	60.2%	12.0%
60-64	22.1%	58.3%	11.1%
65+	1.3%	48.7%	3.7%

As seen in Table 6, almost half of the individual market is age 50 and older, compared to 37.5% of the small group market. The table also shows that ages 25 to 49 are the most likely to be subsidized. This could be due to the higher uninsured rate at ages 25-44, implying that younger individuals are more likely to remain uninsured unless they receive subsidies. Children are least likely to be subsidized, likely since Medicaid covers most low-income children.

The following shows member month distributions by county. For small group, the data is shown based on the county where the employer is located as well as the county where the enrollee resides.

Table 7: 2018 County Distribution by Market

County	Individual Market Distribution	% Individual Market Subsidized	Small Group Market Distribution - Group	Small Group Market Distribution - Enrollee
Addison County, VT	6.8%	64.6%	6.1%	6.5%
Bennington County, VT	6.8%	61.9%	5.8%	4.5%
Caledonia County, VT	4.0%	73.3%	3.2%	3.3%
Chittenden County, VT	23.6%	56.2%	32.0%	24.9%
Franklin County, VT	4.9%	77.0%	4.2%	5.6%
Grand Isle County, VT	1.3%	56.8%	0.3%	1.0%
Lamoille County, VT	5.7%	60.1%	3.8%	4.0%
Orange County, VT	3.9%	71.2%	2.8%	3.5%
Essex County, VT	0.8%	78.3%	0.2%	0.4%
Orleans County, VT	4.1%	74.9%	2.5%	2.7%
Rutland County, VT	8.8%	70.4%	8.6%	8.3%
Washington County, VT	9.3%	64.5%	11.6%	9.3%
Windham County, VT	9.0%	67.4%	8.1%	6.2%
Windsor County, VT	9.8%	62.6%	10.7%	8.2%
Unknown	1.1%	36.7%	0.1%	1.2%
Adjacent State	0.0%	0.0%	0.0%	7.4%
Out of State not Adjacent	0.0%	0.0%	0.0%	3.1%

The table shows that based on where the enrollee or member resides, the distribution of enrollment is fairly consistent for individual and small group. The exception is that more than 10% of the small group members live out of state, although over 7% of these live in adjacent states to

Vermont. Chittenden County is where the largest portion of members and employers reside in both markets. For the individual market, Chittenden County has the lowest percent of subsidized members in the state.

The following table shows member month distributions by metal level. The enrollment distribution, especially in the individual market, changed significantly in 2019 so both years are shown. The detailed breakout for the silver plan enrollment for cost sharing reduction plans is shown in the gray cells for the individual market.

Table 8: 2018 and 2019 Metal Level Distribution by Market

Metal Level	2018 Individual Market Distribution	2018 % Individual Market Subsidized	2018 Small Group Market Distribution	2019 Individual Market Distribution	2019 Small Group Market Distribution
Catastrophic	0.9%	0.0%	0.0%	1.0%	0.0%
Bronze	19.2%	53.2%	15.9%	22.5%	15.2%
Silver Total	59.2%	80.5%	26.3%	46.4%	26.2%
Gold	11.7%	30.4%	36.3%	21.7%	36.5%
Platinum	9.1%	29.2%	21.5%	8.4%	22.1%
Silver 70%	16.9%	36.4%		13.3%	
Silver 73%	6.7%	100.0%		3.5%	
Silver 77%	11.5%	97.7%		8.2%	
Silver 87%	17.6%	97.6%		16.1%	
Silver 94%	6.5%	98.3%		5.4%	

The individual market distribution changed as a result of silver loading and reflective plans (silver plans without CSR loading) being offered off-Exchange. The silver-loading provides subsidy eligible members with higher premium subsidies that can be used to buy down to a bronze (potential for a zero premium plan) or up to a gold plan. This is likely the primary driver for the silver plans to drop from 59% of the market to 46% from 2018 to 2019. In 2018, almost all members who were enrolled in CSR plan variants were also receiving premium subsidies. More than half of bronze members were also receiving premium subsidies.

