August 9, 2017

Commissioner Doug Ommen
Iowa Insurance Division
Two Ruan Center
601 Locust Street, 4th Floor
Des Moines, Iowa 50309-3738

Subject: Actuarial Review of Medica Insurance Company Proposed 2018 Individual Health Insurance Rates and Analysis of Effect of the Iowa Stopgap Measure

Dear Commissioner Ommen:

On behalf of NovaRest Actuarial Consulting, attached is our report that presents our analysis of the proposed 2018 individual health insurance rates, as filed by Medica Insurance Company (Medica Rate Filing), and the effect of Medica Insurance Company (Medica) operations on the Iowa Stopgap Measure (ISM), as filed with the Centers for Medicare and Medicaid Services.

Should you have any questions regarding our report, please do not hesitate to contact me at 520-908-7246 or Donna.Novak@novarest.com. Thank you very much for the opportunity to assist you.

Sincerely,

Donna C. Novak

Donna C. Novak FCA, ASA, MAAA, MBA
President and CEO of NovaRest, Inc.

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 tel: 520-908-7246 - fax: 772-673-0318 NovaRest.com

REPORT OF FINDINGS

TO THE IOWA INSURANCE DIVISION

ACTUARIAL REVIEW OF MEDICA INSURANCE COMPANY

PROPOSED 2018 INDIVIDUAL HEALTH INSURANCE RATES

AND ANALYSIS OF THE IOWA STOPGAP MEASURE

NOVAREST, INC.

August 9, 2017

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 tel: 520-908-7246 - fax: 772-673-0318 NovaRest.com

NovaRest
ACTUARIAL CONSULTING

Contents

I. INTRODUCTION 3
II. SCOPE OF SERVICES 5
A. Analysis of Medica's 2018 and 2019 Operations 5
B. Analysis of the impact of Medica's 2018 Rates and of the Iowa Stopgap Measure. 5
1. Availability of Health Insurance Coverage 5
2. Affordability of Health Insurance Coverage 5
3. Comprehensiveness of Health Insurance Coverage 6
4. Deficit Neutrality 6
5. Impact on the Market if Medica does not Offer Coverage 6
6. Impact on Provider Compensation of Medica's 2018 and 2019 Operations.... 6
III. EXECUTIVE SUMMARY 7
A. Approach 7
B. Impact on Medica's financials 7
C. Analysis of the impact of Medica's 2018 Rates and of the Iowa Stopgap Measure 7
1. Availability of Health Insurance Coverage 8
2. Affordability of Health Insurance Coverage 9
3. Comprehensiveness of Health Insurance Coverage 10
4. Deficit Neutrality 10
5. Impact on the Market if Medica does not Offer Coverage 11
6. Impact on Provider Compensation of Medica's 2018 and 2019 Operations.. 11
IV. ANALYSIS OF EFFECT OF THE MEDICA RATE FILING AND IOWA STOPGAP MEASURE 13
A. Impact on Medica Financials 13
1. Medica Financials 2018 13
2. Medica 2019 Financials 13
B. Availability of Coverage 14
1. Availability of Medica Coverage Under Medica Rate Filing 14

2. Availability of Coverage Under Iowa Stopgap Measure 16
C. Affordability of Health Insurance Coverage 17
1. Assumptions for Affordability Determination 18
2. Affordability Determination – Medica Coverage Under Medica Rate Filing 18
3. Affordability Determination – Iowa Stopgap Measure 19
D. Comprehensiveness of Health Insurance Coverage 21
E. Deficit Neutrality 21
1. Factors Affecting Deficit Neutrality Analysis 22
2. Results of Deficit Neutrality Analysis 25
F. Impact on the Market if Medica does not Offer Coverage 26
Appendix A – Methods and Assumptions 28
Iowa 2018 ISM Premium Tax Credit Estimate 29
Iowa 2018 Affordability 31
Affordability of Medica 2018 rates 31
1. Data Sources 31
Affordability of the Iowa Stopgap Measure 31
Iowa 2018 Stopgap Premium 32
1. Assumptions 32
2. Data Sources 33
Iowa ISM Lapse Rate Methodology 34
1. Assumptions 35
2. Data Sources 35
Appendix B (Prior Appendix D) – Sample 2018 Premiums 37
Appendix C - Market Makeup 39
Appendix D – 2018 Premium Rates and Subsidies 41
Appendix E – Reliance Letter 47

I. INTRODUCTION

We are providing this report solely to communicate our analysis of the proposed 2018 Iowa individual ACA-compliant health insurance rates, as filed by Medica Insurance Company (Medica Rate Filing) as filed on August 4, 2017 and the effect of the Iowa Stopgap Measure (ISM), as proposed to the Centers for Medicare and Medicaid Services. Distribution of this report to parties other than the Iowa Insurance Division by us or any other party does not constitute advice from or by us to those parties. The reliance of parties other than the Iowa Insurance Division on any aspect of our work is not authorized by us and is done at their own risk.

On June 12, 2017, the State of Iowa filed a proposed request with the Centers for Medicare and Medicaid Services (CMS) for emergency regulatory relief (Proposal) to allow for the creation of a viable health insurance market for 2018 by allowing Iowa to implement the ISM. The proposal provided for: 1) a single, standardized plan for every eligible consumer from each participating carrier; 2) premium subsidies based on age and income; and 3) a reinsurance program for all plans offered under the ISM.

In order to submit a proposal for regulatory relief, a state making such a request is required to include the following information set forth in Section 5 of Appendix B of Iowa's Stopgap Measure:

- actuarial analysis and actuarial certification to support the state's findings that the waiver complies with the coverage, comprehensiveness, and affordability requirements;
- economic analysis to support the state's finding that the waiver will not increase the federal deficit over specific time periods; and
- data and assumptions that the state relied upon.

Although Iowa requested in its proposal that the requirements set forth above be waived due to the short-term nature of the proposed solution, the proposal did reference certain information provided with respect to the effect of the ISM in 2018.

After the State of Iowa's filing of the proposal with CMS, Medica Insurance Company (Medica) made the decision to continue to offer coverage in the Iowa individual health insurance market. On June 19, 2017, Medica filed its proposed individual health insurance

rates and rating methodology (Medica Rate Filing) with the Iowa Insurance Division (IID) and on August 4, 2017, it filed revised rates assuming that there will be no funding of cost sharing reductions (CSRs).

On June 23, 2017, the IID requested that NovaRest, Inc. (NovaRest) perform an actuarial review of the Medica Rate Filing. Further, on June 30, 2017, NovaRest presented its proposal to analyze the effect of the Medica Rate Filing on the Proposal and the ISM, as described in Section II, Scope of Services, below. On July 5, 2017, the IID accepted NovaRest's proposal and authorized NovaRest and its team to perform its review and analysis.

II. SCOPE OF SERVICES

In our analysis of the effect of the Medica Insurance Company's proposed 2018 individual health insurance rates on the Iowa proposal and the ISM and pursuant to the IID's direction, we analyzed the following matters:

A. Analysis of Medica's 2018 and 2019 Operations

We were asked to analyze Medica's financial operations in 2018 and 2019 to assure that there would not be undue strain on Medica's financials by being the only carrier in the individual market in Iowa.

B. Analysis of the impact of Medica's 2018 Rates and of the Iowa Stopgap Measure

As previously indicated, Section 5 of Appendix B of the Iowa Stopgap Measure proposal sets forth specific requirements for CMS approval of the proposal and the ISM. Pursuant to the IID's direction, we analyzed the following specific requirements:

1. Availability of Health Insurance Coverage

We analyzed whether a comparable number of Iowa residents will have individual health insurance coverage under the following two scenarios:

- Coverage from Medica in 2018 and 2019 in accordance with the Medica Rate Filing; and
- Coverage under the ISM in 2018 and 2019 based on projected ISM premium costs.

We did not consider as part of our analysis projected coverage specifically for Iowa's Medicaid recipients or vulnerable populations under these two scenarios.

