STATE CAPITOL
P.O. Box 110001
Juneau, AK 99811-0001
907-465-3500
fax: 907-465-3532

550 West Seventh Avenue, Suite 1700
Anchorage, AK 99501
907-269-7450
fax 907-269-7461
www.Gov.Alaska.Gov
Governor@Alaska.Gov

Governor Bill Walker
STATE OF ALASKA

December 29, 2016

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: State of Alaska-Section 1332 State Innovation Waiver

Dear Secretary Burwell,

The State of Alaska is submitting for your review and consideration a Section 1332 State Innovation Waiver application. Alaska is seeking to waive Section 1301 (a)(2) of the Affordable Care Act which would have allowed the state to establish a CO-OP or Community Health Option. The majority of CO-OPs that were created after the enactment of the ACA have failed, and it is not feasible that one will be established in Alaska. Waiving this provision will not have an impact on the healthcare market in Alaska.

In addition, Alaska is seeking federal pass-through funding under section 36B of the Internal Revenue Code and 1402 of the Affordable Care Act (ACA), relating to Advanced Premium Tax Credits (APTC) and cost sharing reductions for plans offered within the marketplaces.

Premiums in the Alaska individual health insurance market have increased substantially since the onset of the ACA. Alaska has been faced with escalating healthcare costs from the utilization of services by individuals with high cost health conditions, a small population spread across a vast geographic area, and insufficient healthcare provider competition.

For 2017, initial rate information indicated that premiums in the individual healthcare market were projected to increase 42 percent. The state passed legislation creating the Alaska Reinsurance Program (ARP), and appropriated $55 million to fund the program in 2017. As a result, the 2017 rates were approved with a modest average increase of 7.3 percent.

Our actuarial analysis estimates the ARP will save the federal government $51.6 million in APTC for 2018, and increase enrollment in the individual market by nearly 1,650 relative to what APTC and enrollment would be absent the ARP. With this increase in enrollment and the promise of federal

funding for the ARP it is expected that the 2018 individual market rates may decrease by up to four-percent.

Under Alaska's 1332 waiver, the federal government would partially fund the Alaska Reinsurance Program beginning in 2018 based on the savings that would be generated as a result of a reduction in APTC absent the reinsurance program. The state would seek an appropriation from our legislature for the remaining funds.

We appreciate your consideration of our waiver. If there are any questions we can answer or assistance that we can provide to you, please do not hesitate to contact me directly.

Sincerely,

Bill Walker
Governor

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P.O. Box 110001
Juneau, AK 99811-0001
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STATE OF ALASKA

550 West Seventh Avenue, Suite 1700
Anchorage, AK 99501
907-269-7450
fax 907-269-7461
www.Gov.Alaska.Gov
Governor@Alaska.Gov

December 29, 2016

The Honorable Jacob J. Lew
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW.
Washington, DC 20220

Re: State of Alaska-Section 1332 State Innovation Waiver

Dear Secretary Lew,

The State of Alaska is submitting for your review and consideration a Section 1332 State Innovation Waiver application. Alaska is seeking to waive Section 1301 (a)(2) of the Affordable Care Act which would have allowed the state to establish a CO-OP or Community Health Option. The majority of CO-OPs that were created after the enactment of the ACA have failed, and it is not feasible that one will be established in Alaska. Waiving this provision will not have an impact on the healthcare market in Alaska.

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Sincerely,

Bill Walker
Governor

Alaska 1332 Waiver Application

December 30, 2016

State of Alaska
Department of Commerce, Community,
and Economic Development
Division of Insurance

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Alaska's Proposal to Waive Certain Provisions of the Patient Protection & Affordable Care Act Per Section 1332, Waivers for State Innovation

Executive Summary

Alaska has not simply accepted the Affordable Care Act (ACA) and let the pieces fall where they may. Governor Bill Walker's administration and the Alaska Legislature crafted policy that buttressed the success of the ACA for all Alaskans. The state devised an innovative solution to reinsure the most vulnerable individuals, which in turn helped lower healthcare premium costs and stabilize the long-term viability of the individual health insurance market. Approval of Alaska's waiver application would be a prime example of a successful state-federal partnership — one in which the ACA meets its goals and insurance is affordable to individual Alaskans.

Alaska is utilizing the flexibility granted to states through the Section 1332 process to stabilize the individual healthcare market and waive the inclusion of the Consumer Operated and Oriented Plan Program (CO-OP) and the Community Health Option under Section 1301(a)(2). Many Alaskans benefitted from the overarching policy changes within the ACA; the ACA made health care more accessible and reduced the number of uninsured Alaskans. However, covering Alaskans with high cost conditions proved to be expensive, insurers pulled out of the individual health insurance market, and premiums skyrocketed. Alaska does not have any qualified health plans operating through the CO-OP or a Community Health Option, and these programs have not performed well in other states.[1] To avoid poor performance experienced through the CO-OP, Alaska is requesting a waiver from the requirement that a "qualified health plan" must include plans offered through the CO-OP program under Section 1322 or a community health insurance option under Section 1323.

Since the onset of the ACA, Alaska has been faced with escalating healthcare costs. For 2017, initial rate information indicated that premiums in the individual healthcare market were projected to increase 42%. The state took action and passed legislation creating the Alaska Reinsurance Program (ARP). The legislature also appropriated $55 million to fund the program in 2017. As a result of state action, premiums in the individual market will increase approximately 7% in 2017. The state's independent actuarial analysis estimates the ARP will save the federal government $51.6 million in

[1] S. Corlette, S. Miskell, J. Lerche et al., "Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition," The Commonwealth Fund, December 2015, http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf;
Louise Norris, "CO-OP health plans: patients' interests first," Healthinsurance.org, LLC, October 21, 2016, https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/https:/www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/;
Tom Murphy, "Once Profitable, Maine's Community Health Option is Now Losing Millions," *Insurance Journal*, December 15, 2015, http://www.insurancejournal.com/news/east/2015/12/15/391818.htm.

Advanced Premium Tax Credits (APTC) for 2018 and will increase enrollment in the individual market by nearly 1,650 individuals relative to what APTC and enrollment would be absent the ARP.

Alaska is seeking federal funding under section 36B of the Internal Revenue Code. Under the proposed waiver, Alaska would avoid the risks and lackluster performance associated with the CO-OP and Community Health Option structure. The federal government would also provide pass-through funds to ensure the long-term stabilization and viability of Alaska's individual health insurance market. Alaska would receive federal funding to subsidize the ARP, based on savings that would be generated as a result of a reduction in APTC. The state would appropriate the remaining amount of funds necessary to ensure the ARP is fully funded, after adjusting for medical inflation. The State Innovation Waiver would be effective January 1, 2018 for an initial period of five years, with an option to renew for an additional five years.

Assurances

Alaska's proposed waiver reduces unnecessary risk by removing the CO-OP and Community Health Option provisions and intends to stabilize the individual healthcare market using pass-through APTC savings to partially fund the ARP. The state would seek appropriations to fully fund the ARP, after adjusting for medical inflation. The ARP mitigates rate increases in the Alaska individual health insurance market and as a result limits the amount of premium tax credits the federal government is responsible for providing to Alaska residents. By removing high cost conditions from the risk pool, the benefits of the ARP are shared by the entire individual health insurance market regardless of income, age, race and ethnic group, or any other demographic characteristic. Alaska does not seek to waive any aspect of the ACA that would reduce access to meaningful, affordable insurance for any resident and does not contemplate changes to the Medicaid program, FFM, FF-SHOP, or direct purchase with this proposal. The State of Alaska provides the following assurances:

A. Scope of Coverage. The proposed waiver meets the comparability guardrail because there will be a small increase in the number of Alaska residents covered by an individual health insurance plan. There will not be any decreases in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic due to the waiver.
B. Affordability. The proposed waiver meets the affordability guardrail in that it will not decrease the coverage and cost sharing protections against excessive out-of-pocket spending. The waiver will not result in any decrease in affordability for individuals with large health care costs, for vulnerable groups, or at-risk populations. There will be no post-waiver increases in net out-of-pocket expenses, deductibles, co-pays, co-insurance, or premium contributions.
C. Comprehensiveness. The proposed waiver will retain the scope of benefits for the affected program and population, including requiring the provision of the ten Essential Health Benefits (EHB), identified in the benchmark plan. It will not result in a decrease in the number of individuals with coverage that meets the EHB requirements or in any way diminish benefits currently provided by Medicaid or employers.
D. Deficit Neutrality. The proposed waiver will not result in increased spending, administrative or other expenses to the federal government. It will reduce federal revenues through individual shared responsibility payments, health insurance provider fees, and exchange user fees. The net effect is large and substantial savings to the federal government.
E. Pass-Through Funding. The state proposes that funds which the federal government would have paid as individual premium tax credits be passed through to the state to supplement the ARP.
F. Effect on Federal Operational Considerations. The proposed waiver requests no consideration of any kind for state-specific changes to federally-facilitated exchanges. The waiver requires federal premium tax credit savings be passed through to the state.
G. Public Input. The proposed waiver has been publicly posted, public hearings were held, and public comments were solicited in compliance with 31 CFR 33.112 and 45 CFR 155.1312. Postings on-line met national standards to assure access to individuals with disabilities.

Summary of Alaska's Waiver Proposal

Rationale

Alaska's individual health insurance market experienced significant rate increases in 2014-2015 and 2015-2016. Moda, one of Alaska's two individual market insurers in 2016, announced they would not be offering plans in 2017. The announcement highlighted the fragility of Alaska's individual health insurance market, with Premera Blue Cross Blue Shield as the sole insurer in Alaska's individual market in 2017. Without state legislative action, Alaska's consumers would have faced another large rate increase.

Benefits of Waiver

Source	Baseline	Waiver
2018 Premiums (Tables 19 & 20)	$1,191 PMPM[2]	$953 PMPM
2018 Enrollment (Tables 1 & 2)	21,253	22,894

Source: Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," November 2016, Tables 19 and 20, p. 47, Tables 1 and 2, p. 33.

Section Impacted by Pass-Through Funding

As permitted by the ACA, Alaska proposes to apply the federal funding that would be paid to Alaska consumers absent the ARP. This funding could be combined with future state appropriations to further stabilize the individual market. The implementation of the ARP directly affects the cost of the "applicable second lowest cost silver plan" (2LCSP) in Section 36B (b) (3) (B) of the Internal Revenue Code.

Impact if Waiver is Not Granted

Alaska has an extremely fragile healthcare market with only one insurer in the individual market in 2017. Without a permanently funded ARP, rates in the individual healthcare market are expected to rise at an unsustainable rate. More Alaskans will drop out of the market and opt to pay fines because they cannot afford insurance. By removing the provisions for CO-OP health plans and the Community Health Options, Alaska can reduce the potential for market disruptions that could result in increased costs and corresponding APTC liabilities.

Due to financial concerns, the state legislature only appropriated funding for the ARP for 2017. The Division of Insurance must seek a funding appropriation on an annual basis, without assurances that the legislature will fund the ARP going forward. As a result of the State of Alaska's ongoing severe fiscal crisis, the sustainable future of the ARP and stabilization of Alaska's individual health insurance market will be in jeopardy without federal pass-through funding. A five-year federal commitment creates stability for the ARP and shows that the ARP has long-term viability. If Alaska's individual health insurance market does not stabilize, premiums are expected to rise sharply and the federal deficit would be negatively impacted due to increases in APTC liabilities.

Without a waiver, there is a likelihood the state will not be able to continue to fund the ARP and cost of premiums will increase substantially. This will result in increased APTC liabilities to the federal deficit and reduced accessibility for many Alaskans to purchase healthcare coverage. With a waiver, from 2018-2022, it is anticipated that an average of 1,460 additional individuals will have

[2] Per Member Per Month

coverage due to the lower cost of healthcare through federal and state subsidization and stabilization of the market.[3]

Characteristics of Alaska's Health Insurance Market

Access to care has long been a challenge in Alaska due to its large geographic size, rural population, and insufficient health care provider competition. Because of these challenges, common managed care practices such as legislated network adequacy levels, closed network plans and the development of Health Maintenance Organizations have not been successful.

With a population of 738,432 spread across 570,641 square miles, Alaska has a small population and is the largest and one of the most geographically isolated states in the nation. Alaska is the least densely populated state; density is 1.3 per square mile in Alaska, while 49th ranked Wyoming has a population density of 6.0. While more individuals are employed by large employers, the majority of employers are small businesses with fewer than 50 employees. According to an Alaska Department of Labor and Workforce Development report in 2011, 95.8% of firms employ fewer than 50 employees; however, half of the jobs are provided by employers with more than 100 employees. The majority of these workers receive health benefits through their employer.[4]

Reflecting its population size, Alaska has a small insurance marketplace. In 2016, there were approximately 24,064 Alaskans with individual health insurance coverage and 17,746 Alaskans with small employer health insurance coverage.

For calendar year 2017, only one insurer is offering individual health insurance coverage both inside and outside the Federally-Facilitated Marketplace (FFM). There are currently four insurance companies offering small group insurance coverage, two of which are participating in the federally facilitated Small Business Health Options Program (SHOP).

Prior to 2014, Alaska's uninsured population was estimated at approximately 134,000 residents, mostly non-elderly adults. After two years of expanded ACA enrollment opportunities, the number of uninsured residents in Alaska is estimated to be 100,000 people.[5]

The cost of health care is very high in Alaska, and access is limited compared to other states, particularly for specialty services.[6] Low population density and limited healthcare provider and facility competition in much of Alaska are primary contributors to Alaska's high healthcare costs. As a result, a significant percentage of health care services are received out of state: Ketchikan residents 25%, Juneau residents 20%, and Anchorage/Fairbanks residents 12%. To protect Alaska's consumers, the Alaska Division of Insurance has carefully monitored adjustments in insurance rates, and the state's rating approval processes have been deemed effective by the Centers for Medicare & Medicaid Services.[7]

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[3] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," November 2016, p. 14.
[4] Neal Fried and Alyssa Shanks, "Most Alaska Employers Are Small … but the majority of private-sector jobs are in larger firms," *Alaska Economic Trends*, September 2012, http://labor.alaska.gov/research/trends/sep12art2.pdf.
[5] Source: Alaska Selected Economic Characteristics, American Community Survey 5-year estimates, American FactFinder, United States Census Bureau, https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml;
Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," Table 1, p. 33.
[6] Milliman, Inc., "Drivers of Health Care Costs in Alaska and Comparison States," Alaska Health Care Commission, November 29, 2011, http://dhss.alaska.gov/ahcc/Documents/drivers_healthcare_costs.pdf.
[7] "State Effective Review Programs," https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html.

Characterizations of Defined Populations

Alaska Native/American Indian

Roughly 14% of the Alaska population identifies as Alaska Native or American Indian (AI/AN). The majority of Alaska Natives have health insurance through employer or government coverage. Alaska Natives also benefit from a Tribal Health Consortium, which provides free access to healthcare. In 1998, Alaska Native Tribal Health Consortium signed a contract to assume responsibility for the operations of the majority of the Indian Health Service (IHS) Alaska office programs. This homegrown effort has resulted in superior services for Alaska Natives – particularly those in rural areas - compared to the IHS services available in the Lower 48. Alaska Natives with access to IHS-based health care may have employer, Medicare, Medicaid, military or individual health insurance. IHS is not considered minimum essential coverage for purposes of the ACA. However, under the ACA, AI/AN may choose to take a lifetime exemption from the individual mandate due to their membership in a recognized Indian Tribe or Native Corporation.

Military

A small percentage of Alaska's population has health coverage related to current or previous military service. This includes Air Force, Army, Coast Guard and Veteran's Administration beneficiaries. Military coverage is included in the "government coverage" line of the charts in Appendix B of the actuarial analysis.[8]

Medicaid

In September 2015, Governor Bill Walker expanded Medicaid to include adults without dependent children who met the financial requirements for coverage. Prior to the expansion, about 18% of Alaskans had health coverage through the Medicaid or Denali Kid Care programs. It was expected that 42,000 Alaskans would be newly eligible for coverage, and about 23,000 newly covered individuals have enrolled since expansion.[9] Children or pregnant women with certain income levels may have multiple coverage sources such as employer-based coverage in addition to Medicaid.

Proposed Waiver: Utilizing Pass-Through Funding

As provided by the ACA, Alaska proposes to apply the federal funding that would be paid to Alaska consumers absent the ARP. This funding could be combined with future state appropriations to further stabilize the individual market. The implementation of the ARP directly affects the cost of the "applicable second lowest cost silver plan" (2LCSP) in Section 36B (b)(3)(B) of the Internal Revenue Code.

> B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—
> The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—
>
> > (i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2) (A) were offered, and
> > (ii) provides—
> > (I) self-only coverage in the case of an applicable taxpayer—

[8] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," p. 32.
[9] "Medicaid in Alaska Dashboard," http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx, updated November 22, 2016.

"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is
not allowed a deduction under section 151 for the taxable year with respect to a dependent, or
"(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

Due to the state's subsidization of the individual market, the required premium is less than it would be absent the program. Because the required premium is less, the federal premium tax credits are also less than they would be absent the program. The state proposes to receive the federal pass-through funding as described in the December 11, 2015 guidance.[10] The federal funding would be utilized to ensure the viability of the individual market by stabilizing the premium rates. Alaska has by far the highest premiums in the nation for ACA plans due to the significant underlying claims incurred by the individual market population.

Description of Waiver Program

On July 18, 2016, Governor Bill Walker signed House Bill 374, enabling legislation that created the ARP and permitted pursuit of a State Innovation Waiver under Section 1332 of the ACA. The ARP legislation allows for the appropriation of funds from various premium taxes to stabilize Alaska's individual health insurance market. Without state legislative action, Alaska's consumers would have faced another substantial rate increase.

Alaska plans to stabilize the individual market by using the funds to totally or partially reimburse the insurer for incurred claims from high-risk residents. These high-risk residents are defined as people who have been diagnosed with one or more of the covered conditions identified in regulation. The insurer will still be administering the claims; the Alaska Comprehensive Health Insurance Association (ACHIA) will receive the state funding, audit the claim requests, and disburse the funds on a periodic basis upon acceptance.

As support for the legislation, ACHIA commissioned an actuarial study to analyze the medical conditions that had the most significant impact on the market's incurred claims. Some of the highest medical cost conditions include hemophilia, metastatic cancer, and lung, brain, and other severe cancers, including pediatric acute lymphoid leukemia. The study produced four sets of conditions projecting each set's costs for 2017. The summary allowed the legislature to consider the extent to which they wanted to appropriate funding; the legislature appropriated $55 million to fund the reinsurance program in 2017.

The remaining insurer in Alaska's individual market considered the amount appropriated when developing the 2017 rates assuming that the full appropriation ($55 million) would be reimbursed for claims during the 2017 policy year. As a result, the overall rate increase was significantly lower than if there were no ARP.

[10] "Waivers for State Innovation," 80 FR 78131, Centers for Medicare & Medicaid Services (CMS), HHS; Department of the Treasury, December 16, 2015, https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation.

Given Alaska's circumstances and the experience of other states, waiving ACA provisions for CO-OP health plans and the Community Health Options will help focus efforts and reduce risks for the individual healthcare insurance market.

Pass-Through Funding Proposal

Table 36 of the actuarial analysis, under the waiver scenario, illustrates that the ARP saves the federal government approximately $51.6 million during 2018.[11] Based on the economic analysis considerations for other items, the total savings are $48.9 million.

Not only do the projected savings reflect the general proportion of the individuals who are eligible for subsidies, the inclusion of the non-APTC consumers under the waiver scenario further assists the pool due to their favorable health status. The premium will generally remain about the same for those receiving premium tax credits. Without the ARP, the state would anticipate lapses for those who are not eligible for subsidies. The proportion of non-APTC consumers affects the amount of expected pass-through funding.

Federal support via pass-through funding would support the continued viability of the ARP and the Alaska individual market.

Tax Credit Proposal

Due to the ARP, the federal government will realize significant savings from the reduced premium tax credits since a significant share of Alaska's individual health insurance market consumers are eligible for subsidies. The formula for a consumer's premium tax credit is the cost of the second lowest cost silver plan (2LCSP) minus the household's required contribution which depends on the percentage of Federal Poverty Level (FPL). With a lower rate increase, the cost of a 2LCSP is less; therefore, the amount of subsidy or APTC provided to the household will be less. As the state's proposal for the innovation waiver, Alaska requests that the savings to the federal government from ARP are provided to the state as pass-through funding to be used as future appropriations to the fund, which will further lessen the financial stress on Alaska's individual health insurance market. [12]

Affected Populations and Demographics

Alaska's waiver proposal would provide the funding in support of the ARP to stabilize the Alaska individual market. The waiver will maintain, rather than reduce coverage, affordability, and comprehensiveness. Its approval will have no material effect on the federal deficit.

In 2016, Alaska had 24,064 people in the individual health insurance market.

[11] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," p. 55.
[12] Ibid., p. 54-55.

Demographics of Alaska's individual health market are shown below.

Alaska Anticipated Coverage Distribution by age (2018)

Age	Baseline (Table 10)	Waiver (Table 11)	Change (Table 12)
0-17	2,277	2,324	48
18-34	5,910	6,783	873
35-49	4,195	4,446	251
50+	8,871	9,341	470

Anticipated Coverage Distribution by Income to Poverty Ratio (2018)

Federal Poverty Level	Baseline (Table 7)	Waiver (Table 8)	Change (Table 9)
0% to 199%	7,687	7,700	13
200% to 299%	4,077	4,083	7
300% to 400%	4,684	4,624	-61
More than 400%	4,805	6,487	1,682

Anticipated Coverage Distribution by Health Status (2018)

	Baseline (Table 13)	Waiver (Table 14)	Change (Table 15)
Excellent	6,244	6,465	222
Very Good	4,694	5,847	1,153
Good	7,331	7,534	203
Fair	2,363	2,429	65
Poor	621	620	-1

Source: Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," November 2016, p. 37-45.

Effect on Residents' Ability to Get Care Out of State

Alaska's proposed waiver will have no effect on residents' ability to obtain care out of state. Benefits would not be changed due to the waiver program. Alaska health plans provide for coverage out of state because of the limited access to care within the state.

Description of Post-Waiver Marketplace

Individual Health Insurance Market

There will be no change to the operating function of the individual market. Individuals and families may apply on the FFM at www.healthcare.gov where eligibility for Medicaid, tax credits, or cost-sharing reductions will be determined. Individuals and families not eligible for other public or private coverage will be able to complete enrollment in a participating Qualified Health Plan on the FFM. Alaska consumers may also continue to purchase health insurance directly from an insurance company. Assistance with plan selection may be provided by an agent or broker, navigator or other in-person assister. Alaska does not currently have any CO-OP health plans or Community Health Options in operation or under development, so the removal of these provisions will have no impact.

Small and Large Employers

There will be no change in the insurance market for small and large employer groups which comply with the ACA. Employers will have the option of purchasing health insurance through the SHOP or directly from an insurance company. Agents or brokers may assist with the selection of an appropriate plan.

Number of Employers Offering Coverage Pre/Post Waiver

Alaska does not expect any changes in the number of employers offering coverage in-state.

Impact on Insurance Coverage in the State

Alaska's proposed waiver seeks pass-through funds based on savings to the federal government. It will not directly affect coverage in the marketplace because the ARP does not affect the benefits or coverage available.

The program is intended, however, to provide stability to the individual health insurance market and potentially attract health insurance companies. Alaska's proposal encourages competition in the state. If additional companies move into the Alaska individual market, consumers will benefit from natural market forces. For 2017, there is one insurer offering individual health insurance, but there may be interest in subsequent years from other insurers if the market remains stabilized.

Actuarial modeling provided by Oliver Wyman indicates that the ARP will help reduce the rates necessary for insurers in the Alaska individual market and thus the premium amounts charged to Alaskans.[13] In addition, the slowing of the growth of rate increases and potential rate decreases due to the ARP may draw additional Alaskans into the market. Modeling indicates that the ARP may attract healthier members to the individual market, further reducing premium rates.

Alaska's waiver does not seek modification of the benefits offered to Alaska consumers. Benefit packages are expected to continue to contain essential health benefits while maintaining historical benefit levels and meeting required out-of-pocket limits.

Under the waiver, Alaska's insurance coverage will continue to meet the requirements of federal law.

Increase/Decrease in Administrative Burden

Alaska expects that the proposed waiver will result in minimal administrative burden and related costs for some relevant parties. Consumers and insurers will be unaffected, but the State of Alaska will have additional reporting requirements to the federal government related to the waiver. The federal government will have additional administrative requirements with regard to pass-through funding.

For Individuals and their Families

There will be no administrative impact to individuals and families related to this waiver. Individuals will continue to purchase individual and family plans in the same manner. Consumers can purchase plans on the FFM at www.healthcare.gov (particularly if they wish to obtain a tax credit), work with a broker or agent, or contact an insurer directly regarding purchasing insurance coverage outside the exchange.

[13] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," p. 15.

For Insurers
Under the proposed waiver, insurers will continue to manage enrollment and administration of claims in the same manner as they have previously. While they will have additional administrative requirements if they participate in the ARP, the waiver would not impact insurers' operations.

For State Agencies
Under the waiver, Alaska will be required to provide to the federal government reports, actuarial studies, and other documentation justifying the amount of pass-through funding provided in support of the ARP.

For Federal Agencies
Alaska's waiver does not necessitate significant operational changes for the FFM or IRS. The proposed waiver's impact on the federal agencies is limited to the administrative work of calculating and facilitating the transfer of pass-through funds. The waiver does not affect the calculation of APTC or the reconciliation of premium tax credits when consumers file their taxes.

Effect on Sections of ACA that are Not Proposed to be Waived

No other section of the ACA would be affected by the proposed waiver.

Comparability: Data and Analysis, Actuarial Certifications, Assumptions, Targets

The actuarial and economic studies find that compared to a baseline without a waiver, the scenario with a waiver will have no impact on comprehensiveness, federal deficit neutrality, or the effect on federal operational considerations.[14] However, coverage comparability and affordability will be positively impacted. Actuarial analysis reflects increased enrollment in the individual market upon implementation of the proposed waiver.

Coverage Comparability
The proposed waiver meets the comparability test because there will be an increase in the number of Alaska residents covered. There will not be any changes in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic due to the waiver. The actuarial analysis, which used Oliver Wyman's Healthcare Reform Microsimulation Model, indicates that additional enrollees will be covered under the waiver scenario. The increased enrollment is expected to come from Alaskans above 400% FPL who are younger and healthier compared to the current individual market. This segment of the population has resisted entering the individual health insurance market due to the high costs in Alaska.

There is no impact to employer group coverage and governmental insurance programs.

Affordability of Coverage
Alaska's healthcare premiums are among the highest in the country.[15] The purpose of the ARP is to mitigate rate increases by removing high cost claims from the individual health market. Premium tax

[14] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification;"
UAA Institute of Social and Economic Research, "Alaska 1332 Waiver – Economic Analysis," December 23, 2016.
[15] "Health Insurance: Premiums and Increases," National Conference of State Legislatures, November 15, 2016, http://www.ncsl.org/research/health/health-insurance-premiums.aspx;

credits associated with the ACA will continue to be paid based on federal methodology, but the growth of such payments are slowed by the ARP. Actuarial modeling shows that due to the ARP, premiums are expected to be 20% lower under the waiver scenario. APTC eligible individuals will see little change in premium due to their receipt of APTC. Alaskans with incomes above 400% FPL who currently pay all premiums without any federal tax credits will experience premium reductions.

Actuarial modeling shows that there may be a small sub-set of the population in the 300-400% FPL that will drop coverage[16] because their premium amounts will increase compared to their current premium due to reductions in APTC amounts. The affordability of coverage guardrail is still met in this instance because this population is not considered vulnerable, and the federal limits of affordability remain in place.

Under the ACA, the amount consumers are expected to contribute to healthcare costs is limited to a percentage of their income. Alaskans with incomes of 250-400% FPL would continue to be eligible for tax credits based on the 2LCSP[17] and if they purchased a silver plan, they would pay premiums that the federal government deems affordable. A small number of currently covered consumers may consider the premiums unaffordable and choose to discontinue their coverage. However, the overall number of Alaska consumers that will be covered is projected to increase. Consumers under 250% FPL will likely choose silver plans with cost share reduction benefits. The Alaska waiver meets the affordability of coverage guardrail because there is no change to the federal definition of affordability, vulnerable populations are not impacted, and aggregate enrollment will increase.

Scope and Comprehensiveness of Coverage

All Alaska individual market plans include the ten EHB as well as state-mandated benefits. None of these benefits will change under the waiver. State-mandated benefits are noted below and at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/alaska-ehb-benchmark-plan.pdf.

Affordable Care Act Essential Health Benefit Category
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Cox, Gonzales, Kamal, et al, "Analysis of 2016 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," The Henry J. Kaiser Family Foundation, October 26, 2015, http://kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/.

[16] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification," p. 14.

[17] Ibid., p. 18.

As noted on https://www.cms.gov/cciio/resources/Data-Resources/downloads/ak-state-required-benefits.pdf, Alaska's mandated benefits are as follows.

Benefit	Name of Required Benefit	Market Applicability	Statutory Authority
Delivery and All Inpatient Services for Maternity Care	Maternity minimum Stay	Individual, small group, large group	AS 21.42.347
Substance Abuse Disorder Outpatient Services	Coverage for treatment of alcoholism or drug abuse	Groups (5 or more covered employees)	AS 21.42.365
Substance Abuse Disorder Inpatient Services	Coverage for treatment of alcoholism or drug abuse	Groups (5 or more covered employees)	AS 21.42.365
Preventive Care/Screening/Immunization	Prostate and cervical cancer detection	Individual, small group, large group	AS 21.42.395
Preventive Care/Screening/Immunization	Colorectal cancer screening	Individual, small group, large group	AS 21.42.377
Preventive Care/Screening/Immunization	Mammograms	Individual, small group, large group	AS 21.42.375
Preventive Care/Screening/Immunization	Well Baby Exams	Individual, small group, large group	AS 21.42.351
Reconstructive Surgery	Reconstructive surgery following mastectomy	Individual, small group, large group	AS 21.42.400
Clinical Trials	Clinical trials for cancer	Individual, small group, large group	AS 21.42.415
Diabetes Care Management	Diabetes	Individual, small group, large group	AS 21.42.390
Inherited Metabolic Disorder - PKU	Phenylketonuria	Individual, small group, large group	AS 21.42.380
Newborn Hearing Screening	Newborn and infant hearing screening	Individual, small group, large group	AS 21.42.349

Federal Deficit Neutrality

It is expected that the proposed waiver will not result in increased spending, administrative or other expenses to the federal government.[18] It will reduce federal revenues through individual shared responsibility payments, health insurance provider fees, and exchange user fees. However, reducing APTC liabilities through the ARP rate stabilization model will avoid substantial federal cost increases. Waiving the CO-OP and Community Health Option provisions will have no impact on the federal deficit.

[18] UAA Institute of Social and Economic Research, "Alaska 1332 Waiver – Economic Analysis."

Effect on Federal Operational Considerations
The proposed waiver requests no consideration of any kind for state-specific changes to FFM nor does it require state-specific modifications of the Internal Revenue Code for administration of the waiver. The waiver requires federal premium tax credit savings be passed through to the state.

10-Year Waiver Budget (Budget Neutrality)

Alaska is proposing APTC savings of $51.6 million in 2018, due to state subsidization of the Alaska Reinsurance Program. The proposed waiver reduces health care premiums and leads to a decrease in APTC sufficient to immediately outweigh any possible negative impact on the federal budget. The actuarial analysis provides projections for the total APTC under the waiver and baseline scenarios from 2018-2026.[19] The total projected APTC is 20-22% lower under the waiver scenario starting in 2018. In 2018, the estimated federal APTC savings from the waiver is more than $51.6 million, and it reaches $97.5 million in 2026. The economic analysis indicates there are three major drivers influencing the federal budget: shared responsibility payments, health insurance provider fees, and exchange user fees.[20]

Under the waiver, the APTC will be 20-22% lower, which provides sufficient federal pass-through funding and allows the state to continue funding the ARP, which in turn reduces premiums. Another factor contributing to savings is the expected change in the composition of the individual market, as participants are expected to become increasingly eligible for subsidies over time. This phenomenon is not specific to either the waiver or baseline scenario. It is expected that the proposed waiver will not result in increased spending, administrative or other expenses to the federal government. The net effect of the proposed waiver is significant savings to the federal government, $48.9 million in 2018, increasing each year to nearly $92 million in 2026.[21]

As there are not any CO-OP or Community Health Option programs operating in Alaska, waiving these provisions will have no budget impact. In fact, eliminating these provisions has the effect of reducing federal budget liabilities. Federal funding for start-up loans and other types of support will not be necessary. Given the poor performance of these healthcare coverage delivery systems in other states,[22] waiving allowances for these alternatives will help avoid risks to Alaska's individual healthcare market that could negatively impact state and federal budgets.

Assuring Compliance, Reducing Waste and Fraud

The Division of Insurance has responsibility for regulating and ensuring compliance and solvency of health insurers, performing market conduct analysis and examinations, conducting investigations, and providing consumer outreach. The Consumer Services section within the Division of Insurance investigates complaints that fall within the division's regulatory authority.

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[19] Oliver Wyman, "Alaska 1332 Waiver Application Actuarial Analyses and Certification."
[20] UAA Institute of Social and Economic Research, "Alaska 1332 Waiver – Economic Analysis."
[21] Ibid.
[22] S. Corlette, S. Miskell, J. Lerche et al., "Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition," http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf;
Louise Norris, "CO-OP health plans: patients' interests first," https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/;
Tom Murphy, "Once Profitable, Maine's Community Health Option is Now Losing Millions," http://www.insurancejournal.com/news/east/2015/12/15/391818.htm.

Alaska Statute 21.55.430 establishes the Alaska comprehensive health insurance fund within the state general fund. The Department of Administration shall account for revenue collected by the Division of Insurance, and deposit net proceeds into the Alaska comprehensive health insurance fund. The legislature may use the annual estimated balance in the Alaska comprehensive health insurance fund to make appropriations to the Department of Commerce, Community, and Economic Development to fund the reinsurance program.

The Division of Finance, located in the Department of Administration is tasked with accounting for the state and all departments and divisions, including the Division of Insurance. The state adheres to sound accounting practices. All policies and procedures are detailed in the accounting procedural manual.[23]

The state is audited annually by Certified Public Accountants employed by Legislative Audit. The state utilizes a double-entry accounting system, as well as an Integrated Resource Accounting System (IRIS) for maintaining records. Every transaction is electronically recorded in detail in the statewide accounting system with specific accounting for each grant and contract.

The state prepares annual financial statements and reports, and prepares monthly projection reports. The state's financial statements are audited annually, with the most recent audit completed for fiscal year ending 2015.

Implementation Timeline and Process

The Division of Insurance has adopted regulations for the ARP. The Department of Revenue set up Fund Code 1248 on July 1, 2016. The ARP is fully funded for the state FY2017.[24] The state contends that implementation of the waiver can be done by January 1, 2018. However, the state requests prefunding the waiver at the beginning of federal FY2018,[25] which will allow the division to lobby the state legislature for an appropriation in the legislative session beginning January 2018.

Should federal revenue streams be in place prior to federal FY2018, the state has the accounting mechanisms in place to receive and spend federal appropriations.

Reporting Responsibilities

Per 45 CFR 155.1308(f)(4), the Alaska Division of Insurance will submit the required quarterly, annual and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement.

As required, Alaska will hold public meetings six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the State of Alaska Online Public Notice website. The division will also notify consumer and business advocacy organizations. Each meeting will be conducted at a site that allows both in-person and telephonic attendance to accommodate residents across the state.

[23] Division of Finance, *Accounting Procedures Manual*, http://doa.alaska.gov/dof/manuals/apm/index.html.
[24] July 1, 2016 - June 30, 2017
[25] October 1, 2017 - September 30, 2018

Waiver Development Process

As required under 1332(a)(1)(B)(i), the 2016 state legislature passed legislation that authorizes submission and implementation of the proposed waiver. House Bill 374 was signed into law by Governor Bill Walker on July 18, 2016.

The Division of Insurance promulgated regulations concerning the ARP.

As required in 1332 (a)(4)(B)(i), public hearings were scheduled and held in accordance with 31 CFR 33.112 and 45 CFR 155.1312 to meet public notice requirements. Public hearing notices and the written draft proposal were duly posted on the State of Alaska Online Public Notice System,[26] as well as the Division of Insurance website on November 22, 2016. Public hearings were held in Anchorage (December 16, 2016) and Juneau (December 19, 2016),[27] and the public comment period closed December 23, 2016. No entities provided comments or made inquiries during the public hearings, but 13 entities submitted written comments in support of the 1332 waiver application.[28]

[26] "Affordable Care Act State Innovation Waiver; Public Hearings for Transparency and Community Input in Alaska," State of Alaska Online Public Notices, November 22, 2016, https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=183687.
[27] Division of Insurance, "Section 1332 Innovation Waiver: Public Hearing for Transparency and Community Input in Alaska," PowerPoint presentation, December 16, 2016, Atwood Building, Anchorage, AK.
[28] "Letters of Support," https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=106311.

LAWS OF ALASKA

2016

FOURTH SPECIAL SESSION

Source SCS CSHB 374(FIN)

Chapter No. _____

AN ACT

Relating to coverage under a state plan provided by the Comprehensive Health Insurance Association; establishing the Alaska comprehensive health insurance fund; relating to a reinsurance program; relating to the definition of "residents who are high risks"; relating to an application for a waiver for state innovation for health care insurance; and providing for an effective date.

_____

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

THE ACT FOLLOWS ON PAGE 1

AN ACT

Relating to coverage under a state plan provided by the Comprehensive Health Insurance Association; establishing the Alaska comprehensive health insurance fund; relating to a reinsurance program; relating to the definition of "residents who are high risks"; relating to an application for a waiver for state innovation for health care insurance; and providing for an effective date.

*** Section 1.** AS 21.55.320 is amended by adding a new subsection to read:

(b) When a person with a disability that is covered under 42 U.S.C. 1395 - 1395b-10 (Title XVIII of the Social Security Act) is referred by an insurer to a state plan under AS 21.55.310, the plan administrator shall request that the Department of Health and Social Services provide information to the person about applying for the federal benefits.

*** Sec. 2.** AS 21.55.400 is amended to read:

Sec. 21.55.400. Duties of director. The director may

(1) approve the selection of the plan administrator by the association and approve the association's contract with the plan administrator, including the coverages and premiums to be charged;

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(3) undertake, directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) formulate general policy and adopt regulations **that are reasonably necessary to administer this chapter**, including regulations establishing a reinsurance program reinsuring residents who are high risks **and specifying covered conditions eligible for payment through the reinsurance program** [, THAT ARE REASONABLY NECESSARY TO ADMINISTER THIS CHAPTER].

*** Sec. 3.** AS 21.55 is amended by adding a new section to read:

Sec. 21.55.430. Alaska comprehensive health insurance fund. (a) The Alaska comprehensive health insurance fund is established in the general fund. The Department of Administration shall separately account for revenue collected under AS 21.09.210, AS 21.33.055, 21.33.061, AS 21.34.180, and AS 21.66.110 and deposit net proceeds into the Alaska comprehensive health insurance fund. The Department of Administration shall deposit interest earned on the Alaska comprehensive health insurance fund in the general fund.

(b) The legislature may use the annual estimated balance in the Alaska comprehensive health insurance fund to make appropriations to the Department of Commerce, Community, and Economic Development to fund the reinsurance program under this chapter.

(c) Payment for claims under the reinsurance program under this chapter is subject to appropriation.

(d) Money in the fund does not lapse.

(e) Nothing in this section creates a dedicated fund.

(f) In this section, "net proceeds" includes

(1) revenue accounted for under (a) of this section, less all return

premiums, fees under AS 23.05.067, errors, and other adjustments;

(2) penalties and interest on late payments accounted for under (a) of this section.

*** Sec. 4.** AS 21.55.500(20) is amended to read:

(20) "residents who are high risks" means residents who

(A) have been rejected for medical reasons after applying for a subscriber contract, a policy of health insurance, or a Medicare supplement policy by at least one association member within the six months immediately preceding the date of application for a state plan; medical reasons may include preexisting medical conditions, a family history that predicts future medical conditions, or an occupation that generates a frequency or severity of injury or disease that results in coverage not being generally available;

(B) have had a restrictive rider placed on a subscriber contract, a health insurance policy, or a Medicare supplement policy that substantially reduces coverage; or

(C) meet other requirements adopted by regulation by the director that are consistent with this chapter [AND THAT INDICATE THAT A PERSON IS UNABLE TO OBTAIN COVERAGE SUBSTANTIALLY SIMILAR TO THAT WHICH MAY BE OBTAINED BY A PERSON WHO IS CONSIDERED A STANDARD RISK];

*** Sec. 5.** AS 21.96 is amended by adding a new section to read:

Sec. 21.96.120. Waiver for state innovation. The director may apply to the United States Secretary of Health and Human Services under 42 U.S.C. 18052 for a waiver of applicable provisions of P.L. 111-148 (Patient Protection and Affordable Care Act) with respect to health insurance coverage in the state for a plan year beginning on or after January 1, 2017. The director may implement a state plan meeting the waiver requirements in a manner consistent with state and federal law and as approved by the United States Secretary of Health and Human Services.

*** Sec. 6.** AS 21.55.430 is repealed June 30, 2018.

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

RETROACTIVITY. If sec. 3 of this Act takes effect after June 30, 2016, sec. 3 of this Act is retroactive to June 30, 2016.

*** Sec. 8.** Sections 1, 2, 4, 5, and 7 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 9.** Section 3 of this Act takes effect June 30, 2016.

THE REGULATIONS REPRODUCED HERE HAVE BEEN PROVIDED BY THE DIVISION OF INSURANCE AS A PUBLIC COURTESY. WHILE EVERY EFFORT HAS BEEN MADE TO ASSURE THE ACCURACY OF THE REPRODUCED VERSION, THE DIVISION OF INSURANCE CANNOT GUARANTEE ITS ABSOLUTE ACCURACY. A COPY OF THE REGULATIONS AS ORIGINALLY FILED BY THE LIEUTENANT GOVERNOR ARE AVAILABLE FROM THE DIVISION OF INSURANCE OR ON THE ALASKA ONLINE PUBLIC NOTICE SYSTEM.

THE REGULATIONS HAVE AN EFFECTIVE DATE OF DECEMBER 22, 2016, ARE IN REGISTER 220, AND WILL APPEAR IN OFFICIAL PUBLISHED FORM IN THE JANUARY 2016 SUPPLEMENT TO THE ALASKA ADMINISTRATIVE CODE.

Title 3. Commerce, Community, and Economic Development.

Part 2. Division of Insurance.

Chapter 31. Miscellaneous.

Article 4. Comprehensive Health Insurance Association Reinsurance Program.

