

# State Policy Options to Reduce ACA Individual Marketplace Premiums

## A Cost and Benefit Comparison

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When employing funds to reduce the cost of ACA individual marketplace coverage, states should consider the advantages and tradeoffs associated with various policy designs.

State policy makers are considering options to reduce the cost of coverage and promote stability within their insurance marketplaces. Section 1332 of the Patient Protection and Affordable Care Act (ACA) grants states flexibility to implement reforms within specific guardrails. In this whitepaper, we explore the features and merits of three policy options: traditional reinsurance, uniform coinsurance, and “wraparound” per member per month (PMPM) premium subsidies. We discuss their financial characteristics, and examine their advantages and disadvantages with respect to various stakeholder perspectives and objectives (summarized in the executive summary on the following pages). At a high level, traditional reinsurance drives the largest decrease in volatility for issuers, uniform coinsurance reduces unsubsidized enrollees’ average cost of coverage the most, while wraparound subsidies reduce the minimum cost of coverage the most for unsubsidized enrollees. These impacts are explored in greater detail in this paper. For detailed discussion of results and methodology, we refer readers to the companion report.<sup>1</sup>

While we discuss various considerations with respect to potential market policies, Milliman is not advocating any particular policy position, nor do this paper and the companion report represent a recommendation for any specific action by state policymakers or other market stakeholders.

## Executive summary

Since ACA individual marketplace reforms first took full effect in 2014, the cost to purchase individual comprehensive health coverage through ACA-compliant qualified health plans (QHPs)<sup>2</sup> has risen by 75% for consumers (e.g., individuals and families) whose household incomes disqualify them for federal premium assistance in the form of advanced premium tax credits (APTCs).<sup>3</sup> This rise in premiums is in addition to increases in consumers’ out-of-pocket medical costs, as plan deductibles and out-of-pocket limits have risen along with claim costs.<sup>4</sup> The cumulative rise in premiums (and out-of-pocket costs) since 2014 has made the cost of coverage unaffordable for many unsubsidized consumers, leading many—particularly those in good health—to decline to purchase or renew coverage. While recent rate actions provide some cause for optimism (the average 2020 benchmark silver premium across the nation has declined slightly since peaking in benefit year 2018),<sup>5,6</sup> the cost of coverage remains high and out of reach for many of these unsubsidized consumers. In recent years, state governments have begun exploring policy options to address this situation and improve access to affordable care for their constituents.

<sup>1</sup> This whitepaper and the companion report were commissioned by Centene Corporation, a managed care organization. The three policy types evaluated in this paper and the companion report were outlined by Centene Corporation and the scope of the paper and report was determined collaboratively. The analysis and conclusions were prepared by Milliman independently and are solely attributable to the authors.

Please refer to the full report for additional background, discussion of results, and information regarding the underlying analysis. It can be accessed by visiting the following web link: <http://www.milliman.com/insight/2019/State-policy-options-to-reduce-ACA-individual-marketplace-premiums/>.

<sup>2</sup> For the remainder of this report, all references to individual coverage can be interpreted as referring to ACA-compliant comprehensive major medical individual market coverage through QHPs, both on and off-marketplace, except where we explicitly note otherwise.

<sup>3</sup> Kaiser Family Foundation. Health Insurance Marketplace Calculator, 2014-2019. Retrieved November 8, 2019, from <https://www.kff.org/interactive/subsidy-calculator-2019/>.

<sup>4</sup> Kaiser Family Foundation. Cost-Sharing for Plans Offered in the Federal Marketplace, 2013-2019. Retrieved November 13, 2019, from <https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace-2014-2019/>.

<sup>5</sup> Kaiser Family Foundation. Average Marketplace Premiums by Metal Tier, 2018-2020. Retrieved November 8, 2019, from <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier>.

<sup>6</sup> Milliman. Has the ACA Death Spiral Kicked the Bucket? Retrieved November 20, 2019, from <http://www.milliman.com/insight/2019/Has-the-ACA-death-spiral-kicked-the-bucket/>.

**POLICY OPTION EVALUATION**

Using a simulation model powered by nearly one million lives of individual ACA data, we evaluated three categories of premium reduction policies that states may consider employing to reduce the cost of coverage. Each policy that we evaluate in this paper reduces marketplace premiums through the injection of the same amount of state funds and (as applicable) the redirection of federal funds into the individual market, but differs with respect to how and to whom these funds are distributed:

1. **Traditional reinsurance:** State funds and federal Section 1332 State Innovation Waiver (1332 waiver) pass-through funds are used to reimburse health plans for a percentage (coinsurance) of enrollees’ annual claim costs between an attachment point and a specified maximum or cap.
2. **Uniform coinsurance:** In this variation on traditional reinsurance, state funds and federal 1332 waiver pass-through funds are used to reimburse health plans for a percentage (coinsurance) of claim costs, *starting from the first dollar incurred*, up to an optional specified annual maximum per enrollee.
3. **Wraparound PMPM subsidies:** This policy, which requires a state-based marketplace<sup>7</sup>, uses state funds to extend premium subsidies that “wrap around” the federal subsidy structure and reduce per member per month (PMPM) premium costs at the point of sale for consumers either ineligible for APTCs or who only receive limited federal premium assistance. For our analysis, we modeled a “defined contribution” subsidy in which the amount of the state subsidy varies with the consumer’s age but does not vary with their plan selections or as plan premiums change.

We evaluated policy impacts for a variety of state funding costs and corresponding policy parameters. For simplicity and in order to establish a common basis for comparison across the three policy types, we report the majority of results assuming a \$20 PMPM state funding cost for a “Composite” state market scenario intended to represent a typical US state<sup>8</sup>. We selected this funding cost as it falls within the typical range for states that have implemented 1332 reinsurance waivers and supports claims and premium reductions of approximately 10% under reinsurance for the Composite scenario.<sup>9</sup>

<sup>7</sup> To be precise, wraparound subsidies that apply directly to consumer premiums at the point of sale require a marketplace enrollment pathway outside of the federal platform, since the current federal platform does not support extensions or modifications to the federal subsidy structure. Our analysis does not model the financial impact of transitioning from a federal platform to a state-based marketplace, which would be a material consideration for each stakeholder.

<sup>8</sup> The \$20 PMPM state funding cost is expressed as the average across all individual QHP enrollees, although most or all of these funds will be financed from sources outside of the individual market. To account for the substantial impact of Medicaid Expansion on states’ individual market populations and

**RESULTS AND CONCLUSIONS**

These results (summarized in Figure 1) demonstrate how each policy differs with respect to its comparative advantages:

- **Traditional reinsurance** drives the largest decrease in the claims volatility to which issuers are exposed (19%). Volatility measures the level of risk and uncertainty issuers face due to random variation in claim costs, and can influence capital requirements and issuers’ willingness to offer coverage at affordable rates.
- **Uniform coinsurance** reduces the average cost of coverage the most for non-federally subsidized enrollees (14% for the benchmark silver and other plans). Uniform coinsurance also slightly outperforms the other two policies’ impacts on the average cost of coverage across the whole market after all subsidies (10% versus 8-9%).
- **Wraparound subsidies** drive the greatest reduction in the minimum cost of coverage for non-federally-subsidized consumers (17%), and can be targeted towards the consumers most in need of assistance.

**FIGURE 1: POLICY OPTION IMPACTS AND RANKINGS UNDER COMPOSITE SCENARIO (RANK OF 1 = MOST EFFECTIVE, IMPACTS ARE FOR A \$20 PMPM STATE FUNDING COST, RELATIVE TO NO-POLICY BASELINE)**

*Results illustrate differences by policy, and are not predictions for any specific state.*

IMPACT MEASURE	POLICY TYPE					
	Variations on 1332 Reinsurance Waiver					
	TRADITIONAL REINSURANCE		UNIFORM COINSURANCE		WRAPAROUND PMPM SUBSIDY	
RANK	IMPACT %	RANK	IMPACT %	RANK	IMPACT %	
Net Claim Reduction	2	-11%	1	-15%	3	0%
Relative Claim Volatility (entire market)	1	-19%	3	+0%	2	0%
Overall Net Premium Impact (entire market)	2	-9%	1	-10%	3	-8%
Benchmark Silver Premium (non-APTC eligible)	3	-9%	1	-14%	2	-13%
Minimum Non-Catastrophic Cost of Coverage (non-APTC eligible)	3	-9%	2	-14%	1	-17%
Modeled parameters	58.6% coinsurance on annual claims between \$75,000 and \$500,000		14.9% coinsurance on all claims up to \$1MM		\$57 PMPM age 40 age-adjusted premium subsidy (members above 400% FPL)	

associated federal subsidies, we also report results separately for representative markets under each of Medicaid Expansion and Non-Expansion.

<sup>9</sup> It is difficult to compare the financial characteristics and trade-offs across the three categories of premium reduction policies without first anchoring them to a shared level of collective investment by all the stakeholders in a state. We also evaluated policy impacts for alternate state funding levels; while the magnitude of impacts changed, core conclusions were unchanged with respect to each policy’s relative advantages.

Across the three policies, there are stark differences in premium impacts for non-APTC-eligible consumers: Traditional reinsurance reduces the benchmark silver premium for non-federally-subsidized consumers by 9%, versus 14% for uniform coinsurance and 13% for wraparound subsidies<sup>10</sup>.

While the policies' premium impacts differ substantially for specific plans and enrollee subpopulations, they do not differ as much in their aggregate impact to net premiums, averaged across the market as whole after state and federal subsidies: 8% for wraparound subsidies, 9% for traditional reinsurance, and 10% for uniform coinsurance.

See the "Math Behind the Policy Differences" box below for an explanation of why premium impacts vary by policy type.

## Math Behind the Policy Differences

The substantial variation across policies' premium impacts for non-federally-subsidized consumers is largely due to differences in how state funds and federal pass-through dollars are allocated. Traditional reinsurance only offsets high cost claims that exceed the attachment point. To the extent that high cost claims are more prevalent for issuers offering high cost plans (which is the case for our simulation), reinsurance will disproportionately benefit these issuers, leading to a compression in claim (and therefore premium) differences between the "benchmark" (second-lowest-cost silver) plan whose premium level is used to set federal APTC payments and plans from higher cost issuers.

This compression in premium rates leads to net savings for APTC-eligible consumers who apply credits based on the benchmark plan towards the purchase of richer plans. Because we assume the same level of state funding for all three scenarios, additional savings for APTC-eligible consumers are offset by lesser savings for unsubsidized consumers earning more than 400% of the FPL. We estimate that approximately 30% of savings under traditional reinsurance accrue to already-subsidized individuals and families in the form of reduced net premiums (e.g. when purchasing plans more expensive than the benchmark silver), compared to approximately 10% of savings under uniform coinsurance and 0% under wraparound subsidies.

When comparing savings in aggregate across all consumer types (both federally subsidized and non-subsidized), the additional variation in *overall* net premium impacts after subsidies comes from

two key factors: (1) The amount of federal APTC dollars repurposed as pass-through funds used to reduce claims, and (2) a proportional reduction in issuer PMPM profit/risk margins when funds are used to reduce issuers' claims responsibility:

- Traditional reinsurance disproportionately reduces premiums for higher cost plans and is therefore inefficient at generating federal pass-through payments tied to reductions in the benchmark silver plan (via APTCs indexed to the benchmark silver). Traditional reinsurance reduces claims by 11% under the Composite scenario using \$20 PMPM in state funding and \$36 PMPM in federal pass-through funds, for a 9% overall net premium reduction.
- Uniform coinsurance allocates a greater portion of savings than traditional reinsurance towards the second-lowest-cost (benchmark) silver plan, thereby reducing APTCs more. By more efficiently converting federal spending on APTCs into federal pass-through funds (without affecting total federal spending),<sup>11</sup> uniform coinsurance can apply more funds than traditional reinsurance towards reducing claims (\$53 PMPM in federal pass-through funds in addition to \$20 PMPM in state funding), in turn supporting a 15% claims reduction and a 10% overall net premium impact.
- Wraparound subsidies (unlike reinsurance and coinsurance) do not require a 1332 waiver and have no direct impact on premium rates prior to subsidies. Therefore, they do not directly impact APTCs and do not generate federal pass-through funds. Wraparound subsidies also have no direct impact on claims, as the subsidies bypass issuer costs and apply directly to member premiums. The \$20 PMPM in state funding is the only source of funding and leads to an 8% net premium reduction on average.

Informed by these results, and after considering potential secondary impacts due to changes in market incentives, we evaluated the qualitative advantages and tradeoffs of each policy option from the perspective of different stakeholders. Figure 2 on the following page summarizes key takeaways from our evaluation, which we discuss in more detail in the remainder of this paper:

<sup>10</sup> For low cost silver plans offered off-exchange without cost sharing reduction (CSR) rate loads, we estimate premium impacts of 9%, 14%, and 14% for traditional reinsurance, uniform coinsurance, and wraparound subsidies, respectively.

<sup>11</sup> Federal pass-through funds are financed by reductions in federal APTCs, which are indexed to the premium for the benchmark silver plan. Unlike uniform coinsurance, which reduces all plan premiums by the same

percentage, traditional reinsurance reduces high cost plan premiums by a greater percentage than the benchmark silver. By allocating a smaller portion of savings to the benchmark silver plan, traditional reinsurance has a smaller impact on APTCs and generates fewer pass-through funds as a result.

FIGURE 2: KEY TAKEAWAYS BY STAKEHOLDER AND POLICY TYPE

STAKE-HOLDERS	KEY TAKEAWAYS
Consumers <b>eligible</b> for federal premium (APTC) subsidies	<ul style="list-style-type: none"> <li>• <b>Traditional reinsurance</b> and <b>uniform coinsurance</b> both reduce the cost for subsidized enrollees to purchase coverage more expensive than the benchmark silver plan. This reduction is greatest for <b>traditional reinsurance</b>, which compresses premium differences between high and low cost plans.</li> <li>• While <b>wraparound subsidies</b> can be used to supplement subsidies for APTC-eligible consumers, this is not the case for the policy scenario we evaluated.</li> </ul>
Consumers <b>not eligible</b> for federal premium (APTC) subsidies	<ul style="list-style-type: none"> <li>• <b>Traditional reinsurance</b> allocates a smaller share of total premium savings than the other policies towards non-federally-subsidized consumers. Of these savings, the impact of traditional reinsurance is greatest for those enrolling in higher cost health plans.</li> <li>• <b>Uniform coinsurance</b> drives the largest reduction in the average (non-subsidized) consumer premium.</li> <li>• <b>Wraparound subsidies</b> drive the greatest reduction in the minimum cost of coverage (e.g. low cost bronze or silver).<sup>12</sup></li> </ul>
State Government	<ul style="list-style-type: none"> <li>• <b>Traditional reinsurance</b> and <b>uniform coinsurance</b> require federal approval of a Section 1332 waiver. <b>Wraparound subsidies</b> require the state to operate its own state-based marketplace.</li> <li>• <b>Traditional reinsurance</b> has been approved and successfully implemented in many states. <b>Uniform coinsurance</b> is untested.</li> <li>• With <b>traditional reinsurance</b>, the state accepts the greatest funding risk for a given set of parameters, and this can create uncertainty for state budget planning or for whether reinsurance payments to issuers will be prorated. Funding risk exists but is lower for uniform coinsurance and is lowest for wraparound subsidies.</li> <li>• <b>Uniform coinsurance</b> drives the greatest reduction in the benchmark silver premium, resulting in the greatest conversion of APTCs into federal pass-through funds used to reduce claims (while maintaining federal deficit neutrality). This results in the greatest return in terms of the overall premium impact for a given state contribution, so that fewer state dollars are required to lower the benchmark silver premiums the same amount as would be required using traditional reinsurance.</li> <li>• <b>Wraparound subsidies</b> enable the most state control over how policy funds are applied and which consumers benefit.</li> </ul>
Federal Government	<ul style="list-style-type: none"> <li>• Under a 1332 waiver, any <b>reinsurance</b> or <b>coinsurance</b> program is prospectively designed to be cost neutral to the federal government.</li> <li>• <b>Wraparound subsidies</b> do not require federal approval.</li> </ul>
Issuers	<ul style="list-style-type: none"> <li>• <b>Traditional reinsurance</b> drives the greatest reduction in issuers' risk from claims volatility.</li> <li>• <b>Traditional reinsurance</b> alters competitive dynamics and the balance of risk adjustment to the benefit of the higher cost issuers.</li> <li>• <b>Uniform coinsurance</b> reduces all issuers' claims and required premiums by approximately the same percentage.</li> <li>• <b>Wraparound subsidies</b> reduce eligible members' premiums by the same amount PMPM regardless of the plan or issuer.</li> </ul>
Providers	<ul style="list-style-type: none"> <li>• Providers may benefit from higher enrollment volume under all three policies.</li> <li>• <b>Traditional reinsurance</b> may encourage greater enrollment in richer benefit plans with broader networks, increasing patient volume for these networks.</li> <li>• <b>Wrap-around subsidies</b> may encourage enrollees to purchase leaner coverage, which may affect providers' patient volumes and incentivize participation in "narrow" provider networks.</li> <li>• <b>Uniform coinsurance</b> is likely to fall in between these two endpoints, by maintaining pre-existing proportions between premiums for richer and leaner benefit plans.</li> </ul>

<sup>12</sup> In this paper, the minimum cost of coverage refers to the lowest cost "metal" (i.e. bronze and above) QHP plan available to all consumers. However, individuals below age 30 or who qualify for certain hardship/affordability exemptions are eligible to purchase ACA-compliant catastrophic plans at a lower rate, if available in their market.

While this paper and the companion report primarily focus on evaluation and comparison of the three policy types defined above (and variations thereof), states that wish to improve access to affordable coverage are not limited to only one policy. For example, states may elect to pair two of these policies together, such as pairing traditional reinsurance or uniform coinsurance with state-based subsidies. While outside of the scope of our review, states may also consider other market reforms, such as policies that address consumer out of pocket costs.

## Market and policy scenarios

Using an ACA marketplace simulation model (see “About the Model,” below), we evaluated policy impacts for a variety of state funding costs and policy parameters. The funding cost represents the level of contribution from all state-based sources (e.g., general funds, assessments on commercial coverage, etc.). For each target funding cost, we estimated policy parameters (e.g. stop loss attachment points, coinsurance, or PMPM premium subsidy amounts for each of traditional reinsurance, uniform coinsurance, and wraparound PMPM subsidies) that could be supported by the state and federal funds generated.

For simplicity and in order to establish a common basis for comparison across the three policy types, we report the majority of results assuming a \$20 PMPM state funding cost, for which the membership denominator is expressed across the entire individual QHP market (even when the policy applies to a subset of enrollees and the source of the funds comes from outside of the market).<sup>13</sup> We selected this funding level as it falls within the typical range we have observed across the states that have already implemented Section 1332 reinsurance waivers, and supports a reduction in issuer premiums of approximately 10% under reinsurance for the Composite scenario (described below).

We found that directional results are robust under a variety of funding levels<sup>14</sup>. The required coinsurance for a given reinsurance attachment point scales linearly with the target state funding cost, and the majority of results share this linear relationship.

## About the Model

To assess the impact of state premium reduction policies on market stakeholders, we implemented a simulation model that leverages the claims and eligibility data for nearly 1 million unique individuals enrolled in individual QHP coverage. We reweighted and adjusted these data to mirror the population and claims profiles of various representative and hypothetical state marketplaces. We then seeded each marketplace with an array of issuers that vary in unit cost and enrollee population profile, and simulated the impact of premium reduction policies on market claims costs, volatility levels (using a Monte Carlo methodology), risk adjustment transfers, and premium rates by issuer and in total across the marketplace. Using this model, we also measured the expected impact of each policy on federal premium subsidies, federal “pass-through payments,” and the total funding cost to the state. For an in-depth discussion of the simulation model and its underlying methodology, please refer to the “Data and methodology” section of the companion report.

Moreover, because the performance of premium reduction policies depends heavily on the marketplace characteristics in each state, we assessed results across three different representative market scenarios: a composite marketplace, or “Composite,” scenario that is broadly representative of the average state market nationwide, and “Medicaid Expansion” and “Non-Expansion” scenarios to represent state markets that either expanded Medicaid or elected not to do so:

- **Composite:** This scenario approximates the weighted average benefit year 2018 individual QHP market composition across both Medicaid Expansion and Non-Expansion states. Baseline claim costs (before applying the state policies) are calibrated to 2018 individual QHP claim costs nationwide, trended forward to 2020.
- **Medicaid Expansion:** This scenario approximates the weighted average benefit year 2018 individual QHP market composition across Medicaid Expansion states. Baseline claim costs reflect the same unit cost level and trend adjustments as the Composite scenario, with differences solely attributable to differences in the plan mix, demographic profile, and average morbidity level of the enrollee population.
- **Non-Expansion:** This scenario is defined in the same way as the previous two scenarios, but based on the 2018 individual QHP market composition across states that had not expanded Medicaid.

<sup>13</sup> It is difficult to compare the financial characteristics and trade-offs across the three categories of premium reduction policies without first anchoring them to a shared level of collective investment by all the stakeholders in a state.

<sup>14</sup> We tested state funding levels ranging from \$10 PMPM to \$40 PMPM, which encompasses the majority of state 1332 reinsurance waivers approved to date.

See the companion report for a comparison of results under alternate funding levels and policy parameters.

While results for the three modeled market scenarios vary with respect to the *magnitude* of each policy's impacts and advantages, the core *directional* conclusions when evaluating and comparing policies remain identical across all three scenarios. Figure 3 on the following page shows the parameter values we estimated for each pairing of policy type and market scenario:

For the wraparound subsidy policy modeled for this analysis, subsidies are age-adjusted to the age of each enrollee using U.S. Department of Health and Human Services (HHS) allowable age rating factors (e.g. a \$57 PMPM age 40 age-adjusted subsidy translates to \$45 subsidy for age 21 and \$135 for age 65). The subsidies are only received by those earning greater than 400% FPL, but composite to \$20 PMPM across the aggregate marketplace membership.

**FIGURE 3: POLICY PARAMETERS BY MARKET SCENARIO (\$20 PMPM STATE FUNDING COST)**

MARKET COMPOSITION SCENARIO	POLICY TYPE		
	Variations on 1332 Reinsurance Waiver		
	TRADITIONAL REINSURANCE	UNIFORM COINSURANCE	WRAPAROUND PMPM SUBSIDY
Composite	58.6% coinsurance on annual claims between \$75,000 and \$500,000	14.9% coinsurance on all claims up to \$1 million	\$57 PMPM age 40 age-adjusted premium subsidy (members above 400% FPL)
Medicaid Expansion	55.3% coinsurance on annual claims between \$75,000 and \$500,000	13.5% coinsurance on all claims up to \$1 million	\$49 PMPM age 40 age-adjusted premium subsidy (members above 400% FPL)
Non-Expansion	62.3% coinsurance on annual claims between \$75,000 and \$500,000	17.5% coinsurance on all claims up to \$1 million	\$70 PMPM age 40 age-adjusted premium subsidy (members above 400% FPL)

For all three scenarios, we balanced baseline premium levels (before applying the state policies) to an 80% traditional loss ratio<sup>15</sup> (claims net of risk adjustment over gross premium), reflecting a 5% profit/risk margin (before income tax, which corresponds to roughly 3-4% post-tax), 7% retention for state and federal taxes and fees, and 8% retention for administrative expenses. Administrative expenses are held constant after application of the state policies, while the other components of retention are assumed to vary with issuer premium rates. We assumed that issuers set premiums correctly on a prospective basis, with all variance in observed loss ratios solely due to random volatility in the risk pool and enrollee claim costs. State funding costs include the cost of forgone state taxes and fees where applicable, while federal pass-through payments reflect

changes to the benchmark silver premium for APTC-eligible enrollees, net of forgone federal revenue (such as exchange user fees or the health insurance provider fee). Please refer to the “Data and methodology” section of the companion report for additional information on how each market scenario was defined and developed.

While we assumed issuers will reduce their *PMPM* profit/risk margins along with benefit costs, for our analysis we held profit/risk margins constant as a *percentage* of premium. Within the text of this paper and the companion report, we also discuss circumstances that may lead issuers to adjust these percentage margins, such as reduced exposure to claims volatility or to hedge against the risk that a state may prorate reinsurance or coinsurance payments due to a fixed state budget. Similarly, we did not model changes in enrollment and consumer plan selections in response to these policies, but in the “Incentives and secondary impacts” section we discuss how each policy may affect consumer behavior and alter incentives for and behavior of other market stakeholders.

## Section 1332 Waivers

Two of the three policies that we consider – traditional reinsurance and uniform coinsurance – require the state to obtain federal approval for a Section 1332 State Innovation Waiver. Section 1332 has been part of the ACA since its initial passage, but came with a statutory delay such that 1332 waivers first became available as a state policy tool in 2017. These waivers permit states to waive specific provisions of the ACA in order to “pursue innovative strategies for providing their residents with access to high quality, affordable health benefits while retaining the basic protections of the ACA.”<sup>16</sup> In order to obtain approval for a 1332 waiver, a state must demonstrate compliance with a series of “guardrails.” One of these guardrails is particularly relevant to the analysis in this paper: the “deficit neutrality” guardrail intended to ensure 1332 waivers neither increase nor reduce the federal deficit.