2. Affordability of Health Insurance Coverage

We analyzed the affordability of individual health insurance coverage for Iowa residents under the following two scenarios:

- Affordability based on Medica's continued participation in the individual health insurance market in 2018 and 2019 assuming the IID approves the Medica Rate Filing; and
- Affordability under the ISM in 2018 and 2019 based on projected ISM premium costs.

3. Comprehensiveness of Health Insurance Coverage

We analyzed the comprehensiveness of available individual health insurance coverage for Iowa residents under the following two scenarios:

- Medica's continued participation in the individual health insurance market in 2018 and 2019; and
- Available coverage under the ISM in 2018 and 2019.

4. Deficit Neutrality

We analyzed the anticipated amount of federal spending net of federal revenues under the following two scenarios:

- 2018 and 2019 operations for the Iowa individual health insurance market based on the Medica Rate Filing; and
- 2018 and 2019 operations for the Iowa individual health insurance market in accordance with the ISM.

Pursuant to the IID's request, we analyzed the impact that advance premium tax credits (APTC) have on Iowa residents' individual health insurance purchasing decisions based on price sensitivity.

5. Impact on the Market if Medica does not Offer Coverage

We also considered the impact if Medica did not provide coverage.

6. Impact on Provider Compensation of Medica's 2018 and 2019 Operations

Finally, pursuant to the IID's direction, we analyzed the potential impact on provider compensation of Medica being the only carrier in the individual health insurance market.

III. EXECUTIVE SUMMARY

A. Approach

Our findings and analysis with respect to the Medica Rate Filing will be provided in a separate report. It is important to note, however, that several assumptions that were made during our actuarial review of the Medica Rate Filing and results of our review are incorporated and referenced in our analysis of the Iowa Proposal and the ISM.

We based our projections on the CCIIO data as much as possible. We used CCIIO's membership for those under 100% of the Federal Poverty Level (FPL) for that population. Since the <400% FPL membership can decrease or increase from year to year, we assumed that the 2018 membership would be the same.

We also did a survey of carriers for data not available from CCIIO. Appendix A provides more information on the data used.

B. Impact on Medica's financials

First, we analyzed Medica's financial operations in 2018 and 2019 assuming that the IID approves Medica Rate Filing. Our analysis considered financial projections for Medica in 2018 and 2019 based on the requested rate increase, as proposed in Medica Rate Filing, and projections of Medica's insured populations in 2018 and 2019.

We tested scenarios where actual claims were 10%, 15%, and 20% more than projected. We did not include any income from 2017 or from other lines of business in 2018, both of which would improve Medica's financial situation at the end of 2018. In the 2018 projections, Medica's risk based capital (RBC) ratio stayed above 275% and for the 2019 projections it stayed above 200%.

We conclude that Medica's financial position will not be severely damaged by providing coverage in 2018 or 2019 under predictable financial outcomes.

C. Analysis of the impact of Medica's 2018 Rates and of the Iowa Stopgap Measure

We performed separate analysis of:

1. Availability of health insurance coverage;
2. Affordability of health insurance coverage;
3. Comprehensiveness of health insurance coverage;
4. Deficit neutrality of the ISM transfer amount;
5. Impact on the market if Medica does not offer coverage; and
6. Impact on provider compensation of Medica's 2018 and 2019 operations.

1. *Availability of Health Insurance Coverage*

Availability of coverage is tied very closely to affordability. For individuals and families less than four hundred (400) percent of the federal poverty level (FPL), ACA subsidizes premiums so that the resulting premium is between 2.04% and 9.69% of the family income. As family size increases the FPL increases, but by much less than an additional premium would be for the additional member. For a couple the FPL increases from $12,060 to $16,240, an increase of 35%.[1] For couples with incomes >400% FPL the premium doubles since they both have to pay the premium for their age.

ACA further subsidizes individuals with family income <250% by reducing the cost of health care that they are responsible to pay in deductibles, copays, and coinsurance.

a. Medica Providing Coverage

If the ISM is not implemented and Medica is providing coverage at the 2018 rates filed with the Iowa Insurance Division, we are assuming that the ACA subsidies for individuals and families with incomes < 400% FPL will result in them retaining coverage.

For individuals and families with incomes > 400% FPL, we used our proprietary models to estimate the number of individuals reducing coverage to access the lower premiums or becoming uninsured. We repeated this exercise by projecting 2019 premiums into 2019 and again estimated the number of individuals reducing coverage or becoming uninsured. This result was that 2018 and 2019 were projected to have fewer individuals having coverage than in 2017.

Under the scenario of Medica offering coverage in 2018 and 2019 in accordance with the Medica rate filing and projecting 2019 premiums forward with a trend of 20%, we predict that between 3,000 and 4,000 individuals will reduce their coverage level in 2018 and between 300 and 400 in 2019 in order to purchase more affordable coverage. We also predict that between 18,000 and 22,000 individuals in 2018 and between 28,000 and 30,000 in 2019 will drop coverage and become uninsured. Of those becoming uninsured in 2019, most of the uninsured are from the Transitional market, which will experience large rate increases.

[1] These are the federal poverty level that will be used for the 2018 coverage and will be updated every year. https://thefinancebuff.com/federal-poverty-levels-for-obamacare.html

b. Iowa Stopgap Measure

For the ISM, the ACA premium and health care cost subsidization will be replaced with a premium credit based on income level and age. Also, a reinsurance pool will be established to reduce overall premiums.

Since the ISM plan only offers is a Silver level plan, for individuals whose family income > 400% FPL, the individuals in the Catastrophic and Bronze metal level plans may see a premium increase, but those in the Silver and Gold metal levels will see a premium decrease. Those in Catastrophic and Bronze plans will also see an increase in benefits, where those in Gold plans will see a decrease in benefits.

We project that between 4,000 and 6,000 individuals with family incomes > 400% will drop coverage in 2018 and become uninsured. This is significantly less than the total of coverage reductions and uninsured under the Medica scenario, which is between 21,000 and 26,000.

Although the actual impact of the ISM is hard to predict because of the way families are subsidized under ACA (those with incomes < 400% of FPL), we believe that that the ISM subsidies and the reduced premium due to the ISM reinsurance will provide sufficient premium relief to families that they will not have an incentive to drop coverage and become uninsured.

For 2019, we assume that subsidies or premiums will be designed so that few, if any, of those purchasing coverage in 2018 would drop coverage in 2019.

Many transitional policies have very low premiums even compared to the subsidized ISM premiums and individuals may see high rate increases. The March carrier survey conducted by the Iowa Insurance Division showed approximately 41,000 individuals covered by transitional policies. Based on our elasticity model, there could be between 13,000 and 15,000 individuals dropping coverage, if the transitional policies are not allowed in 2019. It would also imply that up to 28,000 individuals could be entering the individual ACA market or the ISM market, whichever is active in 2019 in Iowa.

2. Affordability of Health Insurance Coverage

We considered any premium over 10% of income to be unaffordable.

If the ISM is not implemented and Medica is providing coverage at the 2018 rates filed with the Iowa Insurance Division, the premiums for individuals and families > 400% of FPL will have premiums that are unaffordable unless family income reaches the high-income levels. For an individual adult starting at age 20, their income would have to exceed

$50,000 to afford the second lowest Silver plan and for an older adult, starting at age 48 the individual's income would have to exceed $100,000 for the same plan.

To test unaffordability of the ISM, we estimated the ISM base premium and ISM premium net of subsidy. If the ISM is implemented, the carriers will set the base premiums, therefore, if premiums are set at more or less than our estimate, the results will change.

For income levels over 400%, the ISM premiums are much more affordable than Medica's.

For income levels where there is an APTC available, the net ISM premiums for individuals and families will be affordable.

All of the estimated 2018 base premiums, subsidies and net premiums can be found in Appendix D.