As is typical nationally, small group has a much larger proportion of members in gold and platinum plans than the individual market. Small group experienced minor metal level shifting from 2018 to 2019, likely due to the 10% drop in enrollment.

The following table shows the distribution of member months by family tier. While Vermont does not have age rating (i.e., there is community rating), it does have different rating factors depending

on the number and type of dependents on the policy. In Vermont, given the tier structure and required tier factors, premiums are less for children than adults. The family tier information is further broken down by the number of children in the gray section.

Table 9: 2018 Family Tier Distribution by Market

Family Tier	Number of Children	Individual Market Distribution	% Individual Market Subsidized	Small Group Market Distribution
Single		47.3%	70.2%	34.6%
Couple		28.2%	73.7%	19.9%
Parent & Child(ren) Total		2.4%	51.0%	4.6%
Family Total		22.1%	40.1%	40.9%
Parent & Child(ren)	1	1.4%	66.4%	2.3%
Parent & Child(ren)	2	0.8%	32.6%	1.8%
Parent & Child(ren)	3	0.2%	6.6%	0.5%
Parent & Child(ren)	4+	0.0%	0.0%	0.1%
Family	1	7.5%	57.6%	11.2%
Family	2	10.1%	33.6%	19.6%
Family	3	3.5%	28.3%	7.1%
Family	4+	1.0%	15.2%	2.9%

In the individual market, over 75% of the members are in single or couple policies. This represents only 55% of the small group market. Policies with 3 or more children represent less than 5% of the individual market but over 10% of the small group market. These policies tend to be the least profitable, which is expected given they cover more children for the same premium as one or two child policies.

2019 Benchmark Data – Individual Market

Vermont was interested in how the State compared to other states and national averages. Wakely included a comparison of Vermont to nearby states and national averages in the following tables.

Table 10 looks at the average age of members enrolled on-Exchange (through Vermont Health Connect) in Vermont compared to national averages.

Table 10: 2019 On-Exchange Demographic Comparisons[21]

Market	Age < 18	Age 18-25	Age 26-34	Age 35-44	Age 45-54	Age 55-64	Age ≥65
Maine	11%	7%	15%	15%	19%	33%	0%
Massachusetts	4%	10%	22%	19%	20%	22%	1%
New York	4%	8%	19%	17%	21%	31%	1%
New Hampshire	8%	8%	16%	14%	20%	35%	1%
Vermont	3%	9%	17%	17%	21%	33%	1%
National	9%	10%	16%	16%	20%	28%	1%
Difference from National	-5%	-1%	1%	1%	1%	5%	-1%

As can be seen above, Vermont generally has an older population enrolled in the individual ACA market (specifically on-Exchange) than the rest of the nation. This is likely due to a few factors. The first is that the overall population of Vermont is older than the national average. In addition, the community rated nature of insurance in Vermont makes individual health insurance a harder value proposition for younger adults since they pay the same premiums as older adults, but typically are healthier and have less claims costs. Finally, Vermont's CHIP program covers children to a higher income level than the national average, which lowers the portion of children that get coverage in the individual market.

The following table shows the average 2019 on Exchange premium, average ATPC for eligible members, and the percent of members with APTCs. Other Northeast states and the national average are shown for comparison. Given that Vermont has a higher average age than the national average, one could expect the average premiums to be higher in Vermont than national averages.

Table 11 shows that, on average, this is not true. Often comparative analyses is done for a specific age (typically age 40). This is not an appropriate comparison since Vermont does not have premiums that vary by age or smoking status, and age 40 is not the average age of the population. That said, some caution should be taken in using the comparison in Table 11 since other mix changes could be driving differences in premiums, such as the metal level distribution by state.

[21] https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report

Table 11: 2019 Enrollment and Premium Comparisons (On-Exchange Only)[22]

Market	% of On Exchange Enrollees with APTCs	Average APTC PMPM	Average Premium PMPM
Maine	89%	$596.24	$667.83
Massachusetts	79%	$248.77	$391.60
New York	56%	$324.86	$569.44
New Hampshire	75%	$414.55	$536.44
Vermont	84%	$430.46	$571.94
National	87%	$514.01	$594.17

To further illustrate how Vermont's premiums compare to other states at specific ages, the following three tables compare the lowest cost premium available for each of the bronze, silver, and gold metal levels for various ages and markets.