To the extent that a state's market modifications under a 1332 waiver reduce the cost of coverage for the benchmark silver plan against which federal APTCs are indexed, there will be a corresponding reduction in federal APTCs applied to consumer premiums in the state. In order to encourage states to enact reforms that reduce federal APTC payments while retaining compliance with the deficit neutrality guardrail, Section 1332 of the ACA requires the federal government to reimburse states

<sup>15</sup> Unlike the federal Medical Loss Ratio (MLR) calculation prescribed by the ACA, a traditional loss ratio does not include adjustments to remove taxes and fees from the premium revenue denominator nor add qualifying health improvement activity expenses to the benefit expense numerator. For this reason, a traditional loss ratio is typically lower than the corresponding MLR under the federally prescribed calculation.

<sup>16</sup> CMS. Section 1332: State Innovation Waivers. Retrieved October 10, 2019, from [https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section\\_1332\\_state\\_innovation\\_waivers-.html](https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html).

for the expected value of lost APTC subsidies (net of certain offsets) in the form of federal “pass-through payments.”

These federal pass-through payments are essential to the effectiveness of 1332 reinsurance waivers (including variations such as uniform coinsurance). Without these pass-through funds, a substantial portion of state reinsurance funds would go towards reducing premiums for subsidized enrollees already insulated from the cost of coverage, effectively substituting state dollars for federal APTCs and reducing total federal funding to the state. In contrast, under a 1332 waiver, the greater the reduction in the premium for the benchmark silver plan, the greater the reduction in APTCs, and therefore the greater the value of federal pass-through funds to supplement state funds used for the reinsurance program (with no impact to net federal spending).

## Composite scenario results

Figure 4 below provides a high-level quantitative summary of results under the Composite market scenario. Results are boxed and bolded in cases where one policy has a clear advantage over the other two with respect to a given metric. For additional quantitative detail as well as to see how policy parameters and results vary with respect to states’ Medicaid expansion status and other market characteristics, please refer to the full companion report.

**FIGURE 4: POLICY OPTION MARKET IMPACTS (\$20 PMPM STATE FUNDING COST)**

**COMPOSITE SCENARIO (EXPANSION AND NON-EXPANSION COMBINED)**

Results illustrate differences by policy, and are not predictions for any specific state.

MEASURES	BASE No additional waiver funding	Variations on 1332 Reinsurance Waiver		
		TRADITIONAL REINSURANCE 58.6% coinsurance on annual claims between \$75,000 and \$500,000	UNIFORM COINSURANCE 14.9% coinsurance on all claims up to \$1MM	WRAPAROUND PMPM SUBSIDY \$57 PMPM age 40 age-adjusted premium subsidy (members above 400% FPL)
<b>Implementation and Funding</b>				
(a)	Key Implementation Requirements	n/a	1332 waiver	State-Based Exchange
(b)	State Funding Cost PMPM	\$0	\$20.00	
(c)	Premium-Impact-to-State-Funding-Cost Ratio	n/a	1.16	<b>1.21</b>
<b>Premium Impacts</b>				
(d)	Avg. Issuer Premium PMPM (before all subsidies)	\$604	-10%	-14%
(e)	Avg. Member Premium PMPM (net of all subsidies)	\$247	-9%	<b>-10%</b>
(f)	Benchmark Silver Prem. PMPM, Age 40 (non-APTC eligible)	\$457	-9%	<b>-14%</b>
(g)	Lowest Off-Marketplace Silver Prem. PMPM, Age 40 (no CSR rate load)	\$412	-9%	<b>-14%</b>
(h)	Lowest Bronze Prem. PMPM, Age 40 (non-APTC eligible)	\$343	-9%	<b>-17%</b>
(i)	% Change in Volatility of Avg. Issuer Loss Ratio (claims net of risk adj.)	n/a	<b>-11%</b>	+1%
<b>Claims Impacts</b>				
(j)	Net Claims PMPM (net of waivers and HCRP <sup>17</sup> )	\$483	-11%	<b>-15%</b>
(k)	% Change in Absolute (PMPM) Volatility of Net Claims (entire market)	n/a	<b>-28%</b>	-15%
(l)	% Change in Relative (% of Claims) Volatility of Net Claims (entire market)	n/a	<b>-19%</b>	+0%

Notes:

Values are rounded. Except where noted otherwise, all PMPM values are stated relative to total individual QHP market membership, both APTC-eligible and non-APTC-eligible.

<sup>17</sup> High cost risk pooling adjustment (part of the federal risk transfer program).

**FIGURE 5: POLICY OPTION IMPACTS AND RANKINGS UNDER COMPOSITE SCENARIO (RANK OF 1 = MOST EFFECTIVE, IMPACTS ARE FOR A \$20 PMPM STATE FUNDING COST, RELATIVE TO NO-POLICY BASELINE)**

Results illustrate differences by policy, and are not predictions for any specific state.

IMPACT MEASURE	POLICY TYPE					
	Variations on 1332 Reinsurance Waiver					
	TRADITIONAL REINSURANCE		UNIFORM COINSURANCE		WRAPAROUND PMPM SUBSIDY	
RANK	IMPACT %	RANK	IMPACT %	RANK	IMPACT %	
Net Claim Reduction	2	-11%	1	-15%	3	0%
Relative Claim Volatility (entire market)	1	-19%	3	+0%	2	0%
Overall Net Premium Impact (entire market)	2	-9%	1	-10%	3	-8%
Benchmark Silver Premium (non-APTC eligible)	3	-9%	1	-14%	2	-13%
Minimum Non-Catastrophic Cost of Coverage (non-APTC eligible)	3	-9%	2	-14%	1	-17%

Each of the above policy options has its own distinct advantages (summarized in Figure 5 above):

- Traditional reinsurance leads to the greatest reduction in claim volatility, reducing volatility of net claims (relative to expected claim costs) across the entire simulated market by 19% of the baseline (in the absence of reinsurance, row l in Figure 4) and the volatility of the average simulated issuer’s risk-adjusted loss ratio by 11% of the baseline (row i). In this context, volatility measures the level of risk and uncertainty issuers face due to random variation in claim costs, which can influence capital requirements and issuers’ willingness to offer coverage at affordable rates. Net claims are calculated after applying each state policy as well as the federal high-cost risk pooling (HCRP) adjustment for claims above \$1 million.
- Uniform coinsurance leads to the greatest reduction in average market premiums for consumers not eligible for federal premium subsidies (14%, rows d, f, g, and h) by directing a greater proportion of premium savings than traditional reinsurance towards lower cost plans such as the benchmark (i.e., second-lowest cost) silver plan. We also estimate a slight advantage for uniform coinsurance in terms of the average premium impact across all enrollees, net of all subsidies (10%, row e).

