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DEPARTMENT OF

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STATE OF MAINE

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- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

A Report to the Joint Standing Committee on Insurance and Financial Services of the 128th Maine Legislature

**Review and Recommendations Regarding the
Maine Guaranteed Access Reinsurance Association (MGARA)**

February 2017

Maine Bureau of Insurance

Paul R. LePage
Governor

Anne L. Head
Commissioner

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Superintendent

Introduction

This Bureau of Insurance report is in response to 2016 PL Chapter 404, An Act to Amend the Maine Guaranteed Access Reinsurance Act. Chapter 404, §5 requires the Superintendent of Insurance to:

- Review and report on differences between the Maine Guaranteed Access Reinsurance Association (MGARA) and the federal transitional reinsurance program, established and operated pursuant to the Patient Protection and Affordable Care Act, which was operating in Maine between January 1, 2014 and December 31, 2016;
- To make a recommendation to the Joint Standing Committee on Insurance and Financial Services as to whether MGARA should resume operations or be dissolved; and
- To make a recommendation as to whether any changes should be made to the statute with respect to MGARA's continued operation or dissolution.

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Background

Title 24-A M.R.S. Chapter 54-A, the Maine Guaranteed Access Reinsurance Association (MGARA) Act, was enacted by Part B of 2011 PL c. 90 (LD 1333), *An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services*.

Pursuant to that law, MGARA was established as a private, nonprofit association. MGARA's goal was to improve the affordability of coverage in Maine's individual health insurance market through the provision of reinsurance with respect to coverage on high-risk exposures in that market.

MGARA was funded by a combination of reinsurance premiums paid by health insurers ceding coverage to MGARA and an assessment of \$4 per covered person per month (\$48 per year) levied against coverage provided in the individual, small group and large group markets, as well as against third party administrators of self-funded health plans. MGARA began active operations on July 1, 2012 and continued to provide reinsurance through December 31, 2013.

The Affordable Care Act (ACA), which became federal law on March 23, 2010, directed each state to establish a three-year transitional reinsurance program to be effective for calendar years 2014 through 2016. This program was intended to alleviate stress on individual health insurance markets brought about by the significant changes of the ACA. The federal Centers for Medicare and Medicaid Services (CMS), however, adopted rules creating a single national reinsurance pool rather than self-sustaining programs in each state. This federal reinsurance pool was funded by assessments on all insured health markets and many self-funded plans.

Although there were significant operational differences between MGARA and the federal transitional reinsurance program as implemented by CMS, the basic purpose and funding of the two programs was similar. On January 28, 2013 the Superintendent of Insurance requested that CMS authorize MGARA to serve as Maine's transitional reinsurance program and grant Maine an exemption from any conflicting provisions of the federal regulation. On February 7, 2013 that request was denied.

Given the similar functions and sources of funding, it was clear that two simultaneously operating reinsurance programs were inappropriate. In light of these developments, the 126th Maine Legislature enacted 2013 PL Chapter 273, *An Act Regarding the Maine Guaranteed Access Reinsurance Association*, which suspended active reinsurance operations of MGARA for the three year period from 2014 to 2016, but kept MGARA in existence in order to allow future legislative sessions to reactivate it, based on future need. Chapter 273 provided that, absent further legislative guidance, MGARA would recommence active operations with respect to coverage effective on or after January 1, 2017. The Second Regular Session of the 127th Maine Legislature gave further consideration to MGARA. 2016 PL Chapter 404 continued the suspension of MGARA's reinsurance operations through December 31, 2017 and requested this Report.¹ Absent further legislative action during 2017, the "default option" is that MGARA's reinsurance operations will be reactivated as of January 1, 2018.

¹ One reason for the extension of MGARA's suspension through 2017 despite the absence of federal reinsurance was the realization that the ACA's premium tax credits for low income individuals were structured in a way that provides a disincentive for Maine to reactivate MGARA. To the extent that MGARA was successful in reducing premiums for individual policyholders receiving premium tax credits, the lower premiums would reduce the premium tax credits. Those savings, funded by assessments across Maine's health insurance marketplace, would go to the U.S. Treasury.

Comparison of MGARA and Federal Transitional Reinsurance Under the ACA

MGARA and the federal transitional reinsurance program operated under the Affordable Care Act shared the common goal of providing premium relief to the individual health insurance market. However, there are many program differences. Key differences include the following:

- *State-based versus national reinsurance pool.* Under MGARA, assessments collected from Maine individual policyholders, Maine group policyholders and third party administrators of self-funded employee benefit plans in Maine were used to benefit the Maine individual health insurance market. In contrast, the federal transitional reinsurance program utilized a national reinsurance pool. Assessments collected from Mainers were pooled with those collected in other states for the payment of claims.
- *Prospective versus retrospective reinsurance pool.* MGARA operated as a prospective reinsurance pool. Specific individuals with a high risk of incurring large health claims were identified by the health carriers, some by standards developed by MGARA's Board of Directors and others by carrier discretion. MGARA reinsured their coverage on a calendar-year basis, and reinsurance was effective only if the carrier paid the applicable reinsurance premium when due and designated the individual for reinsurance in advance of the coverage year (except for new enrollees, who could be designated up to 60 days after their insurance policies took effect). If those specific individuals then incurred claims in excess of the attachment point² of the reinsurance coverage, the carrier would be eligible for reimbursement from MGARA. Federal transitional reinsurance, by contrast, automatically provided relief to carriers with respect to any individuals covered in the individual market whose claims exceeded the federal attachment points.
- *Covered Services.* The federal program provided reinsurance benefits only with respect to "essential health benefits," as determined under the ACA, whereas MGARA did not restrict the types of claims that were eligible.
- *Assessment amounts.* MGARA's annual assessments were \$4 per covered person per month (\$48 per year). The federal transitional reinsurance assessment was \$63 per covered person per year in 2014, \$44 per covered person per year in 2015, and \$27 per covered person per year in 2016.
- *Assessment base.* While both MGARA and the federal transitional reinsurance program levied assessments on the individual, small group and large group health insurance markets, as well as on third-party administrators of self-funded plans, the federal program also levied assessments on self-administered, self-funded employee benefit plans. Maine's ability to include self-administered, self-funded plans in the MGARA assessment base was and is preempted by federal law.³

² A reinsurance "attachment point" is the dollar amount above which the reinsurance is applicable. Claims below the attachment point remain funded solely by the health carrier issuing the coverage.

³ 29 U.S. Code § 1144(a)

- *Use of assessments.* While all of MGARA’s assessments were utilized for MGARA operations, the ACA required portions of the federally-collected assessments to be paid by CMS to the U.S. Treasury. These amounts were \$2 billion in 2014, \$2 billion in 2015 and \$1 billion in 2016.⁴
- *Reinsurance benefit structure.* MGARA provided for payment of 90% of claims between \$7,500 and \$32,500 and 100% of claims over \$32,500 for an eligible individual in a given year. Benefits under the federal transitional reinsurance program varied by year. They were as follows:
 - 2014: 80% of claims between \$60,000 and \$250,000. (The \$60,000 attachment point was subsequently lowered to \$45,000 and the percentage paid by the program raised to 100%, thereby resulting in additional payments to carriers.)
 - 2015: 50% of claims between \$45,000 and \$250,000 (that percentage was later raised to 55.1%)
 - 2016: 50% of claims between \$90,000 and \$250,000
- *Results.*
 - MGARA collected approximately \$26.3 million in premium from health carriers in the individual market during its 18 months of active operations in 2012 and 2013. Total assessments, including a special organizational assessment, were approximately \$41.2 million. It paid approximately \$66 million in reinsurance claims to individual health insurance market carriers. Based on rate filing information submitted by Anthem in Maine’s individual market, the program resulted in about a 20% reduction in requested rates.
 - The federal transitional reinsurance program paid approximately \$41.9 million with respect to 2014 Maine claims and \$48.9 with respect to 2015 Maine claims.⁵ The Maine Bureau of Insurance does not have the total amount of funds paid by Maine’s health insurance market into the federal transitional reinsurance program’s national pool. The Bureau estimates payments for the fully insured market to have been approximately \$20.25 million in 2014 and \$18 million in 2015, but has no information regarding payments made with respect to self-funded plans.
 - Both MGARA and the federal transitional reinsurance program have helped stabilize Maine’s individual health insurance market. Prior to MGARA, rates had increased on average from 10.9%-16.7% annually. The effect of the absence of federal transitional reinsurance is well illustrated by 2017 rate filings of health carriers. The premium impact of removing the federal reinsurance program ranged from 4.6% to 6.2% in the filings, depending on the carrier.

⁴ It is the Bureau’s understanding that \$4 billion of these payments are currently outstanding. Should CMS be required to remit these funds to the Treasury, it is unclear whether reinsurance payments due to be paid to carriers for 2016 would be effected.

⁵ Federal transitional reinsurance claims payments with respect to 2016 are unavailable as of the time of this report.

Recommendations Regarding MGARA

Maine's current individual health insurance market is very different than it was in 2011 when the 125th Legislature considered LD 1333. At that time, just two health insurers⁶ sold individual coverage in Maine. The majority of purchasers could afford only high deductible plans.⁷ There were fewer than 35,000 covered lives in the individual market, many of whom were in poor health.

By contrast, in 2017 there are four carriers in this market.⁸ There were more than 87,000 insureds in this marketplace after open enrollment in 2016 and maximum annual out of pocket costs for 2017 are \$7,150 per individual and \$14,300 per family. It is likely that many insureds purchased coverage due to the ACA mandate that persons without coverage pay a federal income tax penalty or because their coverage was made affordable by the presence of ACA provisions such as premium tax credits, cost-sharing subsidies and transitional reinsurance. What changes will be implemented at the federal level now, or how any changes will affect marketplace dynamics is unknown at this time.

Since the enactment of PL c. 404 in March 2016, MGARA's Board of Directors has been considering future options. The result of these deliberations is summarized in a December 1, 2016 letter from Christopher Howard, Esq., Counsel for the Board, to the Superintendent of Insurance.⁹ Assuming the continuation of the existing ACA, the Board considered a proposal for the State to seek a waiver pursuant to Section 1332 of the ACA. Section 1332 of the ACA allows states to apply for federal approval to deviate from specific provisions of the ACA, provided that the state can demonstrate that its program will "provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver, would provide coverage that is at least as comprehensive and affordable as would be provided absent the waiver, and would not increase the Federal deficit."¹⁰ Conceptually, the Board envisioned a waiver whereby the federal government would have returned to the State the aggregate amount of premium tax credit savings, as a result of a revitalized MGARA reinsurance program. The Board considered this plan to hold substantial promise. Details of how this would work are set forth in Mr. Howard's letter. At the present time, however, it is unknown whether either federal premium tax credits or the Section 1332 waiver exemption process will continue to exist prospectively, as both the new administration and Congressional leadership have been advocating that the ACA either be repealed or substantially altered.

Should the ACA be completely repealed without any further federal action, a failure to reactivate MGARA at the state level would return Maine's individual health insurance market to the pre-2012 situation of a non-subsidized, guaranteed issue environment in which there would be no individual mandate to purchase coverage. The Bureau would anticipate that under this scenario the market would likely become unstable. If healthy people, who were no longer required to purchase coverage or pay a federal income tax penalty exited the market, the experience would deteriorate and rates would rise. This could lead to a new death spiral where an increasingly unhealthy and shrinking block of covered persons were priced out of a market with fewer carriers and coverage options.

⁶ Anthem Health Plans of Maine and MEGA Life and Health Insurance Company

⁷ \$15,000 per year deductible plans were common

⁸ Anthem Health Plans of Maine, Harvard Pilgrim Health Care, Inc. and Maine Community Health Options both on and off the federally-facilitated marketplace (exchange) and Aetna Health, Inc. off exchange only.

⁹ Attachment A to this report.

¹⁰ 31 CFR Part 33, Guidance issued 12/16/2015

The prior success of MGARA and of the federal transitional reinsurance program in stabilizing the market strongly suggests that such a mechanism would benefit the market in the future. Unless any forthcoming federal reforms contemplate either a reinsurance facility or a federal high-risk pool (or some similar program), a reactivation of MGARA would likely be of assistance to the market.

The timing of any reactivation of MGARA is also a consideration. CMS is requiring final 2018 rates be submitted by August 21, 2017.¹¹ In light of this deadline, rates will need to be filed with the Bureau in early May 2017 in order to allow time for Bureau consideration of the filings and possible rate hearings. Significant lead time is necessary for carriers to consider the anticipated effect of any law changes and to incorporate those expectations in their filings. Additionally, the ACA requires individual health insurance market rates in effect to be guaranteed for a twelve (12) month period (i.e. carriers cannot change their rates). These time frames make it challenging for any legislative action regarding MGARA in 2017 to be reflected in rates before 2019.

Continuing the current suspension of MGARA's active operations while awaiting developments on the federal level is also an option for the Legislature. Should the Legislature decide on this course of action, a further amendment to 24-A M.R.S. § 3953 will be necessary because the default option is that MGARA would be reactivated in 2018.

Another possibility is that the Legislature could decide that the MGARA program should be terminated and the association dissolved. If this were to occur, MGARA would file a Plan of Termination for approval by the Superintendent of Insurance. After satisfaction of debts and liabilities, including contingent liabilities, remaining fund balances would be used and applied for the general purpose for which MGARA was created. It is unclear what specific programs might qualify in this regard. MGARA currently has a fund balance of approximately \$5 million, nearly all of which would be available for this purpose. Given the uncertainty surrounding the health insurance marketplace the Bureau does not recommend dissolution of MGARA.

¹¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program Final Rule published in the Federal Register on December 22, 2016 and the December 16, 2016 CMS 2018 Annual Letter to Issuers.

Recommendations as to Statutory Changes

- As noted, MGARA is currently organized under Maine law¹² to operate as a “prospective” reinsurance program whereby the covered layers of reinsurance, with respect to policies issued on individuals at high risk of large claims, are ceded to MGARA.¹³ MGARA’s Board of Directors has considered using a “retrospective” reinsurance model. The Board’s view, as summarized in Mr. Howard’s December 1, 2016 letter (Attachment A), favors the retrospective reinsurance approach as being less complex to administer, more economically stable and likely more flexible in light of potential federal activity affecting the market. If the Legislature opts for a retrospective reinsurance approach, amendment of 24-A M.R.S. §§ 3955, 3958, 3959 and 3961 as well as MGARA’s Plan of Operation will be necessary.
- Another option may be an expansion of MGARA to the small group insurance market. Maine’s small group health insurance marketplace consists of those group insurance policies issued to employers with 50 or fewer employees. There has been a steady decline in the size of the small group market from a high of 118,000 insured lives in 2003 (98,756 in 2010 when the ACA was enacted) to 70,555 in 2016. Average rate increases had been 10-21% during the years prior to the ACA. Rate increases for the years 2014 through 2017 have been between 2-10% on average. However, providing subsidized reinsurance to this additional market would require additional funding to avoid reducing the effectiveness of the program to the individual health insurance market.

¹² 24-A M.R.S. § 3958(1).

¹³ Ceded coverage is “invisible” to the policyholder. Neither policy benefits nor premiums are affected by the cession of coverage and all benefits payable to the policyholder or health care providers are paid by the issuing carrier. Policyholders have no contractual privity to MGARA, which simply reimburses the carrier for any claims above the attachment points.

Conclusion

During its 18 months of active operation in 2012 and 2013, the Maine Guaranteed Access Reinsurance Association (MGARA) was effective in limiting the increase in the cost of health insurance in Maine's individual health insurance market. There is currently substantial uncertainty regarding the health insurance environment, largely due to uncertainty as to prospective federal reform efforts. It is clear that if circumstances were to return to their pre-2010 status, in which Maine has guaranteed issue coverage, no requirement for individuals to purchase coverage, no premium or cost-sharing assistance to policyholders, and no state or federally-authorized program to provide reinsurance assistance to the market with respect to high risk individuals, a developing death spiral of the individual market could be reasonably anticipated.

While MGARA has been previously shown to effectively stabilize rates in the individual market in prior circumstances, it may be less effective under scenarios that may develop in the future.

Important issues for legislative consideration include the following:

- Should MGARA be reactivated?
- If so, should reactivation begin in 2018 or 2019?
- Should MGARA's reinsurance coverage operate on a prospective or retrospective basis? Should MGARA be expanded to provide reinsurance protection to the small group market? If so, is the \$4 per person per month assessment sufficient or would additional funding be required?

Appendix A

Letter from Christopher E. Howard - Status Report Regarding Analysis of Possible Restart of Maine
Guaranteed Access Reinsurance Association ("MGARA")



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December 1, 2016

Hon. Eric Cioppa
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Re: Status Report Regarding Analysis of Possible Restart of Maine Guaranteed Access Reinsurance Association ("MGARA")

Dear Superintendent Cioppa:

This letter is a follow up to our recent phone conversation regarding the report the MGARA Board has been working on with respect to an analysis of alternatives for the future of a MGARA reinsurance program. As we discussed, the recent events in Washington create significant uncertainty regarding the continuation of the ACA environment. Although an outright repeal of the ACA seems unlikely, based on both President-elect Trump's acknowledgement of the need for some sort of transition plan, and the early signals from Congress, it is simply unclear at this point precisely how the new administration and Congress will address the ACA, and the resulting implications for MGARA.

Although the MGARA Board is taking a wait and see position, the Board wanted to provide you with a summary of the work that has been done to date, so that you have the benefit of that analysis as you consider how to respond to developments on the national front and here in Maine.

Background

In conjunction with the adoption of Public Law Chapter 404, March 23, 2016 ("PL 404"), MGARA committed to provide a report to you regarding possible alternatives for MGARA in an effort to help inform your report to the Insurance and Financial Services Committee ("IFS") due by February 15, 2017. Section 5 of PL 404 adopted March 23, 2016 requires the following report from the Superintendent to IFS:

Before February 15, 2017, the superintendent shall make a recommendation to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters as to whether the Maine Guaranteed Access Reinsurance Association should resume operations following its suspension pursuant to Title 24-A, section 3953, subsection 1 pursuant to a revised plan of operation or should terminate its operations and dissolve and whether any changes should be made to the statutes governing the association in connection with its continued operation or dissolution.

In May 2011, the Legislature approved the establishment of MGARA as a private, nonprofit reinsurance program for the higher-risk segment of Maine's individual health insurance market. Establishment of MGARA was intended to reduce costs in that market by providing reinsurance for a significant portion of the coverage provided through individual health insurance policies in Maine. MGARA funded this coverage through a combination of market-wide assessments and reinsurance premiums.

Over MGARA's period of active operation (Q3/4 of 2012 and 2013), MGARA paid approximately \$66 million in claims and generated a positive fund balance of approximately \$5 million. Based on rate filings submitted by insurance carriers operating in Maine's individual market, MGARA's reinsurance program generated an approximate 20% reduction in requested rates.

The federal Patient Protection and Affordable Care Act (the "ACA"), which took effect on January 1, 2014, established a three-year federal transitional reinsurance program (the "Federal Reinsurance Program"), which, like MGARA, was funded through assessments on each state's insurance market, including Maine's. In order to avoid imposing redundant costs on the Maine market through parallel federal and state individual market reinsurance programs, consistent with recommendations from MGARA and the Superintendent, the Legislature amended Title 24-A, M.R.S. chapter 54-A ("MGARA's Enabling Legislation") to suspend MGARA's reinsurance program during the pendency of the Federal Reinsurance Program. That legislation called for reactivation of MGARA as of January 1, 2017. PL 404 extended this suspension through December 31, 2017. Absent changes to MGARA's Enabling Legislation, MGARA is required to reactivate its operations effective January 1, 2018.

The extension of MGARA's suspension resulted from the realization that the current structure of the ACA's subsidies for exchange participants in the form of premium tax credits ("PTC") creates an economic disincentive for Maine to implement any MGARA-like reinsurance program. To the extent a reactivated program has the effect of reducing premiums for many persons obtaining individual health insurance coverage on the federally-facilitated exchange in Maine (the "Exchange"), these lower premiums would in turn decrease the PTC amount to which Maine's Exchange participants are entitled, and which the federal government must pay, under the ACA. This result would represent a measurable cost-savings to the federal government, effectively funded by assessments on Maine's insurance market.

Existing ACA Section 1332 Waiver -- Potential Solution to Avoid Conflict With Federal Subsidy

Since the adoption of PL 404, a potential solution to the PTC conflict described above has been identified under the ACA as it exists today. Current Section 1332 of the ACA permits a state to apply for approval to waive specific provisions of the ACA to permit the state to operate a health insurance program that deviates from those provisions, provided that the state can demonstrate that its program will "provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver, would provide coverage that is at least as comprehensive and affordable as would be provided absent the waiver, and would not increase the Federal deficit."¹ Maine should be able to demonstrate that MGARA's program meets all of these criteria.

The ACA currently provides that a state that applies for and receives a waiver pursuant to Section 1332 (a "1332 Waiver") is eligible to receive "the aggregate amount of such [premium tax] credits or [cost-sharing] reductions that would have been paid on behalf of participants in the Exchanges ... had the State not received such waiver, ... for the purposes of implementing the State plan under the waiver."²

¹ 31 CFR Part 33, Guidance issued 12/16/2015.

² 42 U.S.C. 18052(a)(3).

Accordingly, if Maine were to apply for and obtain a 1332 Waiver, Maine would be eligible to receive pass-through funding³ equal to the federal government's cost-savings resulting from MGARA's positive effect on premium rates and corresponding reduction in the amount of PTC claimed by Maine's Exchange participants.

The federal Department of Health and Human Services ("USHHS") has issued detailed requirements for a state application for a 1332 Waiver. Set forth below are the principal tenets of a potential application for a 1332 Waiver to operate MGARA while avoiding the PTC conflict:

1. Has the potential to allow for the operation of a MGARA-type program by confirming MGARA's eligibility for federal pass-through funding in accordance with Section 1332 of the ACA.
2. Federal pass-through funding would be deployed through MGARA to supplement market-wide assessment levels, thereby mitigating the cost of MGARA's reinsurance program to Maine while preserving its positive effects on Maine's individual insurance market; this has the potential to result in lower premiums being charged in the marketplace.
3. The 1332 Waiver application is required to provide analysis and supporting data to inform its estimate of the pass-through funding amount, including economic analyses, assumptions, and methodologies consistent with the applicable federal regulations.
4. Section 1332 requires that the 1332 Waiver application be accompanied by enacted state legislation authorizing the implementation of the 1332 Waiver. Legislation amending MGARA's Enabling Legislation could serve as the vehicle for this authorization.
5. A public notice and comment period is required.

It is important to understand the timing realities associated with this process. The process for implementing this type of solution requires both legislation and application to CMS (and its "partner agencies," most notably the U.S. Treasury). We have discussed the possibility of a Section 1332 Waiver with CMS and the U.S. Treasury, and they are very supportive of that approach; however, even without any changes to the ACA, it would have been highly unlikely that both adoption of enabling legislation and approval of any 1332 application would have been concluded in time for carriers to include any cost savings associated with a new MGARA reinsurance program in their 2018 rate filings, which are due in May 2017.

In the current environment of uncertainty, the timing on implementing this approach is even less clear. If there is rapid action at the federal level, and both subsidies and the Section 1332 waiver remain intact, then it may be possible to see legislation adopted here in Maine in the upcoming session, with a formal 1332 application to CMS filed immediately thereafter. At best, the carriers would be in a position to include the impact of the reactivated program in their May 2018 rate filing for the 2019 year. Notably, the State of Alaska is pressing ahead with their Section 1332 Waiver application, in the hope that it will remain relevant in light of whatever changes are made to the ACA. However, they already have Legislative authority for the Section 1332 application, and have appropriated the funds to run the program, so they are really just looking to recoup costs at this point. It is not clear to me that faced with today's environment the Alaska legislature/governor would choose to press ahead were the program not already authorized and funded.

³ The applicable regulations use the term "pass-through funding" to refer to this return of savings to the state pursuant to Section 1332.

Additionally, as discussed in greater detail below, whether, and to what extent, carriers will provide credit for the program is a very significant unanswered question.

Dismantled ACA

It is possible that the ACA could be totally dismantled, or dramatically altered. In that event, MGARA could be a highly relevant piece of the State's approach to maintaining affordability and stability in its individual market. MGARA originated in the pre-ACA environment. A return or partial return to that landscape could see many of the same factors at work in Maine's individual market. MGARA was designed to function in that environment and was, for its brief period of active operation, an effective program in reducing rates in the individual market. There can be little doubt that MGARA's program will need to be adjusted in response to both the dramatic changes in Maine's individual market and any changes in the ACA, but a MGARA-like reinsurance program would be highly relevant in that environment.

Alternatives Analysis

In light of the background provided above, the following are the four basic options the Board has considered pursuant to the mandate in PL 404:

1. Resume MGARA's operations using a prospective reinsurance approach. This model would replicate MGARA's pre-suspension reinsurance program, funded by a \$4.00 per covered person per month ("PMPM") assessment plus reinsurance premiums for ceded lives, together with federal pass-through funding received through a 1332 Waiver, if approved.
2. Resume MGARA's operations using a retrospective reinsurance approach. A retrospective approach would resemble the design of the Federal Reinsurance Program, with reinsurance attachment points, coinsurance amount and other thresholds to be determined based on economic and actuarial analysis. This program would be funded by the same \$4.00 PMPM assessment used in the prospective model, together with federal pass-through funding received through a 1332 Waiver.
3. Continue suspension of MGARA's operations pending greater market stability.
4. Terminate operations and dissolve MGARA.

Following is an analysis of these four alternatives.

Prospective Model

In a prospective model, carriers cede selected lives and receive a specified reinsurance benefit, funded in part by premiums paid on those ceded lives. Although the original MGARA prospective model was effective in rapidly reducing premium rates, the prospective model is unlikely to be as effective in the current ACA landscape, for several reasons. The prospective model is significantly more complex to design and operate – both for MGARA and for carriers – than a retrospective model. Moreover, the prospective model carries heightened solvency risk relative to a retrospective program, a differential that is exacerbated in the current ACA context due to pricing volatility and the multiplier effect of a larger individual insurance market. Each of these factors is discussed in more detail in the following sections.

1. *Complexity relative to impact.* A prospective model is significantly more complex to design

and operate – both for MGARA and for carriers – than a retrospective model. While the prospective model requires both advance selection of auto-ceded conditions and significant underwriting activity by carriers, the retrospective model requires neither. MGARA’s prior prospective model made ceding selections a part of the carriers’ standard underwriting process, while underwriting was eliminated with the ACA.

This differential in complexity in itself is evidently a persuasive factor for some carrier members as it would essentially require them to re-start the underwriting operations that have now been eliminated.

Although there may be positive effects associated with the prospective model, those differences in result are difficult to quantify, and leave a key question for the Board – if we can achieve similar results with a less complex model, why pursue the more complex model?

2. *Insolvency risk.* MGARA’s existing prospective model is associated with greater solvency risk than a retrospective program, a differential that is exacerbated in the post-ACA context. This differential derives from several sources:

- *Reinsurance cap:* MGARA’s prospective program, as currently designed pursuant to statute, pays 90% of claims between \$7,500 and \$32,500 and 100% of claims above \$32,500. In contrast, in 2016 the retrospective Federal Program pays a portion of claims between \$90,000 and \$250,000 (and none above \$250,000), and the applicable portion varies with the available reinsurance pool. The Federal Program’s reinsurance cap and coinsurance adjustment mechanism both limit economic uncertainty within that model.

It should be noted that a reinsurance cap and adjustable coinsurance levels could be included in a redesigned prospective program. However, this would have the effect of injecting further complexity into the prospective model while reducing the potential benefits to the individual market.

- *More significant pricing challenges:* The prospective model relies in large part on reinsurance premiums for lives ceded. The difficulty of accurately pricing reinsurance premium in Maine’s larger and more volatile post-ACA individual market creates heightened insolvency risk relative to a retrospective model, which does not rely on premiums.
- *Multiplier effect:* The number of lives in Maine’s individual market has nearly tripled since implementation of the ACA. In this significantly larger market, the effect of deviations between actuarial assumptions underlying a prospective plan design (e.g., selection of auto-cede conditions) and actual experience is amplified, contributing to heightened exposure for MGARA.

3. *Potential for Changes in New Market Protections.* The ACA ushered in new market protections. The future design of such protective mechanisms could affect the need for the breadth of coverage offered under MGARA’s existing program, and a more complicated prospective program has the potential to be less nimble in responding to future changes. For example, the Centers for Medicare & Medicaid Services (“CMS”) recently proposed modification of the risk adjustment formula for 2018 in an effort to partially address the loss of reinsurance through the Federal Program. Although this is only a proposal, and applies only to

catastrophic losses, it demonstrates the possibility for future changes at the federal level that may indicate certain changes in the MGARA program. Complex programs are more difficult to adjust than simpler programs.

Retrospective Model

In a retrospective model, reinsurance benefits are determined at the end of each year based on actual claims experience of all lives covered by the individual market. This model could essentially mimic the Federal Reinsurance Program, with specific attachment points, coinsurance amount and other thresholds to be determined based on economic and actuarial analysis. Reinsurance benefits that can be supported with the funding from the assessments plus Pass Through Payments can take a variety of forms, ranging from relatively low attachment points (e.g. \$75,000) with relatively low coverage caps (e.g. \$250,000), to more catastrophic reinsurance, such as an attachment point of \$250,000 and a coverage cap of several million dollars.

As noted above, a 1332 Waiver could potentially facilitate reimplementation of MGARA's program on an economically feasible basis. At MGARA's request, the Milliman, Inc. actuarial firm prepared a preliminary analysis estimating the revenues that would be returned to MGARA in the form of Section 1332 pass-through funding ("Pass Through Payments"). These revenues are determined based upon the federal government's cost-savings resulting from MGARA's positive effect on premium rates and corresponding reduction in the amount that CMS would otherwise need to pay. The results of this analysis are summarized below; however, it is important to understand that these results are based on a set of assumptions regarding the structure and operation of the ACA, the Section 1332 Waiver, the carriers' response to the reactivation of the MGARA program and the Maine market that may not be reflective of actual experience as the program is implemented.

1. The value of the \$4 assessment base, net of expenses, is nearly \$26 million annually. Assuming that individual marketplace carriers reduce their premiums by the full value of the assessments, less the \$4 that they need to pay for their share of the assessment, 2018 premiums could decrease by \$22.32 PMPM, which is roughly 4.4% of the average estimated 2018 individual marketplace premium of \$504 PMPM.
2. If 100% of the amount of anticipated Pass Through Payments are also reflected in the 2018 individual rates, premiums could be reduced by \$45.55 PMPM, or about 9.0% of the average 2018 premium. This is the combined effect of the \$4 assessment plus the Pass Through Payments that represent 100% of the premium reduction on the 51% of the individual marketplace for which CMS has received the benefit of the premium reduction.
3. There is likely to be some inefficiencies in the operations of MGARA and the Section 1332 Waiver such that less than 100% of the maximum premium reductions will be realized. By "inefficiencies", we mean that carriers may not price to the maximum premium reduction, CMS may not pay 100% of the PTC savings back to MGARA, there may be additional operational costs that MGARA needs to absorb to cover the administration of the waiver program and there are many "unknowns" that could adversely impact the results of operation (i.e. economic efficiency) of this type of program. For example, there are questions concerning the extent to which CMS will be able to uphold any such commitment to Pass Through Payments on a timely basis, as well as the mechanism for making those payments. Although this could be clarified to some degree through the Section 1332 waiver application process, as of this date, these remain

significant open questions.

4. Reinsurance arrangements (i.e. attachment point, coinsurance, maximum limit) can be structured in various ways, including relatively low attachment points and maximum limits such that the recoveries would cover a large number of claimants, to high attachment points and maximum limits that provide reinsurance protection against the relatively few, high amount claims that are likely to emerge in the individual marketplace.
5. Introduction of a program similar to the federal transitional reinsurance will have less of an effect on the individual marketplace rates than the federal program. This occurs because the portion of the total assessed lives in Maine that arise from the individual insurance marketplace is nearly twice that of the overall nationwide values. For illustration, a \$4.00 PMPM assessment across the entire Maine insurance marketplace generates a subsidy of about \$26 PMPM for the individual marketplace; the same \$4.00 assessment nationwide would generate a subsidy of nearly \$52 PMPM for the individual marketplace.

Continued Suspension

Given the current high levels of both market volatility and political and economic uncertainty, it may be advisable to continue MGARA's current suspension for an additional year in anticipation that a reinstatement determination (and associated economic and actuarial projections) can be made in a more stable environment.

Continued suspension would require passage of legislation amending Section 3953, which, as noted above, currently contemplates resumption of operations on January 1, 2018. During any period of suspension, MGARA would continue to incur and pay certain basic administrative costs associated with maintaining minimum administrative functions.

Termination and Dissolution

Permanent termination of MGARA's program and dissolution of MGARA would require compliance with the Maine Non-Profit Corporation Act and MGARA's Plan of Operation. MGARA's Plan of Operation currently provides that, upon termination, MGARA will file a Plan of Termination for approval by the Superintendent and any funds or assets held by MGARA will be applied and distributed in the following order of priority (i) payment of any remaining debts and/or liabilities, (ii) establishing reserves for any contingent liabilities, and (iii) transfer to a trust, non-profit corporation or other fund established pursuant to the termination plan to be used and applied for the general purposes for which MGARA was originally organized. MGARA currently maintains approximately \$5 million in fund balance, substantially all of which would be available for such transfer.

Additional Considerations

1. Under the existing ACA, in evaluating the benefits generated by reactivation of MGARA, it is important to understand that the direct beneficiaries of the program (whether prospective or retrospective) will be individuals with household income approaching 300% of the federal poverty level ("FPL") because premiums for that group are not afforded the same buffering under the ACA's PTC structure due to their income level. The majority of Exchange participants (i.e., those between 100% and 300% FPL) will, by and large, not be affected by increase or decrease in premium due to the

compensation provided through PTCs, which have the effect of capping Exchange participants' financial exposure based on their household income.

2. Although it is possible to reach the conclusion, based on the foregoing analysis, that a beneficial retrospective program could be successfully implemented assuming a 1332 Waiver and the additional revenues generated by Pass Through Payments, there is a significant margin of uncertainty inherent in the analysis. Even with further analysis the benefits are not certain and there is no guarantee that the program will be successful, which may be the biggest risk in any decision to restart the program.

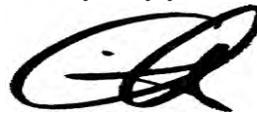
3. A further question remains as to whether the MGARA program could be successfully extended to the small group market. There is some concern around the de-population of the small group market and providing some relief could be an appropriate goal for the program. That said, providing reinsurance to this additional population would place additional demands on MGARA's funding. Such an analysis is beyond the scope of the current analysis.

4. This Memorandum assumes a \$4 PMPM assessment level. Please be aware that a fixed assessment level will have increasingly less market impact over time as medical costs continue to trend upward. The indicated assessment level was established in 2012, and will have inherently less market impact in 2018 than it did originally. In order to maintain a consistent level of market impact, the assessment level should be adjusted to reflect cost increases. The amount of the Pass Through Payments is directly related to the amount of the Assessments made against the Maine insurance marketplace. The larger the assessment amount, the larger the Pass Through Payments could be.

5. The foregoing analysis is based upon various assumptions stated therein. The health insurance and ACA environment is highly dynamic and the validity and accuracy of our assumptions will depend in large part on future events over which we have little or no control. Consequently, we cannot assure that MGARA's operating results will correspond to this analysis. To the extent the assumptions upon which the projections are based are incorrect or inaccurate, the anticipated benefits derived from any MGARA program might be adversely affected and the variations could be material.

Hopefully, you will find the foregoing helpful in reacting to the changes that are afoot in Washington, and guiding Maine's response. Whether any of the analysis provided above will be relevant in addressing those changes is unclear; however, the Board wants to be sure you have its most current thinking in this rapidly changing environment. As discussed at the conclusion of our telephone call, the MGARA Board stands ready to provide whatever assistance it can as this process unfolds.

Very truly yours

A handwritten signature in black ink, appearing to read "C. Howard", written in a cursive style.

Christopher E. Howard