In the following tables, Maine and New Hampshire follow the Federal age rating with a ratio of 3:1, Massachusetts has more narrow age rating with a ratio of 2:1, and New York has community rating, similar to Vermont.

[22] https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf

Table 12: 2019 Premiums for a 40 Year-Old Non-Smoker[23]

		Lowest Cost Bronze Before Tax Credit			2nd Lowest Cost Silver Before Tax Credit			Lowest Cost Gold Before Tax Credit		
State	Major City	2018	2019	% Change	2018	2019	% Change	2018	2019	% Change
Maine[24]	Portland	$337	$335	-1%	$513	$485	-5%	$570	$582	2%
Massachusetts	Boston	$233	$251	8%	$305	$321	5%	$347	$334	-4%
New York	New York	$416	$421	1%	$510	$587	15%	$595	$697	17%
New Hampshire	Manchester	$391	$303	-23%	$475	$402	-15%	$524	$444	-15%
Vermont	Burlington	$422	$426	1%	$505	$622	23%	$569	$584	3%

Table 13: 2019 Premiums for a 21 Year-Old Non-Smoker[25]

		Lowest Cost Bronze Before Tax Credit			2nd Lowest Cost Silver Before Tax Credit			Lowest Cost Gold Before Tax Credit		
State	Major City	2018	2019	% Change	2018	2019	% Change	2018	2019	% Change
Maine[18]	Portland	$264	$262	-1%	$401	$379	-5%	$446	$455	2%
Massachusetts	Boston	$198	$213	8%	$259	$273	5%	$295	$284	-4%
New York	New York	$416	$421	1%	$510	$587	15%	$595	$697	17%
New Hampshire	Manchester	$306	$237	-23%	$372	$315	-15%	$410	$347	-15%
Vermont	Burlington	$422	$426	1%	$505	$622	23%	$569	$584	3%

[23] https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/

[24] Maine had a reinsurance-based 1332 waiver, which started in 2019.

[25] https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/ and Federal or state age factors applied as appropriate.

Table 14: 2019 Premiums for a 60 Year-Old Non-Smoker[26]

		Lowest Cost Bronze Before Tax Credit			2nd Lowest Cost Silver Before Tax Credit			Lowest Cost Gold Before Tax Credit		
State	Major City	2018	2019	% Change	2018	2019	% Change	2018	2019	% Change
Maine[20]	Portland	$716	$711	-1%	$1,089	$1,030	-5%	$1,210	$1,236	2%
Massachusetts	Boston	$396	$426	8%	$518	$545	5%	$589	$567	-4%
New York	New York	$416	$421	1%	$510	$587	15%	$595	$697	17%
New Hampshire	Manchester	$830	$643	-23%	$1,009	$854	-15%	$1,113	$943	-15%
Vermont[27]	Burlington	$422	$426	1%	$505	$622	23%	$569	$584	3%

Vermont does have higher rates than most markets for 40 year-olds and notably higher premiums for 21 year-olds. However, the Vermont premiums have significantly lower rates for 60 year-olds except for New York and Massachusetts, both of which do not use 3:1 age rating. Given community rating and that the average age is much higher in Vermont, these differences are reasonable. If anything, Vermont's premiums are likely even lower than the national average, all else equal, holding constant age differences. Vermont's premiums are also competitive for the population that is mostly enrolled in the individual market, namely adults aged 50 and older. However, further analysis to account for other factors such as metal level differences would need to be completed to get the true comparison to the national average. One relevant comparison is that New York, which also has community rating, has a similar age distribution and premiums by metal level compared to Vermont.

[26] https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/ and Federal or state age factors applied as appropriate.

[27] The larger silver premium increases in Vermont relative to other state is a result of Vermont Silver-loading CSR liabilities for the first time in 2019 while the other states in the table silver-loaded silver in 2018.