3. Comprehensiveness of Health Insurance Coverage

Since Medica must comply with ACA and since the ISM plan is ACA compliant, both scenarios have comprehensive coverage.

4. Deficit Neutrality

The pass-through amount is the projected 2018 premium tax credit (PTC)[2] and CSR adjusted for the change in the risk adjustment fee, shared responsibility revenue, and exchange user fee when going from Medica to the ISM. Currently Medica filed premium rates assuming that CSR will not be funded, therefore there is no impact from CSRs.

[2] Note, the difference between the APTC and the PTC, is that the APTC is the estimate of the PTC that is done when the individual or family applies for coverage and the PTC is the actual credit calculated when the family files its income tax return.

Pass-Through for Budget Neutrality	
	2018
Premium Tax Credits	$421,906,599
CSR	$0
Pass Through	$0
Federal Reinsurance Change	$0
Risk Adjustment Fee Change	$25,479
Shared Responsibility change	($6,916,817)
Exchange User Fee Change	($18,750,382)
Total	$396,264,879

5. Impact on the Market if Medica does not Offer Coverage

If Medica does not offer coverage, individuals will need to be self-insured. This is particularly problematic since they will not have access to provider discounts and will have to pay undiscounted fees for services. Few can afford this cost, which will result in individuals not receiving necessary services and will increase provider uncompensated care.

6. Impact on Provider Compensation of Medica's 2018 and 2019 Operations

Currently, Medica enters into agreements with health care providers (i.e., managed care provider networks), under which providers agree to charge fees for their services that are lower than UCR charges. Enrollees in individual health insurance products benefit from these managed care provider network agreements by obtaining proportionately lower out of pocket costs.

Since Medica would be the only carrier in Iowa in the individual market, Medica would not have market competition so it might be a logical assumption that Medica would not have any incentive to control premium costs or provider compensation costs. Accordingly, Iowa residents might be subject to higher premiums and out of pocket costs, resulting in more residents deciding to terminate coverage

We spoke to Medica and found that they are in negotiations with providers. From our conversations, we believe that resulting negotiated fees will in the range currently negotiated by other carriers. We do not believe that there should be a concern at this time that providers will be forced into lowering their rates so that they are not sustainable or that, on the other side, that Medica will not actively negotiate the best fees possible considering the situation.

IV. ANALYSIS OF EFFECT OF THE MEDICA RATE FILING AND IOWA STOPGAP MEASURE

A. Impact on Medica Financials

1. Medica Financials 2018

Using the average 2017 rates for on and off-exchange plans by area and metal level for all carriers, we determined the average rate increase for each area and metal level. We assumed that the individuals receiving advanced premium tax credits (APTC) would remain in the market and that there would be minimal rate increase after the application of the APTC. We developed a proprietary model to project the individuals that would buy down coverage to a lower metal level and those that would become uninsured in 2018.

We used Medica's 2016 financial statement to determine its risk-based capital level (RBC) level at the end of 2016. Since health insurance RBC is primarily driven by claims costs, we developed a formula to predict 2018 and 2019 RBC based on projected claims costs.

We used Medica's 2016 financials and assuming no profitability in 2017 and that other profit centers break even in 2018. We believe that this creates the worst case possible. If Medica is profitable in 2017 and the other profit centers are profitable in 2018, the resulting 2018 financials will be better.

We ran various scenarios on the impact on incurred claims from the buy downs or the lapses. For the low impact scenario, we used a 10% increase in claim cost, for the middle scenario we used 15% and for the high impact scenario we used a 20% increase in claim costs.

In all scenarios for excess claims we found that Medica's RBC ratio remained above 275% and that it would take our unlikely low profitability assumptions and a 35% increase in projected claims in 2018 to bring Medica's RBC ratio to 200%.

2. Medica 2019 Financials

For 2019 we assumed that the transitional policies would no longer be allowed and that individuals would have to move into the ACA market. Again, we used our proprietary model to project the non-APTC individual and the transitional individuals that would buy down coverage to a lower metal level and those that would become uninsured in 2018. Using the projected membership by area and metal level we projected Medica's total premium.

We ran various scenarios on the impact of incurred claims from the buy downs or the lapses. For the low impact scenario, we used a 10% increase in claim cost, for the middle

scenario we used 15% and for the high impact scenario we used a 20% increase in claim costs.

In all scenarios for excess claims we found that Medica's RBC ratio remained above 200% and that it would take our unlikely low profitability assumptions.

We conclude that Medica's financial position will not be severely damaged by providing coverage in 2018 or 2019 under predictable financial outcomes

B. Availability of Coverage

Section 5 of Appendix D of the Iowa Stopgap Proposal requires evidence that a comparable number of state residents will have coverage under the ISM as would have coverage without the ISM. Accordingly, we projected the number of Iowa residents who would have coverage under the ISM and coverage by Medica in accordance with the Medica Rate Filing.

To perform our analysis, we projected Iowa residents obtaining insurance coverage under two scenarios:

- Coverage from Medica in 2018 and 2019 in accordance with the Medica Rate Filing for benefit structure and premium costs; and

- Coverage under the ISM in 2018 and 2019 based on projected ISM premium costs.

It is important to note that we did not analyze projected coverage specifically for Iowa's Medicaid recipients or vulnerable populations under these two scenarios.

1. Availability of Medica Coverage Under Medica Rate Filing

The availability of health insurance coverage is very closely tied to the affordability of the coverage. Although under either of the scenarios of Medica providing coverage or the implementation of the ISM, there will be coverage available for purchase the affordability differs under the two scenarios.

For 2018 and the scenario of Medica providing coverage, we performed a comparison of Medica's filed 2018 rates compared to four different premium rate levels:

- Medica's premium rates, as determined from its 2017 individual health rating filing based on an average of rates for each geographic area and for each metal level;

- Aetna's premium rates, similarly determined from its 2017 individual health rating filing based on an average of rates for each geographic area and for each metal level; and

- Wellmark's premium rates, similarly determined from its 2017 individual health rating filing based on an average of rates for each geographic area and for each metal level.

- An average of Aetna's, Wellmark's, and Medica's 2017 premium rates based on an average of rates for each geographic area and for each metal level.

Based on our analysis, Medica's 2018 average metal level premium rates by area were:

- Between 27% and 137% higher than Aetna's 2017 premium rates;
- Between 22% and 69% higher than Wellmark's 2017 premium rates;
- Between 37% and 48% higher than Medica's 2017 premium rates; and
- Between 33% and 77% higher than the average of Aetna's, Wellmark's, and Medica's average age 21 non-smoker rate by area and metal level.

Average Rates by Metal Tier All Areas Combined					
	Medica 2018	**Aetna 2017**	**Medica 2017**	**Wellmark 2017**	**Average 2017**
Catastrophic	$338.44	$210.22	$235.12	Not offered	$222.67
Bronze	$472.56	$245.61	$322.46	$304.05	$290.70
Silver	$502.08	$310.34	$363.75	$384.95	$353.01
Gold	$593.59	$392.29	$425.22	$459.21	$425.57

Using our propriety elasticity model and the elasticity slopes presented at a Society of Actuaries meeting,[3] we determined the impact on coverage and therefore the increase in the uninsured.

Under the scenario of Medica offering coverage in 2018 and 2019 in accordance with the Medica rate filing and projecting 2019 premiums forward with a trend of 20%, we predict that between 3,000 and 4,000 individuals will reduce their coverage level in 2018 and between 300 and 400 in 2019 in order to purchase more affordable coverage. We also predict that between 18,000 and 22,000 individuals in 2018 and between 28,000 and 30,000 in 2019 will drop coverage and become uninsured. Of those becoming uninsured in 2019,

[3] https://www.soa.org/pd/events/2017/health-meeting/pd-2017-06-health-session-076.pdf

most of the uninsured are from the Transitional market, which will experience large rate increases.

These projections were developed by analyzing the rate increases from the 2017 premium rates and membership from the carriers participating in the on and off exchange markets. The assumption is that everyone eligible for APTC will continue coverage, therefore those reducing coverage or becoming uninsured will be from the population with >400% FPL.

2. Availability of Coverage Under Iowa Stopgap Measure

For 2018, we performed a comparison of the premium rates, as determined for an individual age 21 in each metal level plan under each of the following rating structures:

- Medica's premium rates, as determined from its 2017 individual health rating filing;
- Aetna's premium rates, as determined from its 2017 individual health rating filing;
- Wellmark's premium rates as determined for its 2017 individual health rate filing; and
- Premium rates, as determined for the ISM.

We first analyzed these premium rates for individuals with income over 400% FPL using our elasticity model.

Next, we made the same premium rate comparisons for individuals with income at or below 400% FPL. For these individuals and families, the change in premium cost equates to the difference between the maximum premium payable, as determined under specific IRS parameters for ACA coverage ("Maximum Family Premium")[4], and the ISM premium. We compared individuals, couples and families separately.

Predicting what choices that families will make when faced with premium increases is extremely difficult. The ISM will heavily subsidize children in order to provide families

[4] The Maximum Family (or Individual as family of size 1) Premium is determined in accordance with IRS guidelines that define the percentage of a family's income that results in the maximum premium a family is required to pay for coverage. These percentages of family income are based on a range of FPL. Under the IRS guidelines, the lowest percentage of family income for purposes of determining the Maximum Family Premium is 2.04% for family income between 100% and 133% of FPL. The highest percentage of family income for purposes of determining the Maximum Family Income is 9.69% for family income between 350% and 400% of FPL. Note that for purposes of determining the Maximum Family Premium, families of one or individuals are treated as a "family".

with affordable coverage. We compared two dimensions, the amount of the premium increase going from the ACA subsidized rates to the ISM subsidized rates and the ISM rate compared to family income.

We project that between 4,000 and 6,000 individuals with family incomes >400% will drop coverage in 2018 and become uninsured. This is significantly less than the total of coverage reductions and uninsured under the Medica scenario, which is between 21,000 and 26,000.

Although the actual impact of the ISM is hard to predict because of the way families are subsidized under ACA (those with income < 400% FPL), we believe that that the ISM subsidies and the reduced premium due to the ISM reinsurance will provide sufficient premium relief to families that they will not have an incentive to drop coverage and become uninsured.

For 2019, we assume that the IID and carriers will make every attempt to ensure that the market stays stabilized and that the insured from 2018 do not experience unaffordable rate increases. Carriers will in all probability attempt to get good provider contracts and manage care so that health care cost remain reasonable. The IID will again study the market and work with CMS to either transition back to the ACA or other federal paradigm or will continue the ISM in a way to continue to ensure affordable premiums. Through these efforts, we believe that the resulting net premiums will be low enough that few if any of those purchasing coverage in 2018 would drop coverage in 2019.

Until 2018 the federal government and the State of Iowa have allowed individuals to continue purchasing the policies that they had prior to ACA. These policies often have much lower premiums than ACA compliant policies because the individuals in them were underwritten when they were purchased and the benefits are lower than the ACA requirements. In 2019, the transitional policies may not be continued. If not, a number of transitional policies have very low premiums even compared to the subsidized ISM premiums and individuals may see high rate increases. The March carrier survey showed approximately 41,000 individuals covered by transitional policies. Based on our elasticity model, there could be 13,000 to 15,000 individuals dropping coverage. It would also imply that up to 28,000 individuals could be entering the individual market.

C. Affordability of Health Insurance Coverage

Section 5 of Appendix D of the Iowa Stopgap Proposal requires evidence that health care coverage under the ISM would be as affordable as coverage without the ISM. As previously indicated, we analyzed whether a comparable number of Iowa residents will have affordable individual health insurance coverage under the following two scenarios:

- Coverage from Medica in 2018 and 2019 in accordance with the Medica Rate Filing; and
- Coverage under the ISM in 2018 and 2019 based on projected ISM premium costs.

1. Assumptions for Affordability Determination

To analyze the affordability of individual health insurance coverage for Iowa residents, we used a measure of 10% of income based on the affordability definition, which is 9.69% in 2017[5] and is adjusted by inflation each year. For simplicity 10% was used.[6]

Finally, we made certain calculations with respect to the affordability of dependent premium charges based on the following analysis: in 2018, the FPL equals $12,060 per person. For each additional family member, the FPL increases by $4,180 per year, or $348.33 per month.

2. Affordability Determination – Medica Coverage Under Medica Rate Filing

For purposes of our analysis under the Medica scenario, it is important to note that the affordability of premiums will not differ for individuals who are eligible for APTCs. Further, the highest income level for an individual or family at which APTC eligibility applies is 400% of the FPL. Accordingly, we have only performed our analysis for individuals whose income exceeds 400% of FPL.

Testing for incomes at 405% of FPL, we found that results varied by area due to the difference in premium rates among areas. In general, premiums for all metal levels except Catastrophic were judged to be unaffordable for ages over 20. For the Catastrophic plan, again results varied by area, but as a generality premium rates became unaffordable at age 33. As income raise above 400% FPL, the premiums become more affordable.

As examples, we show five possible scenarios showing the least expensive Bronze plan:

1) An individual age 29;
2) An individual age 40;
3) An individual age 50;
4) A couple both age 60; and
5) A family of four with two parents both age 35 and two children both under age 15.

[5] Note that these percentages change every year.
[6] https://www.healthcare.gov/glossary/affordable-coverage/

We compared monthly premiums to monthly FPL, that is the FPL, which is annual converted to a monthly amount. We highlighted the percentages premium compared to monthly FPL that are above 10%.

Bronze Plan in the Least Expensive Area			
Single	Age 29	Age 40	Age 50
Net premium	$466	$532	$744
405% Monthly FPL	$4,070	$4,070	$4,070
% of FPL	11.45%	13.07%	18.27%

Bronze Plan in the Least Expensive Area		
Family	Couple age 60	Family 2 parents age 40 and 2 children under 14
Net premium	$1,130	$1,655
FPL	$5,481	$8,303
% of FPL	20.62%	19.93%

Since Silver and Gold plans are even more expensive, which will result in increased unaffordability for those plans.

3. Affordability Determination – Iowa Stopgap Measure

We compared the premiums for all ages to 10% of the monthly FPL. In determining the ISM premium it was decided that there would be no area factors allowed. We estimated premium net of the subsidy that will be provided by Iowa. The subsidy varies by age and income level. The subsidy is still being reviewed and may change as further analysis is done, which will then impact the access and affordability of coverage.

For income levels over 400%, the ISM premiums are much more affordable than Medica's, but older individuals, couples, and families did not pass our affordability criteria.

Using the same examples as above, we show five possible scenarios showing the least expensive Bronze plan:

1) An individual age 29;
2) An individual age 40;
3) An individual age 50;
4) A couple both age 60; and

5) A family of four with two parents both age 35 and two children both under age 15.

We compared monthly premiums to monthly FPL, that is the FPL, which is annual converted to a monthly amount. We highlighted the percentages premium compared to monthly FPL that are above 10%.

ISM Average Area Individual Premium Rate						
Single Age 29	**133%-150 %**	**150%-200 %**	**200%-250 %**	**250%-300 %**	**300%-400 %**	**405%**
ACA max PMPM	$51	$92	$166	$247	$341	
PSM before subsidy	$408	$408	$408	$408	$408	$408
ISM Subsidy	$398	$393	$376	$357	$335	$82
ISM Net premium	$10	$15	$32	$52	$73	$326
Monthly Income	$1,422	$1,759	$2,261	$2,764	$3,518	$4,070
% of FPL	**0.72%**	**0.88%**	**1.44%**	**1.87%**	**2.09%**	**8.02%**
Single Age 40	**133%-150 %**	**150%-200 %**	**200%-250 %**	**250%-300 %**	**300%-400 %**	**405%**
ACA max PMPM	$51	$92	$166	$247	$341	
PSM before subsidy	$466	$466	$466	$466	$466	$466
ISM Subsidy	$455	$449	$429	$407	$383	$94
ISM Net premium	$12	$18	$37	$59	$84	$373
Monthly Income	$1,422	$1,759	$2,261	$2,764	$3,518	$4,070
% of FPL	**0.82%**	**1.00%**	**1.64%**	**2.14%**	**2.38%**	**9.16%**
	3.57%	5.26%	7.32%	8.95%	9.69%	
Single Age 50	**133%-150 %**	**150%-200 %**	**200%-250 %**	**250%-300 %**	**300%-400 %**	**405%**
ACA max PMPM	$51	$92	$166	$247	$341	
PSM before subsidy	$652	$652	$652	$652	$652	$652
ISM Subsidy	$635	$627	$600	$569	$535	$131
ISM Net premium	$16	$25	$52	$83	$117	$521
Monthly Income	$1,422	$1,759	$2,261	$2,764	$3,518	$4,070
% of FPL	**1.15%**	**1.40%**	**2.29%**	**2.99%**	**3.33%**	**12.80%**

ISM Average Area Family Premium Rate						
Couple age 60	**133%-150%**	**150%-200%**	**200%-250%**	**250%-300%**	**300%-400 %**	**405%**
ACA max PMPM	$68	$124	$223	$333	$459	
PSM before subsidy	$1,981	$1,981	$1,981	$1,981	$1,981	$1,981
ISM Subsidy	$1,931	$1,906	$1,824	$1,730	$1,625	$398
ISM Net premium	$50	$75	$157	$251	$356	$1,583
Monthly Income	$1,915	$2,368	$3,045	$3,722	$4,737	$5,481
% of FPL	**2.60%**	**3.16%**	**5.17%**	**6.75%**	**7.51%**	**28.88%**
	3.57%	5.26%	7.32%	8.95%	9.69%	
Family 2 age 40 and 2 under 14	**133%-150%**	**150%-200%**	**200%-250%**	**250%-300%**	**300%-400 %**	**405%**
ACA max PMPM	$104	$189	$338	$505	$695	
PSM before subsidy	$1,451	$1,451	$1,451	$1,451	$1,451	$1,451
ISM Subsidy	$1,414	$1,396	$1,335	$1,267	$1,190	$291
ISM Net premium	$36	$55	$115	$184	$261	$1,159
Monthly Income	$2,901	$3,588	$4,613	$5,638	$7,175	$8,303
% of FPL	**1.26%**	**1.53%**	**2.50%**	**3.26%**	**3.63%**	**13.96%**

All of the estimated 2018 base premiums, subsidies and net premiums can be found in Appendix D.

D. Comprehensiveness of Health Insurance Coverage

To satisfy the comprehensiveness of coverage requirement, health care coverage under the Waiver scenario must be forecast to be at least as comprehensive overall as coverage absent the Waiver. Comprehensiveness refers to coverage requirements for ACA essential health benefits (EHBs) and as appropriate, Medicaid and CHIP standards. The ISM being sought does not impact EHBs for the commercial markets, and will not impact the scope of services required to be covered by the Medicaid or CHIP programs. Therefore, the comprehensiveness of coverage is expected to remain unchanged across all markets.

E. Deficit Neutrality

As previously indicated, we analyzed the anticipated amount of federal spending net of lost federal revenues considering 2018 and 2019 operations for the Iowa individual health insurance market based on the Medica Rate Filing since that is the base scenario. Since the membership <400% FPL can go up or down we assumed the same membership in 2018 and 2019 as in 2017. The largest change between 2018 and 2019 was the premium level.

1. *Factors Affecting Deficit Neutrality Analysis*

For purposes of our analysis, we considered the following factors that affect federal spending and federal revenues with respect to the Iowa individual health insurance market operations and the ISM's proposed operations:

- CSRs (i.e., cost sharing reductions);
- PTCs (i.e., premium tax credits);
- Federal high risk reinsurance associated with the 2018 risk adjustment program;
- Risk adjustment fees;
- Shared responsibility penalties; and
- Exchange user fees.

a. Cost Sharing Reductions

Note, we understand that Medica is refiling its 2018 rates to assume that the CSR will not be funded. This will increase the premiums and the APTCs and eliminate the CSRs. If CRSs are part of the deficit neutrality analysis in the future, the following is our approach.

For the purposes of our analysis, we considered four CSR categories that would apply to Medica's 2018 and 2019 operations and we assumed that these CSR's would apply to Medica's second lowest Silver plan in each area. The standard cost sharing for the Silver plan is 30%. Except for one category, these CSR categories are based on an individual's FPL income:

- For individuals between 100% and 150% of FPL, cost sharing is reduced to 6%;
- For individuals between 150% and 200% of FPL, cost sharing is reduced to 13%;
- For individuals between 200% to 250% of FPL, cost sharing is reduced to 27%; and
- For Native Americans, cost sharing is zero since Native Americans are not required to pay any cost sharing amounts.

For purposes of determining projected Medica membership in each of these four CSR categories, we relied on data from the July 2017 survey of Aetna, Wellmark and Medica (Survey), which included 2016 membership by CSR category and on data from CCIIO on the membership by FPL for 2017 exchange enrollment.

Next, we used the 2018 premium rates for the second highest Silver benefit plan in each geographic area from Medica's 2018 rate filing. We then estimated incurred claim costs for each geographic area by multiplying the calculated premium by 74.76% (the total paid-to-allowed) and dividing the result by the 74% (the Silver plan paid-to-allowed ratio) to estimate the allowed claims. We chose 74% for the paid-to-allowed rather than 70%

because often the actual cost sharing is more than the 72% cost sharing allowed from the federal Actuarial Value Calculator. Finally, we multiplied the incurred claim costs by the difference between the projected paid-to-allowed ratio for the Silver plan (74%) and the paid-to-allowed ratio for each CSR level (100%, 94%, 83% and 73%). Note, one result from the higher loss ratio is that there was no CSR for the 73% category.

b. Premium Tax Credits

Note, we understand that Medica is refiling its 2018 rates to assume that the CSR will not be funded. This will increase the PTCs.

For purposes of determining the effect of PTCs on deficit neutrality, we began our analysis by assuming that PTCs are calculated as the difference between the second lowest Silver plan total premium and the total Maximum Family Premium (see discussion and definition of Maximum Family Premium in Section IV.B.2).

For purposes of determining the total second lowest Silver plan premium for 2018 for Medica coverage, we used Medica's 2018 rate filing.

The membership data from the Iowa carrier survey was by cost-sharing reduction (CSR) categories. We used the 2017 Iowa exchange membership by FPL from CCIIO, which included membership by different categories (100-138%, 139-200%, 201-250%, 251-300%. 301-400%, Other/UK). We allocated this membership to area and age using the distributions from the Iowa carrier survey. The total premium was the Medica premium multiplied by the appropriate age and area membership.

To determine the total Maximum Family Premium, we used the CCIIO 2017 membership for the CSR categories and the family size distributions by CSR category from the Iowa carrier survey. Member months were assumed to be 11.13[7] months per member since there will be some leaving in the middle of the year, but in general the individuals with APTC will tend to stay.

We calculated the total Maximum Family Premium that would be paid in 2018 for Medica coverage using the family size and Maximum Family Premium for that family size and FPL.

The total APTCs were calculated by taking the difference between the total premium for the second lowest premium and the total Maximum Family Premium.

[7] This was taken from an Iowa survey.

When individuals and families file their tax returns there may be an over or under estimation of the PTC when estimating the APTC. We estimated this net adjustment to be -2%. Therefore, an adjustment of -2% was made to the APTC to determine the final PTC that would be allowed in 2018.[8]

c. Federal High-Risk Reinsurance Associated with the 2018 Risk-Adjustment Program

The federal high-risk reinsurance program provides for coverage of 60% of claims that exceed $1 million. Using the claim distribution from 2016 trended to 2018, we estimate that the recoveries under the program for 2018 will be approximately eleven million dollars ($11,000,000).

At the same time, we assume that under either Medica's operations or ISM operations in 2018, the federal high-risk reinsurance program will provide the same protection to both Medica and the ISM. Accordingly, the effect of this program under either scenario will be deficit neutral.

d. Risk Adjustment Fee

In 2018, the risk adjustment fee equals $0.14 PMPM. Accordingly, the amount of the risk adjustment fee is dependent on the number of anticipated enrollees in 2018 for Medica and for the ISM.

Based on our projected enrollment for 2018 for Medica individual health products and for the ISM participation, we project that the number of member months for the ISM in 2018 would exceed the number of member months for the Medica scenario.

We understand that if the ISM reduces membership that the reduction in risk adjustment fee will be used to reduce the pass-through payments, but since they are higher, we assume that the pass-through payments will be increases. CMS will have to confirm this.

e. Shared Responsibility Penalty

Under the ACA, individuals who do not maintain health insurance are subject to a shared responsibility penalty. In 2018, the shared responsibility penalty for individuals who do not purchase insurance and are not eligible for exemption from the penalty is $695 per adult and $347.50 per child, up to a maximum penalty of $2,085 per family.[9] Individuals who are exempt from the shared responsibility penalty include members of certain religious

---

[8] https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf
[9] https://www.healthcare.gov/fees/fee-for-not-being-covered/

groups and Native American tribes; incarcerated individuals; and individuals with income below thresholds that require that federal income tax returns be filed.

Kaiser Family Foundation estimates that almost 90% of the uninsured population is exempt from the individual mandate penalty.[10] We took these estimates into account in determining the projected number of Iowa's uninsured population that will be subject to the shared responsibility penalty in 2018. Finally, we considered statistics on the number of Iowa's uninsured by age in 2014.[11]

The amount of the total shared responsibility penalty that will result in 2018 under Medica's operations, as compared to the ISM operations, will depend on the projected number of uninsured resulting from operations under each scenario.

f. Exchange User Fees

If Medica continues its operations in 2018, it will be subject to the exchange user fee that would equal 3.5% of projected premiums. If the ISM operates in 2018, the exchange user fee will not be charged to participating insurers.

2. Results of Deficit Neutrality Analysis

Based on our examination of all the factors affecting our deficit neutrality analysis, we determined that the anticipated amount of federal spending net of federal revenues under Medica's continuation of its individual health insurance operations in 2018. This amount will be used as a pass-through amount to fund the ISM premium credits and reinsurance. The pass-through amount is the 2018 PTC and CSR adjusted for the change in the risk adjustment fee, shared responsibility revenue, and exchange user fee when going from Medica to the ISM.

[10] http://www.kff.org/health-reform/perspective/the-individual-mandate-how-sweeping/
[11] https://www.census.gov/did/www/sahie/data/interactive/

Pass-Through for Budget Neutrality	
	2018
Premium Tax Credits	$421,906,599
CSR	$0
Pass Through	$0
Federal Reinsurance Change	$0
Risk Adjustment Fee Change	$25,479
Shared Responsibility change	($6,916,817)
Exchange User Fee Change	($18,750,382)
Total	$396,264,879

F. Impact on the Market if Medica does not Offer Coverage

An additional effect of the total collapse of Iowa's individual health insurance market is the effect on Iowans' ability to obtain reasonably priced health care services through managed care provider networks. Currently, health insurers operating in the Iowa individual health market enter into agreements with health care providers (i.e., managed care provider networks), under which providers agree to charge fees for their services that are lower than UCR charges. Enrollees in individual health insurance products benefit from these managed care provider network agreements by incurring proportionately lower out of pocket costs.

If the Iowa individual health insurance market collapses, Iowans will be forced to obtain coverage from providers at UCR charges. For individuals without health insurance coverage, physicians and other providers typically require payment at the time of service. In many cases, these individuals obtain their necessary health care service at hospital emergency rooms, which are required to provide services without obtaining payment at the time of service. If individuals cannot afford the undiscounted fees, they will either forgo necessary services or they may receive the services and not be able to pay, increasing uncompensated care in Iowa.

When individuals use hospital emergency rooms as their primary source of medical care, the health care system is negatively impacted for two reasons:

- First, the health care costs required to treat an individual are substantially higher when treatment is provided in a hospital emergency room, rather than in a setting more appropriate to the individual's needs (for example, a physician office visit is appropriate for monitoring a pregnancy or diabetes);
- In addition, the individual does not have a comprehensive treatment plan in place that addresses his or her complete health care needs and conditions. Instead, the individual's health conditions are treated in an expedient manner as each crisis occurs.

Appendix A – Methods and Assumptions

Iowa 2018 ISM Premium Tax Credit Estimate

The premium tax credit (PTC) is the difference between the second lowest Silver plan premium [benchmark premium] and the Maximum Family Premium for a family including families of 1 or individuals.

At the time this analysis is being completed, Medica will be the only insurer on the exchange in 2018 so the benchmark premium will be Medica's second lowest Silver plan premium from its August 3, 2017 rate filing. For the purposes of this study, we have assumed that 2018 Medica rates will be approved as filed, so we extracted the benchmark premium from the Medica 2018 rate filing. To determine the total premium that would be payable without the PTC, we used the survey membership for the CSR categories by age and the Medica premium rates by age. For the 250%-400% range we used the CCIIO 2017 membership split using the ratio by age from the survey for the Non-CSR population. We had to calibrate the membership so that it matched the CCIIO statistics, which was used to determine the Maximum Family Premium. Member months were assumed to be 11.13[12] months per member since there will be some leaving in the middle of the year, but in general the individuals with APTC will tend to stay. The total premium was the Medica premium multiplied by the appropriate age and membership.

The membership data from the Iowa carrier survey was by cost-sharing reduction (CSR) categories. We used the 2017 Iowa exchange membership by FPL from CCIIO, which included membership by different categories (100-138%, 139-200%, 201-250%, 251-300%. 301-400%, Other/UK). We allocated this membership to age using the distributions from the Iowa carrier survey from March 2017 and July 2017. The total premium was the Medica premium multiplied by the appropriate age membership.

To determine the total Maximum Family Premium, we used the CCIIO 2017 membership to allocate the March carrier survey data to the CSR categories and the family size distributions by CSR category from the Iowa July 2017 carrier survey. Member months were taken as 11.13[13] member months per members since there will be some leaving in the middle of the year, but in general the individuals with APTC will tend to stay.

We calculated the total Maximum Family Premium that would be paid in 2018 for Medica coverage using the family size and Maximum Family Premium for that family size and FPL.

---

[12] This was taken from an Iowa survey.
[13] This was taken from an Iowa survey

The advanced premium tax credit (APTC) was calculated by taking the difference in the premium and the Maximum Family Premium per member. This was then adjusted by the percent of net adjustments to the APTC for 2016 income tax filings of -2%.[14]
Also, a family only has to pay for the first three dependents under 21.

Assumptions

1. The age and CSR distribution of membership for 2018 will be the same as in 2016.
2. Family distribution by CSR will be the same in 2018 as 2016.
3. Families with PTC and CSR will purchase coverage at the same frequency in 2018 as they did in 2016 since they are insulated from the premium increases.
4. There are 11.13 member months for each member since some APTC members may leave, but they are more likely to remain for the full year.
5. The amount of adjustments from the APTC to the PTC and the adjustments for under or over payments would be the same in 2018 as in 2016.

Data Sources

1. A data survey was sent by the Iowa Insurance Division to carriers requesting the 2016 membership by CSR category and age. The survey also requested membership by CSR category and family size. The request was sent to:
    a. Medica Insurance Company
    b. Aetna Health of Iowa
    c. Avera Health Plans
    d. Golden Rule Ins. Co.
    e. Gundersen Health Plan
    f. UnitedHealthcare Life Ins. Co.
    g. UnitedHealthcare of the Midlands
    h. Wellmark, Inc. (and WHPI)
2. Medica's 2018 rate filing includes premium rates, which we used to determine the second lowest Silver plan premium.
3. Kaiser Insurance Market Place Calculator - http://www.kff.org/interactive/subsidy-calculator/
4. Membership by FPL in file CCIIO_PScounts_IA_Final.
5. The ratios of APTC and PTC and net adjustments published by the IRS for 2016. https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf

[14] https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf

Iowa 2018 Affordability

Affordability of Medica 2018 rates

Affordability of insurance premiums is an issue for those over 400% of the federal poverty level (FPL) since the ACA premium tax credits (PTC) subsidize premiums to a percentage of FPL. The affordability definition is 9.69% in 2017 and is adjusted by inflation each year. For simplicity 10% was used.[15] Premium rates will become more affordable as family income increases so we started our analysis at 405% of FPL compared to the 2018 premium rates and increased the income until the premiums were affordable.

To determine affordability, we tested 5 scenarios including individuals ages 29, 40 and 50, couple both age 60, family of 4 with 2 parents age 35 and 2 children under age 15.

1. Data Sources

2. Medica's 2018 rate filing

Affordability of the Iowa Stopgap Measure

1. To test the affordability of the Iowa ISM, we tested the affordability at FPL levels under 400% and 405%, since under the ISM there would be no PTCs. We tested the mid points of the FPL levels or 117%, 142%, 175%, 225%, 275%, 350%, and 405% of FPL. We tested the premium as a percent of FPL and the rate increase by age. We then tested couples of different ages and families of four for different age combinations of parents and children.

Data Used

1. Our estimate of the ISM premiums.
2. Appendix D of the Iowa ISM application for the subsidies.

[15] https://www.healthcare.gov/glossary/affordable-coverage/

Iowa 2018 Stopgap Premium

Determination of the Iowa 2018 Stopgap Premium started with 2016 claim distributions from Aetna, Wellmark Inc., Wellmark Health Plan of Iowa (WHPI), UnitedHealthcare of the Midlands, UnitedHealthcare Life Ins. Co., and Medica. The incurred claims were trended for two years at 16% annual trend to 2018. The claim distributions allowed us to determine the high-cost risk pooling mechanism associated with the Federal Risk Adjustment. The new reinsurance covers 60% of the claims over one million dollars. We used individual claims trended two years to determine the reinsurance reduction to claims.

The proposed Stopgap Reinsurance program will cover 85% of the claims between $100,000 and $1,000,000. It will then coordinate with the federal high-cost pooling and will cover 25% of the claims up to $3,000,000 resulting in 85% total coinsurance between $1,000,000 and $3,000,000. After $3,000,000 the Iowa reinsurance will cover 40% of the claims resulting in 100% coinsurance.

A factor of 96% (74%/77%) was used to convert the market paid-to-allowed (77%) based on the 2016 rate filing base experience from the largest carriers to our assumed Silver level paid-to-allowed (74%) claims.

Paid claims were reduced by $0.14 PMPM for the risk adjustment fee and administrative fees, taxes, and profit margin were added. Administrative expenses and profit margins were based on the 2017 rate filings as more representative of a competitive market.
Taxes and fees were based on Medica's 2018 rate filing, but were compared to the 2017 individual rate filings to confirm that they were reasonable.

The ACA market age distribution was used to adjust the market rate to an age 21 rate.
The weights that we used were the ACA membership in 2017 per the March enrollment survey.

1. Assumptions

a. The 2016 claim distribution was trended by 9% a year in total.
b. The paid-to-allowed ratio for the Silver plan will be 74%.
c. The 2018 age distribution will be the same as the 2016 ACA population.
d. Administrative expense will be the 2017 filed admin PMPM trended to $65 PMPM.
e. Profit margins were set to 5%, which assumes that there will be competitive filings, but some margin for unknown risks.
f. The taxes and fees were estimated to be 7.68%, which excluded the exchange user fee. Tax percentages were taken from Medica's 2018 rate filing and consisted of state premium tax 2%, ACA Health user fee 2.3%, PCORI fee 0.02% and Federal

Income Tax. This was compared to the 2017 filings that were approximately 6% without the ACA Health user fee.

2. *Data Sources*

a. Medica's 2018 rate filing
b. The experience period allowed claims, incurred claims, and membership from Aetna's, Wellmark's, Wellmark Health Plan of Iowa's 2017 rate filings.
c. Claim distributions from file "To NovaRest_Claim Distribution 2016".
d. The ACA membership from the file "0_ACA Compliant Enrollment Summary_3-31-2017.xlsx".
e. The membership in total from the carrier survey.
f. The administrative cost and paid-to-allowed ratio in the 2017 rate filings for Aetna, Wellmark, Wellmark Health Plan, and Medica.

Iowa ISM Lapse Rate Methodology

There are lapse rate assumptions needed to project 2017 enrollment forward to 2018. Non-group market policyholders will consider their premium increases in deciding whether to lapse. Generally speaking, we will use price elasticity functions to model this behavior.

Price Elasticity by Metal Level

Catastrophic	-3.056
Bronze	-1.402
Silver	-1.263
Gold	-0.823
Platinum	-0.530

We estimate the likelihood of taking the coverage based upon the difference in premium before and after the rate increase using the premium elasticity function above. This means that on average a one percent increase in Silver premium corresponds to a 1.263 percent decrease in the number of people taking coverage. In this example those who lapse from Silver coverage will consider available options such as Bronze or Catastrophic coverage where available. Those who lapse may ultimately forgo coverage. Transitional policy members will use the Price Elasticity associated with the ACA Metal Level nearest in premium level to their Transitional coverage when the Transitional policy ends. Prior to that time Transitional members will follow the lapse behavior expected in their carrier's 2018 rate filing.

There are multiple scenarios that need consideration as listed below:

1. Baseline scenario - 2017 ACA membership moving into 2018 Medica ACA coverage.
2. ISM scenario - 2017 ACA membership moving into 2018 ISM coverage.
3. Baseline scenario – 2018 Medica ACA membership moving into 2019 Medica ACA coverage.
4. ISM scenario – 2018 ISM membership moving into 2019 ISM coverage.
5. Baseline scenario – 2018 Transitional Policy membership moving into 2019 Medica ACA coverage.
6. ISM scenario – 2018 Transitional Policy membership moving into 2019 ISM coverage.

1. *Assumptions*

a. The age and FPL distribution of membership for 2018 and 2019 will be the same as in 2016. FPL, on exchange, ACA APTC, and family size statistics will follow CCIIO data where available. When needed, carrier data will be used to supplement CCIIO such as for carrier Metal level membership and Transitional policy membership age.

b. Eligible individuals and families with ACA APTC will re-enroll with no lapsation in the same Metal level since they are insulated from the premium increases due to the APTC's premium contribution maximum capped at percent of income. This is relevant for scenarios (1) and (3).

c. Transitional Policy membership income levels are above 400%. This is because ACA subsidy criteria levels are well known and the members would have already migrated if eligible for subsidy. These members may lapse in scenarios (5) and (6) due to being ineligible for subsidy.

d. Employer sponsored insurance membership for 2018 and 2019 will be the same as in 2016. The same assumption is used for Medicaid, The Healthy and Well Kids in Iowa program (federally known as CHIP), Medicare and Tricare.

e. The projection assumes the 2018 Medica rates from the rate filing by the carrier. For 2019, a 20% increase in premiums is assumed.