Section

3 AAC 31.500 is repealed and readopted to read:

3 AAC 31.500. Purpose and applicability. (a) The purpose of 3 AAC 31.500 – 3 AAC 31.549 is to

(1) implement a reinsurance program for high risk residents in the individual health care insurance market in order to stabilize health care insurance premiums;

(2) encourage participation in this state's individual health care insurance market; and

(3) allow the director to apply to the United States Secretary of Health and Human Services under 42 U.S.C. 18052 for a waiver of applicable provisions of P.L. 111-148 (Patient Protection and Affordable Care Act).

(b) Except for a health care insurance plan providing grandfathered health care coverage and a health care insurance plan providing transitional health care coverage, 3 AAC 31.500 – 3 AAC 31.549 applies to a health care insurance plan in the individual market offered on or off a health care exchange.

(c) A health care insurer shall cede to the program the risk associated with insuring an eligible high risk resident who is issued a health care insurance plan in the individual market on or after January 1, 2017 and before the cessation of the program.

(d) Nothing in 3 AAC 31.500 - 3 AAC 31.549 requires a health care insurer to offer or issue a health care insurance plan in the individual market. (Eff. 2/2/2013, Register 205; am ___/___/____, Register ____)

Authority: AS 21.06.090 AS 21.55.400 **AS 21.96.120**

AS 21.55.220

3 AAC 31 is amended by adding a new section to read:

3 AAC 31.505. Establishment of high risk reinsurance program. (a) There is established within the Comprehensive Health Insurance Association a program to reinsure high risk residents of this state diagnosed with one or more of the covered conditions under 3 AAC 31.540. The program will be referred to as the Alaska Reinsurance Program.

(b) The Alaska Reinsurance Program will have a segregated fund established within the association. The segregated fund will hold all receipts and make all disbursements related to the program. All obligations of the Alaska Reinsurance Program, including payment or reimbursements of claims and expenses, will be limited to the monies available within the program fund.

(c) The association shall administer the reinsurance program under a contract with the director. The program will have its own plan of operation to establish administrative and accounting procedures necessary or proper to implement and administer the program.

(d) The Alaska Reinsurance Program becomes effective January 1, 2017. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.430
AS 21.55.040 AS 21.55.400

3 AAC 31.510 is amended to read:

3 AAC 31.510. Association duties. (a) The association shall establish **a plan of operation** [ADMINISTRATIVE AND ACCOUNTING PROCEDURES] for

the **administration and** operation of **the Alaska Reinsurance Program** [A REINSURANCE PROGRAM] under which a health care insurer **shall** [MAY] cede the risk of **a high risk resident** [ELIGIBLE INDIVIDUALS] to the **program** [ASSOCIATION]. **The plan of operation must include**

(1) a description of the data a health care insurer submitting a reinsurance payment request must provide to the association for the association to implement and administer the reinsurance program, including data necessary for the association to determine a health care insurer's eligibility for reinsurance payments;

(2) guidance to insurers relating to diagnosis codes for identifying residents with covered conditions under the program;

(3) the manner and time period in which a health care insurer must provide the data described under (1) of this subsection;

(4) requirements for reporting and processing reports submitted by health care insurers as required by the association;

(5) requirements for conducting audits under 3 AAC 31.530; and

(6) details of an annual actuarial study of this state's individual market that

(A) measures the impact of the program;

(B) recommends funding levels; and

(C) reveals emerging conditions within the market.

(b) The association shall accept a risk ceded to it **with respect to a high risk resident** in compliance with 3 AAC 31.500 – 3 AAC 31.549 effective on the date coverage becomes effective with the health care insurer and shall continue to accept a risk ceded to it **until March 1**

of the year following the calendar year in which the high risk resident's coverage becomes effective with the health care insurer or, if earlier, the date on which the coverage terminates or the reinsurance program ceases active operation [AS LONG AS THE INDIVIDUAL REMAINS INSURED UNDER THE SAME HEALTH CARE INSURANCE PLAN WITH THE SAME HEALTH CARE INSURER].

3 AAC 31.510 is amended by adding a new subsection to read:

(c) The association shall establish a process to reimburse, on a quarterly basis, participating health insurers for claims paid with respect to risk ceded to the program. (Eff. 2/2/2013, Register 205; am ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 **AS 21.55.430**
AS 21.55.040 AS 21.55.400

3 AAC 31 is amended by adding a new section to read:

3 AAC 31.515. Health care insurer eligibility for reinsurance payments. (a) A health care insurer is eligible for reinsurance payments to reimburse the insurer for the claims of a high risk resident for a benefit year if the health care insurer

(1) provides evidence to the association that the health care insurer has paid a claim of a high risk resident for the applicable benefit year that is for a covered condition listed under 3 AAC 31.540;

(2) continues to pay the claims of a high risk resident for the applicable benefit year;

(3) pays to the association, under (b) of this section, the premium amount the health care insurer receives under the insurance policy for the applicable benefit year covering the eligible high risk resident;

(4) pays to the association, under (c) of this section, pharmacy rebates the health care insurer receives for the applicable benefit year for health care services provided to the applicable high risk resident; and

(5) reports to the association payments, applicable to the high risk resident, the health care insurer collects for

(A) third party liabilities;

(B) payments the health care insurer recovers for overpayments;

(C) payments for commercial reinsurance recoveries; and

(D) estimated federal cost-sharing reduction payments made under 42 U.S.C. 18071.

(b) The health care insurer shall pay to the association the separately identifiable premium amount the health care insurer received under the insurance policy for the applicable benefit year covering the eligible high risk resident not later than 30 calendar days after the association accepts a risk ceded to it with respect to a high risk resident. If the high risk resident is covered under a family policy and the high risk resident has a separately identifiable premium equal to $0, the health care insurer shall pay to the association the highest separately identifiable premium under the family policy. For each additional high risk resident covered under a family policy who has a separately identifiable premium equal to $0, the health care insurer shall pay to the association the next highest separately identifiable premium under the family policy.

(c) A health care insurer shall pay to the association a pharmacy rebate required to be paid to the association under (a)(4) of this section not later than 30 calendar days after receipt of the pharmacy rebate. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.400

3 AAC 31.520 is repealed and readopted to read:

3 AAC 31.520. Health care insurer duties and rules. (a) A health care insurer shall comply with the requirements established by the association in order to cede a risk to the association.

(b) A health care insurer shall continue to administer and manage the policy for risk ceded to the association in accordance with the terms of the insurance policy and with the insurance law of this state.

(c) A health care insurer shall offer individuals that may be ceded to the association the same plans offered to other individuals.

(d) A health care insurer may not vary premium rates based on whether a risk is ceded to the association.

(e) A health care insurer may cede a risk to the association with respect to a high risk resident at any time during the period beginning on the date the high risk resident's coverage becomes effective with the health care insurer and ending on March 1 of the year following the calendar year in which the high risk resident's coverage becomes effective with the health care insurer. A health care insurer that wishes to cede risk with respect to a high risk resident to the association in a subsequent calendar year shall re-cede that risk for that calendar year.

(f) A health care insurer shall submit to the program claims incurred during a calendar year for a ceded risk not later than 18 months after that calendar year for the claim to be eligible for reimbursement from the program. (Eff. 2/2/2013, Register 205; am ___/___/___, Register___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.400

3 AAC 31 is amended by adding a new section to read:

3 AAC 31.525. Premiums and other financial matters. (a) A health care insurer shall forward all premiums to the association for each risk ceded to the program and may not retain any portion of the premium.

(b) A health care insurer shall report to the association amounts collected by a health care insurer for

(1) third party liabilities;

(2) overpayment recoveries;

(3) estimated federal cost-sharing reduction payments made under 42 U.S.C. 18071;

(4) commercial reinsurance recoveries;

(5) pharmacy rebates; and

(6) any other similar amounts with respect to risk ceded to the program.

(c) The association shall retain all premiums it receives in excess of administrative and operational expenses and claims paid for ceded risks in a calendar year and shall apply any

excess premiums toward payment of future administrative and operational expenses and claims incurred by ceded risks in subsequent years of the program.

(d) Premiums received by the association for the program will be used first to pay, or to establish reasonable reserves for payment of, administrative and operational expenses of the program and second to pay claims for risks ceded to the program. Claims for risks ceded to the program will be paid first from premiums remaining available after payment of, or establishment of reasonable reserves for payment of, administration and operational expenses of the program and second from other available program funds. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.430
AS 21.55.040 AS 21.55.400

3 AAC 31.530 is repealed and readopted to read:

3 AAC 31.530. Accounting, reporting, and auditing. (a) A health care insurer that cedes a risk to the program shall submit to the program all data and information when required by the association and in the manner and format required by the association. The data and information must include

(1) eligibility information;

(2) claims information; and

(3) premium information.

(b) The association shall maintain its books, records, accounts, and operations on a calendar-year basis.

(c) The association shall conduct a final accounting with respect to each calendar year after April 15 of the following calendar year.

(d) Claims with respect to ceded risk that are incurred during a calendar year and are submitted for reimbursement not later than April 15 of the following calendar year will be allocated to the calendar year in which they are incurred. Claims submitted after April 15 following the calendar year in which they are incurred will be allocated to a later calendar year in accordance with the operating rules, policies, and procedures of the program.

(e) If the total receipts of the fund with respect to a calendar year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that calendar year, all claims for reimbursement allocable to that calendar year will be reduced proportionately to the extent necessary to prevent a deficit in the fund for that calendar year. Any reduction in claims for reimbursement with respect to a calendar year will apply to all claims allocable to that calendar year without regard to when those claims are submitted for reimbursement, and any reduction will be applied to each claim in the same proportion.

(f) The association shall establish a process for auditing each health care insurer ceding risk to the program. Audits may include both a baseline audit conducted in connection with commencement of an insurer's participation in the program and periodic audits up to four times a year throughout the insurer's participation in the program.

(g) The association shall engage an independent qualified auditing entity to perform a financial and programmatic audit for each benefit year in accordance with generally accepted auditing standards. The association shall provide a copy of the audit to the director at the time the association receives the audit. The association shall make a public summary of the results of the

audit. The public summary must be made available within a time period and in a manner that a prudent person would consider to be timely and informative.

(h) The director or the director's designee may conduct financial and programmatic audits of the reinsurance program and the association to assess compliance with

(1) 3 AAC 31.500 – 3 AAC 31.549;

(2) the contract between the director and the association; and

(3) the plan of operation established for the administration and operation of the program. (Eff. 2/2/2013, Register 205; am ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 **AS 21.55.430**

AS 21.55.040 AS 21.55.400

3 AAC 31 is amended by adding new sections to read:

3 AAC 31.535. Annual true-up. (a) The association shall establish a true-up process with respect to a calendar year to reflect adjustments made in establishing the final accounting for that calendar year, including crediting of premiums received with respect to risk ceded after the end of the calendar year and retroactive reductions or other adjustments in reimbursements necessary to prevent a deficit in the fund for that calendar year and to prevent a windfall to an insurer as a result of third party recoveries, recovery of overpayments, commercial reinsurance recoveries, or risk adjustments made under 42 U.S.C. 18063 (sec. 1343 of the Patient Protection and Affordable Care Act, P.L. 111-148). The true-up must occur after April 15 following the calendar year to which it relates.

(b) With respect to the risk adjustment transfers as determined by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO),

(1) the director or the director's designee will review the risk adjustment transfers to determine the impact of the ceding of risk to the program;

(2) the review will occur not later than 60 days after publication of the notice of final risk adjustment transfers by the Center for Consumer Information and Insurance Oversight;

(3) the director or director's designee will notify a health care insurer of the amount of any risk adjustment transfer it received that does not accurately reflect benefits provided under the program and

(A) the health care insurer shall pay that amount to the program not later than 30 days after receipt of the notice from the director or the director's designee; and

(B) as appropriate, the director or the director's designee will refund that amount to the health care insurer or insurers that made the federal risk adjustment payment; and

(4) to facilitate the true-up process, a health care insurer shall submit to the director or the directors' designee, in a form and manner determined by the director or the director's designee, all data requested by the director in a data call in March of the year following the year to which the risk adjustment applies. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.430
AS 21.55.040 AS 21.55.400

3 AAC 31.540. Covered conditions. A resident of this state diagnosed with one or more of the following covered conditions under this section is a high risk resident under 3 AAC 31.500 – 3 AAC 31.549:

(1) human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS);

(2) septicemia sepsis, systemic inflammatory response syndrome/shock;

(3) metastatic cancer;

(4) lung, brain, and other severe cancers, including pediatric acute lymphoid leukemia;

(5) non-hodgkin's lymphomas and other cancers and tumors;

(6) mucopolysaccharidosis;

(7) lipidoses and glycogenosis;

(8) amyloidosis, porphyria, and other metabolic disorders;

(9) end-stage liver disease;

(10) chronic hepatitis;

(11) acute liver failure or disease, including neonatal hepatitis;

(12) intestinal obstruction;

(13) chronic pancreatitis;

(14) inflammatory bowel disease;

(15) rheumatoid arthritis and specified autoimmune disorders;

(16) hemophilia;

(17) acquired hemolytic anemia, including hemolytic disease of newborn;

(18) sickle cell anemia (hb-ss);

(19) thalassemia major;

(20) coagulation defects and other specified hematological disorders;

(21) anorexia/bulimia nervosa;

(22) paraplegia;

(23) amyotrophic lateral sclerosis and other anterior horn cell disease;

(24) quadriplegic cerebral palsy;

(25) cerebral palsy, except quadriplegic;

(26) myasthenia gravis/myoneural disorders and guillain-barre syndrome/inflammatory and toxic neuropathy;

(27) multiple sclerosis;

(28) parkinson's, huntington's and spinocerebellar disease, and other neurodegenerative disorders;

(29) cystic fibrosis;

(30) end stage renal disease;

(31) premature newborns, including birthweight 2000 – 2499 grams;

(32) stem cell, including bone marrow, transplant status/complications;

(33) amputation status, lower limb/amputation complications. (Eff.___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.400

3 AAC 31.549 is repealed and readopted to read:

3 AAC 31.549. Definitions. In 3 AAC 31.500 – 3 AAC 31.549,

(1) "association" means the Comprehensive Health Insurance Association established under AS 21.55.010 – 21.55.060;

(2) "Comprehensive Health Insurance Association" means the nonprofit incorporated legal entity established under AS 21.55.010 – 21.55.060;

(3) “covered condition” means a high risk resident's health condition, injury, illness, or disease that is listed under 3 AAC 31.540;

(4) "diagnosis code" means a universal code that a health care provider uses to identify a person's diagnosis;

(5) “director” means the director of the division of insurance;

(6) “fund” means the segregated fund established within the association to hold all receipts and make all disbursements related to the program;

(7) "grandfathered health care coverage" means coverage provided by an individual health care insurance policy purchased before March 23, 2010;

(8) "health care exchange" has the meaning given in AS 21.51.500;

(9) "health care insurance plan" has the meaning given in AS 21.42.599;

(10) "health care insurer" has the meaning given in AS 21.54.500;

(11) "health care provider" has the meaning given in AS 21.07.250;

(12) “high risk resident” means a resident of this state who has been diagnosed with one or more of the covered conditions under 3 AAC 31.540;

(13) "individual market" has the meaning given in AS 21.51.500;

(14) “program” means the reinsurance program authorized under AS 21.55.400 and established under 3 AAC 31.500 – 3 AAC 31.549;

(15) "transitional health care coverage" means coverage provided by an individual health care insurance policy purchased after March 22, 2010 and before January 1, 2014. (Eff. 2/2/2013, Register 205; am ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 **AS 21.55.430**

[AS 21.42.345] AS 21.55.400

OLIVER WYMAN

ALASKA 1332 WAIVER APPLICATION

ACTUARIAL ANALYSES AND CERTIFICATION

Tammy Tomczyk, FSA, FCA, MAAA
Ryan Mueller, FSA, MAAA
Peter Kaczmarek, FSA, MAAA

MARSH & McLENNAN COMPANIES

CONTENTS

1

Executive Summary

Premiums in the Alaska individual health insurance market have increased substantially since 2014 when many of the market reforms associated with the Patient Protection and Affordable Care Act (ACA) were implemented. Health insurers have suffered from significant losses as fewer individuals elected to purchase coverage in the individual health insurance market and those who purchased coverage were less healthy relative to initial expectations. Since 2015, insurance premiums in the Alaska individual market have been the highest in the nation. In an effort to stabilize and encourage insurers to offer coverage in the individual health insurance market, the State of Alaska (the State) legislature recently passed a law authorizing the Alaska Division of Insurance (Alaska DOI) to establish a reinsurance program for 2017 individual market enrollees. Additionally, the State has appropriated $55 million to fund the reinsurance program in 2017.

Due to State budgetary pressures, the State is requesting that the Centers for Medicare and Medicaid Services (CMS), the United States Department of Health and Human Services (HHS) and the United States Department of Treasury consider its application for a State Innovation Waiver under Section 1332 of the ACA. Under the State Innovation Waiver, the Federal government would partially fund the Alaska Reinsurance Program (ARP) starting in 2018 based on the savings that would be generated as a result of a reduction in Advanced Premium Tax Credits (APTCs) due to the reinsurance program. The State would appropriate the remaining amount of funds necessary to ensure the ARP is fully funded, after adjusting for medical inflation. The State Innovation Waiver would be effective January 1, 2018 for an initial period of five years with an option to renew for an additional five year period.

Using Oliver Wyman's Healthcare Reform Microsimulation Model (HRM Model), our analysis demonstrates that the ARP will achieve the three guardrails we evaluated that a State Innovation Waiver must accomplish. That is, we expect more individuals to be covered in the individual market and we expect coverage in the individual market to be at least as comprehensive and affordable absent the reinsurance program for the individual market population in aggregate and for various vulnerable populations (e.g., individuals with high-cost conditions, etc.). Additionally, our analysis suggests that the ARP will have minimal impact on the other health insurance markets (e.g., employer-based coverage, Medicare, etc.). An analysis of the impact the State Innovation Waiver is expected to have on the Federal deficit, the fourth guardrail, is outside the scope of our analysis, but is contained in a separate report completed by the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage.

We estimate that the presence of the ARP will save the Federal government $51.6 million in APTCs for 2018, and increase enrollment in the individual market by nearly 1,650 relative to what APTCs and enrollment would be absent the ARP. By 2026, assuming the reinsurance program remains in place, we estimate APTCs savings will grow to $97.6 million; this growth includes the impact of about 750 additional individuals expected to take up coverage with the reinsurance program in place.

The following table summarizes the total APTCs anticipated to be paid by the Federal government and the anticipated enrollment in the individual market, under both the baseline and waiver scenarios by year:

APTCs and Individual Market Enrollment by Scenario and Year

	APTCs			Individual Market Enrollment		
Year	Baseline	Waiver	Difference	Baseline	Waiver	Difference
2015	94,468,271	94,468,271	-	28,159	28,159	-
2016	135,348,085	135,348,085	-	24,064	24,064	-
2017	185,716,278	185,716,278	-	23,822	23,822	-
2018	233,898,461	182,260,689	(51,637,772)	21,253	22,894	1,641
2019	258,351,449	202,372,542	(55,978,906)	21,993	23,558	1,565
2020	279,343,570	219,162,267	(60,181,304)	21,773	23,548	1,775
2021	312,617,789	247,210,983	(65,406,805)	22,176	23,410	1,234
2022	342,289,634	272,477,673	(69,811,961)	22,656	23,866	1,210
2023	380,127,501	303,407,137	(76,720,364)	23,539	24,721	1,182
2024	412,662,662	329,994,712	(82,667,950)	23,713	24,940	1,227
2025	449,544,666	359,539,993	(90,004,673)	24,196	24,937	741
2026	488,186,123	390,635,284	(97,550,838)	24,520	25,263	742

While our modeling suggests greater actions will be needed to increase the affordability of coverage, the reinsurance program will help bring some much needed stability to the individual health insurance market in Alaska.

2

Introduction

Many challenges are threatening the long-term viability of Alaska's individual health insurance market. Insurers participating in the individual health insurance market have lost significant amounts of money since 2014 as a result of the insured population that enrolled in coverage being less healthy relative to initial expectations. Enrollment has also been lower than expected. In an effort to minimize losses, insurers have implemented steep rate increases for 2015 and 2016, and as a result, individual health insurance premiums in Alaska are now the highest in the nation.[1] In 2017, Premera will be the only insurer in the individual health insurance market after Moda announced it will exit the market.[2] Two other insurers, Assurant and Aetna, exited the individual health insurance market at the end of 2015.

In an effort to stabilize the individual health insurance market, the State of Alaska (the State) enacted a law by passing HB 374 which allows the Alaska Division of Insurance (Alaska DOI) to establish the Alaska Reinsurance Program (ARP) within the Alaska Comprehensive Health Insurance Association.[3] Under the ARP, insurers will cede all premiums associated with individual market enrollees identified as having one or more high-cost condition specified as eligible for payment, in exchange for partial or total reimbursement of their claim costs.[4] Thirty-three chronic conditions will be covered under the ARP for 2017, including HIV/AIDS, Multiple Sclerosis and Hemophilia.

According to the provisions of the enacted law, the legislature has the ability to appropriate funds to the ARP for fiscal years 2017 and 2018, with the program currently set to sunset after fiscal year 2018. For fiscal year 2017, the State legislature appropriated $55 million to fund the ARP for calendar year 2017 enrollees. Given the State's fiscal challenges, it is unclear how much funding will be appropriated by the legislature in 2018, so the State is seeking a financial partnership with the Federal government through the approval of a Waiver for State Innovation under Section 1332 (1332 Waiver) of the Patient Protection and Affordable Care Act (ACA).

A 1332 Waiver gives a state the flexibility to implement innovative approaches to improving access to high-quality, affordable healthcare, by waiving one or more applicable provision of the ACA. A 1332 Waiver must meet the following guardrails:[5]

- Coverage must be provided to a comparable number of residents as would be provided absent the waiver
- Coverage must be at least as comprehensive as would be provided absent the waiver

[1] "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces." Kaiser Family Foundation, 25 Oct. 2016, http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

[2] "Moda Health Announces Exit from Alaska Individual Medical Market in 2017." State of Reform, 2 May 2016, http://stateofreform.com/news/states/alaska/2016/05/moda-leaves-alaska-exchange/

[3] http://www.akleg.gov/basis/Bill/Text/29?Hsid=HB0374Z

[4] https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=105097

[5] 80 Fed. Reg. 78131-78135 (December 16, 2015)

- Coverage must be as affordable as would be provided absent the waiver
- The waiver must not increase the Federal deficit

With the exception of evaluating whether a 1332 Waiver increases the Federal deficit, each of the guardrails is required to be met without adversely impacting "vulnerable" populations (e.g., low-income individuals, individuals with serious health conditions, etc.). An analysis of the impact the State Innovation Waiver is expected to have on the Federal deficit, the fourth guardail, is outside the scope of our analysis, but is contained in a separate report completed by the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage.[6]

In its 1332 Waiver application, the State is requesting to receive financial assistance from the Federal government to partially fund the ARP. Approximately 66% of individual market enrollees in Alaska, including individuals enrolled in grandfathered and transitional plans, received Advanced Premium Tax Credits (APTCs) during the first nine months of 2016; however, when limited to Exchange enrollees, 90% of individual market enrollees received APTCs during the first nine months of 2016.[7] APTCs are fully funded by the Federal government and are designed to limit the amount of premium individuals and families pay in relation to their income. APTCs are determined based on the second lowest-cost premium for Silver coverage sold through the Exchange, in the ZIP Code in which the individual resides. For example, the premium for a family of four with a household income that is 250% of the Federal poverty level (FPL) will be "capped" at 8.18% of their household income in 2016, regardless of the market-based premium, assuming the family enrolls in the second lowest-cost silver plan.[8] The family may choose to enroll in a different plan, in which case the dollar value of the calculated APTC (i.e., the difference between the market-based premium for the second lowest cost Silver plan sold through the Exchange and the "capped" premium) will be applied to the selected plan. The ARP is expected to reduce market-based premiums relative to a scenario in which the ARP does not exist. This reduction in market-based premiums will generate fiscal savings to the Federal government in the form of reduced APTC levels.

Under the proposed arrangement, the State would receive an amount of money from the Federal government equal to the anticipated APTC savings the Federal government would realize, relative to an otherwise identical scenario but absent the ARP. The State would fund the remaining amount of money needed to maintain the overall funding level of the ARP relative to the amount appropriated by the State in 2017, after adjusting for inflation. If approved, the 1332 Waiver would be effective January 1, 2018 for an initial period of five years, with an option to renew for an additional five years.

In the following sections, we describe the micro-simulation model Oliver Wyman used to evaluate the impact of the ARP on APTCs, including a description of the data sources underlying the model, and we provide an analysis of the micro-simulation modeling results. The micro-simulation modeling focuses on the impact the ARP is expected to have on premiums in the individual market, the impact on enrollment in various health insurance market segments including an estimate of the number of uninsured individuals, and the potential savings to the Federal government as a result of changes in APTCs. The analysis also highlights the impact the ARP is expected to have relative to the guardrails a 1332 Waiver must achieve for approval.

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[6] "Alaska 1332 Waiver-Economic Analysis," Prepared by the Institute for Social and Economic Research. University of Alaska Anchorage.

[7] Based on an analysis of enrollment information provided by Moda and Premera

[8] Section 2.01, Applicable Percentage Table for 2016, https://www.irs.gov/pub/irs-drop/rp-14-62.pdf

3

Microsimulation Modeling

Model Overview

We utilized Oliver Wyman's Healthcare Reform Microsimulation Model (HRM Model) to understand the impact that passage of HB 374 and establishment of the ARP is expected to have on enrollment and the affordability of health insurance coverage in the individual market, and on the number of uninsured individuals. Any potential effects on the employer-based markets are also captured by the HRM Model. The HRM Model projects the number of individuals expected to seek coverage under each health insurance coverage type through the use of economic utility functions. The decision-making process is made at the health insurance unit (HIU) level, with a health insurance unit defined as all related family members residing in the same household.

An employer-based economic utility function determines whether or not a given employer offers health insurance coverage to its employees and their dependents. The employer-based economic utility function compares the additional costs that would be incurred by the employer as a result of not offering coverage (e.g., the penalty for not offering coverage) to the benefits that would be received by the employee for purchasing insurance in the individual market (e.g., APTCs). If an employer does offer coverage, all employees and their dependents within the HIUs are assumed to take up health insurance coverage through the employer sponsored plan, unless the coverage is deemed unaffordable,[9] or the individuals are eligible for health insurance coverage through government sponsored programs. If coverage is deemed unaffordable or the employer does not offer coverage, employees and their dependents will evaluate health insurance coverage options in the individual market.

The decision as to whether a given HIU will take up coverage in the individual market is based on the results from applying two economic utility functions.[10] The first economic utility function calculates the utility associated with taking up coverage in the individual market, and is a function of the premium the HIU would be expected to pay (net of federal premium subsidies), any cost-sharing the HIU would be expected to pay out-of-pocket (net of any cost sharing subsidies), and the risk aversion[11] of the HIU. The second economic utility function calculates the utility associated with not taking up coverage, and is a function of the penalty the HIU would be assessed, total allowed claim costs for the HIU, and the risk aversion of the HIU. If the utility of being uninsured is greater than the utility associated with taking up coverage in the individual market, the HIU is assumed to be uninsured; otherwise, the HIU is assumed to take up coverage in the individual market.

Individuals that are eligible for Medicare, Medicaid and other government sponsored coverage (e.g., Military), were assumed to retain their government sponsored coverage and the economic utility

[9] Under the ACA, coverage is considered unaffordable if the employee's required contribution toward employer sponsored coverage for self-only coverage is more than 9.50% of household income. This percentage increased to 9.69% in 2017.

[10] The economic utility functions evaluate the economic costs and benefits associated with various coverage options. The economic utility functions are described in greater detail in Appendix A.

[11] Risk aversion is defined as the perceived added value of having health insurance coverage relative to the benefits expected to be utilized (e.g., a willingness to pay more to avoid catastrophic losses even when catastrophic losses are not believed to be imminent).

associated with employer-based coverage, individual market coverage or being uninsured were not evaluated. Additionally, if the primary adult or spouse is identified as being employed by the government, both military and non-military personnel, and the HIU is identified as having employer-based coverage or military coverage, the HRM Model assumes health insurance coverage for the HIU is provided through a government employer. Appendix A provides additional insight into the technical aspects of the HRM Model.

General Model Assumptions and Sources

The basis for the population underlying the HRM Model is data from the 2014 American Community Survey (ACS). The ACS data provide detailed information for each individual in a surveyed household unit, including demographic, socioeconomic and employment information. The data also provides information regarding health insurance coverage type. The 2014 ACS data was calibrated to reflect the 2015 Alaskan population enrolled under each health insurance coverage type, including the uninsured population. This data was projected forward each year to 2026 by the HRM Model, based on a series of assumptions. The assumptions underlying the HRM Model are described in the paragraphs that follow.

2015 Model Calibration

As noted above, the 2014 ACS data was calibrated to reflect the 2015 Alaskan health insurance markets. Information from the 2015 Supplemental Health Care Exhibits (SHCEs) for Alaska enrollees was used to inform our estimates for premiums, claims and membership for the commercial markets (e.g., the individual market and the employer-based markets). A data call was issued to Premera, Moda, Aetna and the Assurant Health companies[12] to collect additional detailed information regarding individual and small employer-based market enrollees. This data summarized membership and claims information for January 2015 through September 2016, and provided additional insight into various aspects of the corresponding populations, such as the distribution of members enrolled in metallic plans and non-metallic plans (i.e., plans that are not compliant with the ACA, also known as non-ACA plans[13]), by cost-sharing reduction (CSR) variant, etc. The 2015 insurer data was compared to information published by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) regarding individuals enrolling during the 2015 open enrollment period, and data from the SHCEs, to assess the reasonability of the information associated with each source.

Allowed claim costs were calculated for the individual and employer-based markets, and for the uninsured. The assumed average allowed claim costs vary by health insurance coverage type and are dependent on the age, gender and health status assigned to individuals. We relied on information from the 2015 Current Population Survey (CPS) to assign health status information to each individual. Individuals were classified as having excellent, very good, good, fair or poor health based on the distribution of members with each health status as observed in the CPS data. The assumed distribution by health status varies by income level of the HIU, age, gender and whether an individual is insured or uninsured.

For the employer-based markets, the member liability for each HIU was determined based on a market average plan design, with the average plan design varying between small group and large

[12] Assurant Health is the brand name for products underwritten and issued in Alaska by Time Insurance Company and John Alden Life Insurance Company

[13] Non-ACA plans refer to grandfathered benefit plans (i.e., health plans in effect prior to when the ACA was signed into law, or March 23, 2010) and transitional benefit plans (i.e., non-grandfathered health plans that were in effect on October 1, 2013)

group employers. For individual market ACA enrollees, member liability was calculated at the bronze and silver metal levels so that the economic utility of selecting a plan at each metal level may be evaluated. Due to the lack of enrollment at the gold and platinum levels, the HRM Model did not evaluate coverage at these metallic levels. For transitional and grandfathered enrollees in the individual market, the member liability for each HIU was determined based on a market average plan design. The difference between allowed claims and the member liability for an HIU represents incurred claims.

The HRM Model was calibrated for each type of health insurance coverage in 2015 as follows:

- ***Individual Market***:
  Enrollment estimates were based on information provided in response to an insurer data call and the SHCEs. To ensure the HRM Model accurately portrays the individual market, we calibrated the model to reflect the appropriate income, age, and benefit mix for 2015. Information published in the Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report[14] by ASPE provided insight into the distribution of Exchange enrollees by metal level, income range and age, and provided the proportion of members receiving APTCs or enrolled in CSR variants. This information was supplemented with information from the insurer data call responses and information from rate filings provided by the Alaska DOI. Due to the lack of available information, actuarial judgment was used to assess the likely distribution of enrollees by FPL for individuals who enrolled in individual market coverage outside of the Exchange, including individuals enrolled in non-ACA plans. Given the availability of subsidies for coverage purchased through the Exchange, we believe a majority of individuals enrolled in non-ACA plans have incomes greater than 400% FPL.

  Premium estimates per member per month (PMPM), including APTC levels, were calculated using information provided in response to the insurer data call, and were compared to information from the SHCEs and the March 2015 open enrollment report published by ASPE for consistency. Premium levels in the HRM Model vary between enrollees in ACA and non-ACA policies.

  Allowed claim costs PMPM were derived from incurred claim costs PMPM based on actuarial value estimates developed using information from the insurer data call responses. The incurred claim estimates utilized were net of any CSR payments received from HHS. The allowed claim cost estimates in the HRM Model vary between enrollees in ACA and non-ACA policies. Member cost-sharing amounts PMPM are derived by the HRM Model. The HRM Model uses simplified plan designs for each available coverage option (e.g., transitional/grandfathered, bronze metallic level, etc.) to determine member cost-sharing for enrollees in the individual market.

- ***Employer-based Market***:
  The HRM Model utilizes information from the Medical Expenditure Panel Survey (MEPS) in conjunction with the employment information supplied on the ACS records to identify individuals with health insurance coverage in the employer-based market. The MEPS data provides information related to the distribution of employees, employer health insurance offer rates and employee take-up rates by group size for Alaska. Individuals identified as being employed in the private sector are randomly assigned into the appropriate mix of employer group sizes (e.g., small employer). The HRM Model projects the small employer

[14] https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-2015-open-enrollment-period-march-enrollment-report

market (i.e., 2 to 50 employees) independently from the large employer market (i.e., 51+ employees).

Fully-insured small employer-based health insurance enrollment estimates were based on information provided in response to the insurer data call and the SHCEs. We calibrated the model to reflect the appropriate mix of enrollees by plan type (e.g., ACA versus non-ACA). Information from the SHCEs was used to estimate the number of large employer-based fully-insured enrollees. Data from the 2016 Annual Health Insurance Survey collected by the Alaska Department of Commerce, Community, and Economic Development, a survey of 2015 health insurance enrollees, was used to estimate the number of self-funded employer-based enrollees.

Premium and incurred claim estimates PMPM for the small employer-based market were calculated using information provided in response to the insurer data call. These estimates were compared to information from the SHCEs. The incurred claim estimate PMPM was grossed up to an allowed claim estimate PMPM using estimates of actuarial values derived from responses to the insurer data call. Premium and allowed claim estimates PMPM utilized by the HRM Model vary between small employer-based enrollees in ACA and non-ACA policies. The actuarial value estimates derived from responses to the insurer data call were used to calculate member cost-sharing PMPM. Our projections assume the average actuarial value does not change over time for the small employer-based market (i.e., benefit buy-downs will equally offset the impact of deductible leveraging).

Premium and incurred claim estimates PMPM for the large employer-based market were calculated using information from the SHCEs. The incurred claim estimate PMPM was grossed up to an allowed claim estimate PMPM based on an estimated actuarial value for the large employer-based market. This estimate was derived based on actuarial judgment. While we acknowledge that the large employer data from the SHCEs reflect fully-insured members, due to the lack of available information, we assumed the average claim cost PMPM and corresponding "premium equivalents" are similar for self-funded groups. The actuarial value estimate used to calculate allowed claim costs PMPM was also used to calculate member cost-sharing PMPM. Our projections assume the average actuarial value does not change over the projection period for the large employer-based market (i.e., benefit buy-downs will equally offset the impact of deductible leveraging).

- ***Medicaid and the Children's Health Insurance Program (CHIP):***
  Medicaid and CHIP enrollment was estimated using information published by CMS for Alaska.[15] The HRM Model identifies individuals who qualify for Medicaid based on family composition and income. Premium and claim cost estimates PMPM for Medicaid and CHIP enrollees were not projected by the HRM Model.

- ***Medicare:***
  Medicare enrollment was estimated using the data from the Medicare Enrollment Dashboard published by CMS.[16] The estimates include individuals enrolled in fee-for-service (FFS) Medicare and Medicare Advantage coverages. The HRM Model identifies individuals who

[15] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/previous-monthly-medicaid-and-chip-application-eligibility-determination-and-enrollment-reports-and-updated-data.html

[16] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html

qualify for Medicare based on age. Premium and claim cost estimates PMPM for Medicare enrollees were not projected by the HRM Model.

- ***Other Government:***
  Other government sponsored coverage reflects individuals working for the military and any covered dependents. This includes individuals enrolled in TRICARE. TRICARE enrollment information was used to validate the number of individuals reported as having Military coverage according to the ACS data.

- ***Uninsured:***
  The remainder of the population reflects the estimated number of uninsured individuals. This number of individuals was compared to other publically available sources for reasonability.

- ***Indian Health Services (IHS):***
  American Indians and Alaskan Natives that are members of Federally recognized tribes may receive medical treatment at no cost when receiving services through an IHS provider or facility. They may also be eligible to enroll in a zero cost-sharing or limited cost-sharing plan. IHS is not a type of insurance coverage, and many individuals who receive care through IHS have health insurance coverage. Individuals who receive care through IHS and do not have health insurance coverage may obtain a coverage exemption to avoid paying an income tax penalty. Given the size of the Alaska Native population, we have separated out estimates of the number of individuals utilizing IHS services for select insurance coverage types. Our analysis relies on information provided on the ACS data to estimate the number of individuals receiving care through IHS.

2016 and Beyond

The HRM Model assumes a "steady state" population for 2016 and beyond. This means the overall distribution of the population by income as a percent of FPL, health status, occupation and family size is not expected to change significantly, with the exception that the overall population is expected to age slightly. Individuals eligible for government sponsored programs are assumed to continue to enroll in that coverage type, while the number of individuals enrolled in individual coverage, employer-based coverage or are uninsured is projected by the HRM Model based on projected changes in premium, demographics and the morbidity of each cohort.

The Alaskan population is projected to grow each year according to projections developed by the Alaska Department of Labor and Workforce Development;[17] however, the estimated number of individuals enrolled in each type of health insurance was projected independently. Changes in enrollment in Medicare, Medicaid and other government sponsored health insurance types are largely based on expected changes in nationwide enrollment in these programs using National Health Expenditure Data (NHED) projections, with one exception. Alaska expanded its Medicaid program in September 2015 to adopt the income limits outlined in the ACA for childless adults (i.e., 138% FPL), but enrollment experience in the months immediately following the expansion suggest most of the newly eligible members did not enroll until December 2015 or early 2016. Therefore, the HRM Model assumes the Medicaid expansion occurred at the beginning of 2016 and captures the corresponding impact of Medicaid expansion on enrollment in the commercial and uninsured markets in 2016. Changes in enrollment in the individual, employer-based, and uninsured markets are based on the results of the HRM Model. The combined change in enrollment for these markets was calculated such that when accounting for the projected changes in enrollment for government sponsored programs, the overall projected change in the population is produced.

[17] http://live.laborstats.alaska.gov/pop/projections/pub/popproj.pdf

For the individual, employer-based and uninsured markets, allowed claims were trended each year based on the NHED forecast of spending per enrollee for private health insurance and employer-sponsored private health insurance; however, an adjustment was made to reflect claim trends specific to Alaska. Health insurance costs in Alaska are significantly higher than the rest of the nation, and based on NHED data published by CMS, health insurance costs have risen at a faster rate in Alaska relative to the rest of the nation.[18] The NHED data summarized annual per enrollee private health insurance costs by state between 2001 and 2009; more recent data was not available. This information shows that the annual increase in per enrollee private health insurance costs in Alaska were approximately 1.1% higher between 2001 and 2009 than the nationwide average; however, between 2005 and 2009, the annual increase in per enrollee private health insurance costs in Alaska were approximately 3.3% higher than the nationwide average. The HRM Model therefore assumes that over the projection period, trends in Alaska are 2.5% higher than the NHED forecasted change in spending per enrollee for private health insurance and employer-sponsored private health insurance. Member cost-sharing, CSR payments from HHS, and incurred claims are calculated by the HRM Model, with the assumed annual limitation on cost-sharing indexed for inflation each year according to Federal regulations, using the most recent projections published by NHED.

Premiums for the individual and small employer-based markets in 2016 and 2017 were projected based on the rate increases filed by insurers with the Alaska DOI. Projected premiums for the individual and small employer-based markets from 2018 through 2026 were calculated using a target loss ratio approach. We assumed a target traditional loss ratio (i.e., incurred claims divided by earned premiums) of 80% for the individual market, net of the impact of the ARP, and 80% for the small employer-based market. Under the baseline scenario, we made an adjustment to the target loss ratio for the individual market in 2018 and beyond. The traditional loss ratio noted in Premera's 2017 ACA individual market rate filing was approximately 85%, net of the impact of the ARP. Given that the impact of the ACA Health Insurer Tax (Provision 9010) will be included in the development of rates for 2018 and beyond and that premiums are expected to decrease in 2018 based on emerging 2016 experience, we believe it is reasonable to expect Premera to price to an 80% traditional loss ratio in 2018 and beyond under the waiver scenario. However, in the baseline scenario, our target loss ratio assumes Premera would not apply a non-benefit expense load to the claims that would have otherwise been ceded to the ARP under the waiver scenario. This adjustment causes the target loss ratio under the baseline scenario to be approximately four percentage-points higher relative to the waiver scenario. While we recognize this is not a perfect representation of non-benefit expenses (e.g., some non-benefit expenses are expressed as a percentage of premium), we believe this approach is sufficient for our purposes.

Premiums for the large employer-based market from 2016 through 2026 were also calculated using a loss ratio approach, with an assumed target traditional loss ratio of 85%. For all lines of business, we anticipate the Federal MLR requirements will be met based due to the treatment of Exchange fees, the ACA Health Insurer Tax, and premium taxes in the MLR calculation.

Federal premium tax credits for individual market enrollees were assumed to increase each year, with the Applicable Percentage Table adjusted each year according to the methodology outlined by the Internal Revenue Service (IRS).[19] Premium and income growth rates utilized in developing the Adjustment Ratio that was applied to the projected Applicable Percentage Tables were based on

[18] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/StatePHI-HighlightsMethodsTables.zip

[19] https://www.irs.gov/pub/irs-drop/rp-14-37.pdf

the most recent projections published by NHED. Employee contributions as a percentage of premiums PMPM were projected to remain steady relative to current levels.

The HRM Model assumes transitional plans in the individual and small employer-based markets will no longer be in-force effective January 1, 2018. Additionally, the HRM Model does not account for any employer behavior changes that may occur as a result of the Cadillac tax that is expected to be implemented in the employer-based markets starting in 2020 given the lack of finalized regulations regarding the implementation of the tax. We believe the Cadillac tax will not have a material impact on enrollment in the individual market, given the richness of coverage currently offered in the employer-based market. Over the period covered by the projections, we anticipate employers would most likely select leaner benefit plans, thereby reducing the cost of coverage, rather than electing to drop employer-sponsored coverage.

We have relied on several sources of information made available to us by the Alaska DOI to assess whether the funding level appropriated by the State for calendar year 2017 is sufficient to reimburse all ceded claims. Based on the analyses and information provided, we believe the fund will be exhausted in 2017. Therefore, the HRM Model assumes funding for the ARP will be exhausted each calendar year, and that premium rates will be set accordingly.

4

Modeled Scenarios

To assess the impact the ARP will have on the individual health insurance market in Alaska, we modeled two scenarios: the baseline scenario and the waiver scenario. In both scenarios, the HRM Model was calibrated to reproduce 2015 enrollment by health insurance coverage type, consistent with levels observed in 2015, with the projections for 2016 modeled to closely replicate our expectations for 2016 based on emerging data. In both scenarios, we recognize that the State appropriated $55 million in general funds to the ARP in 2017. Hence, the projections for 2015 through 2017 will be the same between the baseline and waiver scenarios.

Under the baseline scenario, we assume the State will not appropriate funds to the ARP in the fiscal year 2018 budget, meaning insurers will not be able to cede 2018 individual market enrollees to the ARP. Additionally, the baseline scenario assumes the ARP will be allowed to sunset at the end of fiscal year 2018.

Under the waiver scenario, we assume the ARP will be fully funded in 2018 and the legislature will enact new legislation extending the ARP beyond 2018. Funding levels for 2018 and beyond are assumed to be the same as the funding levels dedicated by the State for calendar year 2017; however, our projections incorporate an adjustment to reflect the impact of claim trends. The trend adjustment applied to the initial funding level of $55 million is consistent with the trend adjustment used to project future allowed claim levels. The funding level is not projected to change with changes in enrollment levels. Under the waiver scenario, it is assumed that CMS will partially fund the ARP based on an amount equal to the APTC savings that would be realized by CMS. The State is assumed to fund the remainder of the ARP through the appropriation of general funds.

5

Analysis of Modeling Results

The projections from the HRM Model were analyzed to assess whether the following guardrails will be achieved by the ARP:

- Scope of Coverage: Coverage will be provided to at least as many residents as would be provided absent the ARP
- Affordability of Coverage: Coverage will be at least as affordable as would be provided absent the ARP
- Comprehensiveness of Coverage: Coverage will be at least as comprehensive as would be provided absent the ARP

Each of the three guardrails above were evaluated in aggregate across all enrollees in the State and for various sub-populations, including low-income HIUs and individuals with high health care costs. The three guardrails listed above are consistent with three of the four guardrails a 1332 Waiver is expected to achieve. The fourth guardrail requires a 1332 Waiver not increase the Federal deficit. The analysis related to this guardrail is addressed in a separate report developed by ISER.

In the sub-sections that follow, we discuss the impact the ARP is expected to have on each of the three key requirements of a 1332 Waiver evaluated by the HRM Model noted above. The results of the HRM Model have been summarized in various tables, which are included in Appendix B. As noted earlier, the projections for 2015 through 2017 will be the same between the baseline and waiver scenario given the assumptions are the same between the two scenarios for these years.

Scope of Coverage Requirement

Under the scope of coverage requirement[20], a comparable number of residents must be forecast to have coverage under the waiver as would have coverage absent the waiver. Coverage refers to minimum essential coverage. Comparable means each year the waiver would be in effect, the forecast number of covered individuals with the waiver in place would be no less than the forecast number of covered individuals absent the waiver.

As can be seen in Tables 1 through 6 in Appendix B, enrollment in the individual market decreased in 2016 as a result of large premium increases and the expansion of Medicaid to cover childless adults with incomes of 138% FPL and below. The decrease in the number of uninsured individuals was a result of the expansion of Medicaid. In 2017, all health insurance markets are largely expected to remain unchanged relative to 2016.

In 2018, we project approximately 1,650 additional enrollees will be covered in the individual market under the waiver scenario compared to baseline scenario. As can be seen in Table 3 of Appendix B, and summarized in Table A below, this number is expected to decrease to approximately 750 by 2026.

[20] Waivers for State Innovation, 45 CFR 155

Table A: Individual Membership by Scenario and Year

Year	Baseline	Waiver	Difference
2015	28,159	28,159	-
2016	24,064	24,064	-
2017	23,822	23,822	-
2018	21,253	22,894	1,641
2019	21,993	23,558	1,565
2020	21,773	23,548	1,775
2021	22,176	23,410	1,234
2022	22,656	23,866	1,210
2023	23,539	24,721	1,182
2024	23,713	24,940	1,227
2025	24,196	24,937	741
2026	24,520	25,263	742

Tables 7 through 9, 10 through 12, and 13 through 15 of Appendix B, respectively, show that a majority of the additional enrollees in the waiver scenario in 2018 are expected to have incomes above 400% FPL and are expected to be slightly younger and healthier relative to the individual market in the baseline scenario. These individuals would have otherwise elected to be uninsured in the baseline scenario. Over time, as increases in individual market health insurance premiums exceed changes in the penalty to forgo health insurance coverage, the number of additional enrollees covered under the waiver scenario relative to the baseline scenario will decrease. This results from the youngest and healthiest of those taking up coverage under the waiver scenario in 2018 gradually dropping their health insurance coverage over time; however, overall, the number of individuals covered under the waiver scenario will be greater than under the baseline.

As can be seen in Tables 7 through 9, a small number of subsidized individuals with incomes between 300% and 400% FPL are modeled to become uninsured in the waiver scenario relative to the baseline scenario. The APTC an HIU is eligible to receive is a fixed dollar amount which is a function of the premium for the second lowest cost silver plan and the subsidized premium the HIU is required to pay for that coverage; the APTC the HIU is eligible to receive does not vary based on the plan the HIU chooses to enroll in through the Exchange. Some subsidized individuals are expected to select benefit plans that have a lower premium than the second lowest-cost silver plan. In some instances, the reduction in the APTC the HIU receives in the baseline scenario compared to the waiver scenario does not entirely offset the reduction in observed premium for the selected plan. In these cases the HIU would pay a higher premium, net of APTCs, in the waiver scenario relative to the baseline scenario.[21] Overall, the number of subsidized individuals expected to pay higher premiums in the waiver scenario relative to the baseline scenario will be nominal, and

[21] The following theoretical example, shown for illustrative purposes, demonstrates how the subsidized premium for an HIU may increase in the waiver scenario relative to the baseline scenario. The plan designs are assumed to be the same between the baseline and waiver scenarios. In the baseline scenario, assuming the annual premium of the second lowest-cost silver plan is $10,000 and the maximum annual premium amount the HIU will pay for that plan, after subsidies, is $2,500, the annual APTC in the baseline scenario would be $7,500 (i.e., $10,000 - $2,500). Assuming the annual premium of the lowest-cost bronze plan in the baseline scenario is $7,500, if the HIU elects to enroll in the lowest-cost bronze plan, the HIU's premium, net of APTCs, would be $0. If premiums are reduced 20% in the waiver scenario relative to the baseline scenario, the annualized premium for the second lowest-cost silver plan is reduced to $8,000 and the annualized premium for the lowest-cost bronze plan becomes $6,000. However, because the maximum premium the HIU will pay for the second lowest-cost silver plan does not change (i.e., $2,500), the APTC in the waiver scenario is $5,500 (i.e., $8,000 - $2,500). If the HIU elects to enroll in the lowest-cost bronze plan, the HIU's annual premium, net of APTCs, would be $500. This is a $500 annualized increase from the $0 premium observed in the baseline scenario.

overall, the ARP is expected to increase enrollment in the individual market and reduce the overall number of uninsured individuals. Additionally, for reasons discussed in the Affordability Requirement section, we believe these individuals are likely not "vulnerable" enrollees.[22]

The decrease in individual market enrollment in 2018 for the baseline scenario is largely driven by the phase out of transitional benefit plans at the end of 2017. Premiums for transitional plan enrollees are significantly less than ACA enrollees, mostly due to the preferred health status of the transitional cohort (e.g., fully underwritten). Given the large premium differential, only transitional plan enrollees with costly health conditions are projected to maintain coverage in the baseline scenario. This anti-selection puts further upward pressure on premiums in the individual market in 2018 and beyond under the baseline scenario.

Under the waiver scenario, premiums for ACA compliant policies are projected to decrease in the individual market in 2018 relative to 2017. The decrease in premiums is in part a result of a greater number of transitional plan enrollees switching to ACA compliant coverage in the individual market. Additionally, claims experience through September 2016 suggests emerging experience is more favorable than initially anticipated. Due to these factors, we expect premiums for ACA compliant policies to be reduced by approximately 4% in 2018 for the individual market in order for insurers to maintain an 80% traditional loss ratio target; however, Table 20 shows a slight increase in average premiums PMPM in the entire individual market due to enrollees in transitional policies switching to ACA compliant policies. Premiums for transitional policies are much lower than premiums for ACA compliant policies in 2017, and when transitional policies are eliminated, the average premium across the entire individual market will rise, all else equal.

The employer-based markets are projected to be unchanged between the baseline and waiver scenarios. Over time, we expect the number of individuals enrolled in employer-based coverage to decrease as coverage becomes less affordable, with most of these individuals becoming uninsured due to having incomes that exceed the level at which they would qualify for subsidies. Table B below compares the number of individuals expected to have employer-sponsored coverage under both the baseline and waiver scenarios

Table B: Membership in Employer-Sponsored Coverage by Scenario and Year

Year	Baseline	Waiver	Difference
2015	283,303	283,303	-
2016	280,647	280,647	-
2017	281,293	281,293	-
2018	281,173	281,173	-
2019	280,293	280,293	-
2020	279,115	279,115	-
2021	278,309	278,309	-
2022	277,537	277,537	-
2023	276,759	276,759	-
2024	275,974	275,974	-
2025	275,192	275,192	-
2026	274,374	274,374	-

[22] Based on guidance published by CMS, vulnerable enrollees or residents includes low-income individuals, elderly individuals and individuals with serious health issues or are at risk of developing serious health issues

Affordability Requirement

To meet the affordability requirement, health care coverage must be forecast to be as affordable overall for State residents as coverage absent the waiver. Affordability refers to the ability of State residents to pay for health care, and is measured by comparing their net out-of-pocket spending for health coverage and services to their incomes. Out-of-pocket expenses include premium contributions and any cost-sharing that is the responsibility of the individual.

As can be seen in Tables 19 through 21 of Appendix B, and summarized in Table C that follows, premiums PMPM are expected to be approximately 20% lower in the individual market under the waiver scenario compared to the baseline scenario in 2018. The premium differential PMPM is expected to decrease to 18% by 2026 due to greater aging of the individual market population in the waiver scenario relative to the baseline scenario.

Table C: Average Individual Market Premiums PMPM by Scenario and Year

Year	Baseline	Waiver	Difference
2015	$587	$587	$0
2016	$789	$789	$0
2017	$947	$947	$0
2018	$1,191	$953	($238)
2019	$1,261	$1,011	($250)
2020	$1,360	$1,087	($273)
2021	$1,457	$1,186	($271)
2022	$1,558	$1,275	($282)
2023	$1,657	$1,362	($295)
2024	$1,789	$1,464	($326)
2025	$1,904	$1,563	($341)
2026	$2,034	$1,671	($363)

Individuals with incomes at or below 400% FPL who are enrolled in ACA compliant plans will see very little premium difference under the baseline and waiver scenarios due to the presence of APTCs (i.e., their premiums are a fixed percentage of their income and due to the high premium costs, nearly all individuals with incomes at or below 400% FPL are expected to receive APTCs). Individuals with incomes in excess of 400% FPL will experience premium reductions in the waiver scenario relative to the baseline scenario.

Tables 16 through 18 of Appendix B suggest average member out-of-pocket premium contributions in aggregate for individual market enrollees are increasing in the waiver scenario relative to the baseline scenario. This occurs as a result of more individuals being covered in the waiver scenario; however, Tables 24 through 26 of Appendix B suggest the average member out-of-pocket health care expenditures PMPM (excluding premium contributions) are increasing in the waiver scenario as well. This phenomenon occurs because the additional individuals insured under the waiver scenario are not eligible for subsidies; therefore, with the proportion of the non-subsidized population being higher under the waiver scenario than the baseline, the average insured premium contribution PMPM will increase as well, all else equal.

Tables 22 through 24 of Appendix B show the expected change in aggregate health care expenditures, split by the cost assumed by the insurer, the ARP, and the insured/employee. Average out-of-pocket spending PMPM for health care services for individual market enrollees is expected to increase 1% under the waiver scenario as shown in Tables 25 through 27 of Appendix B. The difference between the two scenarios is expected to grow to almost 9% by 2026. While this may seem counterintuitive, a majority of the additional individuals insured under the waiver scenario

are expected to enroll in bronze-level coverage, resulting in an average benefit level that is slightly less rich in the waiver scenario relative to the baseline scenario. For example, in the baseline scenario, 34% of individual market enrollees are expected to be enrolled in bronze-level coverage in 2026; however, in the waiver scenario, 43% of individual market enrollees are expected to be enrolled in bronze-level coverage.

Tables 28 through 30 of Appendix B summarize the expected change in the insured/employee aggregate out-of-pocket spending, split between premium contributions and out-of-pocket health care expenditure costs PMPM. Tables 31 through 33 of Appendix B show the expected changes on a PMPM basis.

The reduction in premium levels PMPM under the waiver scenario will have important financial implications for the Federal government as a result of changes in APTCs. As shown in Tables 34 through 36 of Appendix B, and summarized in Table D below, APTCs PMPM under the waiver scenario for APTC-eligible enrollees are projected to be approximately 22% lower than the baseline scenario in 2018.

Table D: Average APTCs PMPM by Scenario and Year

Year	Baseline	Waiver	Difference
2015	$538	$538	$0
2016	$750	$750	$0
2017	$990	$990	$0
2018	$1,223	$954	($269)
2019	$1,294	$1,015	($279)
2020	$1,392	$1,094	($299)
2021	$1,497	$1,185	($311)
2022	$1,598	$1,274	($324)
2023	$1,694	$1,354	($340)
2024	$1,824	$1,457	($367)
2025	$1,940	$1,551	($390)
2026	$2,075	$1,659	($416)

We estimate that the existence of a fully-funded ARP will save the Federal government approximately $51.6 million in 2018 due to a reduction in APTCs, with the potential saving projected to grow to $97.6 million dollars in 2026.

Table E: Total APTCs by Scenario and Year

	APTCs		
Year	Baseline	Waiver	Difference
2015	94,468,271	94,468,271	-
2016	135,348,085	135,348,085	-
2017	185,716,278	185,716,278	-
2018	233,898,461	182,260,689	(51,637,772)
2019	258,351,449	202,372,542	(55,978,906)
2020	279,343,570	219,162,267	(60,181,304)
2021	312,617,789	247,210,983	(65,406,805)
2022	342,289,634	272,477,673	(69,811,961)
2023	380,127,501	303,407,137	(76,720,364)
2024	412,662,662	329,994,712	(82,667,950)
2025	449,544,666	359,539,993	(90,004,673)
2026	488,186,123	390,635,284	(97,550,838)

It is important to note that premiums under both scenarios for 2018 and beyond were determined based on the projected claims experience associated with HIUs modeled to take up coverage under each scenario. Under the baseline scenario, anti-selective behavior is projected to occur among individuals who were previously enrolled in transitional plans in 2017, putting upward pressure on the projected individual market rate increase in 2018, all else equal. This results in greater APTC savings than would otherwise be expected assuming the population remained the same in 2017 and 2018. Additionally, it is important to note that the change in APTCs will be leveraged relative to the overall rate change since the subsidized premiums APTC-eligible members pay are indexed to changes in FPL, which is expected to increase at a lower rate than premiums, with APTCs compensating for the difference (e.g., an overall premium rate increase of 20% will result in an APTC change that is greater than 20%).

The aggregate savings expected to be realized by the Federal government are net of any newly enrolled APTC-eligible enrollees (e.g., a greater number of APTC-eligible enrollees will offset some of the APTC savings realized by the Federal government). Given that APTCs will vary by income level, Table 36 in Appendix B shows the projected change in APTCs PMPM for various income ranges to provide greater context regarding the APTC PMPM change, regardless of total enrollment levels. Please note, the APTC PMPM changes shown in Table 36 have not been normalized for differences in age between the baseline and waiver scenarios.

As noted in the Scope of Coverage Requirement section, a small number of subsidy eligible individuals that select a benefit plan that is priced lower than the second lowest-cost silver plan may see a premium increase, net of APTCs, under the waiver scenario, due to the reduction in the dollar amount of the APTC between the baseline and waiver scenarios being greater than the reduction in the non-subsidized premium for the plan in which they enroll in through the Exchange. Based on our calculations, it is anticipated most subsidy eligible individuals will receive an APTC in 2017 and throughout the projection period given how high premium levels are in Alaska in both the baseline and the waiver scenarios.[23] In effect, this causes the subsidized premium amounts for the second lowest-cost silver plan for subsidy eligible individuals to be the same between the two scenarios for most individuals.

APTCs may be applied to any non-catastrophic benefit plan available through the Exchange. Assuming differences in premiums between benefit plans are only due to differences in benefits and induced demand, subsidy eligible individuals enrolling in a benefit plan that is leaner than the second lowest-cost silver plan are more likely to be healthier than average (e.g., the savings in out-of-pocket premium expenditures relative to the second lowest-cost silver plan will exceed the

[23] Individuals with incomes at 400% FPL receive the lowest APTC among subsidy eligible individuals since the maximum premium an individual will pay out-of-pocket is reduced as incomes decrease below 400% FPL. Twenty-one year olds are charged the lowest premium amongst individuals age 21 and older under the 2017 standardized age curve. For 2017, the premium for the second lowest-cost silver plan in the Exchange will be $707 PMPM for a 21 year old in rating area 1, the Alaska rating area with the lowest premiums for the second lowest-cost silver plan. If we assume the FPL limits will increase 2.3% in 2017, consistent with the projected change in CPI-U as published by NHED, the income for an individual at 400% of FPL will translate to $60,725 (i.e., $14,840 * 1.023 * 4.00, where $14,840 is 100% of the 2016 Alaska FPL for a family size of one, 1.023 is the trend factor applied to obtain the 2017 FPL, and 4 is the FPL multiplier), regardless of age since FPLs do not vary by age. The maximum premium PMPM an individual at 400% FPL will pay, net of subsidies, is capped at 9.69% of income, or approximately $490 PMPM (i.e., $60,725 * 0.0969 / 12). The corresponding APTC amount PMPM will be $217 PMPM (i.e., $707 - $490). Please note, the premium PMPM for a dependent-only policy in which the dependent is under the age of 21 and the household income is 400% FPL could produce a premium PMPM that is lower than the “capped” premium amount of $490.

anticipated or perceived difference in out-of-pocket member cost-sharing expenditures). These individuals could potentially pay higher out-of-pocket premiums in the waiver scenario relative to the baseline scenario; however, this is most likely to occur only for individuals with incomes between 250% FPL and 400% FPL, given the availability of CSR plans for individuals with incomes below 250% FPL. Subsidy eligible individuals with significant healthcare expenditures are more likely to "buy up" coverage levels relative to the second lowest-cost silver plan in order to reduce their out-of-pocket cost-sharing expenditures (e.g., the anticipated or perceived reduction in out-of-pocket cost-sharing expenditures will exceed the increase in out-of-pocket premium expenditures). Premiums, net of any subsidies, would be lower in the waiver scenario relative to the baseline scenario for plans that are richer than the second lowest-cost silver plan (i.e., individuals with significant healthcare expenditures could access richer coverage levels at a lower premium in the waiver scenario). Additionally, virtually all individuals with incomes at or below 250% FPL are expected to enroll in CSR plans, which should minimize the potential impact for households with the lowest incomes. Given these expectations, the affordability guardrail is not only met in aggregate but also for the most vulnerable segments of the population.

Comprehensiveness of Coverage Requirement

To meet the comprehensiveness of coverage requirement, health care coverage under the waiver must be forecast to be at least as comprehensive overall for residents of the State as coverage absent the Waiver. Comprehensiveness refers to coverage requirements for ACA essential health benefits (EHBs) and as appropriate, Medicaid and CHIP standards. The 1332 Waiver being sought by the State does not impact EHBs for the commercial markets, and no provisions of this waiver that will impact the scope of services required to be covered by the Medicaid or CHIP programs. Therefore, the comprehensiveness of coverage requirement is expected to remain unchanged across all markets.

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Considerations and Limitations

The State of Alaska, engaged Oliver Wyman Actuarial Consulting, Inc. to assist in performing actuarial analyses as part of their State Innovation Waiver application under Section 1332 of the Patient Protection and Affordable Care Act, also known as a 1332 Waiver. The actuarial services we provided consisted of analyses and forecasting in support of our actuarial certification of compliance with the 1332 Waiver requirements related to scope of coverage, affordability and comprehensiveness of coverage.

This report was prepared for the sole use of the State. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the State. This report is not intended for general circulation or publication, nor is it to be used or distributed to others for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report was issued. The estimates included within are based on regulations issued by the United States Department of Health and Human Services and the applicable laws and regulations of the State of Alaska. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

For our analysis, we relied on a wide range of data and information and other sources of data as described throughout this report. This includes information received from insurers currently offering coverage in the State. Though we have reviewed the data for reasonableness and consistency, we have not independently audited or otherwise verified this data. Our review of data may not reveal errors or imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised.

All projections are based on information and data available as of November 18, 2016, and the projections are not a guarantee of results which might be achieved. In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment, medical trend rates, insurer behavior, the behavior of individuals and employers in light of incentives and penalties, and a number of other factors. These assumptions are disclosed within the report and have been discussed with State of Alaska representatives and other consultants assisting the State. While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

The sources of uncertainty affecting our estimates are numerous and include factors internal and external to the State. The most significant external influences include, but are not limited to, changes in the legal, social, or regulatory environment surrounding the determination of premiums. Uncontrollable factors such as general economic conditions also contribute to the variability.

Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for, legal advice. Accordingly, Oliver Wyman recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

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Distribution and Use

This report was prepared for the sole use of the State of Alaska for the purpose of supporting their 1332 waiver application. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the State.

Oliver Wyman's consent to any distribution of this report (whether herein or in the written agreement pursuant to which this report has been issued) to parties other than the State does not constitute advice by Oliver Wyman to any such third parties and shall be solely for informational purposes and not for purposes of reliance by any such third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

Neither all nor any part of the contents of this report, any opinions expressed herein, or the firm with which this report is connected, shall be disseminated to the public through advertising media, public relations, news media, sales media, mail, direct transmittal, or any other public means of communications, without the prior written consent of Oliver Wyman.

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Actuarial Certification

I, Tammy Tomczyk, am a Fellow in the Society of Actuaries, and a member of the American Academy of Actuaries, and am qualified to provide the following certification.

This actuarial certification applies to the State of Alaska's application for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act. The State is seeking financial assistance from the Federal government to partially fund the Alaska Reinsurance Program. The requested funding levels would be consistent with the Advanced Premium Tax Credit savings the Federal government would have realized assuming the Alaska Reinsurance Program was not funded and allowed to sunset in 2018.

Reliance

In performing the analyses outlined in this report and arriving at my opinion, I used and relied on information provided by the State of Alaska, information obtained from insurers currently offering coverage in the Individual and Small Employer-based markets in Alaska, and additional information published by the Federal government.

I used and relied on this information without independent investigation or audit. If this information is inaccurate, incomplete, or out of date, my findings and conclusions may need to be revised. While I have relied on the data provided without independent investigation or audit, I have reviewed the data for consistency and reasonableness. Where I found the data inconsistent or unreasonable, I requested clarification.

Actuarial Certification

In my opinion, the State of Alaska 1332 Waiver application complies with the following requirements.

- **Scope of Coverage Requirement** – The 1332 Waiver will provide coverage to at least a comparable number of the State's residents as would be provided absent the 1332 Waiver.
- **Affordability Requirement** - The 1332 Waiver will provide coverage and cost-sharing protections against excessive out-of-pocket spending that results in coverage which is at least as affordable for the State's residents as would be provided absent the 1332 Waiver.
- **Comprehensiveness of Coverage Requirement** – The 1332 Waiver will provide coverage that is at least as comprehensive for the State's residents as would be provided absent the 1332 Waiver.

This certification conforms to the applicable Actuarial Standards of Practice promulgated by the Actuarial Standards Board.

Tammy Tomczyk, FSA, FCA, MAAA

November 22, 2016

Date

Appendix A

Oliver Wyman Healthcare Reform Microsimulation Model

The Oliver Wyman Healthcare Reform Microsimulation Model (HRM Model) was used to assess potential premiums and enrollment in Alaska's health insurance markets under two scenarios. This model is a leading edge tool for analyzing the impact of various healthcare reforms or proposed legislation. Economic modeling that captures the flow of individuals across various markets based on their economic purchasing decisions is integrated with actuarial modeling designed to assess the impact various reforms are anticipated to have on the health insurance markets. It is this rare integration of economic and actuarial modeling that allows us to capture the complex migration likely to occur as a result of various market reforms.

The HRM Model has three primary modules. The first module characterizes the current population; the second module calibrates the simulated population to the current market; and the third module projects the simulated population in future years given coverage options, choice and market reforms.

Characterization of the Current Population

In the first module, the population module, the current population was built from several data sources. Data from the 2014 American Community Survey (ACS) was selected as the primary data source and serves as the population basis. The ACS includes information for each respondent's age, gender, income, insurance coverage type, employment status, geographic place of work, geographic place of residence, industry in which he/she is employed, and many other characteristics. The ACS requests information on households, however our model is built on decisions made at the health insurance unit (HIU) level. An HIU is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. Therefore, when preparing the ACS data for our model, it is adjusted to reflect HIUs.

While there are various sources of data that could be used as a primary data source, we chose to rely on the ACS data for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. National analysis of this "Medicaid undercount" indicates that many individuals enrolled in Medicaid report their status as either privately insured or uninsured,[24] and the ACS applies logical edits to the data to adjust for this. Second, the ACS questionnaire includes the question, "Is this person CURRENTLY covered by any…health insurance or health coverage plans?"[25] In contrast, the Current Population Survey (CPS) conducted by the Census Bureau assesses insured status over an entire year. The presentation of the question by ACS is more consistent with the HRM Model since it examines the population at a single point in time. Third, enrollees are legally obligated to respond to the ACS,[26] so the response rate is quite high (i.e., 97% in 2014).[27] Finally, the ACS includes measures that permit the calculation of standard errors from the sample.

The ACS data is supplemented and synthesized with several other data sources in order to approximate the current marketplace. Information from the Medical Expenditure Panel Survey

[24] http://www.shadac.org/publications/snacc-phase-v-report

[25] http://www2.census.gov/programs-surveys/acs/methodology/questionnaires/2014/quest14.pdf

[26] http://www.census.gov/programs-surveys/acs/about/why-was-i-selected.html

[27] https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates/

(MEPS) is used to create the current Alaskan employer market. Individuals identified as working for private employers are randomly categorized into employer group size segment (e.g., small employer groups) based on the distribution of group size using the MEPS data. Information from the insurer/employer component of MEPS is used to determine which employed individuals will be offered insurance coverage. The results from the 2014 MEPS insurance/employer component data were used to establish the distribution of groups by group size (i.e., small employers and large employers) and the rates at which coverage was offered in Alaska at various group sizes. Membership reports from CMS are used to size the current Medicaid and Medicare populations.

Definition of Insurance Coverage Types

Individual

Major medical health insurance coverage purchased by HIUs from health insurers, whether purchased directly from health insurers, through an agent or broker, or via the federal Exchange. This purchasing option is evaluated for all individuals, with the exception of those eligible for Medicare, Medicaid, Military and other government sponsored coverage. Individuals enrolled in transitional and grandfathered plans will be allowed to maintain such coverage as allowed by federal regulations.

Small Employer

Major medical health insurance coverage purchased by small group employers (i.e., employers with 2 to 50 employees) from health insurers, whether purchased directly from health insurers, through an agent or broker, or through the federal SHOP. This includes non-military government employees at the local, state and federal level. This purchasing option is evaluated for an HIU if the primary or spouse is currently employed or is an early retiree (i.e., under the age of 65) according to the employment information on the ACS record. The employer must be identified as offering health insurance coverage to employees in order for the HIU to evaluate employer-based coverage.

Large Employer

Major medical health insurance coverage either purchased by large group employers (i.e., employers with more than 50 employees) from health insurers, whether directly or through an agent or broker, or administered by a third party administrator (TPA). This includes non-military government employees at the local, state and federal level. This purchasing option is evaluated for an HIU if the primary or spouse is currently employed or is an early retiree (i.e., under the age of 65) according to the employment information on the ACS record; however, the employer must be identified as offering health insurance coverage to employees in order for the HIU to evaluate employer-based coverage.

Medicare

All individuals age 65 and older are assumed to be eligible for and enrolled in Medicare. Individuals eligible for Medicare are assumed to remain eligible for Medicare, and no other purchasing options are evaluated for them. In the tables shown in Appendix B, the “Medicare” segment is included in the “Government Coverage” cohort.

Medicaid/CHIP

This purchasing option is evaluated if the requirements for Medicaid eligibility are met based on family income reported on the ACS record. This option is not evaluated for those receiving Military coverage as indicated on their ACS record, regardless of income.

It is important to note that not all individuals eligible for Medicaid or CHIP choose to enroll in such coverage. There any many possible reasons why an individual may choose not to enroll in Medicaid. A Government Accountability Office study found that many do not enroll because of the perceived stigma associated with filing for public assistance.[28] Others may choose not to enroll because they do not need access to medical services. As such, the HRM Model attempts to replicate that not all individuals who qualify for Medicaid or CHIP will elect to be covered under Medicaid or CHIP. In the tables shown in Appendix B, the "Medicaid" segment is included in the "Government Coverage" cohort.

Other Government Coverage
This includes individuals who are enrolled in TRICARE and other military coverage types. HIUs are identified as being eligible for military coverage types based on the ACS data. In the tables shown in Appendix B, the "Other Government Coverage" segment is included in the "Government Coverage" cohort.

Uninsured
Residents who are not covered by any of the health insurance coverage types described above or have coverage that does not comply with the federal minimum essential coverage requirement are considered uninsured.

Health Status
Health status is strategically assigned to various sub-populations based on a statistical analysis of self-reported health status obtained from the CPS. The CPS provides the starting assumptions for the population morbidity because the data includes a self-reported health status indicator as well as fields classifying income, age, gender, coverage type and other categories. Respondents to the survey classify their health into one of five categories: excellent, very good, good, fair and poor. The model reflects these classifications numerically by assigning a morbidity load to each category.

It is important to note that the CPS data lacks credibility for select cohorts by age and gender for Alaska residents. As a result, the HRM Model uses nationwide CPS data as the basis for assigning health status to Alaska enrollees. Additionally, adjustments have been made to the nationwide CPS data to reflect our expectations of market average morbidity. Individual market claims experience through September 2016 suggests newly eligible Medicaid enrollees that were previously insured in the individual market may have had significantly higher morbidity levels than implied by the nationwide CPS data.

Synthetic Insurance Insurers
The HRM Model assumes there will be one insurer in each of the individual, small group and large group health insurance markets. Information obtained from rate filings, the Supplemental Health Care Exhibits, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) were used to determine premium levels in the market and to assess the adequacy of the premium levels from 2015 through 2017.

For the individual market, the HRM Model assumes the synthetic insurer offers select metallic-level plans and one transitional/grandfathered plan. For metallic-level plans, the HRM Model allows individual market enrollees to select between the lowest-cost bronze plan and the lowest and second lowest-cost silver plans available on the individual Exchange. Premiums for gold and platinum metallic-level plans in Alaska have not been included in the HRM Model due to low

[28] http://archive.gao.gov/t2pbat4/150626.pdf

enrollment in these metallic levels. Premiums for the transitional/grandfathered plan are assumed to represent average benefit levels and are based on premiums obtained through rate filings. Additionally, premiums for the transitional/grandfathered plan are assumed to comply with the rating rules of non-ACA plans (e.g., full underwriting, etc.). Individuals modeled to take up individual health insurance coverage are randomly assigned to metallic or transitional/grandfathered coverage, with the distribution of enrollees consistent with the distribution of individual market enrollees observed in 2015 in aggregate and by income range and age group.

For the group health insurance market, the HRM Model assumes the synthetic insurer offers one silver metallic-level plan and one transitional/grandfathered plan for small employer-based coverage. The silver metallic-level plan is based on the lowest-cost silver plan available in the Small Business Health Options Program (SHOP). Premiums for the transitional/grandfathered plan are assumed to represent average benefit levels and are based on premiums obtained through rate filings. Additionally, premiums for the transitional/grandfathered plan are assumed to comply with the rating rules of non-ACA plans (e.g., rating bands, etc.). Individuals working for small employers offering health insurance coverage are randomly assigned metallic or transitional/grandfathered coverage, with the distribution of enrollees consistent with the distribution of small group market enrollees by product type (e.g., metallic) observed in 2015. For large employer-based coverage, the synthetic insurer is assumed to offer one plan that reflects market average benefit and premium levels. It is important to note that premium levels for a given employer-based group will be reflective of the modeled demographic and risk mix, using the demographic information from the ACS data and the assigned health status factors.

Premium levels for 2018 and beyond have been developed using a target loss ratio approach, and assumes the synthetic insurer will price to the following target loss ratios by market:

Health Insurance Market	Traditional Loss Ratio
Individual	80%
Small Employer	80%
Large Employer	85%

The traditional loss ratios for the individual health insurance market have been adjusted in 2015 and 2016 to account for the impact of the temporary federal transitional reinsurance and risk corridor programs. Additionally, in the waiver scenario, the traditional loss ratio for the individual health insurance market was adjusted in 2017 and beyond to be net of any claims ceded to the Alaska Reinsurance Program.

Calibration of the HRM Model

Once the current market landscape is known, the market migration module of the HRM Model is calibrated to reflect the current market landscape. The calibrated market migration module projects the market into which HIUs will enroll, based on the options and corresponding premiums available to them.

The purpose of the calibration is to solve for the model parameters that replicate the characteristics (e.g., size, premium, claims cost, etc.) of the known insurance markets during the base period. This step is critical to ensure that the appropriate utility functions are utilized in the market migration module. While a utility function can model people's desire for consumption of healthcare services, as well as their aversion to financial risk, it cannot predict certain behaviors, such as why people eligible to enroll in Medicaid do not enroll, or why individuals with sufficient financial means to

purchase health insurance chose to be uninsured. It is because of these behaviors that the model calibration is important and necessary.

To perform this calibration, all of the information resulting from the simulation module is considered except the known market in which the individual was enrolled in 2015. Individuals with coverage through Medicare, military coverage and coverage through local, state or Federal government employers were excluded from the calibration, as individuals with these types of coverage are assumed to continue with those coverages throughout the projection. Individuals with Medicaid were also excluded because a majority of individuals with this coverage are also assumed to continue to be covered by Medicaid.

For each of the remaining HIUs, the various coverage options available to them in 2015 are examined and the utility associated with each option is calculated. If the primary and the spouse have access to employer-based coverage, the utility curves assume the HIU would select the lowest-cost premium option. The cost of individual health insurance coverage is calculated for each HIU, including HIUs that have access to employer-based coverage. HIUs with household incomes greater than the Medicaid income requirements are not allowed to evaluate the option of enrolling in Medicaid. Once an HIU has evaluated all premium options, the lowest premium is chosen, and the economic utility is calculated for that coverage and compared to the economic utility of being uninsured. The option with the greatest utility is selected and the HIU is assumed to enroll in that health insurance option.

The results were examined to ensure the appropriate number of people is simulated to have each type of current coverage (e.g., individual, small group, etc.). If the projected enrollment results did not replicate the known 2015 distribution, the various parameters in the utility function were revised until the projected enrollment was consistent with the known enrollment at several key sub-population levels. This step is critical to the modeling as without such calibration the reliability of the results is diminished significantly. The model is calibrated to ensure the known market is replicated at several levels, such as by broad age and income ranges within various markets.

Projection of the Future Populations

Once the model was calibrated, the model is ready to be used to project the markets into which individuals will enroll based on the coverage options available to them, and the resulting premiums for those markets. The process of determining which coverage option each HIU elects to enroll in is based on the application of economic utility maximization. Employers that decide to offer coverage in 2015, the base year, are assumed to continue offering coverage in the future; however, the model will determine whether each HIU with employer-based coverage continues to meet the affordability requirement. The response from employers and individuals to changes in premiums and other financial incentives is a critical element of the model.

The model incorporates the various aspects of the ACA and other economic assumptions that will impact premiums and enrollment. These items include but are not limited to:

- Premium and cost sharing subsidies available to low income individuals
- Individual coverage mandate and penalties for not taking coverage (unless exempt)
- Medicaid eligibility rules, including changes in Medicaid eligibility in Alaska that occurred on September 1, 2015
- Application of an affordability test to determine whether individuals offered employer coverage are eligible for subsidized coverage in the individual Exchange
- Changes in FPL in future years

- Population growth estimates consistent with projections developed by the Alaska Department of Labor and Workforce Development and the NHED
- Medical inflation, adjusted to reflect higher inflation trends in Alaska
- Consumer Price Index for All Urban Consumers (CPI-U) growth consistent with the National Health Expenditure Data (NHED)
- Wage inflation is assumed to be consistent with CPI-U growth
- Income tax rates specific to the state including state, Federal, FICA, and Medicare taxes
- Pent-up demand for newly insured individuals
- Differences in utilization between individuals with insurance and similarly situated individuals without insurance
- An inertia factor to model the likelihood of an individual switching to alternate coverage
- Transitional health benefit plans are assumed to terminate at the end of 2017

The resulting simulated population is input into the calibrated market migration module, and the purchasing decisions for each HIU are modeled each year from 2015 through 2026. Individuals currently enrolled in Medicaid or Medicare, those having coverage through the military and those receiving coverage as a result of being an employee or a dependent of an employee that works for a local government entity or the state or Federal government are assumed to retain that coverage.

Incomes are assumed to increase with annual changes in the CPI-U, consistent with the statutory formula for projecting changes in FPL levels in Alaska. Based on the income, family size and composition of each HIU, income as a percentage of FPL is calculated for each projection year. These FPL percentages are then used for:

- Determining whether the HIU is eligible for Medicaid or children within the HIU are eligible for CHIP
- Determining whether the HIU is eligible for premium subsidies within the Individual Exchange
- Determining whether the HIU is eligible for cost sharing subsidies within the Individual Exchange
- Determining whether the HIU is eligible for exemption from the individual mandate penalty if they elect not to enroll in coverage
- Determining whether the employer-sponsored coverage made available to the HIU is deemed “unaffordable” and as a result the HIU is eligible to enroll in the Individual Exchange and receive premium and potentially cost sharing subsidies

The market migration module evaluates several different options in which the HIU is eligible to enroll. The model calculates the utility for each one of these options. HIUs are only allowed to evaluate employer-sponsored coverage if they are currently enrolled in this market as the model does not assume new offerings of employer-sponsored coverage.

The potential options that are evaluated for each HIU (where eligible) include:

- All individuals in the HIU enroll in employer-sponsored coverage made available by the employer for the year modeled
    - Small employer groups offering transitional or grandfathered coverage will evaluate whether to switch to ACA compliant coverage based on the employer economic utility function, with the employee evaluating the selected premium amounts (net of employer contributions); please note, transitional plans are assumed to terminate at the end of 2017

- All individuals in the HIU enroll in coverage within the Individual Exchange and receive premium subsidies and cost sharing subsidies, where applicable; the metal level purchased in the Individual Exchange will be based on the economic utility associated with the lowest-cost bronze plan and the two lowest-cost silver plans
- All individuals in the HIU enroll in ACA compliant coverage with no subsidies; the metal level purchased will be based on the economic utility associated with the lowest-cost bronze plan and the two lowest-cost silver plans
- All individuals enrolled in transitional or grandfathered plans enroll maintain their current coverage; please note, transitional plans are assumed to terminate at the end of 2017
- All individuals in the HIU elect to remain uninsured

The HRM Model assumes a steady state population. This means the distribution of the overall population by income, gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period. For example, we have not attempted to project rates of employment in 2016 and beyond, but have assumed that rates of employment in 2016 and beyond will be the same as 2015. The steady state population assumptions can be summarized as follows:

- The distribution of the population by income level (i.e. as a percent of FPL) in aggregate remains unchanged. Incomes are modeled to increase each year based on salary inflation assumptions which are consistent with the change in CPI-U
- The population is projected to grow each year, with the population growth varying by type of health insurance coverage. Significant migration of individuals of a specific age or gender into or out of Alaska is not assumed to occur. Instead, the distribution by age and gender changes slightly to reflect the aging of the population in aggregate. This is primarily due to growth in the Medicare cohort exceeding general population growth
- The distribution of the overall population by health status, occupation, and family size are assumed to remain relatively constant through 2026, with the exception of the impact aging of the population will have. The steady state assumption does not mean the health status of specific individuals will remain unchanged over time, only that the overall relative health status by specific subsets of the population (e.g., by FPL and age) do not change. However, as described below, we expect that people will move between various modes of insurance (e.g., small group, individual and uninsured) and that this migration will result in changes to the average morbidity of those markets. Similarly, the family composition of a given household may change; however, it is assumed that the overall distribution of the State's population by family composition does not change

The overall rate of employment over the period between 2016 through 2026 is assumed to be consistent with 2015 employment levels.

HIU Utility

HIUs are assumed to make insurance purchasing decisions by evaluating the various options above and making an economically rational decision to select the option that maximizes the utility for the HIU. The utilities for all members of the HIU are aggregated to develop the corresponding utility for the HIU under that option. The HRM Model assumes the decision to take up coverage is based on the utility of the HIU and does not allow individual members within an HIU to enroll in different markets, with one exception. Individuals eligible for Medicaid and Medicare are assumed to enroll in such coverage and have been removed from the decision-making process for each HIU.

In order to model this behavior, a utility function and the associated parameters were selected. As previously described, the utility function and parameters selected were those that replicated the

status quo upon application of the market migration module to the simulated population. The underlying utility functions utilized are as follows:

$$U1_{i,j} = -E(OOP_{i,j}) - premium_{i,j} - r*VAR(OOP_{i,j}) + u*(H_{i,j})$$

$$U2_{i,j} = -w*E(HEP_{i,j}) - Penalty_i - w*r*VAR(HEP_{i,j}) + \frac{1}{2}*u*(H_{i,j})$$

In the equations above, U1 represents the utility of having health insurance and U2 represents the utility of being uninsured. If U1 is greater than U2, the HIU selects coverage option j. If U1 is smaller than U2, the HIU selects being uninsured. $OOP_{i,j}$ is the out-of-pocket health care expenditures for HIU i under purchasing option j, HEP_i represents the expected health care expenditures to be incurred if the HIU elects to be uninsured, r is the risk aversion coefficient, u is the perceived value of having access to health insurance and $(H_{i,j})$ is the perceived value associated with consuming health services.

In calibrating the model, we elected to vary the parameters r and u at seven different ranges of incomes to reflect the fact that individuals with higher incomes are more risk averse and have different perceptions of accessing health care services. We also varied the parameters for six different age ranges to reflect the fact that individuals with similar incomes may behave differently at different ages. For example, an early retiree with greater accumulated assets drawing income from a lifetime of investments may be more risk averse than a young individual with a similar income but more limited assets. We also applied a separate parameter w for health expenditure for HIUs between Group and Individual coverages to account for higher perceived cost of not having a comprehensive Group coverage versus leaner coverage usually available in the Individual market.

Inertia Factors

In many cases, the evaluation of multiple competing options using the selected utility function results in utility values that are very similar. For example, the utility associated with purchasing Bronze level coverage in the individual market may be only marginally different than the utility associated with being uninsured. From year to year, the impact of medical trend and the change in the penalty under the individual mandate for not taking coverage do not change at the same rate. This can result in individuals alternating back and forth between these two options in subsequent years under a pure utility maximization approach.

Several studies have documented the inertia related to individual decision making, where people elect the status quo even though utility theory indicates it is rational to elect an alternate option.[29, 30] Therefore, to reflect this behavior and add stability to the modeled results, we have built inertia factors into the model.

[29] Su, X. (2009). "A Model of Consumer Inertia with Applications to Dynamic Pricing. Production and Operations Management." 18: 365–380. doi: 10.1111/j.1937-5956.2009.01038.x

[30] "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." Brigitte Madrian and Dennis Shea.

Appendix B

Modeling Results

AK 1332 Waiver Application

Actuarial Analysis and Certification

Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 1 - Alaska Coverage By Category - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Individual Market - Non Native Population	27,402	23,631	23,389	20,818	21,541	21,326	21,720	22,188	23,051	23,220	23,692	24,009
Individual Market - Native Population	757	433	433	435	452	447	457	468	488	492	504	511
Total Individual Market	**28,159**	**24,064**	**23,822**	**21,253**	**21,993**	**21,773**	**22,176**	**22,656**	**23,539**	**23,713**	**24,196**	**24,520**
Employer Based												
Small Group Employer Market	17,370	17,746	16,924	16,426	16,471	16,496	16,511	16,559	16,602	16,637	16,676	16,679
Large Group Employer Market	265,933	262,902	264,368	264,747	263,821	262,620	261,799	260,978	260,157	259,337	258,516	257,695
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
Uninsured - Non Native Population	84,144	73,373	73,530	75,621	76,190	77,615	78,387	79,233	79,632	80,640	81,346	82,055
Uninsured - Native Population	30,370	26,483	26,540	27,294	27,499	28,014	28,292	28,598	28,742	29,106	29,361	29,616
Total Uninsured	**114,515**	**99,856**	**100,070**	**102,915**	**103,689**	**105,629**	**106,679**	**107,831**	**108,374**	**109,746**	**110,707**	**111,671**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: AK DOI, Carrier Survey, CMS Medicare Enrollment, AK Medicaid Enrollment, American Community Survey, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 2 - Alaska Coverage By Category - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Individual Market - Non Native Population	27,402	23,631	23,389	22,422	23,071	23,061	22,926	23,371	24,206	24,420	24,418	24,736
Individual Market - Native Population	757	433	433	472	487	487	484	495	514	519	519	527
Total Individual Market	**28,159**	**24,064**	**23,822**	**22,894**	**23,558**	**23,548**	**23,410**	**23,866**	**24,721**	**24,940**	**24,937**	**25,263**
Employer Based												
Small Group Employer Market	17,370	17,746	16,924	16,426	16,471	16,496	16,511	16,559	16,602	16,637	16,676	16,679
Large Group Employer Market	265,933	262,902	264,368	264,747	263,821	262,620	261,799	260,978	260,157	259,337	258,516	257,695
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
Uninsured - Non Native Population	84,144	73,373	73,530	74,016	74,659	75,880	77,180	78,050	78,476	79,440	80,621	81,328
Uninsured - Native Population	30,370	26,483	26,540	27,257	27,464	27,974	28,265	28,571	28,716	29,079	29,345	29,601
Total Uninsured	**114,515**	**99,856**	**100,070**	**101,274**	**102,124**	**103,854**	**105,445**	**106,622**	**107,192**	**108,519**	**109,966**	**110,929**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: AK DOI, Carrier Survey, CMS Medicare Enrollment, AK Medicaid Enrollment, American Community Survey, Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 3 - Alaska Coverage By Category - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Individual Market - Non Native Population	0	0	0	1,605	1,530	1,735	1,207	1,183	1,156	1,200	725	727
Individual Market - Native Population	0	0	0	37	35	40	27	27	26	27	16	16
Total Individual Market	**0**	**0**	**0**	**1,641**	**1,565**	**1,775**	**1,234**	**1,210**	**1,182**	**1,227**	**741**	**742**
Employer Based												
Small Group Employer Market	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Government Coverage	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Uninsured												
Uninsured - Non Native Population	0	0	0	-1,605	-1,530	-1,735	-1,207	-1,183	-1,156	-1,200	-725	-727
Uninsured - Native Population	0	0	0	-37	-35	-40	-27	-27	-26	-27	-16	-16
Total Uninsured	**0**	**0**	**0**	**-1,641**	**-1,565**	**-1,775**	**-1,234**	**-1,210**	**-1,182**	**-1,227**	**-741**	**-742**
Total AK	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: AK DOI, Carrier Survey, CMS Medicare Enrollment, AK Medicaid Enrollment, American Community Survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 4 - Alaska Coverage Distribution By Category - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Individual Market - Non Native Population	3.71%	3.17%	3.11%	2.74%	2.81%	2.76%	2.79%	2.83%	2.92%	2.92%	2.95%	2.97%
Individual Market - Native Population	0.10%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%
Total Individual Market	**3.81%**	**3.23%**	**3.17%**	**2.80%**	**2.87%**	**2.82%**	**2.85%**	**2.89%**	**2.98%**	**2.98%**	**3.02%**	**3.04%**
Employer Based												
Small Group Employer Market	2.35%	2.38%	2.25%	2.16%	2.15%	2.14%	2.12%	2.11%	2.10%	2.09%	2.08%	2.07%
Large Group Employer Market	36.01%	35.27%	35.15%	34.89%	34.47%	34.02%	33.64%	33.27%	32.91%	32.57%	32.23%	31.91%
Total Employer Based	**38.37%**	**37.66%**	**37.40%**	**37.06%**	**36.62%**	**36.16%**	**35.76%**	**35.38%**	**35.02%**	**34.66%**	**34.31%**	**33.97%**
Total Government Coverage	**42.31%**	**45.72%**	**46.12%**	**46.58%**	**46.96%**	**47.33%**	**47.68%**	**47.98%**	**48.30%**	**48.58%**	**48.87%**	**49.16%**
Uninsured												
Uninsured - Non Native Population	11.39%	9.84%	9.78%	9.97%	9.95%	10.06%	10.07%	10.10%	10.07%	10.13%	10.14%	10.16%
Uninsured - Native Population	4.11%	3.55%	3.53%	3.60%	3.59%	3.63%	3.64%	3.65%	3.64%	3.66%	3.66%	3.67%
Total Uninsured	**15.51%**	**13.40%**	**13.31%**	**13.56%**	**13.55%**	**13.69%**	**13.71%**	**13.75%**	**13.71%**	**13.78%**	**13.80%**	**13.83%**
Total AK	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Sources: AK DOI, Carrier Survey, CMS Medicare Enrollment, AK Medicaid Enrollment, American Community Survey, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 5 - Alaska Coverage Distribution By Category - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Individual Market - Non Native Population	3.71%	3.17%	3.11%	2.96%	3.01%	2.99%	2.95%	2.98%	3.06%	3.07%	3.04%	3.06%
Individual Market - Native Population	0.10%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.07%	0.07%	0.06%	0.07%
Total Individual Market	**3.81%**	**3.23%**	**3.17%**	**3.02%**	**3.08%**	**3.05%**	**3.01%**	**3.04%**	**3.13%**	**3.13%**	**3.11%**	**3.13%**
Employer Based												
Small Group Employer Market	2.35%	2.38%	2.25%	2.16%	2.15%	2.14%	2.12%	2.11%	2.10%	2.09%	2.08%	2.07%
Large Group Employer Market	36.01%	35.27%	35.15%	34.89%	34.47%	34.02%	33.64%	33.27%	32.91%	32.57%	32.23%	31.91%
Total Employer Based	**38.37%**	**37.66%**	**37.40%**	**37.06%**	**36.62%**	**36.16%**	**35.76%**	**35.38%**	**35.02%**	**34.66%**	**34.31%**	**33.97%**
Total Government Coverage	**42.31%**	**45.72%**	**46.12%**	**46.58%**	**46.96%**	**47.33%**	**47.68%**	**47.98%**	**48.30%**	**48.58%**	**48.87%**	**49.16%**
Uninsured												
Uninsured - Non Native Population	11.39%	9.84%	9.78%	9.75%	9.75%	9.83%	9.92%	9.95%	9.93%	9.98%	10.05%	10.07%
Uninsured - Native Population	4.11%	3.55%	3.53%	3.59%	3.59%	3.62%	3.63%	3.64%	3.63%	3.65%	3.66%	3.67%
Total Uninsured	**15.51%**	**13.40%**	**13.31%**	**13.35%**	**13.34%**	**13.46%**	**13.55%**	**13.59%**	**13.56%**	**13.63%**	**13.71%**	**13.74%**
Total AK	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Sources: AK DOI, Carrier Survey, CMS Medicare Enrollment, AK Medicaid Enrollment, American Community Survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 6 - Alaska Coverage Distribution By Category - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Individual Market - Non Native Population	0.00%	0.00%	0.00%	0.21%	0.20%	0.22%	0.16%	0.15%	0.15%	0.15%	0.09%	0.09%
Individual Market - Native Population	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Individual Market	**0.00%**	**0.00%**	**0.00%**	**0.22%**	**0.20%**	**0.23%**	**0.16%**	**0.15%**	**0.15%**	**0.15%**	**0.09%**	**0.09%**
Employer Based												
Small Group Employer Market	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Large Group Employer Market	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Employer Based	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
Total Government Coverage	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
Uninsured												
Uninsured - Non Native Population	0.00%	0.00%	0.00%	-0.21%	-0.20%	-0.22%	-0.16%	-0.15%	-0.15%	-0.15%	-0.09%	-0.09%
Uninsured - Native Population	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Uninsured	**0.00%**	**0.00%**	**0.00%**	**-0.22%**	**-0.20%**	**-0.23%**	**-0.16%**	**-0.15%**	**-0.15%**	**-0.15%**	**-0.09%**	**-0.09%**
Total AK	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**

Sources: AK DOI, Carrier Survey, CMS Medicare Enrollment, AK Medicaid Enrollment, American Community Survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 7 - Alaska Coverage Distribution By Category and Income to Poverty Ratio - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
0% to 199%	10,293	7,262	7,505	7,687	8,281	8,350	8,963	9,090	9,161	9,299	9,352	9,592
200% to 299%	4,279	3,758	3,992	4,077	4,166	4,172	4,236	4,543	5,302	5,314	5,703	5,758
300% to 400%	3,662	4,581	4,547	4,684	4,687	4,698	4,707	4,715	4,716	4,724	4,730	4,735
More than 400%	9,926	8,464	7,778	4,805	4,859	4,553	4,271	4,308	4,359	4,376	4,411	4,435
Total Individual Market	**28,159**	**24,064**	**23,822**	**21,253**	**21,993**	**21,773**	**22,176**	**22,656**	**23,539**	**23,713**	**24,196**	**24,520**
Employer Based												
0% to 199%	35,048	26,119	25,822	26,708	25,274	23,865	22,454	21,499	21,248	20,871	20,455	19,728
200% to 299%	58,220	61,044	61,270	61,029	61,162	61,217	59,789	59,623	59,500	59,371	59,016	58,306
300% to 400%	59,828	60,914	61,139	60,898	61,031	61,086	61,727	61,836	61,709	61,621	61,618	61,813
More than 400%	130,207	132,571	133,062	132,537	132,826	132,946	134,340	134,579	134,302	134,110	134,103	134,527
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Government Coverage												
0% to 199%	204,962	232,562	236,769	241,231	245,304	249,348	253,226	256,861	260,542	264,042	267,503	271,014
200% to 299%	31,623	31,823	32,398	33,009	33,566	34,120	34,650	35,148	35,651	36,130	36,604	37,084
300% to 400%	35,485	35,709	36,355	37,040	37,665	38,286	38,882	39,440	40,005	40,542	41,074	41,613
More than 400%	40,385	40,639	41,374	42,154	42,866	43,573	44,250	44,885	45,529	46,140	46,745	47,359
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
0% to 199%	59,687	41,408	41,310	39,980	40,698	42,089	41,991	43,005	43,758	44,392	45,090	45,412
200% to 299%	38,009	37,863	37,391	37,143	37,128	37,183	38,373	38,382	37,797	38,247	38,307	39,025
300% to 400%	10,415	9,686	9,661	9,562	9,588	9,603	9,416	9,462	9,596	9,699	9,771	9,744
More than 400%	6,403	10,899	11,709	16,230	16,275	16,754	16,900	16,982	17,223	17,408	17,538	17,490
Total Uninsured	**114,515**	**99,856**	**100,070**	**102,915**	**103,689**	**105,629**	**106,679**	**107,831**	**108,374**	**109,746**	**110,707**	**111,671**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: 2014 American Community Survey for AK, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 8 - Alaska Coverage Distribution By Category and Income to Poverty Ratio - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
0% to 199%	10,293	7,262	7,505	7,700	8,294	8,365	8,974	9,101	9,172	9,310	9,359	9,598
200% to 299%	4,279	3,758	3,992	4,083	4,172	4,179	4,241	4,549	5,309	5,320	5,707	5,762
300% to 400%	3,662	4,581	4,547	4,624	4,628	4,637	4,650	4,659	4,661	4,723	4,732	4,737
More than 400%	9,926	8,464	7,778	6,487	6,464	6,366	5,545	5,558	5,579	5,587	5,140	5,165
Total Individual Market	**28,159**	**24,064**	**23,822**	**22,894**	**23,558**	**23,548**	**23,410**	**23,866**	**24,721**	**24,940**	**24,937**	**25,263**
Employer Based												
0% to 199%	35,048	26,119	25,822	26,708	25,274	23,865	22,454	21,499	21,248	20,871	20,455	19,728
200% to 299%	58,220	61,044	61,270	61,029	61,162	61,217	59,789	59,623	59,500	59,371	59,016	58,306
300% to 400%	59,828	60,914	61,139	60,898	61,031	61,086	61,727	61,836	61,709	61,621	61,618	61,813
More than 400%	130,207	132,571	133,062	132,537	132,826	132,946	134,340	134,579	134,302	134,110	134,103	134,527
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Government Coverage												
0% to 199%	204,962	232,562	236,769	241,231	245,304	249,348	253,226	256,861	260,542	264,042	267,503	271,014
200% to 299%	31,623	31,823	32,398	33,009	33,566	34,120	34,650	35,148	35,651	36,130	36,604	37,084
300% to 400%	35,485	35,709	36,355	37,040	37,665	38,286	38,882	39,440	40,005	40,542	41,074	41,613
More than 400%	40,385	40,639	41,374	42,154	42,866	43,573	44,250	44,885	45,529	46,140	46,745	47,359
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
0% to 199%	59,687	41,408	41,310	39,967	40,684	42,074	41,980	42,994	43,747	44,381	45,084	45,406
200% to 299%	38,009	37,863	37,391	37,136	37,121	37,175	38,368	38,377	37,791	38,240	38,303	39,021
300% to 400%	10,415	9,686	9,661	9,622	9,647	9,664	9,472	9,518	9,651	9,700	9,770	9,742
More than 400%	6,403	10,899	11,709	14,548	14,671	14,941	15,625	15,733	16,003	16,197	16,809	16,760
Total Uninsured	**114,515**	**99,856**	**100,070**	**101,274**	**102,124**	**103,854**	**105,445**	**106,622**	**107,192**	**108,519**	**109,966**	**110,929**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: 2014 American Community Survey for AK, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 9 - Alaska Coverage Distribution By Category and Income to Poverty Ratio - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
0% to 199%	0	0	0	13	13	15	11	11	11	11	6	7
200% to 299%	0	0	0	7	7	8	5	5	6	6	4	4
300% to 400%	0	0	0	-61	-59	-61	-57	-56	-55	-1	2	2
More than 400%	0	0	0	1,682	1,604	1,813	1,275	1,250	1,220	1,211	729	730
Total Individual Market	**0**	**0**	**0**	**1,641**	**1,565**	**1,775**	**1,234**	**1,210**	**1,182**	**1,227**	**741**	**742**
Employer Based												
0% to 199%	0	0	0	0	0	0	0	0	0	0	0	0
200% to 299%	0	0	0	0	0	0	0	0	0	0	0	0
300% to 400%	0	0	0	0	0	0	0	0	0	0	0	0
More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Coverage												
0% to 199%	0	0	0	0	0	0	0	0	0	0	0	0
200% to 299%	0	0	0	0	0	0	0	0	0	0	0	0
300% to 400%	0	0	0	0	0	0	0	0	0	0	0	0
More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Government Coverage	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Uninsured												
0% to 199%	0	0	0	-13	-13	-15	-11	-11	-11	-11	-6	-7
200% to 299%	0	0	0	-7	-7	-8	-5	-5	-6	-6	-4	-4
300% to 400%	0	0	0	61	59	61	57	56	55	1	-2	-2
More than 400%	0	0	0	-1,682	-1,604	-1,813	-1,275	-1,250	-1,220	-1,211	-729	-730
Total Uninsured	**0**	**0**	**0**	**-1,641**	**-1,565**	**-1,775**	**-1,234**	**-1,210**	**-1,182**	**-1,227**	**-741**	**-742**
Total AK	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: 2014 American Community Survey for AK, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 10 - Alaska Coverage Distribution By Category and Age - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
0 to 17	3,788	3,155	2,954	2,277	2,341	2,346	2,381	2,489	2,653	2,658	2,661	2,664
18 to 34	7,535	6,513	6,803	5,910	6,377	6,455	6,882	7,000	7,591	7,644	7,688	7,901
35 to 49	6,076	5,205	5,043	4,195	4,229	3,905	3,960	4,163	4,170	4,250	4,637	4,660
50+	10,760	9,190	9,022	8,871	9,047	9,067	8,953	9,005	9,125	9,161	9,210	9,295
Total Individual Market	**28,159**	**24,064**	**23,822**	**21,253**	**21,993**	**21,773**	**22,176**	**22,656**	**23,539**	**23,713**	**24,196**	**24,520**
Employer Based												
0 to 17	70,985	71,964	72,230	71,946	72,102	72,168	72,853	72,983	72,832	72,728	72,725	72,955
18 to 34	69,045	66,979	66,834	66,664	65,926	65,811	63,458	62,977	62,683	62,414	62,132	60,898
35 to 49	72,965	71,467	71,732	72,702	72,835	71,645	72,219	71,800	71,609	71,363	71,308	71,472
50+	70,308	70,237	70,497	69,862	69,429	69,492	69,779	69,779	69,635	69,468	69,027	69,049
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Government Coverage												
0 to 17	127,045	128,804	131,134	133,606	135,861	138,101	140,249	142,262	144,301	146,239	148,156	150,101
18 to 34	51,784	65,358	66,540	67,794	68,939	70,075	71,165	72,187	73,221	74,205	75,177	76,164
35 to 49	33,503	38,479	39,175	39,914	40,588	41,257	41,898	42,500	43,109	43,688	44,261	44,841
50+	100,123	108,092	110,047	112,121	114,014	115,894	117,696	119,386	121,096	122,723	124,332	125,964
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
0 to 17	14,585	15,234	15,441	16,394	16,354	16,379	16,087	16,027	16,033	16,205	16,326	16,281
18 to 34	48,812	38,711	38,528	39,717	40,071	40,217	41,807	42,443	42,407	42,987	43,538	44,559
35 to 49	21,476	20,483	20,601	20,587	20,626	22,356	22,028	22,402	22,753	23,040	22,738	22,712
50+	29,642	25,428	25,499	26,217	26,637	26,677	26,757	26,960	27,182	27,514	28,105	28,119
Total Uninsured	**114,515**	**99,856**	**100,070**	**102,915**	**103,689**	**105,629**	**106,679**	**107,831**	**108,374**	**109,746**	**110,707**	**111,671**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: 2014 American Community Survey for AK, Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 11 - Alaska Coverage Distribution By Category and Age - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
0 to 17	3,788	3,155	2,954	2,324	2,389	2,394	2,423	2,531	2,652	2,657	2,662	2,665
18 to 34	7,535	6,513	6,803	6,783	7,252	7,329	6,854	6,943	7,545	7,641	7,691	7,904
35 to 49	6,076	5,205	5,043	4,446	4,482	4,372	4,432	4,637	4,645	4,726	4,781	4,804
50+	10,760	9,190	9,022	9,341	9,435	9,453	9,702	9,756	9,879	9,916	9,803	9,889
Total Individual Market	**28,159**	**24,064**	**23,822**	**22,894**	**23,558**	**23,548**	**23,410**	**23,866**	**24,721**	**24,940**	**24,937**	**25,263**
Employer Based												
0 to 17	70,985	71,964	72,230	71,946	72,102	72,168	72,853	72,983	72,832	72,728	72,725	72,955
18 to 34	69,045	66,979	66,834	66,664	65,926	65,811	63,458	62,977	62,683	62,414	62,132	60,898
35 to 49	72,965	71,467	71,732	72,702	72,835	71,645	72,219	71,800	71,609	71,363	71,308	71,472
50+	70,308	70,237	70,497	69,862	69,429	69,492	69,779	69,779	69,635	69,468	69,027	69,049
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Government Coverage												
0 to 17	127,045	128,804	131,134	133,606	135,861	138,101	140,249	142,262	144,301	146,239	148,156	150,101
18 to 34	51,784	65,358	66,540	67,794	68,939	70,075	71,165	72,187	73,221	74,205	75,177	76,164
35 to 49	33,503	38,479	39,175	39,914	40,588	41,257	41,898	42,500	43,109	43,688	44,261	44,841
50+	100,123	108,092	110,047	112,121	114,014	115,894	117,696	119,386	121,096	122,723	124,332	125,964
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
0 to 17	14,585	15,234	15,441	16,346	16,306	16,331	16,046	15,986	16,034	16,206	16,325	16,280
18 to 34	48,812	38,711	38,528	38,844	39,196	39,343	41,836	42,500	42,453	42,989	43,535	44,556
35 to 49	21,476	20,483	20,601	20,336	20,373	21,889	21,556	21,928	22,278	22,564	22,595	22,568
50+	29,642	25,428	25,499	25,747	26,249	26,291	26,008	26,208	26,428	26,760	27,512	27,525
Total Uninsured	**114,515**	**99,856**	**100,070**	**101,274**	**102,124**	**103,854**	**105,445**	**106,622**	**107,192**	**108,519**	**109,966**	**110,929**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: 2014 American Community Survey for AK, Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 12 - Alaska Coverage Distribution By Category and Age - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
0 to 17	0	0	0	48	49	48	41	42	-1	-1	1	1
18 to 34	0	0	0	873	875	874	-28	-57	-46	-2	3	3
35 to 49	0	0	0	251	253	467	472	474	475	476	144	144
50+	0	0	0	470	388	385	749	751	754	755	593	594
Total Individual Market	**0**	**0**	**0**	**1,641**	**1,565**	**1,775**	**1,234**	**1,210**	**1,182**	**1,227**	**741**	**742**
Employer Based												
0 to 17	0	0	0	0	0	0	0	0	0	0	0	0
18 to 34	0	0	0	0	0	0	0	0	0	0	0	0
35 to 49	0	0	0	0	0	0	0	0	0	0	0	0
50+	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Coverage												
0 to 17	0	0	0	0	0	0	0	0	0	0	0	0
18 to 34	0	0	0	0	0	0	0	0	0	0	0	0
35 to 49	0	0	0	0	0	0	0	0	0	0	0	0
50+	0	0	0	0	0	0	0	0	0	0	0	0
Total Government Coverage	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Uninsured												
0 to 17	0	0	0	-48	-49	-48	-41	-42	1	1	-1	-1
18 to 34	0	0	0	-873	-875	-874	28	57	46	2	-3	-3
35 to 49	0	0	0	-251	-253	-467	-472	-474	-475	-476	-144	-144
50+	0	0	0	-470	-388	-385	-749	-751	-754	-755	-593	-594
Total Uninsured	**0**	**0**	**0**	**-1,641**	**-1,565**	**-1,775**	**-1,234**	**-1,210**	**-1,182**	**-1,227**	**-741**	**-742**
Total AK	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: 2014 American Community Survey for AK, Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 13 - Alaska Coverage Distribution By Category and Health Status - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Excellent	8,739	7,233	6,811	6,244	6,751	6,496	6,618	6,828	7,545	7,646	8,021	8,083
Very Good	7,742	6,357	6,370	4,694	4,719	4,730	4,907	5,017	5,025	5,053	5,075	5,104
Good	8,088	7,606	7,811	7,331	7,530	7,547	7,599	7,754	7,921	7,960	8,042	8,094
Fair	2,321	2,406	2,388	2,363	2,372	2,378	2,428	2,432	2,433	2,437	2,440	2,622
Poor	1,268	462	441	621	621	622	624	625	615	616	617	618
Total Individual Market	**28,159**	**24,064**	**23,822**	**21,253**	**21,993**	**21,773**	**22,176**	**22,656**	**23,539**	**23,713**	**24,196**	**24,520**
Employer Based												
Excellent	107,311	106,676	107,070	106,649	106,042	106,138	106,205	105,337	105,120	104,776	104,770	105,010
Very Good	87,263	89,596	89,745	89,464	89,615	89,521	87,934	87,966	87,764	87,527	87,299	87,493
Good	65,842	62,765	62,787	63,792	63,346	62,147	62,729	62,756	62,462	62,288	61,793	61,090
Fair	16,873	16,114	16,173	16,110	16,120	16,134	16,212	16,241	16,207	16,184	16,131	15,566
Poor	6,014	5,497	5,517	5,159	5,170	5,175	5,229	5,239	5,206	5,199	5,198	5,215
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Government Coverage												
Excellent	87,751	96,100	97,839	99,683	101,366	103,037	104,639	106,141	107,662	109,109	110,539	111,990
Very Good	95,839	101,898	103,741	105,697	107,481	109,253	110,952	112,545	114,157	115,691	117,208	118,746
Good	77,789	86,106	87,664	89,316	90,824	92,321	93,757	95,103	96,466	97,762	99,043	100,343
Fair	35,241	38,680	39,379	40,122	40,799	41,471	42,116	42,721	43,333	43,915	44,491	45,075
Poor	15,835	17,949	18,274	18,618	18,932	19,244	19,544	19,824	20,108	20,378	20,646	20,917
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
Excellent	39,224	35,742	36,160	37,005	37,253	37,676	37,802	38,741	38,321	38,805	38,590	38,503
Very Good	31,701	27,409	27,434	29,729	29,825	30,043	31,662	31,801	32,264	32,695	33,141	33,098
Good	29,765	26,179	25,955	25,494	25,879	27,163	26,651	26,673	26,988	27,329	27,924	28,682
Fair	10,163	7,487	7,467	7,541	7,577	7,588	7,467	7,503	7,609	7,691	7,801	8,147
Poor	3,661	3,040	3,055	3,146	3,155	3,160	3,098	3,113	3,192	3,226	3,250	3,241
Total Uninsured	**114,515**	**99,856**	**100,070**	**102,915**	**103,689**	**105,629**	**106,679**	**107,831**	**108,374**	**109,746**	**110,707**	**111,671**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: Current Population Survey, 2015 Annual Social and Economic (ASEC) Supplement; Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 14 - Alaska Coverage Distribution By Category and Health Status - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Excellent	8,739	7,233	6,811	6,465	6,974	6,933	7,205	7,416	8,135	8,290	8,167	8,229
Very Good	7,742	6,357	6,370	5,847	5,790	5,801	5,286	5,397	5,363	5,392	5,418	5,448
Good	8,088	7,606	7,811	7,534	7,736	7,750	7,801	7,928	8,097	8,136	8,224	8,276
Fair	2,321	2,406	2,388	2,429	2,438	2,443	2,496	2,501	2,502	2,506	2,511	2,692
Poor	1,268	462	441	620	620	621	623	624	625	616	617	618
Total Individual Market	**28,159**	**24,064**	**23,822**	**22,894**	**23,558**	**23,548**	**23,410**	**23,866**	**24,721**	**24,940**	**24,937**	**25,263**
Employer Based												
Excellent	107,311	106,676	107,070	106,649	106,042	106,138	106,205	105,337	105,120	104,776	104,770	105,010
Very Good	87,263	89,596	89,745	89,464	89,615	89,521	87,934	87,966	87,764	87,527	87,299	87,493
Good	65,842	62,765	62,787	63,792	63,346	62,147	62,729	62,756	62,462	62,288	61,793	61,090
Fair	16,873	16,114	16,173	16,110	16,120	16,134	16,212	16,241	16,207	16,184	16,131	15,566
Poor	6,014	5,497	5,517	5,159	5,170	5,175	5,229	5,239	5,206	5,199	5,198	5,215
Total Employer Based	**283,303**	**280,647**	**281,293**	**281,173**	**280,293**	**279,115**	**278,309**	**277,537**	**276,759**	**275,974**	**275,192**	**274,374**
Government Coverage												
Excellent	87,751	96,100	97,839	99,683	101,366	103,037	104,639	106,141	107,662	109,109	110,539	111,990
Very Good	95,839	101,898	103,741	105,697	107,481	109,253	110,952	112,545	114,157	115,691	117,208	118,746
Good	77,789	86,106	87,664	89,316	90,824	92,321	93,757	95,103	96,466	97,762	99,043	100,343
Fair	35,241	38,680	39,379	40,122	40,799	41,471	42,116	42,721	43,333	43,915	44,491	45,075
Poor	15,835	17,949	18,274	18,618	18,932	19,244	19,544	19,824	20,108	20,378	20,646	20,917
Total Government Coverage	**312,455**	**340,732**	**346,896**	**353,434**	**359,402**	**365,326**	**371,008**	**376,335**	**381,727**	**386,855**	**391,926**	**397,070**
Uninsured												
Excellent	39,224	35,742	36,160	36,783	37,030	37,239	37,216	38,152	37,731	38,161	38,444	38,356
Very Good	31,701	27,409	27,434	28,576	28,754	28,972	31,283	31,421	31,926	32,356	32,798	32,755
Good	29,765	26,179	25,955	25,291	25,674	26,960	26,449	26,500	26,813	27,153	27,743	28,500
Fair	10,163	7,487	7,467	7,476	7,510	7,523	7,399	7,435	7,541	7,622	7,731	8,076
Poor	3,661	3,040	3,055	3,147	3,156	3,161	3,099	3,114	3,182	3,226	3,250	3,241
Total Uninsured	**114,515**	**99,856**	**100,070**	**101,274**	**102,124**	**103,854**	**105,445**	**106,622**	**107,192**	**108,519**	**109,966**	**110,929**
Total AK	**738,432**	**745,299**	**752,082**	**758,775**	**765,377**	**771,844**	**778,173**	**784,360**	**790,399**	**796,288**	**802,021**	**807,635**

Sources: Current Population Survey, 2015 Annual Social and Economic (ASEC) Supplement; Oliver Wyman Healthcare Reform Microsimulation Model.

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Coverage Requirement

A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver.

Table 15 - Alaska Coverage Distribution By Category and Health Status - Change from Baseline to Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market												
Excellent	0	0	0	222	224	437	586	588	590	645	146	146
Very Good	0	0	0	1,153	1,071	1,071	378	380	338	338	343	343
Good	0	0	0	203	206	203	202	174	175	175	181	182
Fair	0	0	0	65	66	65	68	68	69	69	71	71
Poor	0	0	0	-1	-1	-1	0	0	9	0	0	0
Total Individual Market	**0**	**0**	**0**	**1,641**	**1,565**	**1,775**	**1,234**	**1,210**	**1,182**	**1,227**	**741**	**742**
Employer Based												
Excellent	0	0	0	0	0	0	0	0	0	0	0	0
Very Good	0	0	0	0	0	0	0	0	0	0	0	0
Good	0	0	0	0	0	0	0	0	0	0	0	0
Fair	0	0	0	0	0	0	0	0	0	0	0	0
Poor	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Coverage												
Excellent	0	0	0	0	0	0	0	0	0	0	0	0
Very Good	0	0	0	0	0	0	0	0	0	0	0	0
Good	0	0	0	0	0	0	0	0	0	0	0	0
Fair	0	0	0	0	0	0	0	0	0	0	0	0
Poor	0	0	0	0	0	0	0	0	0	0	0	0
Total Government Coverage	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Uninsured												
Excellent	0	0	0	-222	-224	-437	-586	-588	-590	-645	-146	-146
Very Good	0	0	0	-1,153	-1,071	-1,071	-378	-380	-338	-338	-343	-343
Good	0	0	0	-203	-206	-203	-202	-174	-175	-175	-181	-182
Fair	0	0	0	-65	-66	-65	-68	-68	-69	-69	-71	-71
Poor	0	0	0	1	1	1	0	0	-9	0	0	0
Total Uninsured	**0**	**0**	**0**	**-1,641**	**-1,565**	**-1,775**	**-1,234**	**-1,210**	**-1,182**	**-1,227**	**-741**	**-742**
Total AK	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Current Population Survey, 2015 Annual Social and Economic (ASEC) Supplement; Oliver Wyman Healthcare Reform Microsimulation Model.

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Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 16 - Alaska Premium Contribution - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Other (APTC)	94,468,271	135,348,085	185,716,278	233,898,461	258,351,449	279,343,570	312,617,789	342,289,634	380,127,501	412,662,662	449,544,666	488,186,123
Individual Market	Insured Contribution	103,747,964	92,418,138	84,903,527	69,973,761	74,513,114	76,066,237	75,127,736	81,235,397	87,809,785	96,476,384	103,294,375	110,286,692
Total Individual Market	**Total**	**198,216,235**	**227,766,223**	**270,619,805**	**303,872,222**	**332,864,563**	**355,409,807**	**387,745,525**	**423,525,031**	**467,937,286**	**509,139,047**	**552,839,041**	**598,472,814**
Employer Based													
Small Group Employer Market	Employer + Other	111,536,276	118,279,134	129,054,628	138,310,776	149,559,397	159,976,982	173,609,361	187,762,816	202,797,524	218,727,421	235,735,125	253,046,732
Small Group Employer Market	Employee	22,216,324	24,358,415	25,559,606	27,451,869	29,684,467	31,752,323	34,418,137	37,224,292	40,204,561	43,362,831	46,734,491	50,174,779
Small Group Employer Market	Total	133,752,599	142,637,549	154,614,234	165,762,644	179,243,864	191,729,305	208,027,498	224,987,108	243,002,085	262,090,252	282,469,616	303,221,512
Large Group Employer Market	Employer + Other	1,581,635,579	1,793,611,404	1,925,307,631	2,076,727,324	2,226,012,317	2,363,883,724	2,557,165,384	2,744,670,840	2,946,674,596	3,160,132,736	3,384,262,810	3,621,047,702
Large Group Employer Market	Employee	410,202,083	465,178,669	498,606,089	539,470,525	581,618,338	618,927,589	665,986,818	717,751,103	770,927,936	826,903,693	886,192,802	949,435,015
Large Group Employer Market	Total	1,991,837,662	2,258,790,074	2,423,913,720	2,616,197,849	2,807,630,655	2,982,811,313	3,223,152,202	3,462,421,944	3,717,602,532	3,987,036,429	4,270,455,613	4,570,482,717
Total Employer Based	**Employer + Other**	**1,693,171,855**	**1,911,890,539**	**2,054,362,259**	**2,215,038,099**	**2,375,571,714**	**2,523,860,706**	**2,730,774,745**	**2,932,433,657**	**3,149,472,120**	**3,378,860,158**	**3,619,997,935**	**3,874,094,434**
Total Employer Based	**Employee**	**432,418,407**	**489,537,085**	**524,165,695**	**566,922,394**	**611,302,805**	**650,679,912**	**700,404,955**	**754,975,395**	**811,132,497**	**870,266,524**	**932,927,294**	**999,609,795**
Total Employer Based	**Total**	**2,125,590,262**	**2,401,427,623**	**2,578,527,954**	**2,781,960,493**	**2,986,874,519**	**3,174,540,618**	**3,431,179,700**	**3,687,409,052**	**3,960,604,617**	**4,249,126,682**	**4,552,925,229**	**4,873,704,229**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 17 - Alaska Premium Contribution - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Other (APTC)	94,468,271	135,348,085	185,716,278	182,260,689	202,372,542	219,162,267	247,210,983	272,477,673	303,407,137	329,994,712	359,539,993	390,635,284
Individual Market	Insured Contribution	103,747,964	92,418,138	84,903,527	79,559,167	83,397,983	87,941,611	86,096,017	92,771,610	100,543,268	108,069,560	108,180,968	115,862,686
Total Individual Market	**Total**	**198,216,235**	**227,766,223**	**270,619,805**	**261,819,856**	**285,770,525**	**307,103,878**	**333,307,000**	**365,249,283**	**403,950,405**	**438,064,272**	**467,720,961**	**506,497,970**
Employer Based													
Small Group Employer Market	Employer + Other	111,536,276	118,279,134	129,054,628	138,310,776	149,559,397	159,976,982	173,609,361	187,762,816	202,797,524	218,727,421	235,735,125	253,046,732
Small Group Employer Market	Employee	22,216,324	24,358,415	25,559,606	27,451,869	29,684,467	31,752,323	34,418,137	37,224,292	40,204,561	43,362,831	46,734,491	50,174,779
Small Group Employer Market	Total	133,752,599	142,637,549	154,614,234	165,762,644	179,243,864	191,729,305	208,027,498	224,987,108	243,002,085	262,090,252	282,469,616	303,221,512
Large Group Employer Market	Employer + Other	1,581,635,579	1,793,611,404	1,925,307,631	2,076,727,324	2,226,012,317	2,363,883,724	2,557,165,384	2,744,670,840	2,946,674,596	3,160,132,736	3,384,262,810	3,621,047,702
Large Group Employer Market	Employee	410,202,083	465,178,669	498,606,089	539,470,525	581,618,338	618,927,589	665,986,818	717,751,103	770,927,936	826,903,693	886,192,802	949,435,015
Large Group Employer Market	Total	1,991,837,662	2,258,790,074	2,423,913,720	2,616,197,849	2,807,630,655	2,982,811,313	3,223,152,202	3,462,421,944	3,717,602,532	3,987,036,429	4,270,455,613	4,570,482,717
Total Employer Based	**Employer + Other**	**1,693,171,855**	**1,911,890,539**	**2,054,362,259**	**2,215,038,099**	**2,375,571,714**	**2,523,860,706**	**2,730,774,745**	**2,932,433,657**	**3,149,472,120**	**3,378,860,158**	**3,619,997,935**	**3,874,094,434**
Total Employer Based	**Employee**	**432,418,407**	**489,537,085**	**524,165,695**	**566,922,394**	**611,302,805**	**650,679,912**	**700,404,955**	**754,975,395**	**811,132,497**	**870,266,524**	**932,927,294**	**999,609,795**
Total Employer Based	**Total**	**2,125,590,262**	**2,401,427,623**	**2,578,527,954**	**2,781,960,493**	**2,986,874,519**	**3,174,540,618**	**3,431,179,700**	**3,687,409,052**	**3,960,604,617**	**4,249,126,682**	**4,552,925,229**	**4,873,704,229**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 18 - Alaska Premium Contribution - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Other (APTC)	0	0	0	(51,637,772)	(55,978,906)	(60,181,304)	(65,406,805)	(69,811,961)	(76,720,364)	(82,667,950)	(90,004,673)	(97,550,838)
Individual Market	Insured Contribution	0	0	0	9,585,406	8,884,869	11,875,374	10,968,281	11,536,213	12,733,482	11,593,175	4,886,593	5,575,995
Total Individual Market	**Total**	**0**	**0**	**0**	**(42,052,366)**	**(47,094,038)**	**(48,305,929)**	**(54,438,525)**	**(58,275,748)**	**(63,986,881)**	**(71,074,774)**	**(85,118,080)**	**(91,974,844)**
Employer Based													
Small Group Employer Market	Employer + Other	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Employee	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employer + Other	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**Employer + Other**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Employee**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 19 - Alaska Premium Contribution PMPM - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Other (APTC)	280	469	650	917	979	1,069	1,175	1,259	1,346	1,450	1,548	1,659
Individual Market	Insured Contribution	307	320	297	274	282	291	282	299	311	339	356	375
Total Individual Market	**Total**	**587**	**789**	**947**	**1,191**	**1,261**	**1,360**	**1,457**	**1,558**	**1,657**	**1,789**	**1,904**	**2,034**
Employer Based													
Small Group Employer Market	Employer + Other	535	555	635	702	757	808	876	945	1,018	1,096	1,178	1,264
Small Group Employer Market	Employee	107	114	126	139	150	160	174	187	202	217	234	251
Small Group Employer Market	Total	642	670	761	841	907	969	1,050	1,132	1,220	1,313	1,412	1,515
Large Group Employer Market	Employer + Other	496	569	607	654	703	750	814	876	944	1,015	1,091	1,171
Large Group Employer Market	Employee	129	147	157	170	184	196	212	229	247	266	286	307
Large Group Employer Market	Total	624	716	764	823	887	946	1,026	1,106	1,191	1,281	1,377	1,478
Total Employer Based	**Employer + Other**	**498**	**568**	**609**	**656**	**706**	**754**	**818**	**880**	**948**	**1,020**	**1,096**	**1,177**
Total Employer Based	**Employee**	**127**	**145**	**155**	**168**	**182**	**194**	**210**	**227**	**244**	**263**	**283**	**304**
Total Employer Based	**Total**	**625**	**713**	**764**	**825**	**888**	**948**	**1,027**	**1,107**	**1,193**	**1,283**	**1,379**	**1,480**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 20 - Alaska Premium Contribution PMPM - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Other (APTC)	280	469	650	663	716	776	880	951	1,023	1,103	1,201	1,289
Individual Market	Insured Contribution	307	320	297	290	295	311	306	324	339	361	362	382
Total Individual Market	**Total**	**587**	**789**	**947**	**953**	**1,011**	**1,087**	**1,186**	**1,275**	**1,362**	**1,464**	**1,563**	**1,671**
Employer Based													
Small Group Employer Market	Employer + Other	535	555	635	702	757	808	876	945	1,018	1,096	1,178	1,264
Small Group Employer Market	Employee	107	114	126	139	150	160	174	187	202	217	234	251
Small Group Employer Market	Total	642	670	761	841	907	969	1,050	1,132	1,220	1,313	1,412	1,515
Large Group Employer Market	Employer + Other	496	569	607	654	703	750	814	876	944	1,015	1,091	1,171
Large Group Employer Market	Employee	129	147	157	170	184	196	212	229	247	266	286	307
Large Group Employer Market	Total	624	716	764	823	887	946	1,026	1,106	1,191	1,281	1,377	1,478
Total Employer Based	**Employer + Other**	**498**	**568**	**609**	**656**	**706**	**754**	**818**	**880**	**948**	**1,020**	**1,096**	**1,177**
Total Employer Based	**Employee**	**127**	**145**	**155**	**168**	**182**	**194**	**210**	**227**	**244**	**263**	**283**	**304**
Total Employer Based	**Total**	**625**	**713**	**764**	**825**	**888**	**948**	**1,027**	**1,107**	**1,193**	**1,283**	**1,379**	**1,480**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 21 - Alaska Premium Contribution PMPM - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Other (APTC)	0	0	0	(254)	(263)	(294)	(295)	(308)	(323)	(348)	(347)	(371)
Individual Market	Insured Contribution	0	0	0	15	13	20	24	25	28	22	6	7
Total Individual Market	**Total**	**0**	**0**	**0**	**(238)**	**(250)**	**(273)**	**(271)**	**(282)**	**(295)**	**(326)**	**(341)**	**(363)**
Employer Based													
Small Group Employer Market	Employer + Other	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Employee	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employer + Other	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**Employer + Other**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Employee**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 22 - Alaska Health Expenditure Source of Funds - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insurer & Other (e.g., CSRs)	205,342,737	187,872,747	174,120,595	254,131,054	278,604,608	299,126,027	327,276,893	357,235,621	392,017,363	425,409,584	460,107,208	497,721,537
Individual Market	AK Reinsurance Fund	0	0	55,000,000	0	0	0	0	0	0	0	0	0
Individual Market	Insured Out-of-Pocket	57,248,085	53,252,906	59,479,345	60,502,780	64,836,384	68,580,131	73,061,038	78,531,359	86,984,082	87,673,653	95,009,818	101,945,266
Total Individual Market	**Total**	**262,590,821**	**241,125,653**	**288,599,940**	**314,633,834**	**343,440,992**	**367,706,159**	**400,337,931**	**435,766,979**	**479,001,445**	**513,083,237**	**555,117,026**	**599,666,803**
Employer Based													
Small Group Employer Market	Insurer	117,787,157	123,245,446	125,870,738	132,853,522	143,532,769	153,657,742	166,377,073	180,299,467	194,741,190	210,106,573	226,019,395	243,239,861
Small Group Employer Market	Employee Out-of-Pocket	45,620,766	48,337,876	49,150,697	54,240,198	58,607,744	62,746,308	67,943,038	73,638,478	79,546,153	85,830,754	92,341,084	99,377,345
Small Group Employer Market	Total	163,407,923	171,583,322	175,021,436	187,093,720	202,140,513	216,404,049	234,320,111	253,937,945	274,287,343	295,937,327	318,360,479	342,617,206
Large Group Employer Market	Insurer	1,830,256,795	1,919,618,451	2,069,212,264	2,228,610,480	2,392,601,208	2,545,875,734	2,745,533,528	2,957,112,597	3,175,682,728	3,408,149,381	3,646,097,176	3,910,759,518
Large Group Employer Market	Employee Out-of-Pocket	375,106,260	393,220,268	423,863,503	456,515,101	490,107,442	521,504,645	562,403,133	605,743,609	650,516,155	698,135,306	746,877,229	801,091,439
Large Group Employer Market	Total	2,205,363,055	2,312,838,720	2,493,075,767	2,685,125,580	2,882,708,651	3,067,380,379	3,307,936,661	3,562,856,206	3,826,198,883	4,106,284,687	4,392,974,405	4,711,850,957
Total Employer Based	**Insurer**	**1,948,043,952**	**2,042,863,898**	**2,195,083,002**	**2,361,464,001**	**2,536,133,978**	**2,699,533,476**	**2,911,910,601**	**3,137,412,065**	**3,370,423,918**	**3,618,255,954**	**3,872,116,571**	**4,153,999,380**
Total Employer Based	**Employee Out-of-Pocket**	**420,727,026**	**441,558,144**	**473,014,201**	**510,755,299**	**548,715,186**	**584,250,953**	**630,346,171**	**679,382,087**	**730,062,308**	**783,966,060**	**839,218,313**	**900,468,783**
Total Employer Based	**Total**	**2,368,770,978**	**2,484,422,042**	**2,668,097,203**	**2,872,219,300**	**3,084,849,163**	**3,283,784,429**	**3,542,256,772**	**3,816,794,152**	**4,100,486,226**	**4,402,222,014**	**4,711,334,884**	**5,054,468,163**

Sources: Carrier survey, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 23 - Alaska Health Expenditure Source of Funds - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insurer & Other (e.g., CSRs)	205,342,737	187,872,747	174,120,595	208,645,078	228,388,683	245,640,146	268,069,862	293,301,021	323,769,458	350,223,214	375,550,008	407,261,333
Individual Market	AK Reinsurance Fund	0	0	55,000,000	59,983,000	64,126,326	68,950,229	74,137,010	79,789,956	85,873,941	92,333,808	98,711,766	105,530,281
Individual Market	Insured Out-of-Pocket	57,248,085	53,252,906	59,479,345	65,919,090	70,250,907	74,791,254	78,302,222	84,047,103	93,078,821	99,927,683	106,199,481	114,044,039
Total Individual Market	**Total**	**262,590,821**	**241,125,653**	**288,599,940**	**334,547,168**	**362,765,916**	**389,381,628**	**420,509,094**	**457,138,080**	**502,722,219**	**542,484,705**	**580,461,255**	**626,835,653**
Employer Based													
Small Group Employer Market	Insurer	117,787,157	123,245,446	125,870,738	132,853,522	143,532,769	153,657,742	166,377,073	180,299,467	194,741,190	210,106,573	226,019,395	243,239,861
Small Group Employer Market	Employee Out-of-Pocket	45,620,766	48,337,876	49,150,697	54,240,198	58,607,744	62,746,308	67,943,038	73,638,478	79,546,153	85,830,754	92,341,084	99,377,345
Small Group Employer Market	Total	163,407,923	171,583,322	175,021,436	187,093,720	202,140,513	216,404,049	234,320,111	253,937,945	274,287,343	295,937,327	318,360,479	342,617,206
Large Group Employer Market	Insurer	1,830,256,795	1,919,618,451	2,069,212,264	2,228,610,480	2,392,601,208	2,545,875,734	2,745,533,528	2,957,112,597	3,175,682,728	3,408,149,381	3,646,097,176	3,910,759,518
Large Group Employer Market	Employee Out-of-Pocket	375,106,260	393,220,268	423,863,503	456,515,101	490,107,442	521,504,645	562,403,133	605,743,609	650,516,155	698,135,306	746,877,229	801,091,439
Large Group Employer Market	Total	2,205,363,055	2,312,838,720	2,493,075,767	2,685,125,580	2,882,708,651	3,067,380,379	3,307,936,661	3,562,856,206	3,826,198,883	4,106,284,687	4,392,974,405	4,711,850,957
Total Employer Based	**Insurer**	**1,948,043,952**	**2,042,863,898**	**2,195,083,002**	**2,361,464,001**	**2,536,133,978**	**2,699,533,476**	**2,911,910,601**	**3,137,412,065**	**3,370,423,918**	**3,618,255,954**	**3,872,116,571**	**4,153,999,380**
Total Employer Based	**Employee Out-of-Pocket**	**420,727,026**	**441,558,144**	**473,014,201**	**510,755,299**	**548,715,186**	**584,250,953**	**630,346,171**	**679,382,087**	**730,062,308**	**783,966,060**	**839,218,313**	**900,468,783**
Total Employer Based	**Total**	**2,368,770,978**	**2,484,422,042**	**2,668,097,203**	**2,872,219,300**	**3,084,849,163**	**3,283,784,429**	**3,542,256,772**	**3,816,794,152**	**4,100,486,226**	**4,402,222,014**	**4,711,334,884**	**5,054,468,163**

Sources: Carrier survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 24 - Alaska Health Expenditure Source of Funds - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insurer & Other (e.g., CSRs)	0	0	0	(45,485,976)	(50,215,925)	(53,485,882)	(59,207,031)	(63,934,600)	(68,247,905)	(75,186,371)	(84,557,200)	(90,460,204)
Individual Market	AK Reinsurance Fund	0	0	0	59,983,000	64,126,326	68,950,229	74,137,010	79,789,956	85,873,941	92,333,808	98,711,766	105,530,281
Individual Market	Employee Out-of-Pocket	0	0	0	5,416,310	5,414,523	6,211,122	5,241,184	5,515,744	6,094,739	12,254,030	11,189,664	12,098,773
Total Individual Market	**Total**	**0**	**0**	**0**	**19,913,334**	**19,324,924**	**21,675,469**	**20,171,163**	**21,371,101**	**23,720,774**	**29,401,467**	**25,344,230**	**27,168,850**
Employer Based													
Small Group Employer Market	Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**Insurer**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Employee Out-of-Pocket**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Carrier survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 25 - Alaska Health Expenditure Source of Funds PMPM - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insurer & Other (e.g., CSRs)	608	651	609	996	1,056	1,145	1,230	1,314	1,388	1,495	1,585	1,692
Individual Market	AK Reinsurance Fund	0	0	192	0	0	0	0	0	0	0	0	0
Individual Market	Insured Out-of-Pocket	169	184	208	237	246	262	275	289	308	308	327	346
Total Individual Market	**Total**	**777**	**835**	**1,010**	**1,234**	**1,301**	**1,407**	**1,504**	**1,603**	**1,696**	**1,803**	**1,912**	**2,038**
Employer Based													
Small Group Employer Market	Insurer	565	579	620	674	726	776	840	907	977	1,052	1,129	1,215
Small Group Employer Market	Employee Out-of-Pocket	219	227	242	275	297	317	343	371	399	430	461	497
Small Group Employer Market	Total	784	806	862	949	1,023	1,093	1,183	1,278	1,377	1,482	1,591	1,712
Large Group Employer Market	Insurer	574	608	652	701	756	808	874	944	1,017	1,095	1,175	1,265
Large Group Employer Market	Employee Out-of-Pocket	118	125	134	144	155	165	179	193	208	224	241	259
Large Group Employer Market	Total	691	733	786	845	911	973	1,053	1,138	1,226	1,319	1,416	1,524
Total Employer Based	**Insurer**	**573**	**607**	**650**	**700**	**754**	**806**	**872**	**942**	**1,015**	**1,093**	**1,173**	**1,262**
Total Employer Based	**Employee Out-of-Pocket**	**124**	**131**	**140**	**151**	**163**	**174**	**189**	**204**	**220**	**237**	**254**	**273**
Total Employer Based	**Total**	**697**	**738**	**790**	**851**	**917**	**980**	**1,061**	**1,146**	**1,235**	**1,329**	**1,427**	**1,535**

Sources: Carrier survey, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 26 - Alaska Health Expenditure Source of Funds PMPM - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insurer & Other (e.g., CSRs)	608	651	609	759	808	869	954	1,024	1,091	1,170	1,255	1,343
Individual Market	AK Reinsurance Fund	0	0	192	218	227	244	264	279	289	309	330	348
Individual Market	Insured Out-of-Pocket	169	184	208	240	249	265	279	293	314	334	355	376
Total Individual Market	**Total**	**777**	**835**	**1,010**	**1,218**	**1,283**	**1,378**	**1,497**	**1,596**	**1,695**	**1,813**	**1,940**	**2,068**
Employer Based													
Small Group Employer Market	Insurer	565	579	620	674	726	776	840	907	977	1,052	1,129	1,215
Small Group Employer Market	Employee Out-of-Pocket	219	227	242	275	297	317	343	371	399	430	461	497
Small Group Employer Market	Total	784	806	862	949	1,023	1,093	1,183	1,278	1,377	1,482	1,591	1,712
Large Group Employer Market	Insurer	574	608	652	701	756	808	874	944	1,017	1,095	1,175	1,265
Large Group Employer Market	Employee Out-of-Pocket	118	125	134	144	155	165	179	193	208	224	241	259
Large Group Employer Market	Total	691	733	786	845	911	973	1,053	1,138	1,226	1,319	1,416	1,524
Total Employer Based	**Insurer**	**573**	**607**	**650**	**700**	**754**	**806**	**872**	**942**	**1,015**	**1,093**	**1,173**	**1,262**
Total Employer Based	**Employee Out-of-Pocket**	**124**	**131**	**140**	**151**	**163**	**174**	**189**	**204**	**220**	**237**	**254**	**273**
Total Employer Based	**Total**	**697**	**738**	**790**	**851**	**917**	**980**	**1,061**	**1,146**	**1,235**	**1,329**	**1,427**	**1,535**

Sources: Carrier survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 27 - Alaska Health Expenditure Source of Funds PMPM - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insurer & Other (e.g., CSRs)	0	0	0	(237)	(248)	(276)	(276)	(290)	(296)	(325)	(330)	(348)
Individual Market	AK Reinsurance Fund	0	0	0	218	227	244	264	279	289	309	330	348
Individual Market	Insured Out-of-Pocket	0	0	0	3	3	2	4	5	6	26	28	30
Total Individual Market	**Total**	**0**	**0**	**0**	**(16)**	**(18)**	**(29)**	**(8)**	**(7)**	**(1)**	**10**	**28**	**30**
Employer Based													
Small Group Employer Market	Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Total	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**Insurer**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Employee Out-of-Pocket**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Carrier survey, Oliver Wyman Healthcare Reform Microsimulation Model.

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Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 28 - Alaska Total Net Out-of-Pocket Spending - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insured Premium Contribution	103,747,964	92,418,138	84,903,527	69,973,761	74,513,114	76,066,237	75,127,736	81,235,397	87,809,785	96,476,384	103,294,375	110,286,692
Individual Market	Insured Out-of-Pocket	57,248,085	53,252,906	59,479,345	60,502,780	64,836,384	68,580,131	73,061,038	78,531,359	86,984,082	87,673,653	95,009,818	101,945,266
Total Individual Market	**Total Insured**	**160,996,049**	**145,671,044**	**144,382,871**	**130,476,541**	**139,349,498**	**144,646,368**	**148,188,774**	**159,766,756**	**174,793,867**	**184,150,037**	**198,304,192**	**212,231,957**
Employer Based													
Small Group Employer Market	Employee Premium Contribution	22,216,324	24,358,415	25,559,606	27,451,869	29,684,467	31,752,323	34,418,137	37,224,292	40,204,561	43,362,831	46,734,491	50,174,779
Small Group Employer Market	Insured Out-of-Pocket	45,620,766	48,337,876	49,150,697	54,240,198	58,607,744	62,746,308	67,943,038	73,638,478	79,546,153	85,830,754	92,341,084	99,377,345
Small Group Employer Market	Total Employee	67,837,090	72,696,291	74,710,303	81,692,067	88,292,211	94,498,630	102,361,175	110,862,770	119,750,714	129,193,585	139,075,575	149,552,124
Large Group Employer Market	Employee Premium Contribution	410,202,083	465,178,669	498,606,089	539,470,525	581,618,338	618,927,589	665,986,818	717,751,103	770,927,936	826,903,693	886,192,802	949,435,015
Large Group Employer Market	Insured Out-of-Pocket	375,106,260	393,220,268	423,863,503	456,515,101	490,107,442	521,504,645	562,403,133	605,743,609	650,516,155	698,135,306	746,877,229	801,091,439
Large Group Employer Market	Total Employee	785,308,343	858,398,938	922,469,592	995,985,626	1,071,725,780	1,140,432,234	1,228,389,951	1,323,494,713	1,421,444,091	1,525,038,998	1,633,070,031	1,750,526,454
Total Employer Based	**Employee Premium Contribution**	**432,418,407**	**489,537,085**	**524,165,695**	**566,922,394**	**611,302,805**	**650,679,912**	**700,404,955**	**754,975,395**	**811,132,497**	**870,266,524**	**932,927,294**	**999,609,795**
Total Employer Based	**Insured Out-of-Pocket**	**420,727,026**	**441,558,144**	**473,014,201**	**510,755,299**	**548,715,186**	**584,250,953**	**630,346,171**	**679,382,087**	**730,062,308**	**783,966,060**	**839,218,313**	**900,468,783**
Total Employer Based	**Total Employee**	**853,145,433**	**931,095,229**	**997,179,895**	**1,077,677,693**	**1,160,017,991**	**1,234,930,865**	**1,330,751,126**	**1,434,357,482**	**1,541,194,805**	**1,654,232,584**	**1,772,145,606**	**1,900,078,578**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 29 - Alaska Total Net Out-of-Pocket Spending - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insured Premium Contribution	103,747,964	92,418,138	84,903,527	79,559,167	83,397,983	87,941,611	86,096,017	92,771,610	100,543,268	108,069,560	108,180,968	115,862,686
Individual Market	Insured Out-of-Pocket	57,248,085	53,252,906	59,479,345	65,919,090	70,250,907	74,791,254	78,302,222	84,047,103	93,078,821	99,927,683	106,199,481	114,044,039
Total Individual Market	**Total Insured**	**160,996,049**	**145,671,044**	**144,382,871**	**145,478,257**	**153,648,890**	**162,732,865**	**164,398,238**	**176,818,713**	**193,622,089**	**207,997,243**	**214,380,449**	**229,906,725**
Employer Based													
Small Group Employer Market	Employee Premium Contribution	22,216,324	24,358,415	25,559,606	27,451,869	29,684,467	31,752,323	34,418,137	37,224,292	40,204,561	43,362,831	46,734,491	50,174,779
Small Group Employer Market	Employee Out-of-Pocket	45,620,766	48,337,876	49,150,697	54,240,198	58,607,744	62,746,308	67,943,038	73,638,478	79,546,153	85,830,754	92,341,084	99,377,345
Small Group Employer Market	Total Employee	67,837,090	72,696,291	74,710,303	81,692,067	88,292,211	94,498,630	102,361,175	110,862,770	119,750,714	129,193,585	139,075,575	149,552,124
Large Group Employer Market	Employee Premium Contribution	410,202,083	465,178,669	498,606,089	539,470,525	581,618,338	618,927,589	665,986,818	717,751,103	770,927,936	826,903,693	886,192,802	949,435,015
Large Group Employer Market	Employee Out-of-Pocket	375,106,260	393,220,268	423,863,503	456,515,101	490,107,442	521,504,645	562,403,133	605,743,609	650,516,155	698,135,306	746,877,229	801,091,439
Large Group Employer Market	Total Employee	785,308,343	858,398,938	922,469,592	995,985,626	1,071,725,780	1,140,432,234	1,228,389,951	1,323,494,713	1,421,444,091	1,525,038,998	1,633,070,031	1,750,526,454
Total Employer Based	**Employee Premium Contribution**	**432,418,407**	**489,537,085**	**524,165,695**	**566,922,394**	**611,302,805**	**650,679,912**	**700,404,955**	**754,975,395**	**811,132,497**	**870,266,524**	**932,927,294**	**999,609,795**
Total Employer Based	**Employee Out-of-Pocket**	**420,727,026**	**441,558,144**	**473,014,201**	**510,755,299**	**548,715,186**	**584,250,953**	**630,346,171**	**679,382,087**	**730,062,308**	**783,966,060**	**839,218,313**	**900,468,783**
Total Employer Based	**Total Employee**	**853,145,433**	**931,095,229**	**997,179,895**	**1,077,677,693**	**1,160,017,991**	**1,234,930,865**	**1,330,751,126**	**1,434,357,482**	**1,541,194,805**	**1,654,232,584**	**1,772,145,606**	**1,900,078,578**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 30 - Alaska Total Net Out-of-Pocket Spending - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insured Premium Contribution	0	0	0	9,585,406	8,884,869	11,875,374	10,968,281	11,536,213	12,733,482	11,593,175	4,886,593	5,575,995
Individual Market	Insured Out-of-Pocket	0	0	0	5,416,310	5,414,523	6,211,122	5,241,184	5,515,744	6,094,739	12,254,030	11,189,664	12,098,773
Total Individual Market	**Total Insured**	**0**	**0**	**0**	**15,001,716**	**14,299,391**	**18,086,496**	**16,209,465**	**17,051,957**	**18,828,221**	**23,847,206**	**16,076,257**	**17,674,768**
Employer Based													
Small Group Employer Market	Employee Premium Contribution	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Total Employee	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee Premium Contribution	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Total Employee	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**Employee Premium Contribution**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Employee Out-of-Pocket**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Total Employee**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

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Affordability Requirement

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Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 31 - Alaska Total Net Out-of-Pocket Spending PMPM - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insured Premium Contribution	307	320	297	274	282	291	282	299	311	339	356	375
Individual Market	Insured Out-of-Pocket	169	184	208	237	246	262	275	289	308	308	327	346
Total Individual Market	**Total Insured**	**476**	**504**	**505**	**512**	**528**	**554**	**557**	**588**	**619**	**647**	**683**	**721**
Employer Based													
Small Group Employer Market	Employee Premium Contribution	107	114	126	139	150	160	174	187	202	217	234	251
Small Group Employer Market	Insured Out-of-Pocket	219	227	242	275	297	317	343	371	399	430	461	497
Small Group Employer Market	Total Employee	325	341	368	414	447	477	517	558	601	647	695	747
Large Group Employer Market	Employee Premium Contribution	129	147	157	170	184	196	212	229	247	266	286	307
Large Group Employer Market	Insured Out-of-Pocket	118	125	134	144	155	165	179	193	208	224	241	259
Large Group Employer Market	Total Employee	246	272	291	314	339	362	391	423	455	490	526	566
Total Employer Based	**Employee Premium Contribution**	**127**	**145**	**155**	**168**	**182**	**194**	**210**	**227**	**244**	**263**	**283**	**304**
Total Employer Based	**Insured Out-of-Pocket**	**124**	**131**	**140**	**151**	**163**	**174**	**189**	**204**	**220**	**237**	**254**	**273**
Total Employer Based	**Total Employee**	**251**	**276**	**295**	**319**	**345**	**369**	**398**	**431**	**464**	**500**	**537**	**577**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 32 - Alaska Total Net Out-of-Pocket Spending PMPM - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insured Premium Contribution	307	320	297	290	295	311	306	324	339	361	362	382
Individual Market	Insured Out-of-Pocket	169	184	208	240	249	265	279	293	314	334	355	376
Total Individual Market	**Total Insured**	**476**	**504**	**505**	**530**	**544**	**576**	**585**	**617**	**653**	**695**	**716**	**758**
Employer Based													
Small Group Employer Market	Employee Premium Contribution	107	114	126	139	150	160	174	187	202	217	234	251
Small Group Employer Market	Employee Out-of-Pocket	219	227	242	275	297	317	343	371	399	430	461	497
Small Group Employer Market	Total Employee	325	341	368	414	447	477	517	558	601	647	695	747
Large Group Employer Market	Employee Premium Contribution	129	147	157	170	184	196	212	229	247	266	286	307
Large Group Employer Market	Employee Out-of-Pocket	118	125	134	144	155	165	179	193	208	224	241	259
Large Group Employer Market	Total Employee	246	272	291	314	339	362	391	423	455	490	526	566
Total Employer Based	**Employee Premium Contribution**	**127**	**145**	**155**	**168**	**182**	**194**	**210**	**227**	**244**	**263**	**283**	**304**
Total Employer Based	**Employee Out-of-Pocket**	**124**	**131**	**140**	**151**	**163**	**174**	**189**	**204**	**220**	**237**	**254**	**273**
Total Employer Based	**Total Employee**	**251**	**276**	**295**	**319**	**345**	**369**	**398**	**431**	**464**	**500**	**537**	**577**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

Table 33 - Alaska Total Net Out-of-Pocket Spending PMPM - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market													
Individual Market	Insured Premium Contribution	0	0	0	15	13	20	24	25	28	22	6	7
Individual Market	Insured Out-of-Pocket	0	0	0	3	3	2	4	5	6	26	28	30
Total Individual Market	**Total Insured**	**0**	**0**	**0**	**18**	**16**	**22**	**28**	**30**	**34**	**48**	**33**	**37**
Employer Based													
Small Group Employer Market	Employee Premium Contribution	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Small Group Employer Market	Total Employee	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee Premium Contribution	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Employee Out-of-Pocket	0	0	0	0	0	0	0	0	0	0	0	0
Large Group Employer Market	Total Employee	0	0	0	0	0	0	0	0	0	0	0	0
Total Employer Based	**Employee Premium Contribution**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Employee Out-of-Pocket**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Employer Based	**Total Employee**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Sources: Carrier Survey, Employee and APTC contributions based on MEPS and ASPE, Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 34 - Alaska Advance Premium Tax Credits For Eligible Members By Income to Poverty Ratio - Baseline Scenario

		Baseline Year		Waiver Period									
		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Subsidy Eligible Members	**FPL**												
Individual Market	0% to 199%	8,523	7,262	7,505	7,687	8,281	8,350	8,963	9,090	9,161	9,299	9,352	9,592
Individual Market	200% to 299%	4,015	3,758	3,992	4,077	4,166	4,172	4,236	4,543	5,302	5,314	5,703	5,758
Individual Market	300% to 400%	2,089	4,016	4,143	4,179	4,191	4,197	4,209	4,222	4,232	4,241	4,251	4,259
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Subsidy Eligible Members		**14,627**	**15,036**	**15,640**	**15,943**	**16,637**	**16,719**	**17,408**	**17,855**	**18,696**	**18,854**	**19,306**	**19,609**
Annual Subsidy Amount	**FPL**												
Individual Market	0% to 199%	63,428,046	72,963,228	97,115,366	121,782,915	138,277,774	149,483,325	172,185,138	186,444,105	201,032,268	218,007,208	233,582,966	254,859,518
Individual Market	200% to 299%	22,481,494	37,256,045	51,448,103	64,257,408	68,899,736	74,236,457	80,282,467	90,612,491	108,308,827	118,335,206	133,837,494	144,992,733
Individual Market	300% to 400%	8,558,730	25,128,812	37,152,809	47,858,139	51,173,938	55,623,788	60,150,183	65,233,038	70,786,405	76,320,248	82,124,206	88,333,871
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Annual Subsidy		**94,468,271**	**135,348,085**	**185,716,278**	**233,898,461**	**258,351,449**	**279,343,570**	**312,617,789**	**342,289,634**	**380,127,501**	**412,662,662**	**449,544,666**	**488,186,123**
APTC PMPM	**FPL**												
Individual Market	0% to 199%	620	837	1,078	1,320	1,392	1,492	1,601	1,709	1,829	1,954	2,081	2,214
Individual Market	200% to 299%	467	826	1,074	1,314	1,378	1,483	1,579	1,662	1,702	1,856	1,956	2,098
Individual Market	300% to 400%	341	521	747	954	1,018	1,104	1,191	1,288	1,394	1,499	1,610	1,728
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total APTC PMPM		**538**	**750**	**990**	**1,223**	**1,294**	**1,392**	**1,497**	**1,598**	**1,694**	**1,824**	**1,940**	**2,075**

Sources: Oliver Wyman Healthcare Reform Microsimulation Model.

Table 35 - Alaska Advance Premium Tax Credits For Eligible Members By Income to Poverty Ratio - Waiver Scenario

		Baseline Year		Waiver Period									
		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Subsidy Eligible Members	**FPL**												
Individual Market	0% to 199%	8,523	7,262	7,505	7,700	8,294	8,365	8,974	9,101	9,172	9,310	9,359	9,598
Individual Market	200% to 299%	4,015	3,758	3,992	4,083	4,172	4,179	4,241	4,549	5,309	5,320	5,707	5,762
Individual Market	300% to 400%	2,089	4,016	4,143	4,138	4,150	4,157	4,166	4,179	4,189	4,247	4,254	4,262
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Subsidy Eligible Members		**14,627**	**15,036**	**15,640**	**15,922**	**16,616**	**16,702**	**17,381**	**17,828**	**18,669**	**18,877**	**19,319**	**19,622**
Annual Subsidy Amount	**FPL**												
Individual Market	0% to 199%	63,428,046	72,963,228	97,115,366	96,982,422	110,531,465	119,535,804	138,477,691	150,743,492	163,064,722	177,755,940	190,509,068	207,904,508
Individual Market	200% to 299%	22,481,494	37,256,045	51,448,103	50,558,937	54,418,737	58,698,534	63,808,005	72,404,873	86,455,427	93,297,085	105,434,742	114,126,833
Individual Market	300% to 400%	8,558,730	25,128,812	37,152,809	34,719,330	37,422,340	40,927,929	44,925,287	49,329,308	53,886,989	58,941,687	63,596,184	68,603,944
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Annual Subsidy		**94,468,271**	**135,348,085**	**185,716,278**	**182,260,689**	**202,372,542**	**219,162,267**	**247,210,983**	**272,477,673**	**303,407,137**	**329,994,712**	**359,539,993**	**390,635,284**
APTC PMPM	**FPL**												
Individual Market	0% to 199%	620	837	1,078	1,050	1,111	1,191	1,286	1,380	1,482	1,591	1,696	1,805
Individual Market	200% to 299%	467	826	1,074	1,032	1,087	1,170	1,254	1,327	1,357	1,461	1,540	1,651
Individual Market	300% to 400%	341	521	747	699	752	821	899	984	1,072	1,157	1,246	1,341
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total APTC PMPM		**538**	**750**	**990**	**954**	**1,015**	**1,094**	**1,185**	**1,274**	**1,354**	**1,457**	**1,551**	**1,659**

Sources: Oliver Wyman Healthcare Reform Microsimulation Model.

AK 1332 Waiver Application

Actuarial Analysis and Certification

Affordability Requirement

Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.
We only consider residents with Individual Market and Employer Based coverage.
Residents under Government coverage are not affected by the 1332 Waiver and no projection is provided. For Uninsured residents net out of pocket spending is not readily available and no projection is provided.
Affordability is measured as residents net out-of-pocket spending = Premium contribution + Cost sharing (Deductibles, copays, coinsurance)

Table 36 - Alaska Advance Premium Tax Credits For Eligible Members By Income to Poverty Ratio - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Subsidy Eligible Members	**FPL**												
Individual Market	0% to 199%	0	0	0	13	13	15	11	11	11	11	6	7
Individual Market	200% to 299%	0	0	0	7	7	8	5	5	6	6	4	4
Individual Market	300% to 400%	0	0	0	-41	-41	-40	-43	-43	-43	5	3	3
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Subsidy Eligible Members		**0**	**0**	**0**	**-21**	**-21**	**-18**	**-27**	**-27**	**-27**	**23**	**13**	**13**
Annual Subsidy Amount	**FPL**												
Individual Market	0% to 199%	0	0	0	-24,800,493	-27,746,308	-29,947,521	-33,707,447	-35,700,613	-37,967,547	-40,251,268	-43,073,898	-46,955,011
Individual Market	200% to 299%	0	0	0	-13,698,471	-14,480,999	-15,537,924	-16,474,462	-18,207,618	-21,853,401	-25,038,120	-28,402,753	-30,865,901
Individual Market	300% to 400%	0	0	0	-13,138,809	-13,751,599	-14,695,859	-15,224,896	-15,903,730	-16,899,417	-17,378,562	-18,528,022	-19,729,927
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total Annual Subsidy		**0**	**0**	**0**	**-51,637,772**	**-55,978,906**	**-60,181,304**	**-65,406,805**	**-69,811,961**	**-76,720,364**	**-82,667,950**	**-90,004,673**	**-97,550,838**
APTC PMPM	**FPL**												
Individual Market	0% to 199%	0	0	0	-271	-281	-301	-315	-329	-347	-363	-385	-409
Individual Market	200% to 299%	0	0	0	-282	-291	-313	-326	-336	-345	-394	-416	-448
Individual Market	300% to 400%	0	0	0	-255	-266	-284	-292	-304	-322	-343	-364	-387
Individual Market	More than 400%	0	0	0	0	0	0	0	0	0	0	0	0
Total APTC PMPM		**0**	**0**	**0**	**-269**	**-279**	**-299**	**-311**	**-324**	**-340**	**-367**	**-390**	**-416**

Sources: Oliver Wyman Healthcare Reform Microsimulation Model.

Oliver Wyman
411 East Wisconsin Avenue
Suite 1300
Milwaukee, WI 53202-4419
414 223 7989

Alaska 1332 Waiver - Economic Analysis

Prepared for:
Alaska Division of Insurance

Prepared by:
Andrew Bibler
Institute of Social and Economic Research
University of Alaska Anchorage
3211 Providence Drive
Anchorage, Alaska 99508

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About ISER The Institute of Social and Economic Research (ISER) is an institute within the College of Business and Public Policy at UAA, with a staff of approximately 35—including faculty, research associates, and support staff. ISER has been at the forefront of public policy research in Alaska for half a century. ISER's multidisciplinary staff studies virtually all the major public policy issues Alaska faces. That work helps Alaskans better understand the state's changing economy and population—and the challenges and opportunities that come with change.

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About the Author Andrew Bibler is an Assistant Professor of Economics at ISER and in the Department of Economics and Public Policy at the University of Alaska Anchorage. He received a Ph.D. in Economics from Michigan State University in 2016, and joined UAA in August 2016.

1 Executive Summary

The four guardrails that a successful 1332 waiver must meet are as follows:

1. *Coverage* - There must be at least a comparable number of individuals with coverage under the waiver as would have had coverage without the waiver.
2. *Affordability* – The waiver should not result in an increase in out-of-pocket spending required of residents to obtain coverage, relative to income.
3. *Comprehensiveness* – The waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark.
4. *Deficit Neutrality* – The waiver should not have any negative impact on the federal deficit.

In this report, the first three guardrails are briefly discussed to reaffirm that the actuarial analysis conducted by Oliver Wyman demonstrates that the proposed waiver meets them. The actuarial report from Oliver Wyman projects that the proposed waiver will increase the number of individuals taking up insurance in the individual market, lower average premiums, and have no impact on the comprehensiveness of coverage. The numbers reported in the actuarial analysis are then used to help evaluate the impact that the proposed waiver will have on the federal budget. There are at least four ways in which the waiver will have an important impact on the federal budget, which are summarized in Table 1.

Table 1: Impact of Proposed Waiver on Budget

	Direction of Effect
APTC Savings	+
Individual Shared Responsibility Payments	-
Health Insurance Providers Fee	-
Federal Exchange User Fees	-
Overall Impact on Budget	+

The first and most important impact of the waiver is that it will lead to a reduction in premiums. The reduction in premiums reduces the amount of Advanced Premium Tax Credits (APTC) that individuals will be eligible for and generates savings of $50 - $100 million per year from 2018 through 2026. There are also three routes through which the waiver will negatively impact the budget by decreasing revenue: individual shared responsibility payments, health insurance providers fees, and federal exchange user fees. Because the waiver will lead to more individuals taking up insurance in the individual market, fewer individuals will owe

the individual penalty for not having health insurance. The health insurance providers fee depends on the amount of premiums aggregated to the national level. Because the waiver depresses premiums in the Alaska individual insurance market, it will have a secondary negative effect on the total amount collected through the providers fee for years 2019 through 2026. Lower premiums also reduce the amount collected in federal exchange user fees, a 3.5% tax imposed on premiums sold through the Federally Facilitated Marketplace. The aggregate impact on the budget is positive, because the APTC savings outweigh the combined negative impact of the other three channels. Table 2 summarizes the aggregate impact of the four components on the federal budget.

Table 2: Estimated Savings from Waiver
(Before Pass-Through Funding)

Year	Final Savings
2016	$0
2017	$0
2018	$48,973,684
2019	$52,260,336
2020	$56,108,411
2021	$61,486,732
2022	$65,612,013
2023	$72,213,851
2024	$77,717,467
2025	$84,814,665
2026	$91,785,506

The overall impact through these four components is about $49 million in savings in 2018. Savings increase in every year thereafter, reaching nearly $92 million in 2026. The savings listed in Table 2 are before the granting of any pass-through funding, so they suggest that as long as pass-through funding is less than or equal to these figures, the proposed waiver will meet the federal deficit neutrality requirement.

2 Introduction

The first three guardrails are discussed extensively in the actuarial analysis conducted by Oliver Wyman. We will briefly discuss them here to reaffirm the main points of their analysis, and demonstrate how their analysis lends itself to the evaluation of the fourth guardrail, which we discuss more extensively below. In the actuarial analysis, Oliver Wyman directly modeled the decisions of the residents to forego insurance, or take up insurance in the individual, employer, and public markets. They accomplish this by specifying the decisions

that Alaska residents face, and they use data on the prior decisions of residents to take up insurance in different markets to calibrate a microsimulation model that can be used to project outcomes under different scenarios. They define a waiver and baseline (no-waiver) scenario and compare projected outcomes between those scenarios to determine the impact of the waiver on various outcomes including the number of individuals who take up insurance in each market, the number who choose to forego insurance, average premiums, average advance premium tax credits, and out-of-pocket expenses, among other things. They focus primarily on demonstrating why the first three guardrails are met based on these projections.

Coverage The actuarial analysis conducted by Oliver Wyman suggests that the proposed waiver will decrease premiums, inducing more individuals to take up insurance coverage in every year from 2018 to 2026. The waiver will lead to between 741 and 1,641 more individuals being covered each year, thus supporting the first guardrail for the number of individuals receiving insurance coverage. Please refer to Table A, and Table 3 of Appendix B in Alaska 1332 Waiver Application, Actuarial Analyses and Certification for more details.

Affordability The actuarial analysis suggest that premiums will be 18 – 20% lower in each year, from 2018 – 2016, under the waiver scenario. The increase in average out-of-pocket premium contributions and expenditures occurs because the individuals induced to take-up coverage by the waiver are less frequently eligible for subsidies, and does not necessarily reflect a real increase in the cost of insurance to particular individuals. The estimated decrease in premiums provided in the actuarial analysis is critical for evaluating the impact on the federal deficit. As discussed below, this premium difference is the main mechanism that generates a positive impact on the federal budget, through decreased costs from lower APTC payments, and justifying pass-through funding to enable the continuation of the Alaska Reinsurance Program (ARP). Please refer to Tables C, D, and E of Alaska 1332 Waiver Application, Actuarial Analyses and Certification for more details.

Comprehensiveness Finally, since the proposed waiver will have no impact on the Affordable Care Act (ACA) essential health benefits, or the Medicaid and Children's Health Insurance Program (CHIP) standards, there is no anticipated impact of the waiver on the comprehensiveness of coverage.

Due to the thorough and comprehensive review given on the first three guardrails in the actuarial analysis, we turn to evaluating the impact of the waiver on the federal deficit. In what follows, we draw on the actuarial analysis provided by Oliver Wyman to evaluate the potential impact of the waiver on the federal budget. Analysis of the impact on the federal deficit will rely heavily on the following estimates generated from the actuarial analysis conducted by Oliver Wyman: The average and total premiums in each market, advanced

premium tax credits, savings in APTC, the number of individuals moving between uninsured status and the individual insurance markets, and movement between uninsured status and the other insurance markets. The figures produced in the actuarial analysis are critical for evaluating the potential impact on the federal deficit, and the accuracy of the following analysis is dependent upon those estimates.

3 Federal Deficit Neutrality

In evaluating any impact on the federal budget, there are many avenues through which a waiver could influence federal spending and revenue. However, results from the actuarial analysis limit the scope of the possible impacts on the federal budget. The analysis suggests that all movement in coverage is between the uninsured category and the individual insurance market.[1] In other words, the waiver will have no impact on the number of individuals taking up employer or government based coverage. The ARP reduces risks to insurance providers in the individual insurance market by removing the risk related to covering high-cost individuals. The reinsurance program is limited to the individual market, and corresponding effects on total premiums are also confined to the individual market, according to the actuarial analysis.[2] The decrease in individual market premiums is unlikely to induce individuals to switch from employer based insurance to individual market insurance, because the cost to the insured in premiums tends to be relatively high in the individual market.[3] For example, in both the baseline and waiver scenarios, the projected average employee monthly premium contributions in 2018 are $139 and $170 for small group employer and large group employer coverage, respectively. In contrast, the projected average monthly premium contribution in 2018 for those in the individual market is $274,[4] so it is reasonable to find that individuals are more likely to take up the employer sponsored insurance when faced with the decision between that and coverage in the individual market in either scenario. Since the waiver will not influence the number of individuals with employer or government sponsored insurance, or the costs in those markets,[5] we do not expect any impact of the waiver on related costs and revenues, such as excise taxes on high-cost employer sponsored plans, small business tax credits, employer shared responsibility payments, tax exclusions related to employer-sponsored insurance, or changes in Medicaid spending.[6] This allows us to focus on a few

[1] See Table 3 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[2] See Table 21 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[3] See Table 20 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[4] See Table 19 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[5] See Tables 21, 27, and 33 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[6] Excluding impacts through these channels hinges on the result that there are no spillovers across insurance markets, i.e. a change in the individual market has no impact on the costs or populations in the

channels through which the federal budget might be impacted.

Based on the actuarial analysis, the most important impact that the waiver will have on the federal budget is the 20 to 22% reduction in APTC payments. The waiver will allow the state to continue funding the ARP, which reduces premiums, and in turn average APTC, relative to the baseline scenario. In addition, individuals who are induced to take up coverage in the individual market because of the waiver tend to be healthier, on average, than the non-waiver scenario individual market pool. Nearly 84% of the individuals projected to take up coverage in the individual market in 2018 because of the waiver are of very good or excellent health status.[7] Whereas, only about 51% of the projected 2018 individual market participants are considered in very good or excellent health in the baseline scenario.[8] The addition of relatively healthy individuals to the pool could reinforce downward pressure on premiums. Additionally, the ARP could encourage potential competition in the insurance market, as it reduces risk to the insurers. It is not clear whether the entrance of another competitor would further reduce premiums, but it is possible. In any case, we would not expect a new entrant to increase premiums. However, if the future of the ARP is uncertain, potential competitors might be less likely to make the investments required to enter the market.

In short, the effective reduction in the premiums and resulting decrease in total APTC is large enough to outweigh any possible negative impact on the federal budget by roughly $49 million in 2018, a figure that increases gradually to almost $92 million in 2026. There are several other influences on the budget that are worth noting. The movement of individuals from uninsured to insured status could increase the number of anticipated tax credits to be paid out if those individuals are eligible for the credit. This is unlikely to be an important factor, because almost every person induced to take up insurance in the individual market by the waiver is at or above 400% of the poverty line, and therefore will not receive an APTC after joining the individual market.[9] As a result, the increase in APTC eligible individual market participants in any given year is minimal, and in some cases there is a decline anticipated in APTC eligible participants. The decline is a result of the waiver inducing only a small number of APTC eligible individuals to take up insurance, and inducing a slightly larger number of individuals in the 300 to 400% FPL income range to choose no insurance rather than the lowest level of coverage in the individual market. When the ARP and waiver depress premiums, they also depress the APTC, which is based on the second lowest level

employer sponsored and government based markets. It is difficult to assess the viability of this outcome or the potential impact in this particular scenario ex ante. If spillovers do exist, as long as they are minimal relative to the other changes, there would be minimal to no impact on the costs and revenues through these channels.

[7] See Table 15 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[8] See Table 13 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[9] See Table 9 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

of coverage (silver). It is possible that individuals in the 300 to 400% FPL income range who would otherwise choose the lowest coverage level (bronze) could then find it optimal to choose no coverage. Nonetheless, it is worth noting that in years 2024 to 2026 there is a small increase in the number of projected APTC eligible individuals who take up coverage, which would have a net negative effect on the federal budget through increased costs.

In addition to decreasing costs through APTC payments, the proposed waiver is likely to decrease federal revenues in three important ways: through individual shared responsibility payments, health insurance provider fees, and exchange user fees. There will likely be a decrease in the number of individuals expected to pay the penalty, i.e. the individual shared responsibility payment, which constitutes a net loss to the federal budget through decreased revenues. The proposed waiver will also influence federal revenue through the exchange user fee, which is charged to insurers for using the federal exchange system and based on a percentage of the total premiums written through the federal exchange. Because the waiver will decrease total premiums written through the federal exchange, the difference in total premiums multiplied by the fee percentage would represent the decrease in federal revenues.[10] Lastly, the waiver will have an impact on the total amount collected in the health insurance providers fee, although the route through which this occurs is more convoluted. The total size of the health insurance providers fee is pre-determined through fee year 2018 (based on 2017 total premiums). The total fee for 2018 is set at $14.3 billion, so the waiver will not impact the total collection in 2018. After fee year 2018 the total tax bill is set to increase at the same rate as the aggregate written premiums.[11] Since the waiver will alter the total premiums in the Alaska invididual market, and in turn the total premiums aggregated to the national level, it could influence the size of the total fee collected in years 2019 and beyond. Tables 1 and 2 above summarize the overall impact the waiver will have on the federal budget. In what follows, the different channels, APTC savings, individual shared responsibility payments, health insurance provider fees, and exchange user fees, are discussed in more detail. A reasonable estimate is provided for the impact of each on the federal budget. When considering the decrease in total APTC payments, and the losses in individual shared responsibility penalty payments, provider fees, and federal exchange user fees altogether, the aggregate impact on the federal deficit, prior to any pass-through funding, is overwhelmingly positive.

[10] Assuming that the entire difference in premiums would be subject to the fee.

[11] The premium base calculation is more complex than this, but is essentially the aggregate of all premiums written with exceptions and reductions for companies that meet certain qualifications.

3.1 APTC Savings

The actuarial analysis projects the total amount of APTC under the waiver and baseline scenarios for every year from 2018 to 2026. Using the differences in these numbers between the waiver and baseline scenarios, the projected total APTC is substantially lower under the waiver scenario in every year starting in 2018.

Table 3: Projected APTC Savings from Waiver

Year	Estimated Savings
2016	$0
2017	$0
2018	$51,637,772
2019	$55,978,906
2020	$60,181,304
2021	$65,406,805
2022	$69,811,961
2023	$76,720,364
2024	$82,667,950
2025	$90,004,673
2026	$97,550,838

*Note: See Table 18 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

In 2018 the estimated savings in APTC payments from granting the waiver is more than $51.6 million, and reaches $97.5 million in 2026. The source of the steep growth in savings is twofold, stemming from both an increasing raw gap in premiums between the baseline and waiver scenarios, and an increasing number of APTC eligible individuals with coverage in the individual market. Although the reduction in premiums as a percentage of the baseline premium remains relatively stable, between 18 and 20%, the actual gap in premiums grows. The projected dollar value of the average gap in premiums goes from $238 in 2018 to $363 in 2026. The increase in the spread is mainly due to the one-time large increase projected in the baseline scenario for 2018, when the ARP is set to end in the baseline scenario. After 2018, the average yearly growth in premiums is actually quite similar between the two scenarios, but the shock to premiums in 2018 in the baseline scenario effectively sets them at different base levels leading to an increasing spread in the two numbers over time. The other factor contributing to the increasing estimated savings is the increasing number of subsidy eligible participants expected to take up coverage in the individual market. The total number of individuals expected to take up coverage in 2026 is higher than that number for 2018 in both scenarios, but more importantly the income distribution among those individuals is changing. The number of subsidy eligible individuals expected to take up coverage in the

baseline scenario is 15,640 in 2017, but that number is 19,609 in 2026, meaning 3,969 more subsidy-qualifying individuals will have coverage in the individual market.[12] For comparison, the total market is only expected to see an increase of 698 individuals between those two years.[13] In other words, the expected change in the composition of the individual market is such that they are expected to become increasingly eligible for subsidies over time. This phenomenon is not specific to either the waiver or baseline scenario.[14] The total savings in APTC depends positively on the gap in the average APTC between scenarios, but also depends on the total number of APTC eligible individuals with coverage in the individual market. Even if an equal number of individuals are eligible in the two scenarios, a higher number of eligible individuals increases savings, because more individuals qualify for subsidies. To put it another way, one more subsidy eligible individual taking up coverage in the baseline scenario facilitates more savings, even if they take up coverage in the waiver scenario as well. This is true because baseline scenario premiums are larger than waiver scenario premiums, i.e. subsidy eligible individuals qualify for a larger APTC in the baseline scenario than they do in the waiver scenario.

It is also important to note the relative similarity between the total amount expected in state and federal appropriations and funding through the ARP, and the APTC savings. For example, the projected cost of funding the ARP in 2018 is roughly $60 million[15] and the anticipated total reduction in APTC payments is $51.6 million. This is a result of the majority of the increase in premiums in the baseline scenario being funded through APTC. Individuals who are below 400% FPL do not have to cover the full increase in premiums, because they are eligible for APTC. In some cases they would not have to cover any of it. This is evident from comparisons of premium and APTC growth in the individual market for individuals below 400% FPL. The average individual market premium is expected to increase from $947 in 2017 to $1,191 in 2018 in the baseline scenario, an increase of $244.[16] For that same year the projected average APTC increases are $242, $240, and $207 for the 0 to 199% FPL, 200 to 299% FPL, and 300 to 400% FPL income categories, respectively.[17] A projected 15,943 individuals, 75% of the market, will be under 400% FPL in 2018 and eligible for a subsidy. The similarity in the premium and APTC increases for subsidy eligible individuals, in conjunction with a large portion of the market being covered by subsidies, means that the majority of the premium increases in the baseline scenario would be covered by APTC. This is all reflected in the high APTC savings to ARP funding ratio, which is 86% in 2018.

[12] Table 34 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.
[13] Table 1 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.
[14] Tables 7 & 8 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.
[15] Table 23 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.
[16] Table C of Alaska 1332 Waiver Application, Actuarial Analyses and Certification.
[17] Table 34 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

3.2 Individual Responsibility Insurance Payments

The estimated savings in APTC produced in the actuarial analysis, and shown in Table 3, capture the impact that the passage of the waiver will have on average APTC, as well as any increase or decrease in the number of individuals eligible for the APTC. They do not capture any impact on the federal budget from the decrease in the number of individuals paying the penalty, but the amount of extra revenue from penalties that would be collected absent the waiver is a small percentage of the projected APTC savings. Using Congressional Budget Office (CBO) projections and the size of the flat rate individual penalties, two estimates for the amount of additional penalties that would be collected if the waiver were not granted are obtained. For 2016, an uninsured individual adult without an exemption will pay a penalty of $695 or 2.5% of income, whichever is higher, and an uninsured child without an exemption would require a payment half that size. However, the average penalty paid by an uninsured individual is much lower than this baseline, presumably because many uninsured individuals are eligible for an exemption. Based on projections from the CBO, Table 4 shows the expected approximate average penalty per uninsured individual for each year.[18]

Table 4: Average Penalty for Uninsured

	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Uninsured	27m	26m	26m	27m	27m	27m	27m	27m	28m	28m	28m
Total Penalties	$3b	$3b	$3b	$3b	$3b	$4b	$4b	$4b	$4b	$4b	$5b
Approximate Average	$111	$115	$115	$111	$111	$148	$148	$148	$142	$142	$178

Source:
https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf
Estimates for the number of uninsured are based on calendar year. The estimated penalties collected are based on fiscal year.

If the projections in Table 4 are reflective of the average penalty payments that would be made by individuals induced to take up insurance in the individual market, then we can use them, in conjunction with the actuarial projections for the number of individuals moving from uninsured to insurance in the individual market, to obtain a rough estimate of the

[18] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf (See Table 1, *Health Insurance Coverage for People Under Age 65*, of CBO report for the number uninsured. See Table 2, *Net Federal Subsidies Associated with Health Insurance Coverage for People Under Age 65*, of CBO report for the total penalty payments.)

difference in penalty payments in the waiver and baseline scenarios. The estimated losses in penalty payments are displayed in Table 5. Using the flat rate penalty, which is the minimum twelve-month penalty to be paid by an uninsured individual without an exemption, will produce a more conservative estimate. This rate is $695 for an adult for 2016, and will be adjusted yearly. This fee is much higher than the national average penalty paid by an uninsured individual shown in Table 4, so we expect these figures to be conservative. One likely reason that the average payment from the CBO projections are so much lower than the flat rate is that there could be a large number of individuals who are uninsured but exempt from paying the penalty. The exemption for not having access to affordable coverage is particularly relevant in this case. If an individual does not have access to coverage that costs less than a certain percentage of their income, then they are exempt from the penalty. This is especially relevant in Alaska, because of the high premiums in the state. There could be a relatively large number of individuals who are not eligible for subsidies but would have to pay a high percentage of their income to obtain coverage, and therefore would not be required to make an individual responsibility payment if they forego coverage. It is possible that some of the individuals who move from uninsured status to the individual market in the waiver scenario would not be required to make a penalty payment in the baseline scenario. To the extent that the individuals who make that switch are exempt from penalties, the figure using the flat rate is overestimating the number of individuals who will have to pay the penalty in the baseline scenario. On the other hand, the estimate using the CBO projection is accurate if we assume that the portion of the population making that switch to the individual market in Alaska is comparable to the national uninsured population in terms of exemption status and average penalty payments.[19]

Table 5 shows two estimates for the potential loss in individual penalty payments. The estimates using the average penalty from the CBO projections, shown in the last column of Table 5, range from about $105,000 in 2025 to more than $197,000 in 2020. These estimates are much lower than the estimates that assume the average penalty paid by the uninsured would equal the flat rate penalty. In 2018 the estimated loss using the flat rate calculation is almost $1.2 million, but the estimated loss using the average penalty is only about $189,000 for the same year. It is difficult to say which is more accurate, because it is not clear from the actuarial analysis which individuals would qualify for an exemption.

One impact of the waiver that is not captured in these estimates is that the lower premiums can also change the number of uninsured individuals who would be required to make an indi-

[19]Without more details on the characteristics of the individuals who are induced to switch from the uninsured category to the individual insurance market because of the waiver, we cannot accurately evaluate the legitimacy of this assumption.

Table 5: Estimated Loss in Penalty Payments

	Change in Insured			Estimated Loss	
Year	**Total**	**Adults**	**Children**	**Using Flat Rate**	**Using Avg. Penalty**
2016	0	0	0	$0	$0
2017	0	0	0	$0	$0
2018	1,641	1,593	48	$1,192,255	$188,715
2019	1,565	1,516	49	$1,169,925	$173,715
2020	1,775	1,727	48	$1,369,682	$197,025
2021	1,234	1,193	41	$977,711	$182,632
2022	1,210	1,168	42	$986,711	$179,080
2023	1,182	1,183	-1	$1,010,756	$174,936
2024	1,227	1,228	-1	$1,080,697	$174,234
2025	741	740	1	$671,498	$105,222
2026	742	741	1	$692,577	$132,076

*Note: The projected changes in number insured are from Table 12 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B. The flat rate calculation is based on the $695 and $347.50 flat fee for uninsured adults and children in 2016, and assuming 3% growth per year. The calculation using the average penalty uses the approximate averages from Table 3 of the CBO report. The estimated impacts of the reduction in penalty payments on the budget are based on calendar years and attributed to the year that the penalties are based on. However, since penalties are reconciled on tax returns, all or a portion of them may be collected in the following year.

vidual responsibility payment. Since the premiums will be lower in the waiver scenario, the income cutoff for whether or not insurance is considered affordable will also differ between the two scenarios. There could be a group of individuals who are not eligible for subsidies and forego insurance in both scenarios, but would only be required to make a penalty payment in the waiver scenario. This is most relevant for the group of individuals who are over 400% FPL, because that is the group that will see the largest change in out-of-pocket premiums. There are more than 14,000 uninsured individuals with income above 400% FPL in the waiver scenario in 2018. To the extent that some uninsured individuals would qualify for an exemption in the baseline scenario, but not in the waiver scenario because of the depressed premiums, this represents a net gain to the federal budget. However, without more precise information on the income distribution and other exemption-relevant characteristics of the uninsured population, we cannot tell the exact size of this gain.

3.3 Health Insurance Providers Fee

The proposed waiver will also impact the federal budget through the health insurance provider fee,[20] which is essentially a tax on insurance providers based on the amount of premiums that they wrote in the previous year. However, the tax is assessed in such a way that the total collection amount from all providers adds up to a pre-specified amount, which is already determined through fee year 2018.[21] The total amount collected through this tax will equal $14.3 billion for 2018. Since the total amount collected is pre-determined, the decrease in premiums under the waiver scenario will have no impact on federal revenues through this channel for fee year 2018 (collected in 2018 for premium revenues in 2017). For years 2019 and beyond, the proposed waiver could decrease the size of the total fee, because the total amount of the fee depends on growth in national aggregate premiums for every year after 2018. The waiver will impact total national premiums through changes in premiums in the individual market in Alaska. The slowed growth in premiums only impacts the individual market in Alaska, a market of between 23,500 and 25,300 individuals for the years 2019 through 2026.[22] That represents a small fraction of the number of insured individuals across the country, but still changes the amount of premiums aggregated to the national level.[23] Table 6 shows yearly estimated losses to the budget that the waiver would cause through this channel. Please refer to the appendix for more detail on the health insurance provider fee and further explanation on the calculations in Table 6.

The waiver will have no impact on the total amount collected through the insurer tax in 2018, because the total amount is already set at $14.3 billion for 2018. The waiver will lead to an estimated loss in the total amount collected through the insurer tax of about $900,000 in 2019. The amount lost increases each year after that, as the size of the market in terms of total premiums increases, rising to over $1.9 million in losses for 2026. While these losses are substantial, much like the loss in individual penalty payments, they are less than 2% of the size of the savings from the reduced APTC in any given year. On average, the size of the loss in the insurer tax is about 1.5% of the savings in APTC. This table does not capture any differences in provider fees for years after 2026. Since the estimates provided in the table are based on premiums in the prior year, and aggregate premiums are lower in 2026 in the waiver scenario, we should expect that the waiver will also lead to a reduction in the providers fee in 2027 as well.

[20] Affordable Care Act Section 9010

[21] https://www.irs.gov/irb/2013-51_IRB/ar12.html (see section 57.4 *Fee Calculation*)

[22] See Table 2 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

[23] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf

Table 6: Estimated Loss in Health Insurance Providers Fee

Year	Differences in Health Insurance Providers Fee
2016	$0
2017	$0
2018	$0
2019	$900,354
2020	$1,012,503
2021	$1,037,013
2022	$1,173,585
2023	$1,256,216
2024	$1,382,168
2025	$1,539,377
2026	$1,853,635

*Note: Estimated losses are for calendar years and based on premiums from the prior year. Please see the appendix for details on how these differences were calculated.

3.4 Exchange User Fees

The decrease in premiums written in the individual market will also have a direct impact on the amount collected through the exchange user fee. A 3.5% tax is imposed on all premiums that are written through the federal exchange marketplace. Since the Alaska individual market uses the federal marketplace, there will be a negative impact on the federal budget of 3.5% of the difference in premiums between the baseline and waiver scenario. The yearly differences in total premiums in the Alaska individual market between the baseline and waivers scenarios and the corresponding loss in exchange user fees are listed in Table 7.[24] The waiver leads to about $42 million less in aggregate premiums in the Alaska individual market in 2018. The corresponding loss in exchange user fees is 3.5% of the difference in premiums, leading to a loss in user fees of almost $1.5 million in 2018. The loss increases gradually as the difference in total premiums increases, reaching over $3.2 million in 2026. Much like the expected losses in insurer tax revenues and individual penalty payments, the size of the loss in exchange user fees is small relative to the APTC savings. On average, the loss in exchange user fees is about 3% of the savings in APTC.

[24]The estimated decreases in revenue displayed in Table 7 assume that all of the premiums in the individual market are subject to the fee. They represent a bound of the impact on revenue, because individuals who take up insurance are not required to do so through the federal exchange. To the extent that premium decreases from the waiver are for premiums that are not written through a federal exchange, and are not subject to the fee, the estimates in Table 7 are exaggerating the decrease in revenue to the federal budget.

Table 7: Estimated Loss in Exchange User Fees

Year	Diffference in Total Premiums	Loss in Exchange User Fees
2016	$0	$0
2017	$0	$0
2018	$42,052,366	$1,471,833
2019	$47,094,038	$1,648,291
2020	$48,305,929	$1,690,708
2021	$54,438,525	$1,905,348
2022	$58,275,748	$2,039,651
2023	$63,986,881	$2,239,541
2024	$71,074,775	$2,487,617
2025	$85,118,080	$2,979,133
2026	$91,974,844	$3,219,120

*Note: The projected changes in total premiums come from Table 18 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B. The calculation for loss in exchange user fees is based on a 3.5% fee on premiums for every year, and assume the entire decrease in premiums due to the waiver would have been subject to the fee. The estimated losses in this table are based on calendar year and attributed to the same year as the premiums that they are attached to. In practice, a portion of the fee may be collected in the following calendar year.

3.5 Overall Impact on Budget

Comparing the estimates for the losses in individual shared responsibility payments, health insurance provider fees, and exchange user fees with APTC savings indicates that the net impact on the federal budget is positive and large. Table 8 shows yearly estimates for the combined impact of the channels through which the waiver will influence the federal budget, savings in APTC payments, and decreases in individual shared responsibility payments from uninsured individuals, health insurance provider fees, and exchange user fees. The losses in individual penalties in this table are from the calculations using the flat rate penalties, which are much higher than projected national average penalty, so the estimates in Table 8 are relatively conservative.

All of the estimates shown in Table 8 are for savings prior to any pass-through funding. The savings in 2016 prior to any pass-through funding is about $49 million. Moreover, the estimated savings increase every year thereafter and are expected to reach almost $92 million in 2026. So long as the amount of pass-through funding granted in the waiver does not exceed these estimates, the proposed waiver will not have any anticipated negative impact on the federal deficit, and could instead have a large positive impact.

Table 8: Estimated Savings From Waiver (Before Pass-Through Funding)

Year	APTC Savings		Individual Penalties		Provider Fees		Exchange User Fees		Final Savings
2016	$0	-	$0	-	$0	-	$0	=	$0
2017	$0	-	$0	-	$0	-	$0	=	$0
2018	$51,637,772	-	$1,192,255	-	$0	-	$1,471,833	=	$48,973,684
2019	$55,978,906	-	$1,169,925	-	$900,354	-	$1,648,291	=	$52,260,335
2020	$60,181,304	-	$1,369,682	-	$1,012,503	-	$1,690,708	=	$56,108,411
2021	$65,406,805	-	$977,711	-	$1,037,013	-	$1,905,348	=	$61,486,732
2022	$69,811,961	-	$986,711	-	$1,173,585	-	$2,039,651	=	$65,612,014
2023	$76,720,364	-	$1,010,756	-	$1,256,216	-	$2,239,541	=	$72,213,851
2024	$82,667,950	-	$1,080,697	-	$1,382,168	-	$2,487,617	=	$77,717,468
2025	$90,004,673	-	$671,498	-	$1,539,377	-	$2,979,133	=	$84,814,665
2026	$97,550,838	-	$692,577	-	$1,853,635	-	$3,219,120	=	$91,785,506

*Note: The estimated losses in individual penalties and exchange user fees in this table are based on calendar year and attributed to the same year as the premiums that they are attached to. In practice, all or a portion of those fees may be collected in the following calendar year.

4 Other considerations

We have considered the most important mechanisms through which the proposed waiver will directly impact federal spending and revenues. One indirect avenue through which granting a waiver could impact the federal budget is through administrative costs. However, the proposed waiver will only require granting of pass-through funding and granting a greater number of premium tax credits, neither of which are expected to have large impacts on administrative costs.

There are a few small fees collected based on the number of insured individuals. Since the waiver will increase the number of insured individuals, it would increase revenue through these channels, but the impact would be marginal. One fee that helps to fund the Patient-Centered Outcomes Research Institute (PCORI) is scheduled to equal $2.28 per member per year in 2017. This fee is set to increase the following years based on increases in health care expenditures, but phase out after 2019. Another per member fee, the risk adjustment administration fee, is set for $1.80 per member per year for 2017. Between these two fees, the waiver would increase revenue by almost $7,000 in 2018 based on the expected increase in number of individuals covered. Given the small increase in total revenue, due to the low amount and phasing out of the PCORI fee in 2019, this difference is omitted from the analysis. However, the waiver would have a slight positive impact on government revenue through this channel.

5 Conclusion

This report considers the different ways in which the proposed waiver may impact the federal budget to assist in evaluating whether the waiver will meet the fourth guardrail, that it have no adverse impact on the federal deficit. Projections from the actuarial analysis related to this waiver proposal are used to rule out a number of mechanisms through which a waiver could influence the budget. Because the proposed waiver will only impact movement of individuals between the uninsured category and the individual insurance market, and will only impact premiums in the individual insurance market, we can focus on a few channels through which the waiver will impact federal costs and revenues. The most important impact of the waiver is that by depressing premiums, it will also drastically decrease the amount of APTC payments. The savings generated through this channel are large enough to overpower any negative impact on revenues through other channels. With that being said, the proposed waiver will likely decrease revenues through at least three channels: individual shared responsibility payments, health insurance provider fees, and exchange user fees. The increased number of individuals taking up insurance in the individual market means that fewer individuals will be required to make individual responsibility payments. The waiver also reduces the aggregate premiums written in the Alaska individual market, which has an impact on the total premiums aggregated to the national level, and in turn decreases the total amount collected in the health insurance providers fee for years 2019 and beyond. Lastly, revenue collected through the exchange user fee, a tax on premiums generated through the federal exchange marketplace, will be lower in the waiver scenario, because the waiver decreases premiums in the Alaska individual market, which uses a federal exchange marketplace. The savings from decreased APTC is much greater than the estimated decreased revenue through the other three channels combined, lost penalties paid by uninsured individuals, decreased provider fees collected from insurers, and decreased exchange user fees. The analysis of the impact of the waiver on the federal deficit suggests that the waiver can meet the fourth guardrail of no negative impact on the deficit, although the final impact is dependent on the amount of pass-through funding granted. Prior to any pass-through funding, the waiver generates savings of about $49 million in 2018. The savings gradually increases all the way up to almost $92 million in 2026. So long as the amount of pass-through funding granted by the waiver does not exceed these estimated savings (final column of Table 8) then we expect the proposed waiver to have no negative impact on the federal deficit.

Appendix

Health Insurance Providers Fee Estimates

Disentangling the impact of the waiver through the health insurance provider fee is complex because of the multiple moving parts and dynamic feature of the fee calculation. The total fee for fee year 2019 can be written as a function of the market share of the Alaska individual market multiplied by the growth rate in premiums in the Alaska individual market, added to the rest of the national market share and growth rate (premiums written in other markets, aggregated nationally). Using the projections of total premiums written in the Alaska individual market produced by the actuarial analysis, along with an assumption about the initial total market size and growth rate of the aggregate premiums in all other markets, we can calculate the impact of the waiver on federal revenues through this channel.

The total insurer tax is of a pre-determined size through collection year 2018. It is important to distinguish between the year of collection and the year that the collection is based on. In 2018 the total fee will be $14.3 billion, split across the national industry based on share of total premiums written. The $14.3 billion collection will be based on the premium revenues in 2017. Thereafter, the total fee will increase at the same rate as the total premiums. Consider the following equations describing the nature of the fee for collection year 2019 (the first in which the fee size has not yet been determined):

$$Premium\ Growth_{2018} = \frac{National\ Premiums_{2018} - National\ Premiums_{2017}}{National\ Premiums_{2017}} \tag{1}$$

$$Total\ Fee_{2019} = (\$14.3\ billion) \times (1 + Premium\ Growth_{2018}) \tag{2}$$

This is how the total size of the fee collected in 2019, based on revenues from 2018, will be determined.[25] Every year after 2019 will follow a similar calculation, where the increase in the total fee collected will be tied to growth in premiums. The proposed waiver will impact the growth in total premiums because it changes the growth in premiums in the Alaska individual insurance market. In order to understand this channel and to calculate the difference in total premiums resulting from the passage of the proposal, it is instructive to re-write equation (1) as the weighted summation of the growth in the individual Alaska market and the growth in all other markets combined.

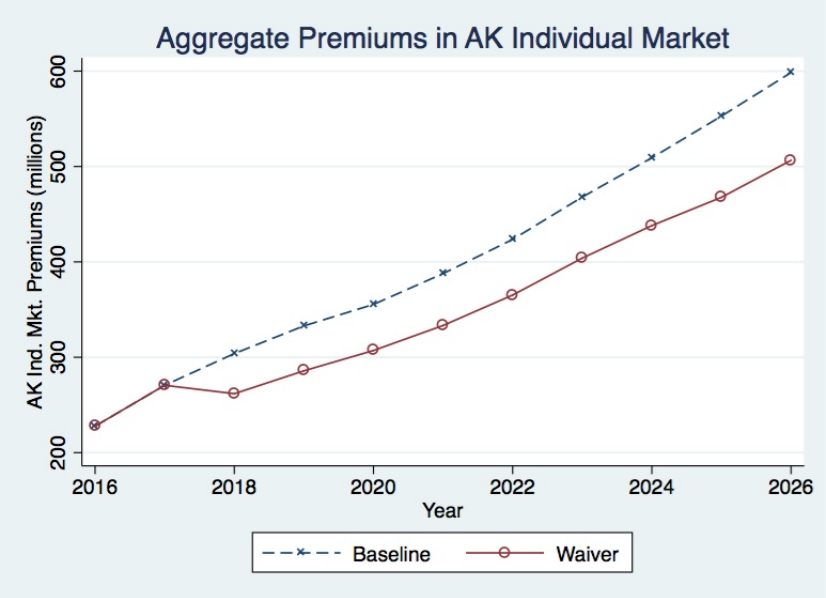
[25] https://www.irs.gov/irb/2013-51_IRB/ar12.html

$$Premium\ Growth_{2018} = (Market\ Share_{2018}^{AKIndividual}) \times (Growth_{2018}^{AKIndividual})$$

$$+(1 - Market\ Share_{2018}^{AKIndividual}) \times (Growth_{2018}^{Else}) \quad (3)$$

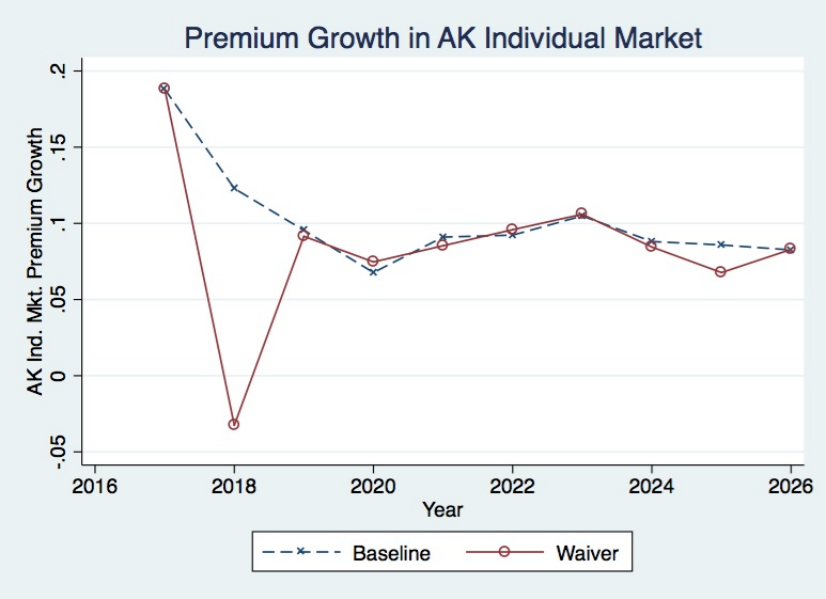
In other words, the changes in the Alaska individual market influence the overall growth in premiums through the change in share of the total market that the Alaska individual market makes up, as well as any change in the growth rate of premiums in the Alaska individual market. The actuarial analysis provides projected total premiums in the Alaska market in Table 18 of the Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B, and those numbers are represented in Figure 1.

Figure 1: Aggregate Premiums in AK Individual Market



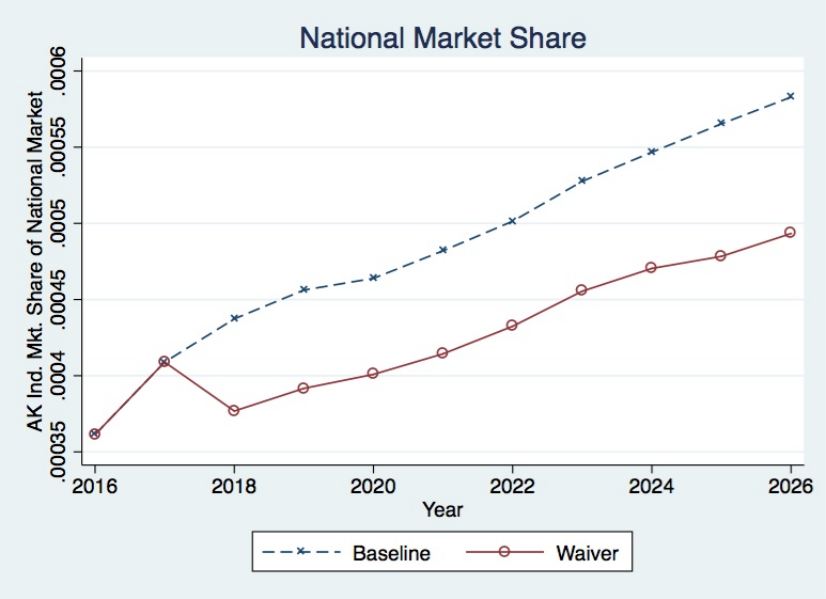
As shown in Figure 1, the proposed waiver will decrease the total (aggregate) premiums written in the Alaska individual market. This just means that the waiver depresses premium rates enough to overpower the impact from inducing more individuals to join the market, so that aggregate total premiums decrease. The total premium projections were used to calculate the growth in total premiums written in the Alaska individual market for both the baseline and waiver scenarios, and are displayed in Figure 2.

Figure 2: Premium Growth in AK Individual Market



The biggest deviation of premium growth in the waiver scenario from the baseline scenario occurs in 2018, because that is the year that ARP is scheduled to run out if the proposed waiver is not granted. As shown in Figure 1, under the waiver scenario aggregate premiums actually decrease from 2017 to 2018. On the other hand, in the baseline scenario aggregate premiums increase from 2017 to 2018, which is driven by an increase in premium rates. Because of this difference in the two scenarios, growth in 2018 is 12% of the baseline scenario, but negative in the waiver scenario, about -3%. In the years after 2019, total premiums in the Alaska individual market grow at similar rates in the two scenarios. However, this one time difference in growth leads to differences in market size that are reflected in the relative shares of the national market. The market shares under the waiver and baseline scenarios are shown in Figure 3.

Figure 3: National Market Share



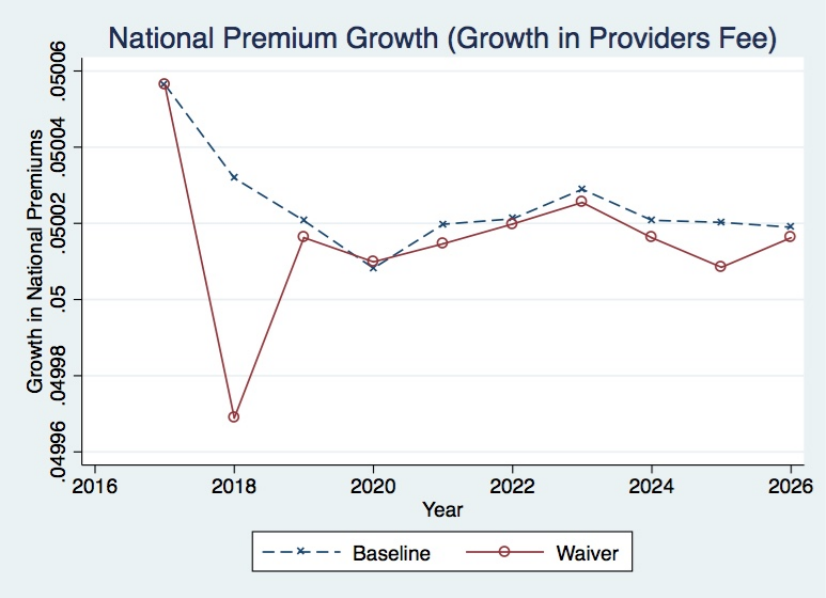
The market shares were estimated by assuming an initial market size and growth rate. The initial market size is based on the size of the market in 2013, which comes from an estimate of the health insurance providers fee in 2014 as a percentage of total premiums. The total providers fee was $8 billion in 2014, estimated to be 1.47% of total premiums. That estimate is used to calculate an estimated initial market size ($8 billion)/(0.0147) in 2013. A growth rate of the total market premiums of 5% is used to project market size in every year after 2014. The 5% figure is roughly the average growth rate from 2018 to 2026 in the projected total health insurance provider fee, based on the CBO report projecting ACA related figures.[26] The differences displayed in Figure 3 may seem small, e.g. market shares in 2018 are about 0.00038 and 0.00044 in the waiver and baseline scenarios, respectively, but they still influence the total growth in the market. The weighted growth in the national market is shown in Figure 4, which is also the growth rate used to calculate the increases in the insurer tax each year.

The impact on the national premium growth rate mirrors that difference in the rate in the Alaska individual market. The biggest difference is in 2018, for which the national premium growth rates are 0.04997 and 0.05003 in the waiver and baseline scenarios, respectively. Again, rates are similar in the years that follow. However, this one time difference leads

[26] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsurance Baseline_OneCol.pdf (See Table 2, *Net Federal Subsidies Associated with Health Insurance Coverage for People Under Age 65*, of CBO report for projected taxes on health insurance providers for this group of individuals.)

to differences in fee size calculated for the 2018 premium revenues (collected in 2019). The market shares and growth rates in the Alaska individual market, along with figures for the size of the national market and growth rates, were used in Equation 3 to calculate the total size of the health insurance providers fee in the waiver and baseline scenarios.

Figure 4: National Premium Growth (Growth in Providers Fee)



Although the difference in growth seems small, it results in meaningful differences in the total fee, because the base for the fee is so large ($14.3 billion for the 2017 premium revenues, collected in 2018). A 5% growth rate for the national aggregate premiums is also assumed used when using equation (3) to determine the total impact of the waiver on providers fee size. Table A1 displays the total providers fee under each scenario, and the difference in those fees. The waiver will not impact the total fee in 2018, because the size of the 2018 fee is already determined. In collection years 2019 to 2026, the proposed waiver will reduce the size of the total fee collected. The proposed waiver will reduce the amount collected in the insurer tax by $900,353 in fee year 2019. The reduction in total fees collected is larger with each year, because the size of the market increases and the difference in total premiums between the waiver and baseline scenarios increases as well (See Figure 1). However, the size of the reduction in insurer taxes collected is small relative to the size of the APTC savings. For example, the reduction in insurer taxes is about 1.6% of the APTC savings in 2018. The projected reduction in insurer taxes caused by the waiver is figured in to the total savings shown in Table 8.

Table A1: Estimated Loss in Insurer Tax

Year	Total Tax Baseline	Total Tax Waiver	Difference
2018	$14,300,000,000	$14,300,000,000	$0
2019	$15,015,455,719	$15,014,555,365	$900,354
2020	$15,766,539,567	$15,765,527,064	$1,012,503
2021	$16,554,996,233	$16,553,959,220	$1,037,013
2022	$17,383,073,059	$17,381,899,474	$1,173,585
2023	$18,252,595,183	$18,251,338,967	$1,256,216
2024	$19,165,753,265	$19,164,371,097	$1,382,168
2025	$20,124,439,606	$20,122,900,229	$1,539,377
2026	$21,131,069,242	$21,129,215,607	$1,853,635

*Note: The size of the aggregated market, excluding the Alaskan individual market, is estimated by assuming that the total market premiums were equal to roughly $550B in 2013 and applying a 5% growth rate. The estimated size of the market in 2013 is based on an Association for Community Affiliated Plans report in which it is stated that the $8B fee in 2014 was equivalent to a 1.47% tax rate. See http://www.communityplans.net/Portals/0/Exchanges/Fees%20and%20Taxes%20Report%20Update%20for%20the%20Exchange%20Requirement%20Reports.pdf for more details. The assumed 5% growth rate is roughly equal to the average growth in the total tax on insurance providers from 2019 - 2026 projected by the CBO. See https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf for more details (Table 2). Projected total premiums (outside of the Alaska individual market) are calculated by applying the estimated growth in premiums at the national level in each scenario. Total premiums in the Alaska individual market come from Table 18 of Alaska 1332 Waiver Application, Actuarial Analyses and Certification, Appendix B.

Alaska 1332 Waiver Proposal
Reporting Targets

Per 45 CFR 155.1308(f)(4)(vi) Alaska will submit quarterly, annual, and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive coverage requirement, and the federal deficit requirement.

In addition, the State proposes to include the following information in the reports:

• Evidence of compliance with public forum requirements (within six-months after waiver implementation and annually thereafter), including date, time, place, description of attendees, the substance of public comment and the State's response, if any.

• Information about any challenges the State may face in implementing and sustaining the waiver program and its plan to address the challenges.

• A description of any substantive changes in Alaska's insurance market such as the number of insurers serving the individual market.

• Any other information consistent with the terms and conditions in the State's approved waiver.

Alaska proposes to provide the following information related to scope, affordability, comprehensiveness, and deficit neutrality on a quarterly, annual and cumulative basis, where appropriate.

Please note that numbers in the tables that follow may be rounded to the nearest one.

Scope of Coverage/Comparability

Alaska's waiver is not expected to affect eligibility on individual enrollment or on coverage for vulnerable residents, who are more likely to be enrolled in Medicaid or Medicare. Alaska's waiver will help stabilize participation and will have a small increase in the number of Alaska residents covered by individual health insurance. The waiver is not expected to have an impact on employer-sponsored insurance.

(Projections per table 2 of Actuarial Analysis)

Total Individual Market Enrollment on and off Marketplace					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	22,894	22,894	22,894	22,894	22,894
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	23,558	23,558	23,558	23,558	23,558
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	23,548	23,548	23,548	23,548	23,548
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	23,410	23,410	23,410	23,410	23,410
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	23,866	23,866	23,866	23,866	23,866
Actual					

(Projections per table 2 of Actuarial Analysis)

Small Group Employer Market Enrollment					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	16,426	16,426	16,426	16,426	16,426
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	16,471	16,471	16,471	16,471	16,471
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	16,496	16,496	16,496	16,496	16,496
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	16,511	16,511	16,511	16,511	16,511
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	16,559	16,559	16,559	16,559	16,559
Actual					

(Projections per table 2 of Actuarial Analysis)

Government Enrollment (Medicare, Medicaid/CHIP, Military)					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	353,434	353,434	353,434	353,434	353,434
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	359,402	359,402	359,402	359,402	359,402
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	365,326	365,326	365,326	365,326	365,326
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	371,008	371,008	371,008	371,008	371,008
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	376,335	376,335	376,335	376,335	376,335
Actual					

Affordability

Alaska's waiver is not expected to affect affordability of coverage in the individual market.

(Projections per table 20 of Actuarial Analysis)

Average Individual Market Premium Contribution Per Member					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	$870	$870	$870	$870	$3,480
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	$885	$885	$885	$885	$3,540
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	$933	$933	$933	$933	$3,732
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	$918	$918	$918	$918	$3,672
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	$972	$972	$972	$972	$3,888
Actual					

(Projections per table 32 of Actuarial Analysis)

Average Individual Market Premiums + Cost Sharing (Total Out-of-Pocket) Per Member					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	$1,590	$1,590	$1,590	$1,590	$6,360
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	$1,632	$1,632	$1,632	$1,632	$6,528
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	$1,728	$1,728	$1,728	$1,728	$6,912
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	$1,755	$1,755	$1,755	$1,755	$7,020
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	$1,851	$1,851	$1,851	$1,851	$7,404
Actual					

(Projections per table 20 of Actuarial Analysis)

Average Small Group Market Premiums Contribution Per Employee					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	$417	$417	$417	$417	$1,668
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	$450	$450	$450	$450	$1,800
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	$480	$480	$480	$480	$1,920
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	$522	$522	$522	$522	$2,088
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	$561	$561	$561	$561	$2,244
Actual					

(Projections per table 32 of Actuarial Analysis)

Average Small Group Market Premiums + Cost Sharing (Total Out-of-Pocket) Per Member					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	$1,659	$1,659	$1,659	$1,659	$6,636
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	$1,791	$1,791	$1,791	$1,791	$7,164
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	$1,911	$1,911	$1,911	$1,911	$7,644
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	$2,073	$2,073	$2,073	$2,073	$8,292
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	$2,235	$2,235	$2,235	$2,235	$8,940
Actual					

Comprehensiveness

Alaska is not proposing to waive or amend any aspects of the ACA that pertain to comprehensiveness of benefits.

Proposed Report

Every quarter, Alaska will report on modifications, if any, which have been made in plans resulting from changes in federal or state law. The Alaska annual report will list all changes (if any) that occurred in the preceding year. The cumulative report will list any benefit changes and their effective date over the course of the waiver period.

Deficit Neutrality

Alaska's waiver is expected to produce substantial savings to the Federal Government.

(Projections per table 35 of Actuarial Analysis)

APTC Spending in Alaska with Waiver					
	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	Annual
Projected	$45,565,172	$45,565,172	$45,565,172	$45,565,172	$182,260,689
Actual					
	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	Annual
Projected	$50,593,136	$50,593,136	$50,593,136	$50,593,136	$202,372,542
Actual					
	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	Annual
Projected	$54,790,567	$54,790,567	$54,790,567	$54,790,567	$219,162,267
Actual					
	2021 Quarter 1	2021 Quarter 2	2021 Quarter 3	2021 Quarter 4	Annual
Projected	$61,802,746	$61,802,746	$61,802,746	$61,802,746	$247,210,983
Actual					
	2022 Quarter 1	2022 Quarter 2	2022 Quarter 3	2022 Quarter 4	Annual
Projected	$68,119,418	$68,119,418	$68,119,418	$68,119,418	$272,477,673
Actual					

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development

DIVISION OF INSURANCE

550 West Seventh Avenue, Suite 1560
Anchorage, AK 99501-3567
Main: 907.269.7900
Fax: 907.269.7910

Addendum No. 1 to Alaska 1332 Innovation Waiver Application

The Alaska Division of Insurance seeks to waive provision 1301(a) of the Affordable Care Act.

Section 1301(a)

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.— Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

Rationale: CMS offered informal guidance to the division on December 5th, requesting the division include a waivable item for consideration of a 1332 Innovation waiver. The division requests to waive a provision of Section 1301 (a) as there are not any CO-OPs in the state, nor are there likely to be any in the foreseeable future. Waiver of Section 1301 (a) will not require an additional actuarial or economic study. In essence, waiving this provision of Section 1301(a) will not have any impact on the Alaska individual or small group markets. Alaska's hope is that this addendum will expedite the federal review process.

Anticipated impact: The state does not currently have a CO-OP, so waiver of this provision will not affect the Alaska individual market. Performance of CO-OPs across the US has been abysmal, and it is unlikely that a CO-OP would seek to enter the Alaska individual healthcare market. Waiving this item will have no impact on the baseline or waiver scenarios. It is not anticipated that waiving this item will have any impact on the federal deficit, comparability, affordability or comprehensiveness of the Affordable Care Act.

Lori Wing-Heier
Director, Alaska Division of Insurance

December 7th 2016
Date

Chris Hladick
Commissioner
P.O. Box 110800
Juneau, AK 99811-0800
www.commerce.alaska.gov

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY & ECONOMIC DEVELOPMENT

Press Release

FOR IMMEDIATE RELEASE

COMMISSIONER'S OFFICE

No. 16-021

Contact: Lori Wing-Heier
Director, Division of Insurance
(907) 269-7900
lori.wing-heier@alaska.gov

State Innovation Waiver Seeks to Stabilize Alaska's Individual Health Insurance Market

November 30, 2016 ANCHORAGE – In an effort to ensure the long-term viability of the individual healthcare insurance market in the state, the Division of Insurance is seeking a Section 1332 State Innovation Waiver, which would allow changes to the administration of the Affordable Care Act in Alaska. The division is seeking federal pass-through funding to subsidize the Alaska Reinsurance Program, the innovative short-term solution passed by the 29th Alaska Legislature last spring to make healthcare insurance more affordable for individual Alaskans.

"We are able to seek this waiver because of the leadership of Governor Bill Walker and the near-unanimous support of the Alaska Legislature to pass House Bill 374," said Lori Wing-Heier, director of the Division of Insurance. "The combined impact of HB 374 and a successful state innovation waiver will hopefully convince additional insurers to serve Alaskans in the individual market."

The waiver application is available for review at notice.alaska.gov/183687. You may submit written comments to the Division of Insurance by no later than 5:00 p.m. on December 23, 2016. Oral comments will be accepted at the following public hearings:

Anchorage	December 16, 2016 from 1 to 3 p.m.
	Atwood Building (550 West 7th Ave.), Room 102
Juneau	December 19, 2016 from 10 a.m. to 12 noon
	State Office Building (333 Willoughby Ave.), 9th Floor Conference Room A South

The Alaska Reinsurance Program mitigates the substantial rate increases in the individual healthcare insurance market. With the reinsurance program, rates in the individual market increased by approximately 7 percent for 2017 as opposed to the initially projected 42 percent; in the two years prior to the establishment of the reinsurance program, insurance premiums in the individual market increased almost 80 percent. In addition to providing relief to Alaskans, the relatively lower rates reduce the amount of Advanced Premium Tax Credits the federal government is responsible for providing to Alaska residents. Alaska is requesting that the federal savings that will be generated as a result of a reduction in tax credits be passed to the state to ensure the long-term stabilization of Alaska's individual health insurance market.

The Division of Insurance, along with the Division of Banking and Securities, the Division of Corporations, Business and Professional Licensing, the Alcohol and Marijuana Control Office, and the Regulatory Commission of Alaska, is an agency housed within the Alaska State Department of Commerce, Community and Economic Development tasked with protecting consumers in Alaska. For additional information about the division, please visit insurance.alaska.gov. For additional information about the Department of Commerce, Community, and Economic Development and its other agencies, please visit commerce.alaska.gov.

# # #

THE STATE of ALASKA

GOVERNOR BILL WALKER

SECTION 1332 INNOVATION WAIVER
Public Hearing for Transparency and Community Input in Alaska

Department of Commerce, Community and Economic Development
Division of Insurance

Lori Wing-Heier, Director

December 16, 2016

Patient Protection and Affordable Care Act

Passed on March 23, 2010, President Obama's landmark legislation provided, in *Section 1332*, that:

"a State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State beginning on or after January 1, 2017. Such application shall-

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including-

  i. a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

  ii. A 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) Provide an assurance that the State has enacted the law described in subsection (b)(2)."

What can be waived?

- Part I of subtitle D of Title I of the ACA relating to the establishment of qualified health plans (HHS);
- Part II of subtitle D of Title I of the ACA relating to consumer choices and insurance competition through health benefit exchanges (HHS);
- Section 1402 of the ACA relating to reduced cost sharing for individuals enrolling in qualified health plans (HHS); and
- Section 36B relating to refundable credits for coverage under a qualified health plan, 4980H relating to shared responsibility for employers regarding health coverage and 5000A relating to tax penalties for the failure to maintain minimum essential coverage of the Internal Revenue Code (IRS)

What can be waived in plain English?

- Benefits and Subsidies – States may modify rules governing covered benefits, as well as the subsidies that are available through the marketplace. States seeking to reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies to implement their alternative approach
- Marketplace and Qualified Health Plans – States may replace their marketplaces or supplant the plan certification process with alternative ways to provide health plan choice; determine eligibility for subsidies and enroll consumers in plans;
- The Individual Mandate – States may modify or eliminate the requirement that individuals maintain minimum essential coverage;
- The Employer Mandate – States may modify or eliminate the requirement that large employers offer affordable coverage to their full-time employees

What cannot be waived?

- States cannot waive any nondiscrimination provision contained within the Affordable Care Act which prohibits an insurer from denying insurance or increasing premiums based on medical history
- States may also not waive any "fair play" rules that guarantee equal access at fair prices to all enrollees

The "Guardrails"

Each waiver application must satisfy four criteria:

1. Comprehensive Coverage – States must warrant that the coverage provided to consumers remains "at least as comprehensive" as coverage absent the waiver;
2. Affordable Coverage – States must provide "coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as coverage absent the waiver;
3. Scope of Coverage – States must provide coverage to "at least a comparable number of residents" as would have been covered without the waiver; and
4. Federal Deficit – The waiver must not increase the federal deficit.

Other Items that need to be submitted

- The regulations and guidance does not contain a defined or published application.
- The regulations and guidance do require that the application for the waiver include:
  - ✓ Compliance with the application procedures of 31 CFR 33.108 (a)(2)(iv) and 45CFR 155.1308(a)(2)(iv); and
  - ✓ Provides written evidence of the state's compliance with the public notice requirements set forth in 31 CFR 33.112 and 45 CFR 155.1312 and provides all of the following:
    - A comprehensive description of the enacted state legislation and program to implement a plan meeting the requirements for a waiver under section 1332;
    - A copy of the enacted state legislation authorizing such waiver requested;
    - A list of the provisions of the law that the state seeks to waive including a brief description of the reason for the specific request(s); and
    - The analyses, actuarial certifications, data, assumptions, targets and other information sufficient to provide the secretaries with the necessary data to determine that the state's proposed waiver provides coverage that is at least as comprehensive as in the absence of a waiver, would provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable absent the waiver, provide coverage to at least a comparable number of residents and would not increase the federal deficit.

Public Comment Periods

- 31 CFR 33.112 and 45 CFR 155.1312 require states to provide a public notice and comment period for a waiver application sufficient to ensure a meaningful level of public input prior to submitting an application
- A state with one or more federally-recognized tribes must conduct a separate process for meaningful consultation with such tribes
- The period(s) can be no less than 30-days

Where did we begin?

Timeline for the Division of Insurance

June 2016

- Legislature passes HB374 providing statutory authority for Section 1332 Innovation Waiver

July 2016

- On July 19th, Governor Bill Walker signs HB374 in Anchorage, Alaska

August 2016

- Worked with Manatt and Princeton University to develop goals and policy priorities for innovation waiver
- Kevin Counihan, CEO/CMS-CCIIO Marketplace, issues blog referencing HB374 and is encouraging of Alaska applying for innovation waiver for future funding
- Met with Kevin Counihan to discuss the innovation waiver and the premium tax credits not being paid to consumers as a result of the passage of HB374
- Developed reclassification of existing position to add Healthcare Coordinator to assist with the Alaska Reinsurance Program, external reviews of healthcare benefits as required by the ACA and other healthcare issues

Where did we begin?

Timeline continued…

September 2016

- Numerous discussions with Manatt/Princeton team and CMS-CCIIO/IRS team regarding 1332 Innovation Waiver. Discussions regarding baseline, technicality, need for hearing, detail and depth of actuarial analysis, etc.
- Began discussions with Oliver Wyman, same actuarial firm used by the State of Hawaii, for sole-source contract
- Began discussions with University of Alaska, Institute of Social and Economic Research (ISER), for economic study needed to quantify impact to federal budget, etc.

October 2016

- Oliver Wyman begins actuarial analysis
- ISER begins economic impact study

November 2016

- Received actuarial analysis from Oliver Wyman
- Division reviewed ISER economic impact study
- Draft narrative and internal review
- Published for public comment on OPN November 23rd
- Notified members of Alaska Native Health Board to fulfill Tribal Outreach
- Scheduled public hearings

Where are we going?

December 2016

- Continuing review and editing of draft waiver with CMS and IRS
- Public hearings scheduled for December 16th in Anchorage and December 19th in Juneau
- Incorporate public comments and submit final waiver application to Center for Medicare and Medicaid and the Internal Revenue Service
- Request Governor Walker contact Secretary Burwell to finalize and approve Alaska's Section 1332 Innovation Waiver application
- Request Senator Sullivan contact Secretary Burwell to finalize and approve Alaska's Section 1332 Innovation Waiver application

Building on Premium Stabilization for the Future

By Kevin Counihan, Health Insurance Marketplace CEO

The Affordable Care Act (ACA), the Medicare Part D prescription drug benefit, and a number of states' insurance plans include reinsurance programs as a way to promote stable, affordable health coverage. Because high-cost enrollees and events are rare, they create disproportionate uncertainty in setting health insurance premiums: it is hard for any given issuer to predict how many people with very high-cost conditions will enroll, or how many expensive but unusual events will occur. By protecting against some of this risk, reinsurance programs help stabilize health insurance markets, promote issuer participation, and reduce premiums for consumers. Reinsurance programs also reduce insurers' incentives to discourage enrollment by people with very high-cost conditions, thereby helping ensure those individuals can access the care they need.

The three-year, transitional reinsurance program established under the ACA was designed to buffer the new individual market as new federal reforms were implemented, enrollment grew, and issuers gained experience pricing and planning for new consumers. New data released today show that per-enrollee costs in the ACA individual market were essentially unchanged from 2014 to 2015, falling by 0.1 percent, even as per-enrollee costs in the broader health insurance market grew by at least 3 percent.

This finding suggests a year-over-year improvement in the ACA individual risk pool, with the Marketplaces gaining healthier, lower-cost consumers as it expanded. Meanwhile, independent researchers recently estimated that 2016 Marketplace premiums are between 12 percent and 20 percent below what the Congressional Budget Office (CBO) initially predicted. At the same time, the Health Insurance Marketplace remains a young, maturing market, one where all participants – insurers, consumers, providers, states, and we as federal regulators – are still learning.

Given this evolution and as part of our ongoing efforts to strengthen the Marketplace, we are exploring options to modify the ACA's permanent risk adjustment program to better adjust for the highest-cost enrollees and their actuarial risk, which would achieve some of the same risk-sharing benefits as the reinsurance program. The ACA's risk adjustment program plays an important role in distributing the costs of sicker, more expensive enrollees, and data show that the program worked as intended in its first two years.

But as described in a white paper released this spring, the current HHS risk adjustment methodology cannot easily adjust for certain high-cost enrollees. In future rulemaking, we plan to propose modifying the risk adjustment program to absorb some of the cost for claims above a certain threshold (e.g. $2 million), funded by a small payment from all issuers. This type of risk sharing would reduce uncertainty for issuers who are not yet able to reliably predict the prevalence and nature of high-cost cases in their Marketplace business, while also protecting access to robust coverage options for people with very high-cost conditions.

Some states are also considering creating their own reinsurance programs to help stabilize and strengthen their markets. Recently, Alaska enacted a law to allocate $55 million from an existing premium tax to provide reinsurance for the individual market and to pursue a State Innovation Waiver under the ACA. Alaska had previously collected funds for the state's high-risk pool that is no longer needed because the ACA guarantees coverage to individuals with pre-existing conditions; about 35 states had high-risk pools prior to the ACA as well and may have similar opportunities.

Alaska 1332 Waiver Application

- Alaska's proposed waiver intends to pass-through Advanced Premium Tax Credits (APTC) that were not paid to Alaskans because of HB374 to partially fund the Alaska Reinsurance Program (ARP).
- The state would appropriate the remaining amount to fully fund the ARP, after adjusting for medical inflation.
- The ARP mitigates rate increases in the Alaska individual health insurance market and as a result limits the amount of premium tax credits the federal government is responsible for providing to Alaska residents.
- By removing high cost conditions from the risk pool, the benefits of the ARP are shared by the entire individual health insurance market regardless of income, age, race and ethnic group, or any other demographic characteristic.
- Alaska does not seek to waive any aspect of the ACA that would reduce access to meaningful, affordable insurance for any resident and does not contemplate changes to the Medicaid program, individual exchange, or direct purchase with this proposal.

Assurances

The State of Alaska provides the following assurances:

- Scope of Coverage
- Affordability
- Comprehensiveness
- Deficit Neutrality
- Pass-Through Funding
- Effect on Federal Operational Considerations
- Public Input

Oliver Wyman Actuarial Report

APTCs and Individual Market Enrollment by Scenario and Year

	APTCs			Individual Market Enrollment		
Year	Baseline	Waiver	Difference	Baseline	Waiver	Difference
2015	94,468,271	94,468,271	-	28,159	28,159	-
2016	135,348,085	135,348,085	-	24,064	24,064	-
2017	185,716,278	185,716,278	-	23,822	23,822	-
2018	233,898,461	182,260,689	(51,637,772)	21,253	22,894	1,641
2019	258,351,449	202,372,542	(55,978,906)	21,993	23,558	1,565
2020	279,343,570	219,162,267	(60,181,304)	21,773	23,548	1,775
2021	312,617,789	247,210,983	(65,406,805)	22,176	23,410	1,234
2022	342,289,634	272,477,673	(69,811,961)	22,656	23,866	1,210
2023	380,127,501	303,407,137	(76,720,364)	23,539	24,721	1,182
2024	412,662,662	329,994,712	(82,667,950)	23,713	24,940	1,227
2025	449,544,666	359,539,993	(90,004,673)	24,196	24,937	741
2026	488,186,123	390,635,284	(97,550,838)	24,520	25,263	742

While our modeling suggests greater actions will be needed to increase the affordability of coverage, the reinsurance program will help bring some much needed stability to the individual health insurance market in Alaska.

Critical Path or Other Issues

- CMS/CCIIO and IRS not being able to confirm baseline or revenue stream for funding
- 2016 Presidential Elections and CMS/CCIIO and IRS entering transition
- President-elect Trump not allowing for Section 1332 Innovation Waivers or the funding of the Alaska Reinsurance Program
- CMS/CCIIO and/or the IRS not approving the Section 1332 Innovation Waiver application

Conclusion

Questions?

Affordable Care Act State Innovation Waiver; Public Hearings for Transparency and Community Input in Alaska

Transparency and community input are important aspects of any state's development process for seeking an Affordable Care Act (ACA) State Innovation Waiver.

Alaska is utilizing the flexibility afforded to states through the 1332 process to stabilize the individual health insurance market. Premiums in the Alaska individual health insurance market have increased substantially since the onset of the ACA. Alaska has been faced with escalating healthcare costs from the utilization of services by individuals with high cost health conditions, a small population spread across a vast geographic area, and insufficient health care provider competition.

For 2017, initial rate information indicated that premiums in the individual health insurance market were projected to increase 42%. The state took action, and passed legislation creating the Alaska Reinsurance Program (ARP). The legislature also appropriated $55 million to fund the program in 2017. As a result of state action, premiums in the individual health insurance market will increase approximately 7% in 2017. Actuarial analysis prepared for the Alaska Division of Insurance estimates the Alaska Reinsurance Program will save the Federal government $51.6 million in Advanced Premium Tax Credits (APTCs) for 2018, and increase enrollment in the individual market by nearly 1,650 relative to what APTCs and enrollment would be absent the ARP.

Alaska's 1332 waiver application seeks federal funding under section 36B of the Internal Revenue Code. Under the proposed waiver, Alaska would receive federal pass-through funding to subsidize the Alaska Reinsurance Program, based on savings that would be generated as a result of a reduction in APTCs absent the reinsurance program. The State would appropriate the remaining amount of funds necessary to ensure the ARP is fully funded, after adjusting for medical inflation. The State Innovation Waiver would be effective January 1, 2018 for an initial period of five years, with an option to renew for an additional five years.

Alaska is fulfilling the public notice requirements by holding the following public hearings:

Anchorage
December 16, 2016 1:00p.m. -3:00 p.m.
Atwood Building, 1st Floor, Room 102, located at 550 West 7th Avenue, Anchorage, Alaska, 99501

Juneau
December 19, 2016 10:00 a.m. -12:00 p.m.
State Office Building, 9th Floor, Conference Room A South, located at 333 Willoughby Avenue, Juneau, Alaska 99801

The hearings may be extended to accommodate those present before 12:00 p.m. who did not have an opportunity to comment. If you are unable to attend a hearing in person and would like to participate by teleconference, please call 1-800-315-6338 and enter access code 42070 followed by # (pound sign).

You may submit oral or written comments on the proposed waiver at the hearings. You also may comment on the proposed waiver by submitting written comments to the Division of Insurance. All comments must be received **no later than 5:00 p. m., December 23, 2016 at the address, fax or email below.**

Division of Insurance
Attn: Sarah Bailey
P.O. Box 110805
Juneau, AK 99811-0805
Fax 907-465-3422

Email: sarah.bailey@alaska.gov

Individuals or groups of people with disabilities, who require special accommodations, auxiliary aids or service, or alternative communication formats in order to participate in the process may contact Laura Watson at

laura.watson@alaska.gov or (907)-465-2597, or call TDD at (907) 465-5437 **no later than December 15, 2016** to ensure any necessary accommodations can be provided.

DATE: November 22, 2016

_____/ss/_____

Lori Wing-Heier

Director

Attachments, History, Details

Appendix I: Sections Waivable in §1332

Provisions of the Affordable Care Act that may be Waived under Section 1332

Offering Qualified Health Plans ("QHPs") and required Essential Health Benefits ("EHB")

- Section 1301: Definition of **QHPs**
- Section 1302: **EHB** requirements, including
    - Identifying EHB
    - Annual limitations on cost-sharing
    - Annual limitations on deductibles for employer-sponsored plans
    - Levels of coverage as currently defined by metal levels (platinum, gold, silver, bronze)
    - Catastrophic plans
    - Child-only plans
- Section 1303: **Special rules** related to abortion services
- Section 1304: **Definitions** related to
    - Group and individual markets
    - Large and small employers and rules related to determining the size of an employer

Providing consumers a health insurance exchange

- Section 1311: Affordable health plan choices via **establishing exchanges**
- Section 1312: **Consumer choice**
    - Employee choice
    - Single risk pool
    - Markets outside of exchanges
    - Individual choice to enroll in a QHP or participate in the exchange
    - Limitations on access to exchanges to citizens and lawful residents
    - Ability of exchanges to offer coverage to large employers starting in 2017
- Section 1313: **Financial integrity** expectations that exchanges will keep accurate accounts of receipts and expenditures

Premium tax credits and reduced cost-sharing

- Section 1402: **Cost-sharing reductions** via enrollment in QHPs
- Section 36B of the IRS Code: **Refundable credits/premium assistance** for coverage in a QHP

Individual and employer responsibility requirements

- Section 4980H of the IRS Code: **Shared responsibility** for employee health insurance
    - Penalties for large employers (more than 100 employees) if not providing coverage
    - Penalties for large employers if coverage offered but employees still access premium tax credits or cost sharing
    - Definition of Full Time Employee ("FTE") as at least 30 hours per week employment
    - Exemption for certain employees: FTEs who work seasonally or 120 or fewer days/year
    - Definition of seasonal workers
    - Rules for determining employer size
- Section 5000A of the IRS Code: Requirement to **maintain minimum coverage (Section 1501)**
    - Penalties
    - Exemptions
    - Definition of minimum essential coverage

Appendix II: Section by Section Consideration of Waivable Provisions

Alaska's waiver proposal outlined by section below is founded on **the goal of Stabilizing the Individual Health Insurance Market**. The State seeks pass through funding for the ARP. Alaska will continue to participate in a federally-facilitated marketplace for individuals and families, and strongly choice and affordability for those seeking coverage there as well as off-exchange in the individual health market.

ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Section 1301: Definition of Qualified Health Plans

Key ACA Provisions	Alaska Proposal
The definition of "Qualified Health Plan" including providing EHB, and offering plans conforming to metal levels with the inclusion of at least silver and gold	Alaska proposes to retain these provisions.
Inclusion of Co-Op and Multi-State Plans	Alaska proposes to waive this section. There are currently no Co-ops operating in Alaska and due to their poor performance elsewhere it is unlikely that a Co-op will seek to do business in Alaska.
Treatment of Qualified Direct Primary Care Medical Home Plans	Alaska proposes to retain these provisions.
Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements)	Alaska proposes to retain these provisions.

Section 1302: EHB Requirements

Key ACA Provisions	Alaska Proposal
Defines EHB	Alaska proposes to retain these provisions.
Annual limitations on costsharing	Alaska proposes to retain these provisions.
Annual limitations on deductibles for employer sponsored plans	Alaska proposes to retain these provisions.
Definition of metal levels by actuarial value	Alaska proposes to retain these provisions.
Availability of catastrophic plans	Alaska proposes to retain these provisions.
Availability of child-only plans	Alaska proposes to retain these provisions.
Defines payment to federally qualified health centers	Alaska proposes to retain these provisions.

Section 1303: Special Rules Related to Abortion Services

Key ACA Provisions	Alaska Proposal
Details special rules related to abortion services	Alaska proposes to retain these provisions.

Section 1304: Definitions of Markets and Rules for Large and Small Employers

Key ACA Provisions	Alaska Proposal
Specifies rules for aggregation treatment of employers, employers not in existence in preceding year, and predecessor employers	Alaska proposes to retain these provisions.
Defines when a "growing" small employer that purchased employee coverage through SHOP may continue to do	Alaska proposes to retain these provisions.

Section 1311: Providing Consumers a Health Insurance Exchange

Key ACA Provisions	Alaska Proposal
Requires establishment of an American Health Benefit Exchange, and details responsibilities of the exchange	Alaska proposes to retain these provisions.
Provides for the establishment of a SHOP exchange	Alaska proposes to retain these provisions.
Specifies which entities are eligible to carry out responsibilities of the Exchange	Alaska proposes to retain these provisions.

Section 1312: Consumer Choice

Key ACA Provisions	Alaska Proposal
Details provisions for consumer choice among QHPs through an exchange	Alaska proposes to retain these provisions.
Establishes that all enrollees in the individual market are in a single risk pool	Alaska proposes to retain these provisions.
Establishes that all enrollees in the small group market are in a single risk pool	Alaska proposes to retain these provisions.
Allows states to merge individual and small group insurance in a single risk pool if the state deems it appropriate	Alaska proposes to retain these provisions.
Prevents state law from requiring grandfathered plans to be in the individual or small group risk pool	Alaska proposes to retain these provisions.
Allows health issuers to offer coverage outside an exchange, and allows individuals and qualified employers to purchase coverage outside an exchange	Alaska proposes to retain these provisions.
Maintains state control of plans outside of the exchange	Alaska proposes to retain these provisions.
Provides choice to qualified individuals as to whether or not to enroll via an exchange and which plan to choose	Alaska proposes to retain these provisions.
Describes health plan choices for members of Congress and Congressional staff	Alaska proposes to retain these provisions.
Ensures that individuals who cancel enrollment on the exchange in favor of employer coverage will not be penalized	Alaska proposes to retain these provisions.
Allows enrollment through agents and brokers	Alaska proposes to retain these provisions.
Limits enrollment through an exchange to citizens and lawful residents	Alaska proposes to retain these provisions.
Excludes incarcerated individuals	Alaska proposes to retain these provisions.
Allows coverage via the exchange for the large group market	Alaska proposes to retain these provisions.
Provides that access to coverage through an exchange may be denied to those who are not lawful residents for the entire enrollment period	Alaska proposes to retain these provisions.

Section 1313: Financial Integrity

Key ACA Provisions	Alaska Proposal
Details financial management and protections against fraud and abuse for an exchange	Alaska proposes to retain these provisions.

PREMIUM TAX CREDITS AND REDUCED COST-SHARING

Sections 1402/36B – Premium Tax Credits and Cost Sharing

Key ACA Provisions	Alaska Proposal
Details provisions and eligibility for reductions in cost-sharing and out-of-pocket costs for individuals who enroll in a QHP	Alaska proposes to retain these provisions.

INDIVIDUAL AND EMPLOYER RESPONSIBILITY REQUIREMENTS

IRC Sections 4980H and 5000A: Individual and Employer Responsibility

Key ACA Provisions	Alaska Proposal
Defines and details requirements for offering health insurance coverage by large employers and responsibilities of employees for enrolling	Alaska proposes to retain these provisions.

The CMS Blog

The official blog for the Centers for Medicare & Medicaid Services (CMS) responsible for Medicare, Medicaid and CHIP. For more information, please visit www.cms.gov

Building on Premium Stabilization for the Future

AUGUST 11 BY CMS (HTTPS://BLOG.CMS.GOV/AUTHOR/JEREMYPBOOTH/)

By Kevin Counihan, Health Insurance Marketplace CEO

The Affordable Care Act (ACA), the Medicare Part D prescription drug benefit, and a number of states' insurance plans include reinsurance programs as a way to promote stable, affordable health coverage. Because high-cost enrollees and events are rare, they create disproportionate uncertainty in setting health insurance premiums: it is hard for any given issuer to predict how many people with very high-cost conditions will enroll, or how many expensive but unusual events will occur. By protecting against some of this risk, reinsurance programs help stabilize health insurance markets, promote issuer participation, and reduce premiums for consumers. Reinsurance programs also reduce insurers' incentives to discourage enrollment by people with very high-cost conditions, thereby helping ensure those individuals can access the care they need.

The three-year, transitional reinsurance program established under the ACA was designed to buffer the new individual market as new federal reforms were implemented, enrollment grew, and issuers gained experience pricing and planning for new consumers. New data (https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-Risk-Pool-Analysis-8_11_16.pdf)released today show that per-enrollee costs in the ACA individual market were essentially unchanged from 2014 to 2015, falling by 0.1 percent, even as per-enrollee costs in the broader health insurance market grew by at least 3 percent.

This finding suggests a year-over-year improvement in the ACA individual risk pool, with the Marketplaces gaining healthier, lower-cost consumers as it expanded. Meanwhile, independent researchers recently estimated that 2016 Marketplace premiums are between 12 percent (http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/) and 20 percent (http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/) below what the Congressional Budget Office (CBO) initially predicted. At the same time, the Health Insurance Marketplace remains a young, maturing market, one where all participants – insurers, consumers, providers, states, and we as federal regulators – are still learning.

Given this evolution and as part of our ongoing (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-21.html) efforts (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html) to strengthen (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html) the Marketplace, we are exploring options to modify the ACA's permanent risk adjustment program to better adjust for the highest-cost enrollees and their actuarial risk, which would achieve some of the same risk-sharing benefits as the reinsurance program.

The ACA's risk adjustment program plays an important role in distributing the costs of sicker, more expensive enrollees, and data show (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf) that the program worked as intended in its first two years.

But as described in a white paper (https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf) released this spring, the current HHS risk adjustment methodology cannot easily adjust for certain high-cost enrollees. In future rulemaking, we plan to propose modifying the risk adjustment program to absorb some of the cost for claims above a certain threshold (e.g. $2 million), funded by a small payment from all issuers. This type of risk sharing would reduce uncertainty for issuers who are not yet able to reliably predict the prevalence and nature of high-cost cases in their Marketplace business, while also protecting access to robust coverage options for people with very high-cost conditions.

Some states are also considering creating their own reinsurance programs to help stabilize and strengthen their markets. Recently, Alaska enacted a law (https://www.healthinsurance.org/alaska-state-health-insurance-exchange/) to allocate $55 million from an existing premium tax to provide reinsurance for the individual market and to pursue a State Innovation Waiver under the ACA. Alaska had previously collected funds for the state's high-risk pool that is no longer needed because the ACA guarantees coverage to individuals with pre-existing conditions; about 35 states had high-risk pools (http://www.ncsl.org/research/health/high-risk-pools-for-health-coverage.aspx) prior to the ACA as well and may have similar opportunities.

Alaska's health insurance market has struggled for many years with the highest health care costs in the country, low levels of insurance market competition, and other challenges, which are likely related, at least in part, to its very low population density and unique geography. But after Alaska's governor signed the reinsurance bill into law, Premera, the state's Blue Cross Blue Shield plan, reduced its requested 2017 rate increase to 9.8 percent (http://stateofreform.com/featured/2016/07/premera-requests-9-8-rate-increase-individual-plans-alaska/), less than the previous two years' increases, well below the 40 percent increase the company had previously considered. According to media reports, this difference reflected the fact that nearly a quarter of Premera's claims costs in the first half of 2015 came from just 37 high-cost enrollees (https://www.healthinsurance.org/alaska-state-health-insurance-exchange/) and the plan expects these high claims costs to be partially covered under the state's reinsurance program.

Alaska's reinsurance legislation also includes authority for Alaska to seek a State Innovation Waiver from CMS. Innovation Waivers may be granted for changes that waive specific existing ACA policies and meet four statutory guardrails (https://www.federalregister.gov/articles/2015/12/16/2015-31563/waivers-for-state-innovation): maintaining or improving access to coverage, affordability of coverage, comprehensiveness of coverage, and not adding to federal deficits.

While the details of Alaska's waiver will not be clear until the state submits an application, a reinsurance program has the potential to improve access and affordability by strengthening the state's insurance market and buffering risk for insurers. In addition, to the extent a reinsurance program reduces individual market premiums, it could also reduce federal costs for the Premium Tax Credit. If an Innovation Waiver is approved, the state may receive federal pass-through funding based on any savings realized in Marketplace financial assistance. Thus, a waiver – in Alaska or other states considering creating state reinsurance programs – could potentially provide pass-through funding that would in effect cover part of the cost of a reinsurance program.

Our door is always open to new ideas that help spread the risk of providing coverage for people with

significant health care needs. These ideas contribute to our ongoing work in promoting Marketplace stability and help ensure affordable options for consumers.

###

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FILED UNDER UNCATEGORIZED

Comments are closed.

Letters of Support

1. Aetna
2. America's Health Insurance Plan (1)
3. America's Health Insurance Plan (2)
4. Alaska Dental Society
5. Alaska Native Tribal Health Consortium
6. Alaska Primary Care Association
7. Alaska Regional Hospital
8. Alaska State Hospital and Nursing Home Association
9. Alaska State Medical Association
10. Marsh & McLennan Agency
11. Moda Health Plan, Inc.
12. Premera – Blue Cross Blue Shield
13. Planned Parenthood

aetna℠

December 19, 2016

Director Lori Wing Heier
Alaska Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, Alaska 99501-2567

RE: Federal Funding for Alaska 1332 State Innovation Waiver Application

Dear Director Wing Heier,

We support the federal funding requested in the 1332 State Innovation Waiver that would allow Alaska to receive much needed pass-through funds from the federal government to ensure the long-term stabilization and viability of Alaska's individual health insurance market.

We look forward to continued dialogue with the Division on this matter. In the interim, please do not hesitate to contact me with any questions or to discuss.

Sincerely,

Shannon Butler
Sr. Director of Government Affairs

Transmitted electronically to Lori Wing Heier

America's Health
Insurance Plans

Marilyn Tavenner
President &
Chief Executive Officer

December 13, 2016

Ms. Lori K. Wing-Heier
Director
State of Alaska
Dept. of Commerce, Community & Economic Development
Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, Alaska 99501-3567

Dear Director Wing-Heier:

This past weekend, I met with many of you at the fall national meeting of the National Association of Insurance Commissioners. In follow up to our robust discussion about how your state is critical to ensuring that every American has access to affordable coverage and care, I am sending to you a copy of the key principles that we discussed to bring about solutions to deliver a more affordable and stable health care system. As Washington debates repeal-and-replace proposals for the Affordable Care Act, there are many important questions before us.

While there are different approaches to reform, it is clear that no one wants to disrupt individuals who rely on their coverage today. It is also clear that everyone wants to improve health care in a way that empowers all Americans for better health and financial stability. There are many ideas for how we can achieve these goals.

As a collaborative and constructive voice in Washington and the states, AHIP has been offering proposals for how to ensure consumer stability and financial viability. The attached document comprises our key recommendations.

I know you are likely formulating your response to Congress' questions on how reform would affect your state, which are the front line of implementation. AHIP stands ready to be a partner to understand the impact to your constituents, and to help create a successful path forward. I would welcome the chance to speak with you about how we can help shape the future of health care policy for the benefit of your citizens and taxpayers.

If you or a member of your staff would like to discuss these issues, I would welcome a call or an in-person meeting. I can be reached at 202-778-3269 or mtavenner@ahip.org. I look forward to your call.

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004
202.778.3200

Your voice is an important part of this conversation. Thank you for your leadership and engagement.

I also support the waiver! Well done! ☺

Sincerely,

Marilyn B. Tavenner
President and CEO

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

December 21, 2016

Alaska Division of Insurance
Attn: Sarah Bailey
P.O. Box 110805
Juneau, AK 99811-0805

Re: Alaska 1332 Waiver Draft Application

Dear Ms. Bailey:

I write today on behalf of America's Health Insurance Plans (AHIP) to express our support for the Alaska Division of Insurance's draft 1332 waiver proposal.

America's Health Insurance Plans (AHIP) is the national association representing health insurance plans. Our members provide health and supplemental benefits to the American people through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

Because health insurance markets are inherently local, we support the federal 1332 waiver option for states to develop state-specific solutions to state-specific health insurance challenges. Proposals for 1332 waivers should explore solutions to increase consumer choice and reduce costs while ensuring consumers in that specific state have access to coverage. States that utilize a 1332 waiver should consider how to implement that waiver in a manner that minimizes disruption for individuals who purchase coverage in that state. Stakeholder engagement is a critical step in the development of a 1332 waiver proposal that will accomplish those goals.

Alaska is grappling with unique local challenges facing the individual health insurance market that warrants a unique state-specific response. The Alaska Division of Insurance has thoroughly engaged with a wide variety of stakeholders, including health plans doing business in Alaska and thus the Alaska 1332 waiver application reflects thoughtful consideration of input provided by health plans and others on how to best stabilize the Alaska market.

Specifically, Alaska seeks to establish a state-specific reinsurance program funded through a broad-based assessment. We believe the proposal to provide federal pass-through funding to subsidize the Alaska Reinsurance Program achieves the goal to develop a transition plan which creates innovative and state-specific solutions, while minimizing the burden on individual enrollees. This approach will allow health plans to continue offering affordable products in the individual market that meet the needs of Alaskans. Once the program is implemented, the

individual insurance market in Alaska should stabilize, leading to increased competition and more affordable health plan options for Alaskans.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org or (202-679-6522).

Sincerely,

Grace Campbell

Grace Campbell
Regional Director

Cc: Director Lori Wing-Heier

Alaska
DENTAL SOCIETY

November 30, 2016

The Alaska Dental Society (ADS) supports the State of Alaska's effort to secure a Section 1332 waiver.

Dentists, as small business owners, are purchasers of healthcare insurance for themselves, their families and their employees. Given the small size of dental offices, purchasing insurance through the individual market is the only option available.

The Alaska individual health care insurance market has become unaffordable for all except high utilizers of medical services. Relatively healthy participants, of which the ADS members qualify as, have to balance the cost of insurance premiums, deductibles and co-payments. For a 50 year old man the amortization point is approximately $30,000 encouraging self-insurance. For the insurance pool to remain viable, premiums have to reach more affordable levels to encourage healthy individuals to join.

The State of Alaska's plan to reinvigorate the Alaska Reinsurance plan will bring stability to the market. Granting the State Innovation waiver and allowing federal dollars to pass through and subsidize the plan will allow high utilizers to be removed from the individual healthcare insurance market. The removal of high utilizers will allow the individual market to continue and provide stability to the overall Alaskan healthcare market.

Sincerely,

David Logan, DDS
Executive Director, Alaska Dental Society

9170 Jewel Lake Rd. Ste. 100 Anchorage, AK 99502
Phone: (907) 563-3003 • Fax: (907) 563-3009 • Website: akdental.org • E-mail: info@akdental.org

Office of the
CHAIRMAN & PRESIDENT

November 29, 2016

Lori Wing-Heier, Director
Alaska Division of Insurance
333 Willoughby, 9th Floor
Juneau, AK 99801

RE: Alaska Section 1332 State Innovation Waiver

Dear Ms. Wing-Heier,

The Alaska Native Tribal Health Consortium (ANTHC) is a statewide tribal health organization that serves all 229 tribes and 150,000 Alaska Natives and American Indians (AN/AI) in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AI in Alaska. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for Alaska Natives (AN) and their communities.

We are writing to convey our support for Alaska's Section 1332 State Innovation Waiver to request the Centers for Medicare and Medicaid Services (CMS) to waive certain provisions of the Patient Protection & Affordable Care Act (ACA). Section 1332 allows States to apply for an Innovation Waiver to creatively and effectively provide access to quality health care under the ACA. We understand Alaska is seeking federal approval under section 36B of the Internal Revenue Code to provide pass-through federal funds for Advance Premium Tax Credits (APTC) to ensure the long-term stabilization and viability of Alaska's individual health insurance market.

We have analyzed the waiver data and agree that the savings that will be generated as a result of a reduction in APTCs as a consequence of Alaska's ARP will result in significant savings to the Federal government in the form of reduced premium tax credits. This will result in lower premium adjustments from year to year and help to stabilize the Alaska insurance marketplace and will help maintain and increase enrollment into insurance marketplace plans.

We appreciate the legislature and your office's forethought to create this very innovative program and look forward to working with you to implement the program. Thanks you and if you should need to contact me directly you may do so at (907) 729-1916 or by email at ateuber@anthc.org.

Respectfully,

Andy Teuber
Chairman and President

Alaska Primary Care
ASSOCIATION

December 19, 2016

Lori K. Wing-Heier, Director
State of Alaska – Division of Insurance
PO Box 110805
Juneau, AK 99811-0805
sarah.bailey@alaska.gov

RE: State Innovation Waiver Letter Of Support

Dear Director Wing-Heier:

The Alaska Primary Care Association, (APCA), offers its support of the State of Alaska 1332 State Innovation Waiver application. Alaska Community Health Centers have a vested interest in promoting access to affordable insurance coverage for their patients and strongly support efforts that address the sustainability, affordability, and stability of the individual insurance marketplace in Alaska.

The Alaska proposal to waive certain provisions of the Affordable Care Act through a Section 1332 waiver is an innovative solution to reinsure the costly diagnoses of its sickest policy holders. This will help to lower the rate of inflation of health insurance premiums for other consumers and strengthens the individual health insurance market. It should be noted that two leading Congressional plans to replace the Affordable Care Act support the concept of federal support for reinsurance programs at the state level.

During the 2016 Alaska Legislative session, APCA supported the concept to establish the current state funded reinsurance program that resulted in lowering premiums for the 2017 enrollment year. The 1332 Waiver proposes to sustain this important activity, and serve as a model to other states looking for examples of successful reinsurance programs.

Sincerely:

Nancy Merriman
Executive Director

Further, plans sold on the Marketplace must include a set of standardized benefits, including women's preventive services. Women are able to access, without cost-sharing, preventive services such as birth control, routine well-woman exams, breast and cervical cancer screenings, STI and HIV testing, and mammograms for women 40 and up.[4] The birth control benefit alone has saved an average of $255 per year and women using IUDs have saved an average of $248 as a result of the birth control benefit since 2012.[5]

In order for women to benefit from the advantages of the Marketplace, the Marketplace must be stable. There are currently only two insurers selling plans in the Alaska Marketplace and next year, there will be only one insurer in the Marketplace. Alaska's premiums are the highest in the nation. In 2016, the average monthly premium in Alaska was $863 – which is double the national average monthly premium.[6] Although financial assistance dramatically reduces the premiums most consumers pay, the cost still remains too high for many consumers.[7]

The Alaska Reinsurance Program (ARP) will benefit Alaska consumers. The state legislature passed authorizing legislation earlier this year, and appropriated state funds into the program. The ARP reimburses insurers for all or part of the claims related to care for certain populations. This helps lower the premiums for all of the consumers. Most importantly, this approach allows consumers – including those with high health care needs– to remain in the Marketplace, and not be placed in a plan that provides substandard coverage for a high cost.

The program is already bringing down the rate at which premiums will increase. In 2016, premiums for plans sold on the Alaska Marketplace increased 31 percent, and in 2015, premiums increased 26 percent. Before ARP was created, premiums were expected to increase by 42 percent for 2017. Subsequent, to the authorization of the ARP, premiums are only expected to increase seven percent. For women, this means a continued ability to access the care that women need most. The care that women

---

energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/ACA%20Womens%20Health%20FINAL.pdf.

[3] State of Alaska De'pt of Commerce, Community and Economic Development Division of Insurance, Alaska 1332 Waiver Applications (Dec. 7, 2016).

[4] *See* Health Resources & Services Administration, Women's Preventive Services Guidelines, https://www.hrsa.gov/womensguidelines/

[5] Nora V. Becker and Daniel Polsky, Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing, Health Affairs, 34, no.7 (2015):1204-1211. Available at http://content.healthaffairs.org/content/34/7/1204.full.pdf+html.

[6] Timothy Jost, Alaska Reinsurance Plan Could Be Model for ACA Reform, Plus Other ACA Development, Health Affairs (June 16, 2016).

[7] Ninety-one percent of enrollees in the Alaska market receive financial assistance to pay for tax credits so not stabilizing the marketplace also strains the federal budget. Kaiser Fam. Found., Marketplace Enrollment and Financial Assistance (March 31, 2016), http://kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22alaska%22:%7B%7D%7D%7D.

report accessing the most are birth control, pap test, and breast examinations -- all services that insurers are required to cover on the Marketplace with no out of pocket cost to the woman.[8] These benefits are not likely to continue if the 1332 waiver application is not approved.

During this time when there is a national dialogue on transforming the health care system, Alaska could be an example of a responsible improvement to the insurance Marketplace. We look forward to working with the Department in this important work to improve the health insurance Marketplace. Thank you for the opportunity to comment on the Alaska 1332 application. If you have any questions, please do not hesitate to contact me at 907-841-0092.