Finally, Table 15 looks at the distribution of claims costs for Vermont compared to national averages. Where the prior benchmarks used national on-Exchange enrollment and premium information, the following table uses Wakely's ACA (WACA) database, which represents 63.8 million member months in 2017. We also looked at the northeast data, which represents 11.4 million member months in 2017. It is worth noting that the WACA database does have lower cost/healthier members than the national average but the difference is not expected to notably change the results. Also, the Vermont data is from 2018 and the national data is from 2017, but the one year of difference is not likely to change the relationship between the numbers.

Table 15: Claim Distribution Comparisons

Market	% of Member Months with $0 in Claims	% of Member Months with Claims between $0 and $50,000	% of Member Months with Claims Over $50,000
Individual - National	26.9%	72.0%	1.1%
Individual - NE Region	22.6%	76.0%	1.4%
Individual - Vermont (2018)	18.7%	79.0%	2.3%
Small Group - National	31.7%	67.5%	0.8%
Small Group - NE Region	38.6%	60.7%	0.7%
Small Group - Vermont (2018)	18.6%	79.3%	2.1%

Consistent with the higher age distributions, Vermont also appears to have fewer members with no claims and more members with large claims. For both the individual and small group markets, Vermont has a significantly smaller portion of the market with members with no claims. Similarly, it has a higher portion of the market with over $50,000 in claims in the year. Interestingly, the individual and small group Vermont markets look similar. Typically, the individual market has less members with no claims and more members with high claims due to the individual market having a higher level of selection. The unit of analysis for the above table is member months. Since high cost members tend to have higher duration (that is, enrolled more months in the calendar year), if the analysis looked at unique members, the portion of members with no claims would be higher for both Vermont and the WACA data.

Appendix D: Additional Considerations

1332 Waiver Implications

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

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

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

States may receive funds from the Federal Government, often referred to as "Pass-Through" funds, commiserate with the federal savings the State waiver achieves.

Appendix E: Glossary of Key Terms

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

Adjusted Paid Claims – This metric is equal to paid claims net risk adjustment transfers.

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

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

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

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

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

Community Rating. A rating curve or rating factors in which all members pay the same premium, regardless of age. Vermont merged market is currently community rated.

Cost Sharing Reduction plans (CSRs) – Cost sharing reduction plans are subsidized plans with reduced enrollee cost sharing (lower deductibles, copays, coinsurance, and out of pocket expenses) for lower income members. A member who is eligible for CSR, and who purchases a silver plan, will be placed in a CSR plan based on their income level. There are three CSR plan variations for each standard silver plan based on three different income level tiers. The CSR plan variations are significantly richer than the standard silver plan such that members have less cost sharing (lower deductibles, copays, coinsurance, and out of pocket expenses). As a result, the CSR plans have higher AVs than the standard silver plans. In Vermont there are four income-income-based CSR plan variation AVs are 94 percent, 87 percent, 77, and 73 percent (compared to 70 percent for the standard silver plan). The Silver 94 percent AV CSR plan has the richest coverage of all ACA plans, with an AV above platinum plans, and is offered to members with income levels under 150 percent of the Federal Poverty Level (FPL). There are also CSR plans for tribal members. CSR plans are only applicable to the individual on the Exchange market.

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

Exchange – The Exchange refers to the Vermont Health Connect, the online purchasing marketplace where individuals can purchase ACA state certified benefit plans based on income.

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

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

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

Risk Adjustment Program – The ACA's risk adjustment methodology is intended to reinforce market rules that prohibit risk selection by issuers. Risk adjustment accomplishes this by transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees. The goal

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

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

Appendix F: Disclosures and Limitations

Responsible Actuary. Julie Peper is the actuary responsible for this communication. She is a member of the American Academy of Actuaries and Fellow of the Society of Actuaries. She meets the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen, Nick Shaneyfelt, and Brooke Adams made significant contributions to this report.

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

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

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

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

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change**, including that CSRs will continue to be silver-loaded.** Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Wakely did not also include the potential of impact of recent regulatory changes to health reimbursement accounts or proposed transparency regulations in its estimates. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

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

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

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication