North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER

North Dakota Insurance Department Proposed 1332 Waiver Analysis Report

NovaRest
ACTUARIAL CONSULTING

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I. Executive Summary

About the Model Team

NovaRest Actuarial Consulting (NovaRest) partnered with the North Dakota Insurance Department (Department) to develop a plan to stabilize North Dakota's (State) individual health insurance market using a Section 1332 Waiver (1332 Waiver or Waiver). NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. NovaRest employs some of the most senior actuaries in the industry. The NovaRest actuaries are experts in the Affordable Care Act (ACA), modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects.

The primary tool that NovaRest used for the 1332 Waiver application analysis is the NovaRest Market Migration Model (NRMM). The NRMM is an actuarial tool for analyzing the impact of market migration, take-up and lapse rates resulting from proposed legislative changes.

Intent of This Report

The NovaRest team was hired by the North Dakota Insurance Department to provide Section 1332 Waiver analysis. The goal is to analyze alternate waiver strategies that will lower premiums for consumers, improve market stability, increase consumer choice and meet federal requirements. This report describes the analysis done and the conclusions drawn concerning the North Dakota 1332 Waiver alternatives.

This report is intended to facilitate the design of the North Dakota 1332 Waiver and aid in the decision-making process around the 1332 Waiver. It may be used in part or in its entirety for the ultimate waiver application to CMS, although it is not intended to fulfill all of the requirements of the waiver application. This report is for the use of North Dakota to aid in its Waiver development and is not appropriate for other uses.

The ultimate Waiver application will be required to cover a number of additional topics including the coordination of the reinsurance mechanism with the federal Risk Adjustment program.

North Dakota Waiver

It is North Dakota's desire that its 1332 Waiver will reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims. The proposal is to accomplish this using a reinsurance mechanism to help fund high cost claims. The result therefore, should be more individuals staying in the market and more insurers being willing to write policies in North Dakota counties. Both of these will help stabilize the individual health insurance market in North Dakota.

In addition to the proposed 1332 Waiver, the State would like to consider a North Dakota state based health insurance plan (North Dakota Plan) that would be sold by the current insurance carriers. The State plan would include all of the essential health benefits with a higher cost sharing and a reduced premium.

Reinsurance

Under its 1332 Waiver, North Dakota would implement a reinsurance mechanism that would be similar to a traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance is estimated to reduce premiums between 10% and 20% in 2020 compared to the baseline premium (without the waiver) depending on the attachment point chosen. Due to the reduced premium the membership in the 2020 individual market would increase 1% compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of an "invisible" reinsurance allows enrollees to remain in the individual market with their current plan and carrier, but a portion of their claims are reimbursed by the reinsurance pool. The enrollee is not aware that their claim is being paid via the reinsurance pool meaning there is no effect on the enrollee as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

For 2020, the proposed reinsurance program would cover 75% of paid claims between the attachment point and $1,000,000. The attachment points being considered are $100,000 and $200,000. This level of reinsurance was assumed in the future projections, but North Dakota may have the flexibility to change the parameters in the future.

The reinsurance payable under the Waiver is estimated to be between $26 million and $48 million in 2020. It will increase over the next ten years due to medical inflation unless the reinsurance parameters are modified. The actual amount that will be paid under the reinsurance will depend on submitted claims. Based on NovaRest projections the reinsurance paid in future years will be approximately as shown in Table 1.

Table 1 Reinsurance Paid by Year											
Attachment Point:	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
$100,000	$47,755,003	$50,477,038	$53,354,230	$56,395,421	$59,609,960	$63,007,727	$66,599,168	$70,395,320	$74,407,854	$78,649,101	$83,132,100
$200,000	$26,726,151	$28,249,542	$29,859,765	$31,561,772	$33,360,793	$35,262,358	$37,272,313	$39,396,834	$41,642,454	$44,016,074	$46,524,990

It was decided that the use of CHAND was too disruptive to the individuals and families.

Once the decision was made to structure the 1332 Waiver as an invisible reinsurance mechanism, it was proposed that CHAND administer the reinsurance program. After discussions internally and externally, the Insurance Department decided that for conflict of interest reasons it was not appropriate to use CHAND. CHAND was staffed with Blue Cross Blue Shield of North Dakota employees and it was considered inappropriate for it to administer reinsurance for itself and the other carriers.

North Dakota Plan

North Dakota intends to offer a state specific plan similar to the one proposed in Idaho. The intent of the North Dakota Plan is to have an affordable option for healthier individuals and to inject healthier risk into the single risk pool. Healthier individuals will pay a reduced premium.

The North Dakota Plan will cover all of the essential health benefits (EHBs) but will have higher cost sharing compared to the ACA metal level plans. The plans are still guaranteed issue, but in the event of a coverage lapse, carriers would be allowed to implement a waiting period before pre-existing conditions would be covered.

Meeting the 1332 Waiver Guardrails

CMS has determined four "guardrails" that must be met before a 1332 Waiver can be approved.

As this report shows, the proposed Waiver will meet the required guardrail conditions:

- The Waiver does not make alterations to the required scope of benefits offered in the insurance market in North Dakota and will result in an increase in the number of individuals with coverage that meets the ACA's Essential Health Benefits requirements.
- The Waiver will reduce premium and increase affordability.
- The Waiver will cover more individuals in North Dakota than would be covered absent the Waiver.
- The Waiver will not result in increased spending, administrative, or other expenses to the federal government.

Funding

A portion of the funding for the reinsurance would come from the federal government due to the reduction in advanced premium tax credits (APTC) being passed to North Dakota. The reduction in premiums for the second lowest Silver plan in each region directly reduces the APTC for the individuals eligible for APTCs.

The additional funding required by the reinsurance program would come from assessments against the group health insurance market and Third-Party Administrators (TPAs) that pay claims for self-insured employers. NovaRest projects the APTC pass through in 2020 to be between $14 million and $26 million and the assessment requirement to be between $12 million and $22 million. The 2020 assessment would be between 1% and 1.5% of group health insurance premium and TPA premium equivalent (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

In Conclusion

The North Dakota Waiver would reduce premiums and provide a low-cost alternative to healthier individuals. This would result in more ACA membership and a more stable individual market. It would also protect carriers from unpredictable high cost claims and make the claims costs more predictable. This would result in carriers being more willing to participate in the North Dakota individual insurance market.

The reinsurance would be funded by a combination of federal reduction in APTCs and assessments. The assessments would be against the group health insurance market and TPAs that pay claims for self-insured employers. Since the group insured market and self-insured employers are much larger than the individual market, the assessment needed to stabilize the individual market would be spread over a much larger base.

In addition to the Waiver, the lower premium charged to healthy individuals under the North Dakota Plan will provide an alternative when rate increases result in individuals and families dropping coverage. We expect this will lead to a larger insured population and a more stable market.

II. Background

Section 1332 Waivers
Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.[1]

For 1332 Waivers, there are specific guardrails that the proposed plan must meet including:

Comprehensive Coverage – 1332(b)(1)(A)
The proposed Waiver cannot make alterations to the required scope of benefits offered in the insurance market in North Dakota and cannot result in a decrease in the number of individuals with coverage that meet the ACA's Essential Health Benefits requirements.

Affordability – 1332(b)(1)(B)
The proposed cannot decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The Waiver cannot result in any decrease in affordability for individuals.

Scope of Coverage – 1332(b)(1)(C).
The proposed will provide coverage to at least a comparable number of residents as would be provided coverage absent the Waiver in North Dakota.

Federal Deficit Neutrality – 1332(b)(1)(D)
The proposed waiver cannot result in increased spending, administrative, or other expenses to the federal government.

When examining the options available to stabilize the individual health insurance market in North Dakota each of these guardrails must be met.

[3] "Section 1332:State Innovation Waivers." The Center for Consumer Information & Insurance Oversight. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

Current Environment

Current State of the Affordable Care Act (ACA)

As federal healthcare reform efforts continue to face significant challenges, the ACA continues to strain North Dakota's individual insurance market. Nationally, the cost of health care is still a major barrier to obtaining coverage. According to Kaiser Family Foundation, nationally the unsubsidized premium for the lowest-cost bronze plan is increasing an average of 17% between 2017 and 2018, the lowest-cost silver plan is increasing an average of 32%, and the lowest-cost gold plan is increasing an average of 18%.[2] Since 2014, premiums in North Dakota individual health insurance market have steadily increased. Nationally, ACA market conditions have resulted in carriers leaving the market or reducing the counties in which they offer plans and North Dakota is making efforts to prevent that from happening.

Under the ACA if a family income falls between 100% and 400% of the FPL, they may be eligible for cost sharing and premium subsidies.[3] Cost sharing reductions (CSR) lower the amount of cost sharing that an individual pays out of pocket. The CSR's are available to those between 100% to 250% of the federal poverty line, with families with lower incomes paying less out-of-pocket. APTCs reduce the premium that a family pays based on their income level and are available up to 400% of FPL. Individuals purchasing the silver level plan in the region that has the second lowest premium only have to pay an affordable percentage of their income. The percentage is determined by their income level.

North Dakota Characteristics

North Dakota is one of the fastest growing states in the country. According to Census.gov, North Dakota's total population increased by 12.3% from April 1, 2010 to July 1, 2017, which is only behind the District of Columbia and Texas.[4] The population increase over the same period for the entire United States is 5.5%.[5] As of July 1, 2017, the North Dakota population is estimated to be 755,393.[6] The table below provides a breakdown of the population demographics.[7]

[2] "How premiums are Changing in 2018." Kaiser Family Foundation. November 29, 2017. https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/

[3] "2018 Federal Poverty Level". Obamacare.net. https://obamacare.net/2018-federal-poverty-level/

[4] "Population, percent change – April 1, 2010 (estimates base) to July 1, 2017, (V2017)". United States Census Bureau. https://www.census.gov/quickfacts/geo/chart/nd/PST120217#viewtop

[5] "Quickfacts: North Dakota". United States Census Bureau. https://www.census.gov/quickfacts/fact/table/nd,US/PST045217

[6] Ibid.

[7] Ibid.