Sincerely,

Jessica Cler
Alaska Public Affairs Manager
907.841.0092
Jessica.cler@ppvnh.org

[8] Perry Undem Research & Communication, "Women & OB/GYN providers," *Planned Parenthood Federation of America*, November 2013 http://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

ALASKA REGIONAL
HOSPITAL

Dear Ms. Wing-Heier, December 5, 2016

As CEO of Alaska Regional Hospital, I appreciate the opportunity to voice support for the State of Alaska filing an Affordable Care Act (ACA) State Innovation Waiver (1332) to help stabilize the individual healthcare insurance market here in Alaska.

We recognize the difficult decisions made by the Legislature and Governor Walker's Administration to shore up the market in the closing days of the 2016 Legislative Session. They made the right decision. Appropriating the necessary funds for implementation of the Alaska Reinsurance Program has given the Governor, Administration Commissioners and Directors the time needed to find a more reasonable and less costly mechanism for dealing with the unsustainable cost increases in the individual market. It also led to a premium increase in the individual market that makes those products significantly less expensive for Alaskans than they would have been without the ARP.

Many of Alaska Regional Hospital's patients, providers and employees will be positively impacted by the reinsurance program and a healthier market. Our hospital has been working to expand options for access to care for underserved populations in the Anchorage area by opening our new Medicaid clinic in Mountain View, aggressively expanding our services to seniors in the South Anchorage Medicare clinic and planned expansion of our behavior health presence. Any effort to help assure access to our neighbors is of great interest to us all.

Again, we appreciate the hard work of DOI and DHSS in working through this process to help achieve a more accessible and efficient healthcare system in our home state, and we fully support this effort.

Respectfully,

Julie Taylor

Julie A. Taylor, CEO
Alaska Regional Hospital

2801 DeBarr Road · Anchorage, Alaska 99508 · tel 907.276.1131 · fax 907.264.1143 · www.alaskaregional.com

ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

December 6, 2016

Lori K. Wing-Heier, CIC, CRM
Director
Alaska Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-2567

Dear Ms. Wing-Heier,

The Alaska State Hospital and Nursing Home Association (ASHNHA) would like to offer our support for the Alaska 1332 State Innovation Waiver application. ASHNHA members have significant concerns about the long-term viability of Alaska's individual insurance market and we have been a strong supporter of efforts to stabilize the insurance market.

The Alaska proposal to waive certain provisions of the Affordable Care Act through a Section 1332 waiver is an innovative solution to reinsure the most vulnerable individuals which in turn helps to lower healthcare premium costs and stabilize and support the long term viability of the individual health insurance market.

During the 2016 Legislative session, ASHNHA supported the passage of the legislation to establish a reinsurance mechanism to help stabilize premiums. Alaska's individual market is small and the claims experience of those purchasing policies in that market has been worse than anticipated. We were concerned the market was in danger of failing. The legislation has provided a short-term solution. By appropriating the funds to implement the Alaska reinsurance program the market has been stabilized and the State of Alaska has an opportunity to find a way to sustain the market into the future.

We believe the Alaska waiver application is a good example of a state-federal partnership that will help keep insurance affordable to individual Alaskans. We must maintain access to health insurance for people who do not have other options like employer-based coverage. In addition, a healthy individual insurance market is a key to an economy that fosters entrepreneurship, since the lack of a stable individual insurance market is a deterrent to those who would leave their employers to start a business.

Thank you for the opportunity to provide support for the Alaska 1332 waiver application.

Sincerely,

Becky Hultberg
President/CEO

ANCHORAGE 1049 W 5th Ave., Suite 100, Anchorage AK 99501 *tel* 907.646.1444 JUNEAU 426 Main St., Juneau, AK 99801 *tel* 907.586.1790
ashnha.com

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

December 12, 2016

Division of Insurance
Attn: Sarah Bailey
P.O. Box 110805
Juneau AK 99811-0805

RE: Affordable Care Act State Innovation Waiver

Dear Ms. Bailey:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of Alaskans.

ASMA generally supports efforts to increase access to health care. The State's action last year to stabilize the individual health insurance market by creating the Alaska Reinsurance Program was a good step. This new program reduced the anticipated premium increases from 47% to only 7%. This program will save the federal government $51.6 million dollars in Advanced Premium Credits for 2018. ASMA also recognizes that through the Affordable Care Act the federal government has assumed certain financial responsibilities. The State cannot afford to take on federal financial liabilities over the long term. Therefore, ASMA supports the State's effort to seek an ACA 1332 waiver for federal funding under section 36B of the Internal Revenue Code and request the federal government approve such waiver.

Alaska's re-insurance program is exactly the type of innovative program contemplated under the waiver program.

Thank you for your consideration of our position and if you have any questions please let me know.

Sincerely,

Mike Haugen
Executive Director
Alaska State Medical Association

MARSH & McLENNAN AGENCY

Jennifer Meyhoff
Senior Vice President

Marsh & McLennan Agency LLC
1031 West 4th Avenue, Suite 400
Anchorage, AK 99501
+1 907 257 6350
+1 907 276 6292
jennifer.meyhoff@marshmc.com
www.marshmclennanagency.com

November 29, 2016

Lori Wing-Heier
Director, Division of Insurance

Dear Ms. Wing-Heier,

I am in support of Alaska's actions to seek an Affordable Care Act (ACA) State Innovation Waiver. In the role of consultant to scores of employers offering medical insurance to thousands of consumers in Alaska, MMA values transparency in the healthcare industry.

Premiums in the Alaska health insurance market have increased substantially since the onset of the ACA. Alaska's employers and consumers have faced escalating healthcare costs compounded by multiple factors. Utilization of services by individuals with high cost health conditions, escalating charges from some healthcare providers unchecked due to insufficient provider competition, and cost shifting from uncompensated care are compounded by a small population spread across a vast geographic area.

I am writing in support of the flexibility which will result from a 1332 State Innovation Waiver.

Sincerely,

Jennifer Meyhoff

December 2, 2016

Alaska Division of Insurance
Attn: Sarah Bailey
PO Box 110805
Juneau, AK 99811-0805

Dear Sarah,

Moda Health is supportive of the Alaska Reinsurance Program (ARP) and the 1332 waiver application, as this will help improve the predictability and sustainability of the individual market.

The small number of lives in the Individual market in AK has struggled to support the costs associated with severe chronic conditions and has led to significant premium increases in recent years. The lower required premium increase for 2017 resulting from the ARP will allow more consumers to maintain coverage in the Individual market. Providing federal funding based on these savings in advanced premium tax credits will ensure that there is a fair and balanced assessment across all markets to benefit more consumers.

Please don't hesitate to contact us with any questions regarding our support of the waiver.

Sincerely,

Jason Gootee
Director, Alaska Sales & Service

December 20, 2016

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Sheela Tallman
Senior Alaska Legislative Affairs Executive

Lori Wing- Heier, Director
Division of Insurance
Atwood Building
550 West 7th Ave, Suite 1560
Anchorage, AK 99501

Re: Section 1332 State Innovation Waiver

Director Wing-Heier,

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to express our strong support for the section 1332 state innovation waiver for Alaska. This waiver would allow the state to obtain federal funding to support the Alaska Reinsurance Program to help stabilize the individual market. Premera covers approximately 9,000 individuals and families in the individual market and will be the only insurer in this market in 2017.

The state innovation waiver encourages innovation in health insurance markets to help lower prices for consumers, and Alaska's reinsurance program demonstrates both innovation and an immediate impact on premiums.

Premiums in the individual market increased drastically in 2015 and 2016, and passage of HB 374 created a state-based reinsurance program which helped lower the rate increase for 2017 considerably. Alaska's individual market is small, and there are not enough healthy purchasers to offset the costs of enrollees with very high medical needs. The reinsurance program helps cover claims from the highest cost medical conditions, thereby lowering premium increases in the individual market. The program was funded by a state appropriation for 2017 to provide immediate and much needed premium relief for individual customers. Long-term funding for the program is critical.

Through this waiver, the state seeks to obtain federal funding to help support the innovative reinsurance program that has been instrumental in stabilizing the individual market in Alaska.

We look forward to working together and with other stakeholders to continue to evaluate additional flexibility for the state of Alaska to ensure a sustainable and affordable health insurance market for individuals and employers.

Thank you for the opportunity to provide comments in support of Alaska's 1332 state innovation waiver.

Sincerely,

Sheela Tallman

Sheela Tallman

P.O. Box 327
Seattle, WA 98111

tel 425.918.6013
fax 425.918.5635
sheela.tallman@premera.com

www.premera.com

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Planned Parenthood Votes Northwest and Hawaii

December 23, 2016

Via Electronic Transmission

Director Lori Wing-Heier
State of Alaska Department of Commerce, Community,
and Economic Development
Division of Insurance
Robert B. Atwood Building
550 W. 7th Ave., Ste. 1560
Anchorage, AK 99501-3597

Re: Alaska 1332 Waiver

Dear Director Wing-Heier:

Planned Parenthood Votes Northwest & Hawaii (Planned Parenthood) is pleased to submit comments on the proposed Alaska 1332 Waiver Application. As a trusted women's health provider and advocate, Planned Parenthood supports the Department of Commerce, Community, and Economic Development, Division of Insurance effort to sustain the health insurance Marketplace in Alaska. Each year, Planned Parenthood health centers in Alaska provide services to nearly 8,000 patients. The majority of Planned Parenthood patients have incomes at or below 150%. Because many of Planned Parenthood patients are eligible to purchase their insurance coverage and receive financial assistance through the Marketplace, we have a special interest in ensuring that our patients are able to enroll in plans on the Marketplace that meet their needs. The proposed 1332 waiver is a sensible solution to stabilizing the health insurance marketplace.

Women, in particular, have benefited from the Alaska health insurance Marketplace. Over half of the enrollees on the Marketplace are women.[1] The Marketplace has contributed to the decline in the rate of uninsured women. Between 2012 and 2014, the rate of women uninsured in Alaska fell six percent, and the rate among low-income women fell nine percent.[2] The waiver application reports that an additional 1500 individuals would have coverage if the waiver were approved.[3]

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[1] Kaiser Fam. Found., Marketplace Plan Sections by Gender (Nov. 1, 2015 to Feb. 1, 2016), http://kff.org/health-reform/state-indicator/marketplace-plan-selections-bygender/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22alaska%22:%7B%7D%7D%7D.

[2] U.S. House of Representatives Committee on Energy and Commerce, Turning Back the Clock: Republican Plans to Repeal the Affordable Care Act Will Reverse Progress for Women (Dec. 2016), https://democrats-

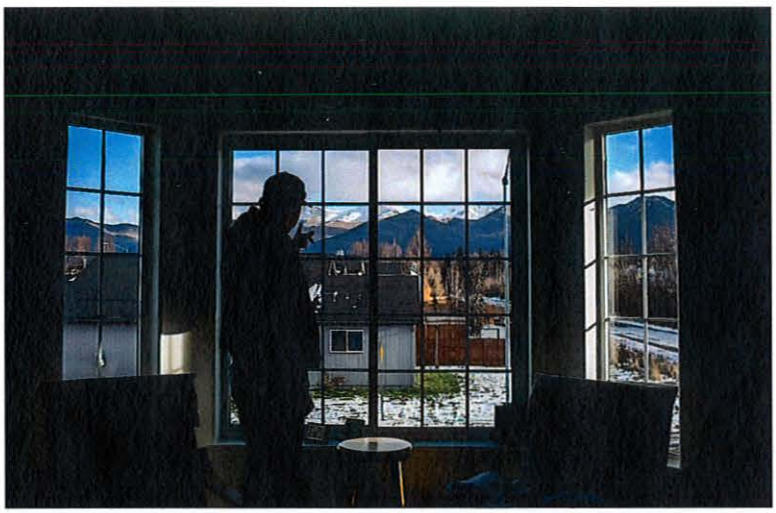
THE WALL STREET JOURNAL.

http://www.wsj.com/articles/alaskas-novel-plan-to-cut-health-premium-costs-1479825777

U.S.

Alaska's Novel Plan to Cut Health Premium Costs

State agrees to pay costs for about 500 sickest residents to hold down insurance prices for everyone else



Carl Michael gestures to the Chugach Mountains from his home in Anchorage: 'This view is why I live here.' Mr. Michael says health insurance under Obamacare is so expensive that he either can pay for coverage or pay his mortgage. *PHOTO: ASH ADAMS FOR THE WALL STREET JOURNAL*

By SHAYNDI RAICE and ANNA WILDE MATHEWS

Nov. 22, 2016 9:42 a.m. ET

ANCHORAGE, Alaska—Health-insurance premiums for individuals in Alaska have been soaring almost 40% a year. The main reason: the cost of covering fewer than 500 residents who are among the sickest in the state, according to one state analysis.

That prompted the state government to come up with a novel solution. It agreed in June to kick in $55 million for at least a year to cover the health-care costs for those patients, whose outsize medical bills prompted insurers to boost premiums for all 23,000 customers in an effort to remain profitable.

Alaska's program—passed by a Republican legislature and backed by an independent governor—may gain new attention with Donald Trump's victory.

The president-elect has said he wants to retain the Affordable Care Act's requirement that insurers can't reject customers even if they are sick. That would ensure that the challenge of covering the costliest patients remains front and center as Republicans look to repeal or alter the law.

Rates in Alaska climbed in part because insurers weren't able to enroll enough healthy people to offset the medical costs of "high-risk" patients, those with conditions such as cancer or advanced diabetes.

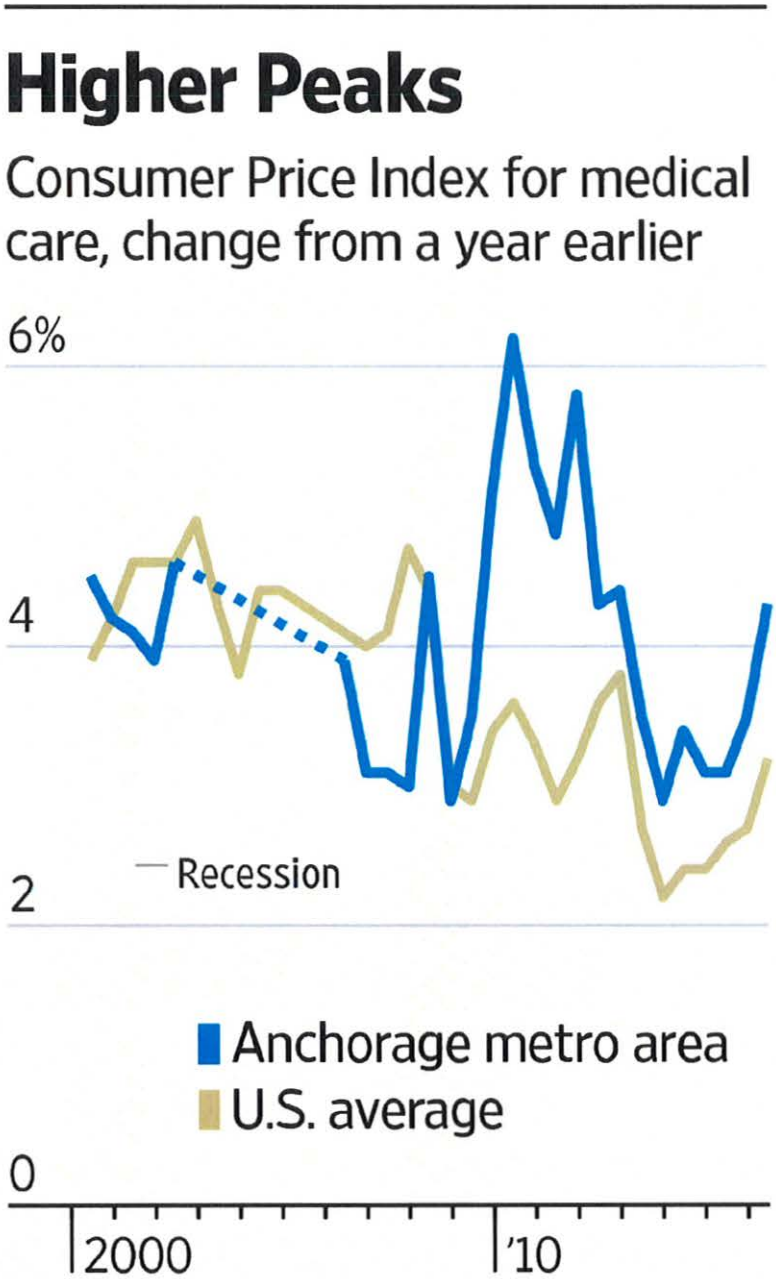
"The functioning of the individual market rests on the assumption that there has to be enough healthy people covering individuals who have high health-care bills," said Mouhcine Guettabi, an economist at the University of Alaska Anchorage. But Alaska's individual market hasn't been large enough to make that work, he said.

Officials even worried that Alaska might have no individual insurance market by 2018 after one of the two Affordable Care Act insurers offering plans in the state said it would exit the business next year.

"We were in pretty dire straits," said Lori Wing-Heier, director of Alaska's Division of Insurance.

While campaigning, Mr. Trump advocated repealing and replacing the Affordable Care Act. But since his election, he has shown an openness to keeping some of its provisions.

His transition website says his administration will support returning "the historic role in regulating health insurance to the states." It also endorses working with Congress and states to re-establish high-risk pools, which sold insurance to people with existing conditions such as diabetes, cancer and AIDS. Such pools have had financial and other problems, requiring significant government subsidies and leading to high premiums.



"Alaska remains confident that our legislation establishing a high-risk pool, as a reinsurance mechanism, is a part of the solution to lowering the costs to the individual market and could be a key reform for the ACA," said Ms. Wing-Heier in an email. "We hope that it is considered by the new administration."

Amid expected changes at the national level, Alaska's program is likely to become a model for other states, said Sean Mullin, senior director at Leavitt Partners, a health-care consulting firm.

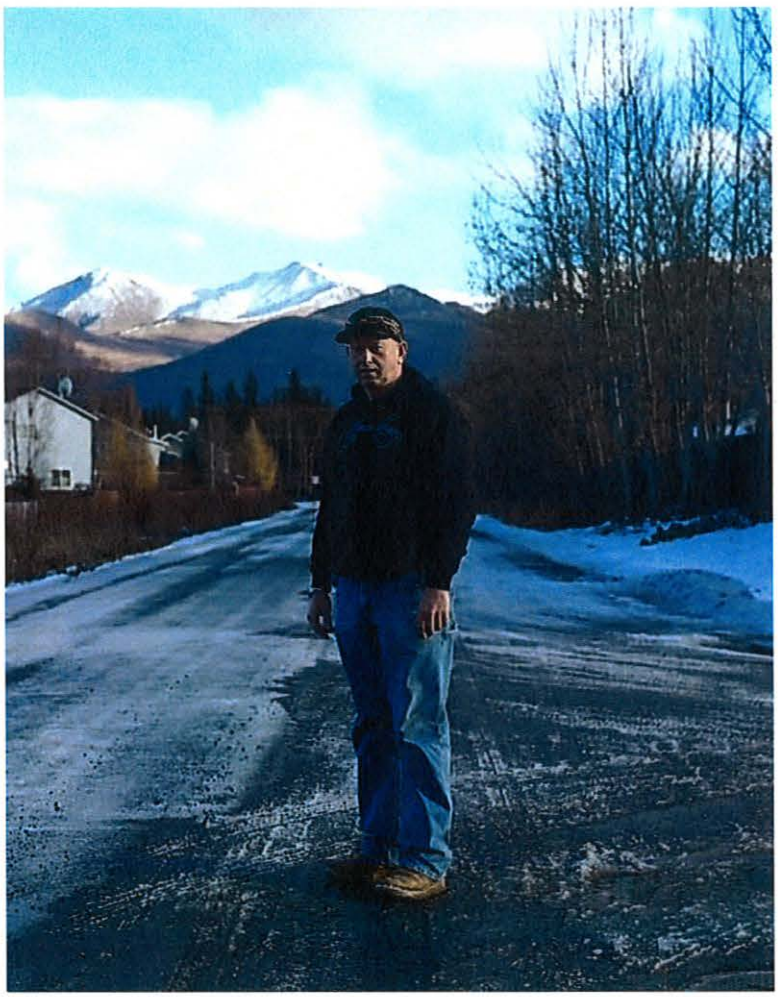
The idea fits with the Republican emphasis on greater autonomy for states, and could help ease the transition if the federal health-insurance framework is substantially revamped, he said.

Alaska reflects an extreme example of problems plaguing many ACA insurance exchanges nationwide, as insurers pulled out due to losses while those remaining often won large rate increases.

Before the changes brought by the health law, Alaskans denied coverage elsewhere could gain plans through a state high-risk pool. As cheaper plans became available through the law, that population switched over to them.

The new Alaska move kicks the costs of those patients back to the state program, which will reimburse Alaska's one remaining heath-exchange insurer, Premera Blue Cross. Those residents won't know the state is footing the bill.

Individual-plan premiums will now go up just 7.3% on average next year, instead of the more than 40% that had been projected, though Alaska's exchange plans are still expected to be among the nation's most expensive.



Carl Michael, 54, on his street in Anchorage. *PHOTO: ASH ADAMS FOR THE WALL STREET JOURNAL*

Alaska is now working on seeking federal funding from the Centers for Medicare and Medicaid Services to help pay the program's ongoing cost, though that option is uncertain given the federal health law's murky future.

"We are hoping for favorable consideration from the incoming Trump administration" on help in funding, said Ms. Wing-Heier.

Alaskans pay more for health care in part because the state has a small population spread across a vast area. Between 2000 and 2015, medical care costs grew 87% in Anchorage, compared with 71% for the rest of the U.S., according to the Labor Department.

Carl Michael, a 54-year-old retired heavy-equipment operator in Anchorage, decided he couldn't afford an ACA plan for 2016 when faced with a premium and deductibles that would have totaled about $18,000 a year, or 35% of the after-tax wages he makes as a seasonal construction inspector.

Because Mr. Michael earns too much to qualify for a federal subsidy under the health law, he faced the choice of being able to afford the mortgage on his house or buying an ACA-compliant plan. He went with non-ACA-compliant health insurance offering limited coverage, so he faces a penalty under the health law.

"Do you want to spend 35% on your health insurance and live in the ghetto or do you want to take a chance that you don't get sick?" said Mr. Michael, who lives in Anchorage. "At 54, you gotta have something."

Most of Alaska's 738,000 residents get health insurance through their employer or a government program, including an expansion of the state Medicaid program as provided under the health law, leaving a small ACA pool.

Premera, the remaining Alaska exchange insurer, said it believes Alaska's "solution will build a more stable and sustainable market without broad swings in premiums."

Write to Shayndi Raice at shayndi.raice@wsj.com and Anna Wilde Mathews at anna.mathews@wsj.com

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development
DIVISION OF INSURANCE

P.O. Box 110805
Juneau, AK 99811-0805
Main: 907.465.2515
Fax: 907.465.3422

May 9, 2017

The Honorable Tom Price
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, DC 20201

Dear Secretary Price,

Based on conversations between the United State Department of Health and Human Services and the United States Department of Treasury, the Alaska Division of Insurance would like to include an addendum to the State's Section 1332 Innovation Waiver to implement a state-operated reinsurance program for 2018 and future years.

Thank you,

Lori Wing-Heier
Director
Alaska Division of Insurance

Cc: Secretary Steven Mnuchin, U.S. Department of Treasury

Enclosures

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development
DIVISION OF INSURANCE

P.O. Box 110805
Juneau, AK 99811-0805
Main: 907.465.2515
Fax: 907.465.3422

Addendum No. 2 to the Alaska 1332 Innovation Waiver Application

The Alaska Division of Insurance seeks to waive Section 1312 (c)(1) of the Patient Protection and Affordable Care Act.

Section 1312. CONSUMER CHOICE.

(c)SINGLE RISK POOL

(1)INDIVIDUAL MARKET.-A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

Rationale: CMS offered guidance to the Division on May 3, 2017 requesting the division waive section 1312 (c)(1) and submit an addendum to the existing waiver application. The Alaska Division of Insurance seeks to waiver Section 1312 (c)(1) for the individual market single risk pool in connection with a Section 1332 waiver to implement a state-operated reinsurance program for 2018 and future years. Currently, that requirement at Section 1312 (c)(1) requires a health insurance issuer to consider "all enrollees in all health plans….offered by such issuer in the individual market….to be members of a single risk pool." To maximize the rate-lowering impact of the reinsurance program, the state would like to waive this single risk pool provision to the extent it would otherwise require excluding state reinsurance payments when determining the market wide index rate.

Anticipated Impact: The Division of Insurance will communicate with issuers participating on the Marketplace that issuers should include state-operated reinsurance dollars in rate setting. The reinsurance program will result in a reduction in premiums and premium tax credits which the state believes will result in pass-through funding that the state can use towards the reinsurance program.

Because Alaska assumed in preparing its application that Section 1312(c)(1) would not preclude inclusion of the reinsurance payments when determining the index rate, waiving this section will not require an additional economic analysis or actuarial analysis or certification. The Division anticipates the implementation of this waiver will be straightforward, as claims for enrollees through the reinsurance program for the high risk pool will still be collected and other programs such as Market Loss Ratio (MLR) will be unaffected.

Lori Wing-Heier
Director, Alaska Division of Insurance

May 9, 2017
Date

On Thursday, February 16, 2017, Oliver Wyman participated in a conference call with the U.S. Department of Treasury (Treasury Department), the U.S. Department of Health and Human Services (HHS) and the State of Alaska (Alaska), pertaining to Alaska's proposed Section 1332 Waiver. This document provides additional details regarding certain aspects of the actuarial analysis, as requested by the Treasury Department and HHS.

Projected Premiums for the Second Lowest Cost Silver Plan

Table 1 shows the projection of the Second Lowest Silver Plan (SLSP) premiums by Alaska rating region for a 21 year old in the Individual Market for the Baseline and Waiver scenarios.

Table 1: Individual ACA Market - Second Lowest Cost Silver Plan - 21 Year Old Non-Tobacco User Premium PMPM

	Baseline Scenario			Waiver Scenario		
Year	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 1	Rating Area 2	Rating Area 3
2017	$707	$743	$725	$707	$743	$725
2018	$852	$895	$873	$686	$721	$704
2019	$904	$950	$927	$730	$767	$749
2020	$972	$1,021	$996	$785	$825	$805
2021	$1,040	$1,093	$1,066	$844	$887	$866
2022	$1,114	$1,171	$1,142	$909	$955	$932
2023	$1,196	$1,256	$1,226	$978	$1,028	$1,003
2024	$1,280	$1,345	$1,312	$1,051	$1,105	$1,078
2025	$1,368	$1,438	$1,403	$1,124	$1,181	$1,153
2026	$1,462	$1,537	$1,500	$1,202	$1,263	$1,232

Verification of modeled APTC amounts PMPM

Average Premium Tax Credit (APTC) information is shown in the actuarial report in Tables 34 through 36 for the Baseline and Waiver scenarios for the APTC eligible population. The tables show the average annual subsidy-eligible membership, the total annual APTC amounts and the average APTC per subsidy eligible member per month metrics by federal poverty level (FPL) ranges. Please note, the "Other (APTC)" premium source shown in Tables 19 through 21 reflects the average APTC PMPM when APTCs are spread across all individual market enrollees, including non-ACA compliant coverage.

We received APTC eligible membership and total APTC amounts by carrier in Alaska for 2015 and for the first 9 months of 2016 from the carrier data request. This information was utilized in the calibration of Oliver Wyman's Healthcare Reform Model (HRM model).

Clarification regarding the Determination of Income

Total income as reported on the 2014 American Community Survey (ACS) data served as the basis for identifying an individual's personal income. The income for a given household insurance unit (HIU) was determined based on summing the total income for each individual within the HIU. HIU incomes were then used to determine the APTC amount for which each HIU is eligible, if any, and the amount of any Individual Shared Responsibility Payment (i.e., individual mandate penalty) that would apply if the HIU were to elect to remain uninsured. The HIU's entire income was used to determine the percentage of FPL that it represents when determining APTC eligibility, while only income above the filing threshold was used in the calculation of any Individual Shared Responsibility Payment. We believe we misspoke during our call last week regarding how income was being used in the calculation of the APTC amounts. Please note that the Individual Shared Responsibility Payment was calculated as the greater of the flat dollar amount and the applicable percentage of income above the filing threshold, with the Individual Shared Responsibility Payment capped at the average premium for a bronze level plan, as outlined in law. Please also note, the 2014 income amounts were adjusted by a factor of 1.001 to trend incomes to the 2015 baseline year. The 1.001 factor is based on the CPI-U change from 2014 to 2015 as reported in the July 2016 version of the National Health Expenditure Data (NHED) report.

Rationale for using CPI-U for determining Income Levels

As described in the report, the microsimulation model assumes a "steady state" population for 2016 and beyond. This means the overall distribution of the population by income as a percent of FPL, health status, occupation and family size is not expected to change significantly, with the exception that the overall population is expected to age slightly. The NHED's projected changes in personal income per capita are higher than the projected changes in CPI-U. FPLs are calculated each year based on the change in CPI-U. If the HRM model utilized NHED's projected changes in personal income per capita to trend HIU incomes, over time the distribution of population by income as a percent of FPL would shift upwards and the proportion of the population qualifying for Medicaid would decrease. Since this would be inconsistent with our underlying assumption of a steady state population, the microsimulation model utilizes projected changes in CPI-U as the basis for changes in income. While this may appear to understate overall changes in income relative to levels that would be produced using the NHED projected changes, to the extent we do not believe the distribution of the population by income as a percent of FPL will change materially over time, we believe the use of changes in CPI-U to trend incomes is appropriate.

Factors used in the Utility Functions

The factors used in the utility functions to account for risk aversion (r), the perceived value of having access to health insurance (u), and the perceived value of consuming health services (Hi,j) were selected in order to replicate known health insurance enrollment in the 2015 Alaskan individual and employer group health insurance markets and the 2015 uninsured population (e.g., the calibration stage). The factors for r, u and Hi,j vary based on age and income; the factors are determined for six age ranges and seven income ranges in relation to the federal poverty level.

In general, the factors for risk aversion tend to increase with age and income. This pattern reflects the notion that as an individual ages, he/she is assumed to become more risk averse (e.g., an individual close to retirement age is more willing to protect his/her accumulated wealth relative to a recent college graduate with a similar income), and as an individual's income increases, he/she will accumulate wealth faster and have a greater interest in protecting his/her accumulated wealth relative to an individual of the same demographic profile but with a lower income.

The factors for u and Hi,j are interrelated, and the product of these two factors tends to also increase with age and income. Older individuals are, on average, more likely to utilize services than a young adult; therefore, older individuals are believed to value having access to health insurance greater than younger individuals. Additionally, individuals with higher incomes are believed to place greater value on access to healthcare services since the relative cost of health care services decreases as incomes increase (e.g., a $50 copay is perceived to be more affordable to someone with an income of 600% FPL compared to someone with an income of 100% FPL).

As noted above, the values for r, u and Hi,j are selected in a manner such that the model will produce the appropriate populations by health insurance coverage type, age and income in the calibration year. In calibrating to specific populations, particularly smaller population sizes, the values for r, u and Hi,j may vary somewhat from the typical patterns described above. Some of this variation may be due to other exogenous factors unique to the decision-making process for that specific population that are not captured by one of the variables in the HRM model. As an example, individuals living in more rural regions may have a different perceived value of health care than individuals living in urban areas due to differences in the ability to easily access care. In addition, individuals of similar age and income may have different levels of accumulated wealth which could also impact their behavior, but wealth is

not included as an explicit variable in the model. In our opinion it is important that the model replicate the known base period population, and that the calibration of the model capture these other factors through the r, u and Hi,j factors that are selected.

State of Alaska Response to CMS Discussion Questions

Discussion questions for the State:

1.
   A.) What amount will the state need to fully fund the ARP each year from 2018 to 2022?
   B.) Was there an assumption used for funding the ARP in the state's actuarial analysis?

   A.) Refer to attachment 1 for the breakdown of state and federal funding.
   B.) The Oliver Wyman actuarial analysis used the $55 million appropriated for 2017 adjusted by inflation. The Oliver Wyman report, which was submitted with the waiver application, details the total amount (page 49, appendix table 24).

2.
   A.) How is the state planning to determine the level of state funding for the ARP each year of the waiver? For example, is the state funding estimate based on issuer claims, a portion of total reinsurance claims, or other evidence?
   B.) For 2017 was the $55 million sufficient to cover claims?

   A.) The state is planning to supplement the federal funding. The state funding estimate is based on a percentage of the total program.
   B.) The $55 million estimate was based on claims. It is too early in 2017 for the state to make a determination on the sufficiency of $55 million covering claims. The Alaska Reinsurance Program began on January 1, 2017. Claims will be paid quarterly and the first quarter has not yet expired. Premera's projection states that reinsurable claims will exceed the $55M, but the program is capped at the amount in the Alaska Comprehensive Health Insurance fund. The original amount is based on actuarial analysis for claims in 2014 – 2015 for a set of diagnosis codes that are detailed in the regulations that were submitted in the waiver application. Please see attachment 2.

3.
   A.) What is the timing for the determination of state funding?
   B.) Could you describe your legislative approach, how much the state plans to appropriate per year, and the source of funding?

   A.) The amount of state funding is determined by the Operating Budget, which must be appropriated by the legislature during the regular session. We've submitted a request for $55 million for FY 18 from the general fund. Due to recent budget difficulties, the budget hasn't been finalized until July the last few years.
   B.) The Alaska legislature has appropriated money for 2017, and submitted a request for funding in 2018. If the state receives a full appropriation for 2018, we will use the state funds to pay for the program as long as possible. The source is the Alaska Comprehensive Health Insurance fund within the general fund (revenue is generated through premium taxes).

4.

A.) Could you describe the provisions for reinsurance coverage under ARP?
B.) Are issuers required to cede all policies with specified conditions to ARP?

A.) Please see the regulations for detailed provision of reinsurance coverage under ARP: https://www.commerce.alaska.gov/web/Portals/11/Pub/ARP-Regulations.pdf Claim information should be submitted to ACHIA. Claims will be paid as long as there are funds available in the fund to pay claims. Insurers will submit to ACHIA the premiums of consumers who are ceded to the program, including CSR payments. They will also pay pharmacy reimbursements and report on third party liabilities, recoveries and reimbursements from other sources. Insurers must have paid a claim for a high risk individual and continue to pay claims for this person. All claims of a high risk individual will be eligible for payment by ARP. Claims must be received within 18 month after the end of the calendar year in which the claim was received. The insurer continues to administer claims for the covered person.
B.) Yes, issuers must cede, 3 AAC 31.510(a). Insurers offering individual health care insurance plans (except grandfathered or transitional plans) are required to cede claims for consumers with specified conditions beginning January 1, 2017.

5.

A.) Does the state have a sense of the 2016 actual and 2017 estimated number of transitional plan enrollees?
B.) Of these lives, what is the expected morbidity distribution of these lives?
C.) How many of these lives are expected to be eligible for APTCs?

A.) There were 1,860 transitional plan enrollees as of September 2016 (source: Oliver Wyman data call 2016). On August 12, 2016, Premera reported in a rate filing: "As of July there are 1,897 members on individual transitional policies, all with very low utilization compared to the metallic pool. It is our assumption that those who wanted richer benefits or were eligible for subsidies have already moved to ACA policies. Those who are left on transitional policies may face sticker shock when they see premiums over twice their current premiums and will elect to pay the tax penalty. To the extent that some may be holding out until transitional relief ends, the impact of including these members at lower utilization may be offset by pent up demand and just a few members coming from the ACHIA pool... ."
B.) We'd need to request this information from Oliver Wyman.
C.) The number of lives expected to be eligible for APTCs is nominal. On August 3, 2016, Premera reported in a rate filing: "Of the 1,922 members left in the individual transitional non grandfathered pool, we do not expect many to enroll due to the large difference in premiums. We have assumed those who were eligible for premium subsidies would have already moved to metallic plans."

6. On Pg. 35 of the application the regulations state that "the association shall establish a true-up process with respect to a calendar year to reflect adjustments made in establishing the final

accounting for that calendar year,…"Could the state confirm that the Alaska Comprehensive Health Insurance Association (ACHIA) is responsible for the true-up of additional reinsurance funds to account for risk adjustment? If so please explain when this would occur in relation to the calendar year.

The state confirms ACHIA is responsible for this true-up. The time frame for this true up process is in the plan of operations which is agreed to between ACHIA and their administrator BM, LLC. The Plan of Operation currently requires data collection to begin March 1st. The proposed true-up would be communicated 45 days after the notice of final risk adjustment transfers by CCIIO. True-up payables would be in September of the same year. The true-up will not use additional reinsurance funds; it will be a pass through transfer between insurers.

7.

A.) Could the state clarify the timing of the reinsurance payment to issuers? For example, when does the state expect to disburse the $55 million for FY 18?

B.) More specifically, when will the payment start, and will it be a one-time payment or will this is a cash flow distribution throughout the year? If throughout the year, when will the payment be final?

A.) Per federal regulations, individual health insurance plans run on a calendar year basis. State funding is already in place for 2017. Reimbursements will be made quarterly beginning May 2017 (May, August, November, February).

B.) The payments will be distributed throughout the year. Final payment for claims allocated to a calendar year must be received by March 1st of the following the calendar year. These final claims will be paid by May.

8.

A.) Would Alaska be willing to share process or methodology for reconciling high risk pool costs into a risk adjusted market?

B.) Could the state share financial data with CCIIO upon completion?

A.) For 2017, there is only one insurer, nothing to be risk adjusted this first year.

B.) We will consider doing so.

9. With regard to the state reinsurance program, can the state elaborate to explain any information the state need from CCIIO to administer the reinsurance program? Are there responsibilities the state was envisioning that CCIIO would undertake? If so, when would the state need that information?

The state doesn't currently need any information from CCIIO to administer the program, except for the risk adjustment report that is released annually on June 30th. There are not any responsibilities that the state envisions CCIIO would take on.

10.

A.) What are the gross (pre ARP) projected number of claims and incurred claims by year for the baseline and waiver scenarios?

B.) Also, please provide the projected number of claims for each year for the baseline and waiver scenarios.

A.) Pre-ARP info for 2015 available in Exhibit 1.5 of Premera rate filing (currently held confidential).

B.) We'll need to request this information on incurred claims from Oliver Wyman.

11.

A.) As proposed, AK would allow issuers to pass enrollees to ARP who have a qualifying condition within 90 days of the qualifying claim.

B.) What about year to year? If the person re-enrolled for the following year, are they automatically entered back into the pool, or would the issuer have to pass them over to ARP again, based on a qualifying claim for the condition?

A.) This is not accurate. It is anytime during the year up until March 1st of the following year.

B.) The person would need to be re-ceded. The insurer must pay a claim for a qualifying condition. For example, if in 2017 a person is ceded due to claims for cancer treatment, goes into remission in December 2017 and has no claims related to cancer (or another listed condition) in 2018, they will be ceded in 2017, but not ceded in 2018.

12. If there are two carriers in the market – how is AK adjusting the RA program - because someone will be paying into the pool, and someone will be getting money, so would AK make an adjustment based on those results? Or would AK want to know that before they made the adjustment?

The adjustments for multiple carriers will be detailed in the plan of operations.

Enclosures

Attachment 1 Oliver Wyman letter

Attachment 2 CC Haus Monin report HB 374 data

Ryan Mueller, FSA, MAAA

Oliver Wyman
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202-4412
414 277 4680 Fax 414 223 3244
ryan.mueller@oliverwyman.com
www.oliverwyman.com

February 9, 2017

Ms. Anna Latham
Deputy Director
Alaska Division of Insurance
333 Willoughby, 9th Floor
Juneau, AK 99801

Subject: **Estimate of the State of Alaska's Contributions to the Alaska Reinsurance Program**

Dear Ms. Latham:

At your request, we have independently calculated an estimate of the State of Alaska's (the State's) expected contribution to the Alaska Reinsurance Program (ARP) by calendar year for 2018 through 2026. Our calculations assume the Centers for Medicare and Medicaid Services (CMS), the United States Department of Health and Human Services (HHS) and the United States Department of Treasury will approve, without modification, the State's application for a State Innovation Waiver under Section 1332 of the Affordable Care Act (Section 1332 Waiver), with the net savings to the Federal government being passed through to the State to assist with funding the ARP.

Information from Oliver Wyman's report pertaining to the actuarial analyses and certification in support of the State's Section 1332 Waiver[1] was used to determine the projected size of the ARP Fund for each year. Additionally, information from the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage was used to determine the estimated net savings to the Federal government, assuming the State fully-funds the ARP[2]. The estimates utilize the more conservative scenario from the ISER report pertaining to net savings that could be achieved by the Federal government. Table 1, shown below, summarizes our estimates pertaining to the State's expected contribution to the ARP by calendar year.

Table 1

Year	Projected ARP Fund	Federal Savings (Pass-through Funds)	State of Alaska ARP Funding
2018	$59,983,000	$48,973,684	$11,009,316
2019	64,126,326	52,260,335	11,865,991
2020	68,950,229	56,108,411	12,841,818
2021	74,137,010	61,486,732	12,650,278
2022	79,789,956	65,612,014	14,177,942
2023	85,873,941	72,213,851	13,660,090
2024	92,333,808	77,717,468	14,616,340
2025	98,711,766	84,814,665	13,897,101
2026	105,530,281	91,785,506	13,744,775

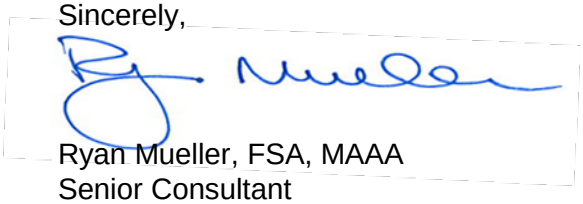
[1] Table 24 from "Alaska 1332 Waiver Application Actuarial Analyses and Certification", Oliver Wyman.
[2] Table 8 from "Alaska 1332 Waiver-Economic Analysis." Prepared by the Institute for Social and Economic Research. University of Alaska Anchorage.

In developing these estimates I have used and relied on the information from the ISER report in calculating the State's contribution to the ARP. Though I have reviewed the data for reasonableness and consistency, I have not independently audited or otherwise verified this data. The review of data may or may not reveal errors or imperfections. I have assumed that the data in the ISER report is both accurate and complete. Our calculations are dependent on this assumption. If this data or information are inaccurate or incomplete, our estimates may need to be revised.

Our estimates also assume no changes are made to the Affordable Care Act relative to its current provisions or enforcement of such provisions. This includes changes ranging from modification of the current law and/or corresponding regulations to full repeal of the law. Should any of these changes occur, our estimates may need to be revised.

If you have any questions regarding this filing, please feel free to contact me. I can be reached at 414 277 4680.

Sincerely,



Ryan Mueller, FSA, MAAA
Senior Consultant

Copy: Tammy Tomczyk, Oliver Wyman Actuarial Consulting, Inc.