This latter advantage is also expressed through a higher “Premium Impact-to-State-Funding-Cost Ratio” for uniform coinsurance relative to the other policies (row c). This metric reflects the ratio of the PMPM reduction to the

<sup>18</sup> Within this paper, the minimum cost of coverage refers to the lowest cost “metal” (i.e. bronze and above) QHP plan available to all consumers. However, individuals below age 30 or who qualify for certain hardship/affordability exemptions are eligible to purchase ACA-compliant catastrophic plans at a lower rate, if available in their market.

average market premium (net of all subsidies) to the PMPM funding cost borne by the state. It increases above 1.00 as state and federal funds used to reduce claims also drive a proportional reduction in issuers’ PMPM profit/risk margins, and is slightly higher for uniform coinsurance than reinsurance due to a greater effectiveness at reducing the benchmark silver premium and thereby generating federal pass-through funds.

- Wraparound subsidies lead to the most affordable minimum cost of coverage for non-APTC-eligible individuals<sup>18</sup>, driving a 17% reduction to the premium for the lowest-cost bronze plan (row h).
- Uniform coinsurance and wraparound subsidies are effectively tied with respect to the impact on the lowest-cost silver premium offered *off-marketplace* (14%, row g), under the assumption that issuers’ rate loads for unpaid federal cost-sharing reduction (CSR) payments are limited to silver plans offered on *on-marketplace*, with each issuer offering “mirrored” *off-marketplace* silver plans that omit this rate load.

While the specific numerical results are sensitive to the \$20 PMPM funding cost and associated policy parameters as well as the assumptions and composition of the Composite market scenario, the directional conclusions regarding each policy’s comparative advantages (as ranked in Figure 5) are robust under a wide array of funding levels, policy parameters, assumptions, and market types.<sup>19</sup>

## Understanding differences in premium impacts

By supporting a reduction in issuers’ PMPM profit/risk margins (holding profit/risk margin constant as a percentage of premium), both traditional reinsurance and uniform coinsurance will reduce premiums by more (in dollars) than the cost of the funds used to reduce claims. This leveraging impact varies with the percentage margin reflected in issuers’ premium rates; we assumed a 5% profit/risk margin before state and federal income tax, which corresponds to roughly 3-4% post-tax.

This leveraging impact also varies based on the percentage of the total cost of the policy paid by federal pass through. Policies that generate a greater proportion of funding from federal pass-through funds are able to reduce claims more for a given state funding cost and thereby drive a greater premium impact.<sup>20</sup>

<sup>19</sup> We discuss and show results for several of these alternate scenarios in the full companion report.

<sup>20</sup> For additional discussion and a quantitative demonstration of this phenomenon, we refer readers to the “Premium Impact Amplification when



Federal pass-through funds are tied to reductions in the premium for the second-lowest-cost (benchmark) silver plan. By disproportionately reducing claim costs for the highest cost plans, traditional reinsurance is less efficient than uniform coinsurance at targeting reductions to the benchmark silver plan (9% vs. 14% in Figure 5, above) and thereby generating federal pass-through funds. At the same time, traditional reinsurance is more efficient than uniform coinsurance at improving the affordability of coverage options other than the benchmark silver for consumers that are already subsidized. By compressing differences in cost between the benchmark silver plan (against which APTCs are indexed) and higher cost plans, we estimate that approximately 30% of traditional reinsurance savings accrue to already-subsidized individuals and families in the form of reduced net premiums (e.g. when purchasing plans more expensive than the benchmark silver), compared to approximately 10% under uniform coinsurance and 0% under wraparound subsidies.

Unlike the two 1332 waiver policies under consideration, wraparound subsidies apply state funds directly to consumer premiums rather than claim costs, and therefore will not directly affect issuers' profit/risk margins. This is apparent in the 1.00 Premium Impact-to-State-Funding-Cost Ratio for wraparound subsidies in Figure 4, above (row c). However, by directing all state funds solely to consumers whom the state deems most in need of premium assistance (e.g. consumers with incomes above 400% FPL), wraparound subsidies can still be more efficient than either traditional reinsurance or uniform coinsurance at reducing premiums for a targeted subset of consumers.

## Stakeholder perspectives

Building on these results, we evaluated each policy option from the perspective of each major stakeholder.

- **Individual consumers:** Consumers who receive federal premium assistance (in the form of APTCs) are unlikely to see any reduction to their out-of-pocket premium from traditional reinsurance. They could, however, see some improvement in their choice of affordable plans, as reinsurance tends to compress differences in cost between plans. This compression will reduce the distance in dollars between the benchmark plan premium against which federal subsidies are indexed and other richer or costlier options.

Wraparound PMPM subsidies may offer the greatest benefit to cost-conscious, healthier consumers not already eligible for federal premium subsidies, by facilitating the lowest minimum cost of coverage across the three options.

Uniform coinsurance strikes a balance between these two endpoints, and maximizes the overall savings across all enrollees.

- **Marketplace issuers:** Both traditional reinsurance and uniform coinsurance are projected to reduce PMPM profit/risk margins as premiums decrease (holding profit/risk margins constant as a percentage of premium). By reducing claims volatility along with the total level of claims in a market, traditional reinsurance may further encourage issuers to reduce profit/risk margins as a *percentage* of premium (although this latter adjustment is outside of the scope of our simulation, which assumes a fixed rating and participation strategy by issuers). This risk-mitigating feature of reinsurance may even encourage market participation by issuers that would have otherwise exited or declined to enter the market.<sup>21</sup>

However, these same issuers, particularly those who may be more efficient at controlling claim costs, may consider reinsurance biased in favor of less efficient competitors. As a result, the benefit of reinsurance on encouraging competition may be mixed.

Traditional reinsurance and uniform coinsurance may be especially attractive to new market entrants because they can ease the capital requirements for new business. In contrast, wraparound PMPM subsidies have no direct effect on issuers, as they are applied directly to consumer premiums at the point of sale, bypassing issuers entirely. However, because this option does not involve parameters that may be adjusted retrospectively, due to changing availability of funds, wraparound subsidies also create no new pricing uncertainty among issuers.

Each policy will also impact the competitive environment that issuers face. By reducing net claim costs the most for issuers with higher unit costs, less effective care management, and/or higher morbidity populations, reinsurance will tend to improve the competitive position of higher-cost issuers and reduce incentives to contain costs. In contrast, by reducing all plan premiums by the same dollar value, wraparound subsidies drive the greatest proportional reduction in premiums for the lowest-cost plans and may further cement the existing competitive advantages of low-cost issuers. Over time, this may increase the incentives for other issuers to pursue aggressive cost containment strategies such as "narrow" provider networks. Uniform coinsurance strikes a balance between these two endpoints.

using State and Federal Funds to Reduce Claims" section of the full companion report.

21 Issuers typically have access to private reinsurance policies from reinsurers, but a state-supported program may allow them to manage high claim risk with a smaller impact on premiums.

- **Healthcare providers:** If current reimbursement rates in ACA markets are acceptable to providers, then they will generally benefit from higher insurance enrollment rates, regardless of which policy option is implemented.

As noted previously, traditional reinsurance may encourage greater reliance on—and patient volume for—broad provider networks, with providers benefiting from this increased demand. In contrast, wraparound subsidies may increase the incentives for providers to participate in low-cost issuers' narrow networks. The incentives created by uniform coinsurance are likely to fall in between these two extremes.

- **State governments:** States may need to seek an optimal balance among the perspectives of the stakeholders represented here, while limiting the funding cost and financial risk borne by the state and its taxpayers. This includes consideration of the following:

- **Implementation requirements:** Reinsurance comes with the advantage of having been successfully approved in 13 states (as of publication), while the acceptance of uniform coinsurance by the federal government and other market stakeholders is still unproven. Wraparound subsidies have the advantage of not requiring federal 1332 waiver approval, but with the limitation that they can currently only be implemented in states that operate their own state-based marketplaces, due to limitations of the federal exchange platform.

- **Financing risk:** Because the value of traditional reinsurance and uniform coinsurance varies with claim costs, which are uncertain, they require the state to bear a greater degree of financing risk for any given set of parameters than fixed wraparound PMPM subsidies. This assumed risk is greatest for traditional reinsurance, as high-cost claims are more volatile than claim costs as a whole. Furthermore, to the extent premium reductions encourage greater unsubsidized enrollment volume, federal pass-through payments will be diluted and states will be responsible for additional funding costs.

If, on the other hand, states choose to set funding levels in advance and let the policy parameters float, then the pricing risk is borne entirely by issuers, and correspondingly higher risk margins may offset a portion of the premium relief.

- **Source of financing and impact on other state stakeholders:** In order to have the intended effect,

states must finance policies to reduce marketplace premiums from outside of the individual ACA market itself. The cost of state funding may be borne by several different groups, including through assessments on providers, taxes on residents and businesses, assessments on employer-based group coverage, and other sources. While some of the groups and individuals tapped for funding may benefit indirectly from increased enrollment or stability in the individual market, all are likely to prefer that the state minimizes the cost required to achieve its objectives.

## Incentives and secondary impacts

While we modeled only the direct financial impacts of each policy on claim costs and premium rates without modeling other behavioral changes among consumers, issuers, and healthcare providers, states must consider the potential secondary impacts of each policy due to the incentives each may create for market participants. For example:

- **Enrollment volume and risk pool composition:** All three policy options may encourage greater market participation by healthier and cost-conscious consumers, further reducing the average cost of coverage. However, increased enrollment volume will also necessitate a greater funding expenditure by the state (regardless of option chosen), and dilute the value of federal pass-through payments as a percentage of total funding costs.
- **Population health:** By encouraging more individuals and families to purchase comprehensive health coverage, all three policies will increase consumers' access to necessary care, which has been shown to improve population health outcomes.<sup>22</sup>
- **Consumer purchasing behavior:** Traditional reinsurance may shift the premium relationships between plans, thereby encouraging consumers to purchase richer and/or higher-cost plans. Wraparound PMPM subsidies will accentuate the premium differences and encourage consumers to select leaner coverage options (such as bronze plans and plans with “narrow” provider networks). The incentives created by uniform coinsurance are likely to fall in between these two end points.
- **Incentives to control costs:** Traditional reinsurance and (to a lesser extent) uniform coinsurance may limit the incentive for issuers to manage claim costs and reduce the incentive for issuers and providers alike to find further cost reductions. As a result, traditional reinsurance and uniform coinsurance have the potential to *increase* gross claim costs (before

<sup>22</sup> Kaiser Family Foundation (January 25, 2019). The Uninsured and the ACA: A Primer—Key Facts About Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act. Retrieved November 8, 2019, from <https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key->

[facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/](https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/).

reinsurance or coinsurance is applied), diverting some of the benefit of these policies away from consumers and toward other stakeholders. In contrast, by driving a greater reduction *as a percentage of premium* for the lowest-cost issuers and plans (through a fixed PMPM premium reduction), wraparound subsidies may increase pressure on issuers and healthcare providers to manage claim costs.

For additional discussion regarding how each policy interacts with the federal risk adjustment program, including quantitative demonstration and derivation of a state flexibility adjustment to counteract risk adjustment / reinsurance double-dipping, please refer to the full companion report.

## Interaction with risk adjustment

The federal ACA risk adjustment program will interact with each policy. While uniform coinsurance and wraparound subsidies are unlikely to lead to substantial distortion in risk adjustment, the traditional reinsurance approach can lead to a “double-dipping” phenomenon, whereby the issuers with the sickest enrollees are reimbursed twice for their costs; once through risk adjustment, and again through a disproportionate share of reinsurance payments. However, a state can use an HHS-approved state flexibility adjustment factor to dampen the magnitude of risk transfers under reinsurance<sup>23</sup> and offset the imbalance associated with “double-dipping.” Under the Composite scenario with a \$20 PMPM state funding cost, we found that a 2% reduction in the magnitude of risk transfers (i.e., 0.98 state flexibility adjustment) was sufficient to restore the original balance of the risk adjuster *for issuers with market average unit cost levels* when paired with the specified traditional reinsurance parameters. The magnitude of this adjustment (0.98) is tied to the particular market characteristics, funding level, and policy parameters that we modeled; we recommend that states considering using the flexibility adjustment in this manner conduct a state-specific actuarial analysis to determine the appropriate factor.

In addition, to the extent that issuers’ reimbursement rates for providers is positively correlated with enrollee population morbidity<sup>24</sup>, reinsurance will amplify the existing imbalances in risk adjustment whereby transfers (which are indexed to the market-wide *average* cost level) favor high-cost/high-morbidity issuers at the expense of low-cost/low-morbidity issuers. States wishing to mitigate this specific form of bias may consider a greater state flexibility reduction to transfers than would be warranted if all issuers and plans shared the same unit cost level. However, due to the revenue neutral design of the federal risk transfer formula (whereby payments and charges net out to \$0 across issuers), no state flexibility adjustment can produce unbiased risk transfers across all possible combinations of unit cost and morbidity.

<sup>23</sup> HHS. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, p. 75. Retrieved November 8, 2019, from <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23599.pdf>.

<sup>24</sup> Correlation between unit cost and morbidity can occur if healthier (i.e. low morbidity) enrollees are more likely to enroll in plans whose units costs are

below average due to narrow provider networks, while higher morbidity enrollees are more likely to enroll in plans whose unit costs are above average due to broad provider networks.

## Qualitative conclusions

Figure 6 provides a high-level qualitative summary of the key benefits and trade-offs associated with each premium reduction policy.

**FIGURE 6: STATE POLICY OPTIONS: COMPARISON OF KEY BENEFITS AND TRADEOFFS**

	POLICY	DEFINITION	KEY BENEFITS	KEY TRADE-OFFS
Variations on 1332 Reinsurance Waiver	Traditional Reinsurance	State funds and federal Section 1332 waiver pass-through funds are used to reimburse health plans for a percentage (coinsurance) of claim costs above a fixed attachment point up to a specified maximum (per member per year).	<ul style="list-style-type: none"> <li>Section 1332 reinsurance waivers have a track record of approval and successful implementation in many states.</li> <li>Reduces the level of volatility risk in a market and reduces capital constraints for market participants, potentially encouraging risk-averse or capital-constrained issuers to offer coverage and reduce profit/risk margins as a percentage of premium.</li> <li>Reducing the spread in the cost of coverage between lower-cost and higher-cost issuers can encourage a greater variety of affordable options for federally subsidized consumers.</li> </ul>	<ul style="list-style-type: none"> <li>Inefficient method of transmitting state funding into reduced costs of coverage for unsubsidized consumers.</li> <li>Savings disproportionately favor issuers with the highest claim costs.</li> <li>Can lead to risk adjustment “double-dipping” (in the absence of corrective action), whereby high morbidity issuers are overcompensated and low morbidity issuers overcharged.</li> <li>Can reduce the incentive for issuers and providers to manage high-cost cases, while encouraging more generous “outlier” clauses in provider reimbursement contracts.</li> <li>State assumes greater volatility risk if setting parameters in advance. Pricing risk is increased if reinsurance parameters are adjusted retrospectively.</li> </ul>
	Uniform Coinsurance	State and federal Section 1332 waiver pass-through funds are used to reimburse health plans for a percentage (coinsurance) of claim costs, starting from the first dollar incurred, up to an optional specified maximum (per member per year).	<ul style="list-style-type: none"> <li>Maximizes the expected impact on non-subsidized market premiums and overall premiums net of subsidies, for a given state funding cost.</li> <li>Strikes a balance between traditional reinsurance (which disproportionately favors higher-cost issuers) and a wraparound PMPM subsidy (which disproportionately reduces premiums for the lowest-cost issuers and plans).</li> <li>Minimizes distortion of risk adjustment and competitive dynamics (in comparison to traditional reinsurance).</li> <li>Reduces capital constraints on new market entrants.</li> </ul>	<ul style="list-style-type: none"> <li>This type of policy is untested in practice and could face opposition at the federal level or by state stakeholders. As of the time of publication, no states have applied for Section 1332 waivers of this type.</li> <li>State assumes some volatility risk if setting parameters in advance (though less than under traditional reinsurance). Pricing risk is increased if parameters are adjusted retrospectively.</li> </ul>
	Wraparound PMPM Subsidy	State funds are used to extend a fixed subsidy per member per month that applies at the point of sale and wraps around the existing federal APTC subsidy structure. The state subsidy is adjusted for the age of the consumer but does not vary with enrollees’ plan selections.	<ul style="list-style-type: none"> <li>Can be implemented in a state-based exchange without requiring any federal approval or involvement.</li> <li>Under typical conditions, may be the most cost-effective way for a state to reduce the minimum cost of coverage for consumers ineligible for federal premium subsidies (of the three options considered).</li> <li>States can vary the value of subsidies by household income in order to directly address the federal “subsidy cliff” and improve affordability for consumers with the greatest need for assistance.</li> <li>State funding and pricing impact is more predictable than for policies that impact claims.</li> </ul>	<ul style="list-style-type: none"> <li>There is no clear pathway to implementing effective wraparound subsidies in a state with a federally facilitated marketplace.</li> <li>Has no direct impact on the level of claim risk in a marketplace, and therefore may be less effective than the other policies at encouraging issuers to offer coverage or reduce profit/risk margins, limiting the effectiveness of the policy to directly reduce the average cost of coverage.</li> <li>May encourage leaner coverage and less comprehensive provider networks.</li> </ul>

## Limitations and Qualifications Statement

This paper and the companion report are subject to the terms and conditions of the Consulting Services Agreement between Centene Corporation and Milliman dated January 13, 2003. The information contained in this paper has been prepared for Centene in support of its communications with state policymakers and other health care industry stakeholders. The material is intended to illustrate considerations and describe expected directional results that may arise if a state establishes a program to reduce ACA marketplace premium rates through the targeted injection of state and/or federal 1332 Waiver pass-through funds. The data and information presented may not be appropriate for any other purpose.

It is our understanding that this paper will be released publicly. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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The policies considered in this paper and the companion report do not represent an exhaustive list of ways states can promote the affordability of ACA marketplace coverage. Through this paper and companion report, Milliman is neither advocating for or against any particular policy position, nor is Milliman recommending that a state policymaker or other stakeholder take a specific action. The considerations, guidance, and results within report are intended for educational purposes, and represent best estimates based on the specified assumptions; actual results will vary. Emerging experience should be monitored and adjustments made as necessary.

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