Table 2 Population by Age	
Under 20 years	197,320
20 to 24 years	64,891
25 to 29 years	60,594
30 to 34 years	53,659
35 to 39 years	48,502
40 to 44 years	39,644
45 to 49 years	39,436
50 to 54 years	42,858
55 to 59 years	49,436
60 to 64 years	45,845
65 years and over	113,208
Total	**755,393**

North Dakota's GDP of $55.5 billion ranks 45th in the US.[8] The growth rate in 2017 was 1% in North Dakota compared with 2.1% for the US. Enterprises with less than 100 employees, represent 80% of the total number of establishments in North Dakota and also employ 40% of the total employed.[9]

The median household income in 2016 was $59,114, which is slightly higher than the median household income for the entire United States, which was $55,322. The income distribution for the North Dakota population, in 2016 inflation adjusted dollars, is shown in the table below:[10]

[8] "GDP for North Dakota." U.S. Bureau of Economic Analysis. May 4, 2018. https://apps.bea.gov/regional/bearfacts/action.cfm.
[9] "2015 SUSB Annual Data Tables by Establishment Industry." United States Census Bureau. January 2018. https://www.census.gov/data/tables/2015/econ/susb/2015-susb-annual.html
[10] "2012-2016 American Community Survey 5-Year Estimates." United States Census Bureau. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_5YR_DP03&prodType=table

Table 3 Population by Income		
	Estimate	**Percent**
Total Households	**305,163**	**100%**
Less than $10,000	18,488	6.1%
$10,000 to $14,999	13,946	4.6%
$15,000 to $24,999	26,735	8.8%
$25,000 to $34,999	29,627	9.7%
$35,000 to $49,999	41,423	13.6%
$50,000 to $74,999	56,626	18.6%
$75,000 to $99,999	42,372	13.9%
$100,000 to $149,999	45,763	15.0%
$150,000 to $199,999	15,324	5.0%
$200,000 or more	14,859	4.9%
Median household income (dollars)	**59,114**	
Mean household income (dollars)	**78,828**	

Per the most recent U.S. Census Bureau estimates, the number of persons in poverty in North Dakota is 10.7%, which is lower than the estimated 12.7% for the entire United States.[11] North Dakota is the 47th most populated state in the US[12], making the population density of North Dakota among the lowest 5 states in the US, with around 11 residents per square mile.[13] This makes providing adequate access to health care difficult. A biennial report by the University of North Dakota School of Medicine and Health Sciences Advisory Council indicated there is a shortage of providers particularly primary care physicians, especially in the rural and western parts of North Dakota.[14] They indicate the problem is driven by a lack of providers and more importantly by a higher concentration of providers in the more urbanized areas of the state.

North Dakota did not establish its own exchange, so enrollments are completed via HealthCare.gov.

North Dakota was one of only two states where insurers were not allowed to add the cost of cost-sharing reductions to premiums when they were defunded.[15] This prompted Medica to leave the exchange at the end of 2017 and left only Blue Cross Blue Shield of North Dakota (Noridian) and Sanford Health Plan on the exchange for the individual market in 2018.

[11] "Quickfacts: North Dakota." United States Census Bureau. https://www.census.gov/quickfacts/fact/table/nd,US/PST045217
[12] Ibid.
[13] "Population density in the U.S. by federal states including the District of Columbia in 2017." Statista. https://www.statista.com/statistics/183588/population-density-in-the-federal-states-of-the-us/
[14] "Fourth Biennial Report, Health Issues for the State of North Dakota." UND School of Medicine and Health Sciences. 2017. https://med.und.edu/alumni-community-relations/_files/docs/fourth-biennial-report-summary.pdf
[15] Norris, Louise. "North Dakota health insurance marketplace: history and news of the state's exchange." HealthInsurance.org. August 27, 2018. https://www.healthinsurance.org/north-dakota-state-health-insurance-exchange/#enrollment

Therefore, individuals looking for coverage on the exchange only had two options, Blue Cross and Blue Shield of North Dakota and Sanford Health Plan. In 2017, Medica provided coverage for 3,073 individuals of the 20,691 on North Dakota's exchange.[16]

The approved 2018 average rate increases for the individual market, including off-exchange are included in the Table 4 below.[17]

Table 4
North Dakota 2018 Final Average Individual Market Rate Increases by Company

Company	2018 Rate Increase
Blue Cross Blue Shield of North Dakota	23.15%
Medica Health Plans	18.33%
Sanford Health Plan	7.86%

For 2019, carriers could add the cost of the federally defunded CSRs to premiums. Medica is proposing to offer plans on the exchange in 2019. The proposed 2019 average rate increases for the individual market, including off exchange, are included in Table 5 below.[18]

Table 5
North Dakota 2019 Proposed Average Individual Market Rate Increases by Company

Company	2019 Rate Increase
Blue Cross Blue Shield of North Dakota	5.79%
Medica Health Plans	29.32%
Sanford Health Plan	23.25%

[16] "Medica to leave ND health insurance exchange in 2018." Post-Bulletin Company. September 28, 2017. http://www.postbulletin.com/news/business/medica-to-leave-nd-health-insurance-exchange-in/article_0190e224-ff87-55ac-9954-8296518786a9.html

[17] North Dakota Rate Review Submissions. https://ratereview.healthcare.gov/. Note: Rate increases are provided at the product level. Product rate increases are weighted by projected membership in the URRT to determine the average carrier increases.

[18] Ibid.

The three North Dakota carriers provided NovaRest with data for each individual as of December 31, 2017 and May 31, 2018. Based on the data received, the individual insurance market membership, average premium and total premium are shown in the following Table 6. Since the premium is the average based on the age mix in the category, the premiums are not totally comparable, but give a sense of what individuals are paying in each market segment.

Table 6
Current North Dakota Individual Market

Membership Active on Census Date			**December 31, 2017**	**May 31, 2018**
	On Exchange			
		APTC	15,588	17,707
		Non-APTC	3,101	3,936
	Total On Exchange		18,689	21,643
	Off Exchange		20,379	17,902
	Total ACA		39,068	39,545
	Transitional		924	0
	Grandfathered		6,381	6,291
	Total Individual Market		46,373	45,836
Average Premium				
	On Exchange			
		APTC Premium Rate	$407 .06	$462.90
		Non-APTC	$371.06	$420.15
	Total On Exchange		$401.08	$455.12
	Off Exchange		$406.75	$493.90
	Total ACA		$404.04	$472.68
	Transitional		$261.57	
	Grandfathered		$451.47	$471.05
	Total Individual Market		$407.73	$472.45
Total Annual Premium				
	Total ACA		$189,421,176	$224,304,283
	Transitional		$2,900,288	$0
	Grandfathered		$34,570,284	$35,561,179
	Total Individual Market		$226,891,748	$259,865,462

The Federal Poverty Level (FPL) is utilized to determine if a citizen is eligible for subsidies to off-set the cost of their monthly premiums. The FPL is also used to determine eligibility for Medicaid, Children's Health Insurance Program (CHIP) and North Dakota Children's Special Health Services (CSHS). In 2017, 211,510 individuals (28% of the population) were under 200% FPL in North Dakota.[19]

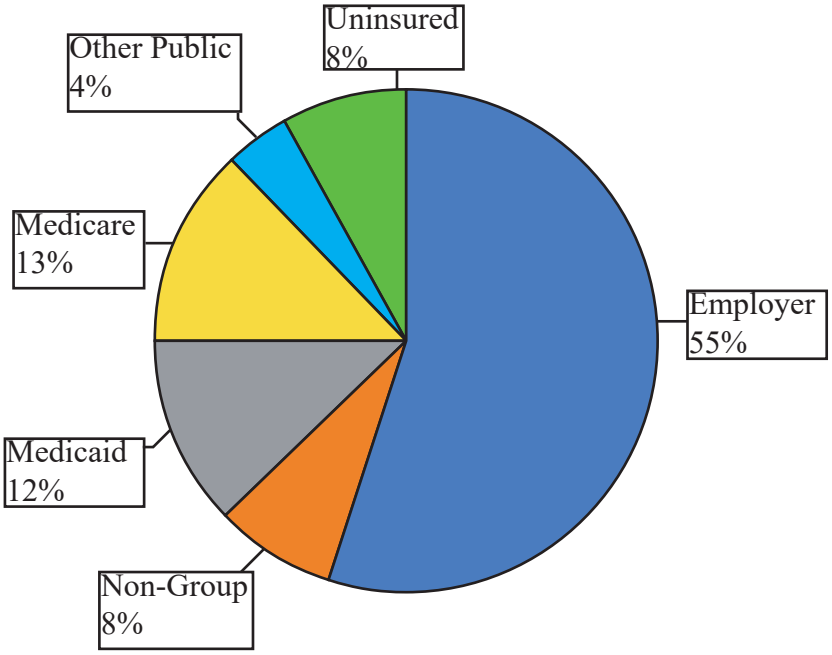
The ACA provided federal funding to states that expanded their Medicaid programs. This expansion provided coverage to many who could not afford health insurance premiums. North Dakota opted to expand Medicaid to 138% FPL utilizing federal funding. Low-income adults without dependent children became eligible for Medicaid in North Dakota in 2014. Along with most states the cost of expanding Medicaid has been higher than expected in North Dakota. According to Louise Norris, "Sanford reported that the cost of claims among the Medicaid expansion group in 2014 averaged $1,215 per member, per month – far higher than the $352 average for their commercially-insured members."[20] The first three years of the program the federal government was responsible paying the cost for the new population. In 2017, North Dakota was responsible for paying 5 percent of the cost. Assuming no major changes in the coverage qualifications or other federal changes, the state will be required to pay 10 percent of the costs in 2020.[21]

Previously, residents of North Dakota who are unable to find adequate health insurance coverage in the private market due to medical conditions or who have lost their employer-sponsored group health insurance, were eligible for Comprehensive Health Association of North Dakota (CHAND). If an individual was denied health insurance coverage, insurance carriers were required to inform that individual about CHAND. Individual premiums fund approximately one-half to two-thirds of the program, not to exceed 135% of premiums charged in the state of North Dakota for similar coverage.[22] The balance is covered by assessments to health insurance carriers that write $100,000 in annual premiums on behalf of residents of North Dakota. Additional dollars may also come through federal grants. Once the ACA was implemented with its guaranteed issue requirement, CHAND was unable to gain new membership, but prior members were allowed to remain in CHAND.

[19] "Medicaid In North Dakota", Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/fact-sheet-medicaid-state-ND
[20] Norris, Louise. "North Dakota and the ACA's Medicaid expansion." August 27, 2018. https://www.healthinsurance.org/north-dakota-medicaid/
[21] Ibid.
[22] The Comprehensive Health Association of North Dakota (CHAND). http://www.chand.org/
[23] Ibid.

A breakdown of the health insurance coverage in North Dakota is shown below[24]:

2016 North Dakota Health Coverage



As evident from the above, North Dakota has seen a lot of change in recent years. It expanded Medicaid, had a carrier leave the Exchange, and saw significant change in population first as the oil and gas industry grew and then as it lessened. Also, a significant number of individuals have moved from the Grandfathered and Transitional policies to the ACA market. All of these changes have resulted in unusual patterns of enrollment in North Dakota's recent history.

[24] "Health Insurance Coverage of the Total Population." Henry J Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22north-dakota%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D . "Other Public" includes those covered under the military of Veterans Administration.

III. NovaRest Analysis

Goals of NovaRest's Analysis

NovaRest's analysis is intended to be used to understand and predict the impact of implementing various strategies to stabilize the individual health insurance market in North Dakota. The plan is to implement a 1332 Waiver for the 2020 plan year. The goal of the Waiver is to increase affordability, competition, and consumer choice. This analysis will allow the State to understand the impact and funding requirements of the options under consideration, thus allowing the State to determine which option to implement.

The options under consideration were:

1. The modification of North Dakota's current high-risk pool, N.D.C.C. ch. 26.1-08 & N.D. Admin. Code ch. 45-06-02.1, (known as the Comprehensive Health Association of North Dakota or "CHAND"; hereinafter "CHAND") to allow a greater number of high-risk North Dakotans to obtain their health insurance from CHAND.
2. Modify CHAND into an invisible high-risk pool where high-risk North Dakotans can obtain their health insurance.
3. Create a reinsurance waiver that would create an invisible high-risk pool independent of CHAND.
4. Implementing a health insurance strategy similar to that implemented by the state of Idaho.

Decisions Made Concerning North Dakota's 1332 Waiver

Reinsurance

It was decided that the North Dakota reinsurance mechanism would be a traditional reinsurance program with an attachment point, coinsurance amount, and a maximum paid claims level rather than a disease-based reinsurance. The pros and cons of each are discussed in Appendix A. This program will be similar to the temporary federal reinsurance program with different attachment points and coinsurance.

There was much discussion as to whether the reinsurance program would be implemented on a prospective or retrospective basis. The final decision was to use a retrospective approach. The pros and cons of each are discussed in Appendix B.

Use of CHAND

Using CHAND for the reinsurance had been considered. CHAND already had the ability to cover high-cost individuals. There was an administrative system in place and staff that understood the process.

Also, if CHAND were used, individuals would be moved from their current plan that they were familiar with, to the CHAND plans. This may result in some family members being in CHAND and some in the exchange plans.

It was decided that the use of CHAND was too disruptive to the individuals and families.

Once the decision was made to structure the 1332 Waiver as an invisible reinsurance mechanism, it was proposed that CHAND administer the reinsurance program. After discussions internally and externally, the Insurance Department decided that for conflict of interest reasons it was not appropriate to use CHAND. CHAND was staffed with Blue Cross Blue Shield of North Dakota employees and it was considered inappropriate for it to administer reinsurance for itself and the other carriers.

IV. North Dakota 1332 Waiver Reinsurance

Reinsurance Design

Under its 1332 Waiver North Dakota proposes to implement a reinsurance mechanism that would reduce premiums between 10% and 20% in 2020, compared to the baseline premium without the waiver. The amount of premium reduction is dependent on the attachment point selected. The reinsurance mechanism would be "invisible reinsurance", like traditional reinsurance or the temporary federal ACA reinsurance that was effective from 2014 to 2016.

Each calendar year the reinsurance would cover, for high claim insureds, a percentage (coinsurance) over a specified level of paid claims (attachment point) until a specified level of paid claims was reached (maximum amount). The current proposal is that the attachment point be either $100,000 or $200,000, the coinsurance would be 75% and the maximum amount would be $1,000,000 in paid claims.

In addition to reducing premiums, the reinsurance would allow carriers to better predict their health care claims costs and protect against unpredictable high-cost claimants.

The reinsurance would be funded by the reduction in federal Advanced Premium Tax Credits (APTC) and assessments against the group carriers and Third Party Administers (TPAs). TPAs process claims for self-insured plans.

The reduction in premiums in North Dakota results in the reduction in APTCs. The APTCs funded by the federal government are the difference between the second lowest Silver premium in a region and the maximum amount that a family pays in premium based on its income and family size. As the Silver premiums are reduced, the APTC is reduced due to the reduction in premiums. The reduction in APTC is slightly offset by exchange user fees, which the federal government will not be able to collect. The fourth guardrail - Federal Deficit Neutrality, requires that any savings from APTC be offset by any loss of income.

Since the individual market is only 13% of the total health insurance commercial market, the assessments from the group market and TPAs would be allocated to a much larger base. NovaRest estimates that the assessments would be between 1% and 1.5% of group health insurance premiums and TPA premium equivalents (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

The reinsurance program would reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims. The result therefore, should be more individuals staying in the market and more insurers being willing to write policies in North Dakota counties. Both of which will help stabilize the individual health insurance market in North Dakota.

NovaRest Reinsurance Analysis Process and Assumptions

Data

Carrier Data Call

NovaRest requested three data files from the carriers in North Dakota, including Blue Cross Blue Shield of North Dakota, Sanford, and Medica.

NovaRest performed a data call for the individual market carriers and identified the number of members in each of the following FPL ranges. Those from 0% of the FPL to 138% of the FPL are covered by Medicaid. Members are eligible for APTC up to 400% FPL. Members at the 100% CSR level who are eligible for APTC (of which there were 560 according to the data call) were evenly distributed between the 138% to 400% FPL ranges. For members eligible for ATPC but not CSR, 45% were allocated to the 250%-300% FPL level and 55% were allocated to the 300%-400% CSR level based on 2018 Consumer Information and Insurance Oversight (CCIIO) data.[25]

Individual Files

The data provided is for fully compliant ACA policies. The individual file was used to simulate a decision-making process to predict market migration based on rate increases. Since health insurance buying decisions are family based, NovaRest requested the information for individuals to be grouped into families.

The individual files contained a record for each covered individual as of December 31 for 2017, and May 31 for 2018. Data included premium and claim information and the 2018 file included the data on individuals such as date of birth and any cost sharing reductions (CSR) or APTC that they are eligible for and the plan that they are in without the claim information.

Historic Claim Distributions

This data requested included ACA-compliant, Grandfathered, Transitional, and CHAND Policies. This historic claim distribution file was used to determine health care cost trends by claim level. That is, in North Dakota is there a significant difference in the increases in health care costs for those with total claim of $100,000 to $200,000 compared to those with total claims between $500,000 and $750,000 NovaRest received data from years 2014 to 2017. Following is a list of all claim ranges:

- Under $50,000
- $50,000 to $99,999
- $100,000 to $199,999
- $200,000 to $499,999
- $500,000 to $749,999
- $750,000 to $999,999
- $1,000,000 to $1,249,999
- $1,250,000 to $1,499,999
- over $1,500,000

[25] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

CCIIO Public Reports

NovaRest used public reports on the CCIIO web site to estimate the membership changes in the North Dakota CSR and APTC populations over time.[26]

MEPS Data

The Medical Expenditure Panel Survey (MEPS) data was used to estimate the total premium equivalent for the self-insured. A more accurate premium equivalent level will be determined by a TPA survey before implementation of the North Dakota Waiver.[27]

The carrier data from the historic claims distributions was brought into the NovaRest model. Data was received for 2014 through 2017. The claim distribution categories were bound by; $50,000, $100,000, $200,000, $500,000, $750,000, $1,000,000, $1,250,000, $1,500,000, and above $1,500,000. The appropriate member months were used to calculate trends by claim level for each carrier and for the market in total. Trends were calculated for each year over year and for the total period.

Rate Filing Information

NovaRest used 2017 and 2018 rate filing information from Medica, Stanford, and Blue Cross and Blue Shield of North Dakota. The Unified Rate Review Templates (URRTs) include the plan metal levels and indicate if the plans were offered on-exchange or off-exchange only. The Rate Templates were used to access the 2017 and 2018 premium rates.

[26] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

[37] "Medical Expenditure Panel Survey." U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Https://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&-year=2017&tableSeries=2&tableSubSeries=B&searchText=&searchMethod=1&Action=Search

2019 Market Projection

The data for individuals covered on December 31, 2017 and on May 31, 2018 included a record for each individual and information that allowed individuals to be grouped into families.

Family information is needed because the maximum amount that individuals pay when eligible for APTC is based on family size and family income. Also, decisions to shop for other coverage based on rate increases is a family decision rather than an individual decision for those with families.

Individuals that were eligible for 94% CSR, 87% CSR, 73% CSR and APTC were determined to be the ones most likely to retain coverage. Although many circumstances can arise that result in turnover in this market segment, such as becoming employed by an employer that offers health insurance or moving out of state, in general North Dakota has seen an increase in the 94% CSR, 87% CSR, 73% CSR membership. NovaRest found that Individuals eligible for APTC, but not CSR, were in Gold, Silver and Bronze metal levels. NovaRest again assumed that these individuals were likely to retain their coverage, unless obtaining employer coverage or moving. Since NovaRest cannot predict employment or moving out-of-state NovaRest treated these members as a stable block.

For non-APTC individuals, total family claims cost was also calculated to determine the probability of a family retaining coverage even when faced with large rate increases.

For all other individuals NovaRest determined elasticity for each metal level. The elasticity estimates the percentage of membership that will shop for other coverage based on the percent of rate increase. Based on the rate increase for Gold level individuals, a percentage will decide to shop for alternative coverage. Those that decide to shop may decide to purchase Silver coverage, based on the difference in the current Gold level premium and the Silver coverage. Others may find the Silver coverage too expensive and may look at Silver off-exchange coverage, Bronze coverage, or may decide to drop coverage and become uninsured.

It was assumed that all non-subsidized individuals that currently have Gold or Silver plans would not select on-exchange Silver plans, but rather would shop for off-exchange Silver plans. This is due to the decision to allow loading of CSR costs into the on-exchange Silver plans starting in 2019, which raised Silver on-exchange premiums significantly.

Individuals in Catastrophic coverage may age out or based on the rate increase decide to drop coverage and become uninsured. For the loss of membership due to aging, NovaRest used a steady state and decided that the individuals aging out would be replaced by new entrants. For the portion of the individuals deciding to drop coverage NovaRest used a Catastrophic specific elasticity.

NovaRest used its proprietary migration model (NRMM) to project the movement between the metal levels and individuals becoming uninsured under the three scenarios of 1) without the reinsurance (base scenario), 2) with the Waiver with a $100,000 attachment point, and 3) with the Waiver with a $200,000 attachment point. This allowed NovaRest to project the number of individuals that would be covered by health insurance under the three scenarios. The NRMM aggregates individuals into families and performs an analysis, using elasticity assumptions, of the likelihood of the individual and families staying with their current plan, shopping for a less expensive option or becoming uninsured. The NRMM projects the 2019 membership and increases in the uninsured with and without the reinsurance under the 1332 Waiver.

The migration model provides the 2019 APTC membership, non-APTC membership on and off the exchange and the increase in the uninsured. Using the projected 2019 membership and the rates filed by the three carriers for 2019, NovaRest calculated the average premium for APTC and Non-APTC without the Waiver's reinsurance. The 2019 Membership and average premiums are shown below for the base period and the two Waiver scenarios.

Table 7 2019 Projection			
Membership			**2019**
			Without Waiver
	On Exchange		
		94% CSR (138% to 150% FPL)	1,957
		87% CSR (150% to 200% FPL)	4,845
		73% CSR (200% to 250% FPL)	2,515
		APTC (250% to 300% FPL)	5,492
		APTC (300% to 400% FPL)	6,713
	Total APTC		21,253
	Total Non- APTC (> 400%)		2,412
	Total On Exchange		23,935
	Off Exchange		15,168
	Total ACA		39,103
Average Premium			
	On Exchange		
		APTC Aggregate Premium Rate	$496.56
		APTC Maximum Premium Paid	$135.87
		APTC	$360.68
		Non-APTC	$431.88
	Total On Exchange		$490.04
	Off Exchange		$526.99
	Total ACA		$504.37
Total Annual Premium			
	Total APTC Aggregate Premium		$128,248,764
	Total APTC Maximum Premium Paid		$35,092,776
	Total APTC		$93,155,988
	Total Non-APTC		$12,501,246
	Total On Exchange Premium		$140,750,010
	Off Exchange		$95,921,084
	Total ACA		$236,671,094

NovaRest estimates that if the North Dakota 1332 Waiver is not implemented that there will be over 400 additional uninsured in 2020. With the Waiver, the amount of new uninsured is reduced to less than 150.

Projection of 2020 Base Line Market

The following table shows the 2020 1332 Waiver Base Line, compared to the 1332 Waiver alternatives. The base line was projected by taking the 2019 NRMM model output and trending membership and premiums. NovaRest did not include the 100% FPL to 138% FPL, since they are covered by Medicaid in North Dakota.[28] NovaRest did not project changes in the subsidized population, but rather assumed a steady state for the subsidized population.

[28] "Medicaid Expansion." North Dakota Department of Human Services. http://www.nd.gov/dhs/medicaidexpansion/

Table 8 2020 Base Line					
Membership			**2020**		
			Without Waiver	**Waiver with $100,000 Attachment Point**	**Waiver with $200,000 Attachment Point**
	On Exchange				
		94% CSR (138% to 150% FPL)	1,957	1,957	1,957
		87% CSR (150% to 200% FPL)	4,845	4,845	4,845
		73% CSR (200% to 250% FPL)	2,515	2,515	2,515
		APTC (250% to 300% FPL)	5,492	5,492	5,492
		APTC (300% to 400% FPL)	6,713	6,713	6,713
	Total APTC		21,523	21,523	21,523
	Total Non- APTC (> 400%)		2,412	2,478	2,498
	Total On Exchange		23,935	24,001	24,021
	Off Exchange		15,168	15,428	15,407
	Total ACA		39,103	39,429	39,428
Average Premium					
	On Exchange				
		APTC Aggregate Premium Rate	$516.92	$419.89	$460.08
		APTC Maximum Premium Paid	$139.95	$139.95	$139.95
		APTC	$376.97	$279.94	$320.13
		Non-APTC	$449.59	$356.50	$396.81
	Total On Exchange		$510.13	$407.64	$453.90
	Off Exchange		$548.60	$440.82	$488.24
	Total ACA		$525.05	$420.63	$467.49
Total Annual Premium					
	Total APTC Aggregate Premium		$133,506,963	$108,447,155	$118,827,763
	Total APTC Maximum Premium Paid		$36,145,560	$36,145,560	$36,145,560
	Total APTC		$97,361,404	$72,301,595	$82,682,204
	Total Non-APTC		$13,013,797	$10,600,187	$11,894,390
	Total On Exchange		$146,520,760	$119,047,342	$130,722,153
	Off Exchange		$99,853,848	$81,611,267	$90,268,865
	Total ACA		$246,374,609	$200,658,610	$220,991,017

The following table shows the 2020 age 40 non-smoker premium rates for the second lowest Silver plan.

Table 9 Second Lowest Silver Monthly Premium AGE 40 Non-smoker			
	2020		
Area	**Without Waiver**	**With $100,000 Attachment Point**	**With $200,000 Attachment Point**
1	$412.42	$329.94	$367.06
2	$412.42	$329.94	$367.06
3	$503.99	$403.20	$448.56
4	$412.42	$329.94	$367.06

Reinsurance and Funding Needs Projection

The reinsurance was calculated for several combinations of attachment point, coinsurance, and maximum claim level. Based on the results, the Insurance Department decided that either a $100,000 or $200,000 attachment point was appropriate. Also, it was decided that a 75% coinsurance be used up to a $1,000,000 maximum paid claims level.

NovaRest modeled 10 scenarios of trend assumptions and chose what it considered the 3 most likely sets of scenarios. The three selected trends resulted in reductions to paid claims that ranged from 10% to 11% of paid claims for the $100,000 attachment point and from 18% to 20% of paid claims for the $200,000 attachment point.

The trend assumptions selected were:

1. The historic three-year trend annualized by claim level from the carrier data;
2. The trend for 2020 and beyond from the National Health Expenditure Projections; and
3. The trend from the National Health Expenditure Projections distributed by the trends for each claim level.

[32] "National Health Care Expenditure Projections 2017-2026." Centers for Medicare & Medicaid Services. August 1, 2018. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

The first trend was selected because it was based on the historic trends in North Dakota and distinguished between trends for high-cost claimants and low-cost claimants. The trend from National Health Expenditure Projections was selected because it was considered a reasonable trend of 4.1% for 2019 to 2020 and 5.7% thereafter and had the endorsement of CMS. The trend from the National Health Expenditure Projections distributed for each claim level was used because it added the precision of distinguishing between high-cost and low-cost claimants.

After researching the issue, NovaRest decided to equate paid claim cost reduction to premium reduction. Typically, premiums increase at a higher rate than claims due to deductible leveraging and changes in morbidity, as well as, influences such as changing geographic factors and network changes. When NovaRest reviewed North Dakota's allowed and paid claim trends they did not follow typical patterns. Also, paid claim trends and premium trends did not follow typical patterns so there was no apparent basis for converting claim reduction to premium reduction based on North Dakota experience. Therefore, it was decided to use the simplifying assumption to equate reduction in claim costs to reduction in premium rates.

Table 10 Reinsurance and Funding, $100,000 Attachment Point											
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Total Reinsurance	$47,755,003	$50,477,038	$53,354,230	$56,395,421	$59,609,960	$63,007,727	$66,599,168	$70,395,320	$74,407,854	$78,649,101	$83,132,100
Federal Funding	$25,766,844	$27,235,554	$28,787,981	$30,428,895	$32,163,343	$33,996,653	$35,934,462	$37,982,727	$40,147,742	$42,436,163	$44,855,025
Funding Needed	$21,988,159	$23,241,484	$24,566,249	$25,966,525	$27,446,617	$29,011,074	$30,664,706	$32,412,594	$34,260,112	$36,212,938	$38,277,075
Percent of group and TPA	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%

Table 11 Reinsurance and Funding, $200,000 Attachment Point											
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Total Reinsurance	$26,726,151	$28,249,542	$29,859,765	$31,561,772	$33,360,793	$35,262,358	$37,272,313	$39,396,834	$41,642,454	$44,016,074	$46,524,990
Federal Funding	$14,165,428	$14,972,857	$15,826,310	$16,728,410	$17,681,929	$18,689,799	$19,755,118	$20,881,160	$22,071,386	$23,329,455	$24,659,234
Funding Needed	$12,560,723	$13,276,684	$14,033,455	$14,833,362	$15,678,864	$16,572,559	$17,517,195	$18,515,675	$19,571,068	$20,686,619	$21,865,757
Percent of group and TPA	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%

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Administrative Requirements for North Dakota Reinsurance Program

A number of functions will be needed in order to administer this program. Claims will have to be filed by the carriers and reinsurance reimbursements will have to be paid. Also, amounts will have to be collected from the federal government for APTC reductions and from the assessments against those identified in the legislation once it is finalized.

Claims Processing

Carriers will provide claim information to the administrator once the initial attachment point is reached. The administrator will accumulate the claims and determine the reinsurance payment owed to the carrier.

Once the payment amount is determined, the administrator will verify that adequate funds are available and either pay the claim or notify the carrier that payment will be delayed.

The administrator will also monitor the total claims and notify the carrier once the maximum claim level is reached.

If funding becomes an issue, the administrator will have to monitor funding levels and pay claims as adequate funding is available.

Funding Collections

It is NovaRest's understanding that federal APTC funds are made available in the first half of the year for the estimated annual funding amount. The administrator will have to coordinate with the appropriate federal office to ensure that funding is made available on a timely basis.

Assessments will be received on a periodic basis from those providing the additional funding needed for the program. The administrator will follow-up on assessments that are not received on a timely basis. NovaRest assumes that assessments will be based on premium or claim levels and therefore the assessed entities will calculate the assessment amount and not the administrator.

Periodic Audits

The administrator should periodically audit both the carrier claim submission and the assessments. An audit can be done by the administrator or an outside vendor. An outside vendor would cost approximately $9,000 according to CHAND administrators.

The audit would verify that the carrier claims were processed appropriately and only included covered services for the contracted rates.

Assessment audits would verify that the assessment base (premium, claims, etc.) was accurate and that the appropriate percentage was used to calculate the assessment.

Miscellaneous Tasks
There will be various additional tasks such as opening banking accounts and balancing account statements.

Tasks would also include reporting requirements back to the State authority that is responsible for the reinsurance program, and to the federal authority, as required.

Relationship management will require an executive director level person that would interact with the federal government, State legislators, carriers, TPAs, and the public.

V. Meeting the Section 1332 Waiver Guardrails

Guardrails
This report will demonstrate that the four 1332 Waiver guardrails will be met by North Dakota's proposed 1332 Waiver structure.

Comprehensive Coverage – 1332(b)(1)(A)
The proposed Waiver does not make alterations to the required scope of benefits offered in the insurance market in North Dakota. It will result in an increase in the number of individuals with coverage that meets the ACA's EHB requirements.

Affordability – 1332(b)(1)(B)
The Waiver will reduce premium and increase affordability.

Scope of Coverage – 1332(b)(1)(C)
The proposed Waiver is projected to cover more individuals in North Dakota than would be covered absent the Waiver. Lower premiums will result in individuals retaining coverage rather than dropping coverage due to unaffordable premium rates.

Federal Deficit Neutrality – 1332(b)(1)(D)
The proposed Waiver will not result in increased spending, administrative, or other expenses to the federal government. There will be no increase in federal administrative expense. The federal funding will be calculated based on actual APTC subsidized enrollment and will be reduced by any reductions in exchange user fees. The Waiver will lower premiums by 10% to 20%, which will reduce the APTC that would be paid by the federal government. Since the exchange user fees are a percentage of premium, the reduced premium will reduce the exchange user fees collected by the federal government. The intention is for the lower APTCs less the reduced exchange user fees be passed to North Dakota and used to fund the reinsurance program under the Waiver.

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Table 12 2020 Difference from Base Line				
Membership			**2020**	
			Waiver with $100,000 Attachment Point	**Waiver with $200,000 Attachment Point**
	On Exchange			
		94% CSR (138% to 150% FPL)	0%	0%
		87% CSR (150% to 200% FPL)	0%	0%
		73% CSR (200% to 250% FPL)	0%	0%
		APTC (250% to 300% FPL)	0%	0%
		APTC (300% to 400% FPL)	0%	0%
	Total APTC		0%	0%
	Total Non- APTC (> 400%)		3%	4%
	Total On Exchange		0%	0%
	Off Exchange		2%	2%
	Total ACA		1%	1%
Average Premium				
	On Exchange			
		APTC Aggregate Premium Rate	-19%	-11%
		APTC Maximum Premium Paid	0%	0%
		APTC	-26%	-15%
		Non-APTC	-21%	-12%
	Total On Exchange		-20%	-11%
	Off Exchange		-20%	-11%
	Total ACA		-20%	-11%
APTC Savings			$25,059,808	$14,679,200
Exchange Fee Reduction			$877,093	$513,772
Net Federal Savings			$24,182,715	$14,165,428

VI. Federal Deficit Neutrality

Federal Budget

The reduced APTC saves the federal government money. To offset this savings are some potential losses to income for the federal government.

The shared responsibility or individual mandate penalty would be reduced if individuals remain insured rather than becoming uninsured and subject to the penalty. In December 2017, Republican lawmakers passed H.R.1, the Tax Cuts and Jobs Act, which repealed the individual mandate penalty.[30] The repeal is effective for 2019 plan year. Therefore, there is no impact on the federal deficit for individuals remaining insured.

The Patient-Centered Outcomes Research Institute (PCORI) fee payable to the federal government based on enrollment. This fee is only applicable for plan years ending between October 1, 2012 and October 1, 2019.[31] Since the fee is not applicable in 2020, it will not impact the federal deficit for the period of the North Dakota Waiver.

The Health Insurance Providers Fee (HIF) is an annual amount of $14,300,000,000 for 2018.[32] There is a moratorium for the HIF in 2019. For 2020 and beyond, the applicable amount in the preceding fee year increased by the rate of premium growth of covered entities (within the meaning of section 36B(b)(3)(A)(ii).

A covered entity is generally any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under subchapter L, Part I or II, or that would be subject to tax under subchapter L, Part I or II, but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).[33]

[30] Norris, Louise. "With the GOP tax bill and the president's 2017 executive order, will the IRS still enforce the individual mandate penalty?" HealthInsurance.org. January 22, 2018. https://www.healthinsurance.org/faqs/does-the-presidents-executive-order-mean-the-irs-wont-enforce-the-individual-mandate-penalty/

[31] "Patient-Centered Outcomes Research Institute Fee." Internal Revenue Service. June 6, 2018. https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee

[32] "Affordable Care Act Provision 9010 - Health Insurance Providers Fee." Internal Revenue Service. September 4, 2018. https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

[33] Ibid.

The fee is assessed as a percentage of net premium. For entities with less than $25,000,000 no fee will be assessed.[34] For entities with between $25,000,000 and $49,999,999, 50% of the net premiums will be taken into account and for entities with over $50,000,000 in net premium, the total net premium will be taken into account.[35] If the Waiver reduces premiums sufficient enough to impact the national premium growth, the HIF collected by the federal government would be reduced. Otherwise since the HIF is a national budgeted amount, the Waiver will not impact the HIF.

The Exchange User Fee is a federally mandated fee used to fund the federal and state exchanges. Because North Dakota did not establish a state-based exchange, the exchange is facilitated by the federal government. The fee is calculated as a percent of on-exchange premiums.[36] Although the fee is calculated on on-exchange business, it is included in the premium for all non-grandfathered on-and-off exchange ACA business. The current fee rate in the individual market is 3.5%.[37]

Aggregate Premium

The NRMM also calculates the aggregate premium rate for the individuals and families that are eligible for APTCs and the maximum that a family will actually pay.

The aggregate premium rate is the premium that the individuals would pay, if they did not receive the APTC. This is the second lowest Silver rate in each region. The table below shows this premium for a person age 40. The tobacco rate charged to smokers was not considered since it is not used in the APTC determination.

Table 13
Second Lowest Silver 2019
AGE 40 Non-smoker

Area	Monthly Premium
1	$396.18
2	$396.18
3	$484.14
4	$396.18

[34] Ibid.
[35] Ibid.
[36] "HHS announces applicable user fees." Blue Cross Blue Shield Blue Care Network of Michigan. May 6, 2013. https://www.bcbsm.com/health-care-reform/reform-alerts/hhs-announces-applicable-user-fees1.html
[37] "HHS Notice of Benefit and Payment Parameters for 2019." The Centers for Medicare & Medicaid Services. April 9, 2018. https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2019

Calculation of an Individual's Maximum Payable Premium for the Advanced Premium Tax Credit
The family Federal Poverty Level (FPL) in 2018 is $12,140 for the first person plus $4,320 for each additional person.[38] A family of 4 is $12,140 plus 3 times $4,320 or $25,100. The single person FPL rate has been increasing by 1% to 3% a year and the additional person has been increasing by 0% to 4% a year.[39]

Maximum premium paid by low income as a percent of income.[40]

- For 133% to 150% of FPL the percentage is between 3.11% and 4.15%.
- For 150% to 200% it is between 4.15% and 6.54%.
- For 200% to 250% it is between 6.54% and 8.36%.
- For 250% to 300% it is between 8.36% and 9.86%.
- For 300% to 400% it is 9.86%.

Table 14
2018 Maximum Premium Paid by APTC Eligible Families

			Annual Premium		Monthly Premium	
FPL Range	**FPL Mid-point**	**Percent of Income**	**Single at $12,140**	**Additional at $4,320**	**Single at $12,140**	**Additional at $4,320**
138% to 150%	144%	3.69%	$645.79	$229.80	$53.82	$19.15
150% to 200%	175%	5.35%	$1,135.55	$404.08	$94.63	$33.67
200% to 250%	225%	7.45%	$2,034.97	$724.14	$169.58	$60.35
250% to 400%	325%	9.52%	$3,757.10	$1,336.96	$313.09	$111.41

If there is one person in a family, the Single premium is used. If there is more than one family member, the family premium is increased by the additional amount for each additional family member. For example, a family of 4 at the 200% to 250% of FPL the annual family premium would be $2,034.97 plus 3 times $724.14 or $4,207.39, which would be a monthly premium of $350.63.

[38] "Prior Poverty Guidelines and Federal Register References". Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references
[39] Ibid.
[40] "Rev. Proc. 2018-34, IRS update of the Applicable Percentage." Internal Revenue Service. https://www.irs.gov/pub/irs-drop/rp-18-34.pdf

The CSR levels are the key to the FPLs used in the calculation.

138-150% FPL = 94% Actuarial Value (CSR 94)
150-200% FPL = 87% Actuarial Value (CSR 87)
200-250% FPL = 73% Actuarial Value (CSR 73)

0%-138% would be covered under Medicaid. The APTC not CSR individuals are between the 250% and 400%. According to CCIIO's 2018 report approximately forty-five percent are in the lower category (250% to 300%) and the other fifty-five percent are in the second (300% to 400%).

Calculation of the APTC

An individual's APTC is the difference between the second lowest cost Silver plan in the region for the individual's age and the maximum premium for an individual. For a family it is the sum of all of the second lowest cost Silver plans in the region for the individual's age for each individual and the maximum family premium.

For the waiver scenario, the APTC is reduced because the second lowest Silver premium for each region is reduced due to the reinsurance. The reinsurance lowers the premiums for all plans, but the second lowest Silver plan is the one that impacts the APTC. NovaRest assumed that the premium reduction was the same percentage for all plans due to the single risk pool requirement.[41] The difference in the premiums for the second lowest Silver plans with and without the reinsurance is the difference in the APTC between the two scenarios. This is the amount that CMS will save in APTC and that can be applied to the reinsurance funding.

The amount that the federal government can contribute and remain budget neutral is the savings from the reduced APTCs less the loss of the exchange user fees. Exchange user fees for the individual market are 3.5% of premium paid on exchange plans in 2019.[42] When the premium is reduced, this income to the federal government is also reduced. The amount of federal budget savings in the reduction in APTC less the exchange user fees. For example, if APTC have a 15% reduction in premiums the net amount of savings to the federal government is 15% less the 3.5% or 11.5%.

[41] Rate increases are rarely the same for all plans due to changes such as changes in morbidity that vary between plans and geographic factor changes. It is not possible to predict these types of factors with an appropriate amount of accuracy.
[42] "HHS Notice of Benefit and Payment Parameters for 2019." The Centers for Medicare & Medicaid Services.

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Table 15 Budget Neutrality Projection, 2020-2030											
Base	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
APTC Agg Prem	$133,506,963	$141,116,860	$149,160,521	$157,662,671	$166,649,443	$176,148,461	$186,188,924	$196,801,692	$208,019,389	$219,876,494	$232,409,454
APTC Max Prem Paid	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$97,361,404	$103,886,934	$110,813,697	$118,165,442	$125,967,297	$134,245,851	$143,029,235	$152,347,213	$162,231,275	$172,714,737	$183,832,844
$100,000 Waiver											
APTC Agg Prem	$106,805,571	$112,893,488	$119,328,417	$126,130,137	$133,319,554	$140,918,769	$148,951,139	$157,441,354	$166,415,511	$175,901,195	$185,927,563
APTC Max Prem Paid	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$70,660,011	$75,663,562	$80,981,593	$86,632,908	$92,637,409	$99,016,159	$105,791,450	$112,986,875	$120,627,398	$128,739,438	$137,350,954
APTC Savings	$26,701,393	$28,223,372	$29,832,104	$31,532,534	$33,329,889	$35,229,692	$37,237,785	$39,360,338	$41,603,878	$43,975,299	$46,481,891
Exchange fee	$934,549	$987,818	$1,044,124	$1,103,639	$1,166,546	$1,233,039	$1,303,322	$1,377,612	$1,456,136	$1,539,135	$1,626,866
Net Federal Savings	$25,766,844	$27,235,554	$28,787,981	$30,428,895	$32,163,343	$33,996,653	$35,934,462	$37,982,727	$40,147,742	$42,436,163	$44,855,025
$200,000 Waiver											
APTC Agg Prem	$118,827,763	$125,600,946	$132,760,200	$140,327,531	$148,326,200	$156,780,794	$165,717,299	$175,163,185	$185,147,486	$195,700,893	$206,855,844
APTC Max Prem Paid	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$82,682,204	$88,371,019	$94,413,375	$100,830,302	$107,644,054	$114,878,184	$122,557,610	$130,708,706	$139,359,373	$148,539,136	$158,279,235
APTC Savings	$14,679,200	$15,515,914	$16,400,322	$17,335,140	$18,323,243	$19,367,668	$20,471,625	$21,638,507	$22,871,902	$24,175,601	$25,553,610
Exchange fee	$513,772	$543,057	$574,011	$606,730	$641,313	$677,868	$716,507	$757,348	$800,517	$846,146	$894,376
Net Federal Savings	$14,165,428	$14,972,857	$15,826,310	$16,728,410	$17,681,929	$18,689,799	$19,755,118	$20,881,160	$22,071,386	$23,329,455	$24,659,234

VII. Ten Year Projections

Assumptions
NovaRest used a uniform or steady state for membership projections from 2020 to 2030.

To project the 2020 premiums that resulted from the NRMM modeling, NovaRest used historic changes in FPL and National Health Expenditure Projections.[43] For the FPL increase, we used 3%, because it was conservative (produced a lower APTC) considering historic changes in the FPLs.

The National Health Expenditure Projections show a 4.1% health care cost increase from 2019 to 2020 and 5.7% thereafter. The NRMM model output premium was trended from 2019 to 2020 by 4.1% and then to 2030 by 5.7% for both the base projections and the Waiver projections. Two Waiver scenarios were modeled. One scenario used a $100,000 attachment point for the reinsurance and the other used a $200,000 attachment point.

Process
Projections were done for membership and premium Per Member Per Month (PMPM) for the following categories:[44]

- 94% CSR (138% to 150% FPL)
- 87% CSR (150% to 200% FPL)
- 73% CSR (200% to 250% FPL)
- APTC (250% to 300% FPL)
- APTC (300% to 400% FPL)
- Total Non- APTC (> 400% FPL)
- Off-Exchange
- Uninsured

The 2019 NRMM model output is used to project the 2020 base line and the following ten years. NovaRest reviewed the CCIIO public use files[45] to determine a membership trend for the CSR and APTC not CSR levels. The CCIIO data did not show a consistent pattern of subsidized enrollment. NovaRest also reviewed historic trends in North Dakota for on-exchange non-subsidized membership and off-exchange membership.The increase in the on-exchange membership was primarily driven by individuals leaving Grandfathered and Transitional policies and did not appear to be a good predictor of the future. The large decrease in off-exchange membership was projected to reverse itself in 2020 due to the increase in Silver premiums when adding the adjustment for non-funding of the CSRs. Again, the historic pattern could not be used. It was decided to use a steady state in membership for the 10-year projections.

[43] "National Health Expenditure Projections 2017-2026." The Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf
[44] Since North Dakota expanded Medicaid to 138% FPL, a project of the population under 138% FPL was not necessary.
[45] be "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services

NovaRest used the National Health Expenditure Projections[46] for health care spending increases. These projections showed increases of 4.1% from 2019-2020 and 5.7% for 2021-2026.

Table 16
2020-2030 Trend Assumptions

Premium		
	On Exchange	5.7%
	APTC Maximum Premium	3.0%
	Off Exchange	5.7%

Projections

The ten-year projections for the base line and for the two potential reinsurance attachment points are in the three tables below.

[46] "Projected." Centers for Medicare & Medicaid Services. August 1, 2018. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

Table 17
2020 Base Line Without Waiver

Membership	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
On Exchange											
94% CSR	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957
87% CSR	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845
73% CSR	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515
APTC	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492
APTC	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713
Total APTC	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523
Total Non-APTC	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412
Total On Exchange	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**
Off Exchange	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168
Total ACA	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**
Average Premium PMPM											
On Exchange											
APTC Agg Prem	$517	$546	$578	$610	$645	$682	$721	$762	$805	$851	$900
APTC Max Prem	$140	$144	$148	$153	$158	$162	$167	$172	$177	$183	$188
APTC	$377	$402	$429	$458	$488	$520	$554	$590	$628	$669	$712
Non-APTC	$450	$475	$502	$531	$561	$593	$627	$663	$701	$740	$783
Total On Exchange	**$510**	**$539**	**$570**	**$602**	**$637**	**$673**	**$711**	**$752**	**$795**	**$840**	**$888**
Off Exchange	$549	$580	$613	$648	$685	$724	$765	$809	$855	$904	$955
Total ACA	**$525**	**$555**	**$587**	**$620**	**$655**	**$693**	**$732**	**$774**	**$818**	**$865**	**$914**
Total Annual Premium											
Total APTC Agg Prem	$133,506,963	$141,116,860	$149,160,521	$157,662,671	$166,649,443	$176,148,461	$186,188,924	$196,801,692	$208,019,389	$219,876,494	$232,409,454
Total APTC Max Prem	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$97,361,404	$103,886,934	$110,813,697	$118,165,442	$125,967,297	$134,245,851	$143,029,235	$152,347,213	$162,231,275	$172,714,737	$183,832,844
Total Non-APTC	$13,013,797	$13,755,584	$14,539,652	$15,368,412	$16,244,412	$17,170,343	$18,149,053	$19,183,549	$20,277,011	$21,432,800	$22,654,470
Total On Exchange	**$146,520,760**	**$154,872,444**	**$163,700,173**	**$173,031,083**	**$182,893,855**	**$193,318,804**	**$204,337,976**	**$215,985,241**	**$228,296,400**	**$241,309,294**	**$255,063,924**
Off Exchange	$99,853,848	$105,545,518	$111,561,612	$117,920,624	$124,642,100	$131,746,699	$139,256,261	$147,193,868	$155,583,919	$164,452,202	$173,825,978
Total ACA	**$246,374,609**	**$260,417,962**	**$275,261,785**	**$290,951,707**	**$307,535,954**	**$325,065,504**	**$343,594,238**	**$363,179,109**	**$383,880,318**	**$405,761,496**	**$428,889,902**

North Dakota Insurance Department
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Table 18
2020 With Waiver and $100,000 Attachment Point

Membership	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
On Exchange											
94% CSR	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957
87% CSR	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845
73% CSR	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515
APTC	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492
APTC	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713
Total APTC	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523
Total Non-APTC	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478
Total On Exchange	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**
Off Exchange	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428
Total ACA	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**
Average Premium PMPM											
On Exchange											
APTC Agg Prem	$414	$437	$462	$488	$516	$546	$577	$610	$644	$681	$720
APTC Max Prem	$140	$144	$148	$153	$158	$162	$167	$172	$177	$183	$188
APTC	$274	$293	$314	$335	$359	$383	$410	$437	$467	$498	$532
Non-APTC	$356	$377	$398	$421	$445	$470	$497	$526	$555	$587	$621
Total On Exchange	**$408**	**$431**	**$455**	**$481**	**$509**	**$538**	**$569**	**$601**	**$635**	**$671**	**$710**
Off Exchange	$441	$466	$493	$521	$550	$582	$615	$650	$687	$726	$767
Total ACA	**$421**	**$445**	**$470**	**$497**	**$525**	**$555**	**$587**	**$620**	**$655**	**$693**	**$732**
Total Annual Premium											
Total APTC Agg Prem	$106,805,571	$112,893,488	$119,328,417	$126,130,137	$133,319,554	$140,918,769	$148,951,139	$157,441,354	$166,415,511	$175,901,195	$185,927,563
Total APTC Max Prem	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$70,660,011	$75,663,562	$80,981,593	$86,632,908	$92,637,409	$99,016,159	$105,791,450	$112,986,875	$120,627,398	$128,739,438	$137,350,954
Total Non-APTC	$10,600,187	$11,204,398	$11,843,049	$12,518,103	$13,231,634	$13,985,838	$14,783,030	$15,625,663	$16,516,326	$17,457,756	$18,452,849
Total On Exchange	**$117,405,758**	**$124,097,886**	**$131,171,466**	**$138,648,239**	**$146,551,189**	**$154,904,607**	**$163,734,169**	**$173,067,017**	**$182,931,837**	**$193,358,952**	**$204,380,412**
Off Exchange	$81,611,267	$86,263,110	$91,180,107	$96,377,373	$101,870,883	$107,677,523	$113,815,142	$120,302,605	$127,159,854	$134,407,966	$142,069,220
Total ACA	**$199,017,025**	**$210,360,996**	**$222,351,573**	**$235,025,612**	**$248,422,072**	**$262,582,130**	**$277,549,312**	**$293,369,622**	**$310,091,691**	**$327,766,917**	**$346,449,631**

Table 19
2020 With Waiver and $200,000 Attachment Point

Membership	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
On Exchange											
94% CSR	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957
87% CSR	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845
73% CSR	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515
APTC	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492
APTC	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713
Total APTC	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523
Total Non-APTC	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498
Total On Exchange	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**
Off Exchange	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407
Total ACA	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**
Average Premium PMPM											
On Exchange											
APTC Agg Prem	$460	$486	$514	$543	$574	$607	$642	$678	$717	$758	$801
APTC Max Prem	$140	$144	$148	$153	$158	$162	$167	$172	$177	$183	$188
APTC	$320	$342	$366	$390	$417	$445	$475	$506	$540	$575	$613
Non-APTC	$397	$419	$443	$469	$495	$524	$553	$585	$618	$654	$691
Total On Exchange	**$454**	**$479**	**$507**	**$536**	**$566**	**$598**	**$632**	**$669**	**$707**	**$747**	**$789**
Off Exchange	$488	$516	$545	$577	$609	$644	$681	$720	$761	$804	$850
Total ACA	**$467**	**$494**	**$522**	**$552**	**$583**	**$616**	**$651**	**$689**	**$728**	**$769**	**$813**
Total Annual Premium											
Total APTC Agg Prem	$118,827,763	$125,600,946	$132,760,200	$140,327,531	$148,326,200	$156,780,794	$165,717,299	$175,163,185	$185,147,486	$195,700,893	$206,855,844
Total APTC Max Prem	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$82,682,204	$88,371,019	$94,413,375	$100,830,302	$107,644,054	$114,878,184	$122,557,610	$130,708,706	$139,359,373	$148,539,136	$158,279,235
Total Non-APTC	$11,894,390	$12,572,370	$13,288,995	$14,046,468	$14,847,116	$15,693,402	$16,587,926	$17,533,438	$18,532,844	$19,589,216	$20,705,801
Total On Exchange	**$130,722,153**	**$138,173,316**	**$146,049,195**	**$154,373,999**	**$163,173,317**	**$172,474,196**	**$182,305,225**	**$192,696,623**	**$203,680,330**	**$215,290,109**	**$227,561,645**
Off Exchange	$90,268,865	$95,414,190	$100,852,799	$106,601,408	$112,677,688	$119,100,317	$125,889,035	$133,064,710	$140,649,398	$148,666,414	$157,140,399
Total ACA	**$220,991,017**	**$233,587,505**	**$246,901,993**	**$260,975,407**	**$275,851,005**	**$291,574,512**	**$308,194,260**	**$325,761,332**	**$344,329,728**	**$363,956,523**	**$384,702,045**

VIII. North Dakota State Plan

North Dakota intends to offer a state specific plan similar to the one proposed in Idaho's state-based plan.[47]

As of the date of this report the Idaho plan includes the following characteristic:

1. Age band is 1 to 4 (the age bands may have to stay at 1 to 3 in order to obtain CMS approval).
2. The plans would prohibit refusal to deny coverage based on a pre-existing condition but would allow carriers a waiting period that is the same as the provisions of the ACA, essentially meaning they would not cover anything that occurred in the previous 6 months, until Jan. 1 of the following year.
3. The plans include a "low risk credit approach" which would provide credits to reduce rates for healthy individuals. It would not allow increases or assessments if the health risk assessment came back at anything less than healthy.
4. The plans would allow different or higher out of pocket maximums than the ACA allows.
5. The plans would all be considered part of the ACA's single risk pool, but there would be no risk adjustment payments made for these plans.
6. No lifetime caps.
7. Plans must cover all 10 Essential Health Benefits (EHB).
8. An insurer must sell at least one plan on the ACA exchange to be permitted to sell a state-based plan.

It is North Dakota's desire that the State plan would be affordable for those that cannot afford the exchange plans and would serve as an alternative to becoming uninsured as premium rates in the individual market become more unaffordable. Having a larger insured population should help stabilize the insurance market in North Dakota.

NovaRest reviewed the impact of the inclusion of the North Dakota Plan off-exchange. The North Dakota Plan would be an option for individuals aging out of eligibility for the Catastrophic plan that is only available to individuals up to age 30. Also, individuals that cannot afford the rate increases for their current non-catastrophic could purchase the less expensive North Dakota plan. When carriers were surveyed, they replied that the North Dakota Plan could be at least 16% less expensive than the current Bronze plans. If the North Dakota Plan allowed rates for ages to differ by 1 to 4 rather than 1 to 3 as currently required by the ACA the impact would vary by age. Currently the premium rate for someone age 64 can only be 3 times the rate of a 21-year-old. If the premium rate for a person age 64 could be 4 times the rate for a 21-year old, the rates for the younger individuals would go down and the rates for older individuals would increase. This would make the North Dakota Plan very attractive to younger individuals and would be unattractive to older individuals. Since the North Dakota Plan would be part of the single risk pool, the ACA market could benefit in total from the retention of younger, healthier individuals.

If the North Dakota Plan were implemented in conjunction with the Waiver's reinsurance mechanism, it would reduce the additional uninsured to almost none. It would also likely attract some individuals that became uninsured in the last few years, but actually would purchase insurance if it were affordable.

[47] "Fair Access to Health Coverage Waiver Application." Idaho Department of Insurance. https://doi.idaho.gov/DisplayPDF?id=Draft1332Application&cat=publicinformation

Since the North Dakota plan would be part of the single risk pool, the addition of healthy individuals would result in a reduction to all premiums. The more uninsured that decide to purchase the North Dakota plan or individuals decide to purchase the North Dakota plan rather than drop insurance the larger impact on the market premiums.

IX. Limitations

There were a number of limitations in the data received and the availability of more accurate assumptions. Even with these limitations, NovaRest believes that the projections included in this report are appropriate for decision making purposes. NovaRest performed sensitivity testing to verify that varying the assumptions used would not significantly change the results. Actual federal funding through reduced APTC will be based on actual enrollment and filed premiums rather than on NovaRest's or other projections.

1. The data that NovaRest used were snap shots as of December 31, 2017 and May 31, 2018. With the turnover in the individual market this may overstate 2018 due to later 2018 migration from the market and understate 2017 due to earlier 2017 migration from the market.
2. NovaRest had little information on individuals eligible for 100% CSR. From the data provided NovaRest knows that they are all eligible for APTCs, but not the actual poverty level. NovaRest allocated the 100% CSR to the CSR levels for the non-100% CSR individuals.
3. For Grandfathered and Transitional, NovaRest only had member months for 2017 and 2018. NovaRest converted the member months to members using 11 months, which may understate the actual number of members in these markets.
4. Medica was not in the individual exchange market in 2018 and therefore did not provide on-exchange data for that year. NovaRest assumed that the majority of Medica's 2017 exchange membership moved to Blue Cross Blue Shield of North Dakota and Sanford.

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X. Actuarial Certification

Reliance
In the analysis described in this report, we relied on information provided by the State of North Dakota, information published by the Federal government, and information provided by insurers offering coverage in the Individual market in North Dakota.

We relied upon this information without independent investigation or audit. If information is inaccurate or incomplete, our findings and conclusions may need to be revised. We have reviewed the data for consistency and reasonableness. Where data was inconsistent or unreasonable, we requested clarification.

Actuarial Certification
I, Donna Novak, am President of NovaRest Actuarial Consulting.

We are providing this report solely for the use of supporting the State of North Dakota's 1332 Waiver application. The intended users of this report are the State of North Dakota Departments. Distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by us and is done at their own risk.

We believe the current North Dakota Waiver proposal complies with the following requirements:

- The coverage provided under this 1332 Waiver is at least as comprehensive as the coverage available absent the 1332 Waiver.
- The coverage provided under this 1332 Waiver is at least as affordable as the coverage available absent the 1332 Waiver.
- The 1332 Waiver will provide coverage to at least a comparable number of residents as would be available absent the 1332 Waiver.
- The 1332 Waiver will not increase the federal deficit.

The actuarial methodologies utilized in order to arrive at our opinion were those which were considered generally accepted within the industry and are consistent with all applicable ASOPs.

I am a Member of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion.

If you have any questions, do not hesitate to call me at (520) 908-7246.

Sincerely,

Donna C. Novak

Donna C. Novak, FCA, ASA, MAAA, MBA

XI. Definitions and Abbreviations

Allowed Claims – The maximum amount a plan will pay for a covered health care service.

Advance Premium Tax Credit "APTC" or "PTC" – A tax credit taken by enrollee to lower monthly health insurance payment. The enrollee will estimate yearly income when they apply for coverage in the Health Insurance marketplace. The APTC will be based on the estimate of the income entered.

Centers for Medicare & Medicaid Services "CMS" – The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

Children's Health Insurance Program "CHIP" – The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

Congressional Budget Office "CBO" – An agency that produces independent analyses of budgetary and economic issues to support the Congressional budget process.

Cost Sharing – The share of costs covered by an insurance plan that an enrollee will pay out of their pocket. In general, cost sharing includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

Cost Sharing Reduction "CSR" – A discount that lowers the amount an enrollee will have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called "extra savings."

Essential Health Benefits "EHB" – A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Federal Poverty Level "FPL" – A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Health Insurance Marketplace "Marketplace" or "exchange" http://www.healthcare.gov – A shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010. In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families.

High-Risk Pool Plan – States offer plans that provide coverage if an individual has been denied health insurance because of a pre-existing condition. High-risk pool plans offer health insurance coverage that is subsidized by a state government.

Metal Level, Metal Plans or Metal Categories – Plans in the Health Insurance Marketplace are presented in 4 "metal" categories: Bronze, Silver, Gold, and Platinum.

Patient Protection and Affordable Care Act "ACA" or "Affordable Care Act" – United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

Per Member Per Month "PMPM" – Per Member Per Month, or the average cost of services per individual per month.

Premium – A health insurance premium is a monthly fee paid to an insurance company or health plan to provide health coverage.

Risk Adjustment – A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

Third Party Administrator "TPA" – A third-party administrator is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.

XII. Appendix A - Summary of Types of Reinsurance Pooling

Summary of Types of Reinsurance Pooling

High-Risk Pool Reimbursement—Based on Health Spending

Carriers have used reinsurance or internal large claim pooling as a mechanism to improve predictability of claim cost and protect against catastrophic claims. Carriers often purchase reinsurance from an independent carrier for individuals that reach a specific level of claim cost or for a whole block of business in aggregate. Large carriers or families of carriers will pool large claims over an attachment point and charge back the business units or "sister" carriers for a share of the large claims. The result for reinsurance or claim pooling is smoother rate increases for specific blocks of business and lower risk margins due to the improved predictability of claim costs.

Similarly, an approach being used to increase market stability and remove variability in expected claims costs, is the use of high-risk pool funds to reimburse health plans a portion of the costs of their high-cost enrollees via a market-wide traditional reinsurance arrangement for all carriers. Individuals with pre-existing conditions would remain in the private individual market. Carriers pay claims, manage care and submit claims for high claim individual enrollees for reimbursement. A portion of each individual's total annual claims above a specific threshold is reimbursed by the high-risk pool each year using a retrospective view of actual claims experience. Examples of this approach include Medicare Part D's reinsurance program, the ACA's transitional reinsurance program, and recent changes to the ACA risk adjustment program to include high-cost risk pooling. The latter two of these affect the ACA market and are described in the following paragraph.

Under the ACA, a transitional reinsurance program was in effect from 2014 to 2016. It used contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market using attachment points, reinsurance maximum caps, and reinsurance coinsurance percentages. During the program's first year, the $10 billion reinsurance fund was estimated to have reduced premiums by about 10-14 percent.[48] In 2018, the ACA's risk adjustment program, which transfers money among insurers based on the relative risk of their enrollees, was altered to include a high-cost risk pooling component. A high-risk outlier payment that covers 60 percent of an enrollee's costs above $1 million will be included, funded by a percentage of insurer premiums.[49] In other words, the program will continue to transfer funds among insurers, with no additional funding source.

[48] "Drivers of 2015 Health Insurance Premium Changes." American Academy of Actuaries Issue Brief. June 2014. http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf

[49] "Using High-Risk Pools to Cover High-Risk Enrollees." American Academy of Actuaries Issue Brief. February 2017. http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf

High-Risk Pool Reimbursement—Based on Health Conditions

Rather than using high-risk pool funds to reimburse plans based on spending exceeding a threshold, reimbursements could be based on an enrollee having one or more specified high-risk conditions. Similar to when insurer eligibility for reimbursements is based on spending exceeding a threshold, this type of approach is a virtual risk pool that is invisible to the enrollee. Conditions-based programs can be tailored to target specific conditions and be used to support public health programs. This can create synergy with existing public policy goals and could potentially dovetail with population health management goals.

An example of this approach is the Maine Guaranteed Access Reinsurance Association (MGARA). MGARA predated the ACA and was suspended in 2014 when the ACA transitional reinsurance program launched. Maine's 1332 waiver application would restart the program.[50] Those with specified conditions are automatically reinsured and carriers can choose to reinsure additional members based on underwriting. The carrier pays a reinsurance premium equal to 90% of the insurance premium. For 2019, the benefit would be 90% of claims paid between $47,000 and $77,000 and 100% of claims paid in excess of $77,000, net of amounts recoverable from the federal high cost risk pool. Funding is provided by an assessment on all health insurers in addition to money recovered from the federal government through the waiver.

Another example of this approach is the Alaska Reinsurance Program (ARP), which provides payments to insurers for individual enrollees who have one or more of 33 identified high-risk conditions.[51] The program is administered by the state's risk pool board. Insurers must request that the ARP funded pool reimburse all claims for the individuals identified with these conditions. Premium revenue, pharmacy rebates, and other revenues the insurers collect for these individuals, is passed to the ARP high-risk fund. In effect, individuals with high-risk conditions are placed in a virtual risk pool separate from the other pool. For 2017, the ARP is funded through state general revenues. Premera, Alaska's only marketplace insurer, reduced its 2017 premium increase request from over 40 percent to just under 10 percent as a result of the ARP. For 2018, the state received approval for a 1332 waiver that would redirect any savings in federal premium subsidies (due to lower premiums) to the high-risk fund. Oliver Wyman projects that Alaska individual market premiums will be 20 percent lower in 2018 with the ARP than they would be without the ARP.

[50] "Executive Summary and Application for Waiver Under Section 1332 of the Patient Protection and Affordable Care Act." State of Maine. https://www.maine.gov/pfr/insurance/mgara/section_1332_innovation_waiver_application.pdf

[51] "Alaska: State Innovation Waiver under section 1332 of the PPACA." The Centers for Medicaid & Medicare Services. July 11, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf

Pros and Cons of the Approaches

Advantages the Programs Have in Common

If individuals are not moved out of the market into a separate high-risk pool, the programs are both invisible to the insured enrollee. Therefore, there is no stigma attached to eligible enrollees or disruption with provider availability in the high-risk pool network.

The premium rates for insured enrollees are the same as other individuals with the same plan, age and geographic location.

The same plan choices exist for high-risk enrollees and all others in the same geographic location.

The administration is primarily a financial function, so it is typically less expensive than administering a traditional high-risk pool where members are moved to a separate plan (like CHAND).

The program can be tailored to encourage carriers to manage care even on high risk enrollees. To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold. High-risk reinsurance programs that reimburse insurers for 100% of the payment of large claims leave the insurer with less incentive to appropriately manage care and seek cost-saving alternatives.

Pros and Cons

Pros – Health Spending Levels

Health Spending level reinsurance results in claims cost being more predictable and therefore can reduce risk charges or margins for unpredictability.

Health Spending-based programs are straightforward. Retrospective analysis shows whether insurers qualify for reimbursement above the threshold. Large claims are always at least partially reimbursed.

Both Conditions-based and Health Spending-based programs require ongoing work to determine if reinsurance parameters need updates, but that work is limited. Parameters include attachment point(s), coinsurance percentage(s), and the reinsurance cap. Each year staff would evaluate attachment point(s), the reinsurance cap and coinsurance percentage(s) using inputs from carrier data calls, rate filings and consideration of funding constraints.

Pros – Conditions-Based

Conditions that are high year after year, but do not reach the attachment point, are reimbursed.

Cons – Health Spending Levels

Conditions that are high year after year, but do not reach the attachment point, may not be reimbursed. Using a dollar threshold approach to reimburse plans for high-cost enrollees can cause some inequities among insurers. Insurers that are able to attain lower provider payment rates and provide more care management and cost-effective care, may benefit less than plans with higher spending. Similarly, insurers in low-cost areas may benefit less from this approach than insurers in high-cost areas. Considerations could be given to whether adjustments to reflect provider payment rates and regional unit cost differentials would be appropriate and feasible.

Cons – Conditions-Based

Conditions-based programs often require the carrier to request reimbursement based upon underwriting. This prospective approach that reinsures claims based on preexisting health conditions and/or medical underwriting results in some members being reinsured who will not have large claims and some large claims not being reinsured due to large claims from conditions not specified and carrier failure to enroll members. Also, if medical underwriting is involved it adds administrative expense and requires applicants to provide medical information.

Conditions-based programs that limit reimbursements to a defined list of conditions may not sufficiently account for the financial impact of rare, costly diseases that occur only occasionally or due to new conditions or expensive treatments.

Conditions-based programs require ongoing work to evaluate new high cost conditions, and to reconsider the current condition list. Among considerations, are whether treatment protocols have changed and whether costs have changed materially. This revision would need to be done in a timely manner each year, so insurers can update their administrative systems and properly set premiums.

Care should be used when establishing a Conditions-based program and its requirements. The list of conditions would need to be determined, and the process for identifying enrollees with specified conditions would need to be defined. To avoid gaming, the conditions included should be those that are not susceptible to discretionary diagnostic coding. If carriers can decide whether to submit claims to the high-risk pool for eligible enrollees, adverse selection against the risk pool could result. For example, adverse selection would result if carriers under this system wait until the end of the year to request reinsurance for those individuals with the identified conditions whose claims are higher than their revenue, rather than requesting reinsurance for all individuals with the conditions. Requiring all insurers to submit claims on all enrollees with the specified conditions eliminates the selection opportunity.

XIII. Appendix B - Reinsurance Based on Health Spending: Prospective vs. Retrospective

On our June 25 call, the ND Department of Insurance expressed a strong preference for a reinsurance program based on health spending above an attachment rather than on specified conditions. We then discussed prospective versus retrospective approaches. The purpose of this memorandum is to flesh out that discussion and list some pros and cons of each approach.

High-Risk Pool Reimbursement Based on Health Spending - Prospective
Under a prospective approach, carriers would need to determine at issue and/or at renewal which of their members to reinsure. The carrier would then be required to pay a reinsurance premium for that member. The carrier would receive reimbursement only if the member is reinsured and the member's claims exceed the attachment point.

An example of this approach is the Maine Guaranteed Access Reinsurance Association (MGARA). Although this program provided for automatic reinsurance based on specified conditions, it also allowed carriers to select other members to reinsure based on medical underwriting. MGARA predated the ACA and was suspended in 2014 when the ACA transitional reinsurance program launched. Maine's 1332 waiver application would restart the program.[52] The carrier pays a reinsurance premium equal to 90% of the insurance premium. For 2019, the benefit would be 90% of claims paid between $47,000 and $77,000 and 100% of claims paid in excess of $77,000, net of amounts recoverable from the federal high cost risk pool. Funding is provided by an assessment on all health insurers in addition to money recovered from the federal government through the waiver.

High-Risk Pool Reimbursement Based on Health Spending - Retrospective
Under a retrospective approach, all members in the individual ACA market would be reinsured. The carrier would receive reimbursement for all members whose claims exceed the attachment point. There would be no need for carriers to pay reinsurance premiums, but they could still be at risk through a coinsurance requirement. That is, the reinsurance benefit would be less than 100% of the portion of the claim that exceeds the attachment point.

An example of this approach is the ACA's transitional reinsurance program. This program was in effect from 2014 to 2016. No reinsurance premiums were required. The program used contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market using attachment points, reinsurance maximum caps, and reinsurance coinsurance percentages. During the program's first year, the $10 billion reinsurance fund was estimated to have reduced premiums by about 10-14%.[53] For that year (2014), the reinsurance benefit was 80% of covered claims costs between the attachment point of $45,000 and the reinsurance cap of $250,000.[54]

[52] "Executive Summary and Application for Waiver Under Section 1332 of the Patient Protection and Affordable Care Act." State of Maine.
[53] "Drivers of 2015 Health Insurance Premium Changes." American Academy of Actuaries Issue Brief. June
[54] In 2015, CMS retroactively increased the 2014 benefit to 100% of covered claims costs between the attachment point of $45,000 and the reinsurance cap of $250,000 because reinsurance contributions exceeded the requests for reinsurance payment.

Pros and Cons of the Approaches

Advantages the Programs Have in Common

Individuals are not moved out of the market into a separate high-risk pool. The programs are both invisible to the insured enrollee. Therefore, there is no stigma attached to eligible enrollees or disruption with provider availability in the high-risk pool network.

The premium rates for insured enrollees are the same as other individuals with the same plan, age and geographic location.

The same plan choices exist for high-risk enrollees and all others in the same geographic location.

Reinsurance results in claims cost being more predictable and therefore can reduce risk charges or margins for unpredictability. This increased predictability also reduces the need for carriers to purchase separately available commercial reinsurance and therefore can reduce costs which would have been included in premiums.

The program can be tailored to encourage carriers to manage care even on high risk enrollees. To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold. High-risk reinsurance programs that reimburse insurers for 100% of the payment of large claims, leave the insurer with less incentive to appropriately manage care and seek cost-saving alternatives.

Both methods would require additional funding from assessments from the carrier's total block of business including small group and large group and from federal funds from reduced advanced premium tax credits. Both of these could be received early in the year. Minnesota received their total federal amount in April in 2018.

Pros and Cons

We understood from our call that you were considering having the carriers pay a reinsurance premium under the prospective approach and have commented on that under the prospective approach.

Pros – Prospective Approach

The requirement for a reinsurance premium paid by the carriers provides an additional source of funds early on, allowing a more generous reinsurance benefit level. However, the premiums collected are just dollar-trading among the carriers in the individual market, so it does not result in additional premium savings to members.

Carriers take on some risk of individuals not being identified at issue or renewal.

Pros – Retrospective Approach

Retrospective reinsurance programs are straightforward. Retrospective analysis shows whether insurers qualify for reimbursement above the threshold. Large claims above the threshold are always at least partially reimbursed.

Carriers are at risk for their share above the attachment point. For example, the reinsurance could only pay a percentage of claims above the attachment point and the carrier would then have a continuing incentive to manage the care being funded.

Cons – Prospective Approach
Carriers would need to medically underwrite applicants. This would add to administrative expenses. Carriers that were in the pre-ACA individual market may no longer have the expertise and personnel to do this effectively. Carriers that were not in the pre-ACA market would have even more difficulty.

Carriers could also obtain medical history from providers and pharmacies / pharmacy benefit managers or their own claim histories in order to predict which enrollees are more likely to have chronic conditions therefore result in claims over the threshold. Creating a need to negotiate third parties for this data adds an additional level of expense in the market.

Applicants would have to answer health questions so that they can be medically underwritten.
If the carriers paid a reinsurance premium, the need to collect reinsurance premiums would add administrative expense for the administrator of the reinsurance program.

The fact that it would not be known in advance how many members the carriers will choose to reinsure, would make it more difficult to predict the funding needs each year or to set an attachment point appropriate to a given amount of available funding.

Cons – Retrospective Approach
We are not aware of any drawbacks to this approach.