2. *Data Sources*

a. A data survey sent by the Iowa Insurance Division to carriers requesting the 2016 membership by FPL ACA subsidy level and age. The survey also requested membership by FPL ACA subsidy level and family size, and Transitional membership age, tobacco use and premium. The request was sent to

   i. Medica Insurance Company

   ii. Aetna Health of Iowa

   iii. Avera Health Plans

   iv. Golden Rule Ins. Co.

   v. Gundersen Health Plan

   vi. UnitedHealthcare Life Ins. Co.

   vii. UnitedHealthcare of the Midlands

viii. Wellmark, Inc. (and WHPI)

b. Medica's 2018 rate filing of premium rates.

c. Wellmark's 2018 rate filing of premium rates for Transitional policy coverage.

d. 2017 market ACA compliant rate filings for all carriers in Iowa.

e. Price elasticity by Metal level came from the Society of Actuaries Health Meeting 2017, Session 76L Understanding Stakeholder Behavior: Hidden Forces in the US Healthcare System meeting slide 43. The data source for this study was 2014-2017 Public Use Files Data for Rate Filing Justification. This was a study of the ACA markets showing how policyholders have lapsed coverage based upon rate increase level. The study shows how the national individual market policyholders behaved by Metal level, recognizing such factors as people who are more sick and elected richer benefits behave differently than those who are relatively healthy and elect catastrophic coverage.

Appendix B (Prior Appendix D) – Sample 2018 Premiums

NovaRest
ACTUARIAL CONSULTING

Appendix B (Prior Appendix D)				
Premium Age	FPL	2018 Premium	Monthly Credit	2018 Premium after Credit
10	133%-150%	$279	$272	$7
10	150%-200%	$279	$269	$11
10	200%-250%	$279	$257	$22
10	250%-300%	$279	$244	$35
10	300%-400%	$279	$229	$50
10	>400%	$279	$56	$223
21	133%-150%	$365	$356	$9
21	150%-200%	$365	$351	$14
21	200%-250%	$365	$336	$29
21	250%-300%	$365	$319	$46
21	300%-400%	$365	$299	$66
21	>400%	$365	$73	$292
29	133%-150%	$408	$398	$10
29	150%-200%	$408	$393	$15
29	200%-250%	$408	$376	$32
29	250%-300%	$408	$357	$52
29	300%-400%	$408	$335	$73
29	>400%	$408	$82	$326
40	133%-150%	$466	$455	$12
40	150%-200%	$466	$449	$18
40	200%-250%	$466	$429	$37
40	250%-300%	$466	$407	$59
40	300%-400%	$466	$383	$84
40	>400%	$466	$94	$373
50	133%-150%	$652	$635	$16
50	150%-200%	$652	$627	$25
50	200%-250%	$652	$600	$52
50	250%-300%	$652	$569	$83
50	300%-400%	$652	$535	$117
50	>400%	$652	$131	$521
60	133%-150%	$991	$966	$25
60	150%-200%	$991	$953	$37
60	200%-250%	$991	$912	$79
60	250%-300%	$991	$865	$126
60	300%-400%	$991	$813	$178
60	>400%	$991	$199	$792

Appendix C - Market Makeup

2018 With ISM Number of Persons							
	FPL						
	133%-150%	150%-200%	200%-250%	250%-300%	300%-400%	400%+	Total
Marketplace (or, ACA credit eligible)							
ISM members:	6,869	14,251	9,446	5,732	6,308	25,023	67,628
Transitional						38,523	38,523
Grandfathered						37,260	37,260
Statewide Uninsured	54,824	25,924	18,953	31,000		23,155	153,856

2018 Without ISM Number of Persons							
	FPL						
	133%-150%	150%-200%	200%-250%	250%-300%	300%-400%	400%+	Total
Marketplace (or, ACA credit eligible)	6,869	14,251	9,446	5,732	6,308	11,310	53,916
ISM members:							
Transitional						38,523	38,523
Grandfathered						37,260	37,260
Statewide Uninsured	54,824	25,924	18,953	31,000		36,867	167,568

Appendix D – 2018 Premium Rates and Subsidies

Gross ISM Premium Before Subsidy			
AGE	ISM Base Premium	AGE	ISM Base Premium
0-14	$279	39	$461
15	$304	40	$466
16	$314	41	$475
17	$323	42	$484
18	$333	43	$495
19	$343	44	$510
20	$354	45	$527
21	$365	46	$548
22	$365	47	$570
23	$365	48	$597
24	$365	49	$623
25	$366	50	$652
26	$374	51	$681
27	$383	52	$712
28	$397	53	$745
29	$408	54	$779
30	$414	55	$814
31	$423	56	$852
32	$432	57	$890
33	$437	58	$930
34	$443	59	$950
35	$446	60	$991
36	$449	61	$1,026
37	$452	62	$1,049
38	$455	63	$1,077
		64 and Older	$1,095

	ISM Subsidy					
	133%-150%	150%-200%	200%-250%	250%-300%	300%-400%	>400%
0-14	$272	$269	$257	$244	$229	$56
15	$296	$293	$280	$265	$249	$61
16	$306	$302	$289	$274	$257	$63
17	$315	$311	$297	$282	$265	$65
18	$325	$321	$307	$291	$273	$67
19	$335	$330	$316	$300	$282	$69
20	$345	$341	$326	$309	$290	$71
21	$356	$351	$336	$319	$299	$73
22	$356	$351	$336	$319	$299	$73
23	$356	$351	$336	$319	$299	$73
24	$356	$351	$336	$319	$299	$73
25	$357	$353	$337	$320	$301	$74
26	$364	$360	$344	$326	$307	$75
27	$373	$368	$352	$334	$314	$77
28	$387	$382	$365	$346	$325	$80
29	$398	$393	$376	$357	$335	$82
30	$404	$399	$381	$362	$340	$83
31	$412	$407	$389	$369	$347	$85
32	$421	$415	$397	$377	$354	$87
33	$426	$421	$403	$382	$359	$88
34	$432	$426	$408	$387	$364	$89
35	$435	$429	$411	$389	$366	$90
36	$438	$432	$413	$392	$368	$90
37	$441	$435	$416	$395	$371	$91
38	$443	$438	$419	$397	$373	$91
39	$449	$443	$424	$402	$378	$93
40	$455	$449	$429	$407	$383	$94

	ISM Subsidy					
	133%-150%	150%-200%	200%-250%	250%-300%	300%-400%	>400%
41	$463	$457	$437	$415	$390	$95
42	$471	$465	$445	$422	$397	$97
43	$483	$477	$456	$432	$406	$100
44	$497	$491	$469	$445	$418	$102
45	$514	$507	$485	$460	$432	$106
46	$534	$527	$504	$478	$449	$110
47	$556	$549	$525	$498	$468	$115
48	$582	$574	$549	$521	$490	$120
49	$607	$599	$573	$544	$511	$125
50	$635	$627	$600	$569	$535	$131
51	$664	$655	$627	$594	$558	$137
52	$695	$686	$656	$622	$584	$143
53	$726	$716	$685	$650	$611	$150
54	$760	$750	$717	$680	$639	$157
55	$793	$783	$749	$711	$668	$164
56	$830	$819	$784	$744	$699	$171
57	$867	$856	$819	$777	$730	$179
58	$907	$895	$856	$812	$763	$187
59	$926	$914	$875	$830	$779	$191
60	$966	$953	$912	$865	$813	$199
61	$1,000	$987	$944	$896	$841	$206
62	$1,022	$1,009	$965	$916	$860	$211
63	$1,050	$1,037	$992	$941	$884	$216
64 and Older	$1,067	$1,054	$1,008	$956	$898	$220

	ISM Net Rates					
	133%-150%	150%-200%	200%-250%	250%-300%	300%-400%	>400%
0-14	$7	$11	$22	$35	$50	$223
15	$8	$11	$24	$39	$55	$243
16	$8	$12	$25	$40	$56	$251
17	$8	$12	$26	$41	$58	$258
18	$8	$13	$26	$42	$60	$266
19	$9	$13	$27	$44	$62	$274
20	$9	$13	$28	$45	$64	$283
21	$9	$14	$29	$46	$66	$292
22	$9	$14	$29	$46	$66	$292
23	$9	$14	$29	$46	$66	$292
24	$9	$14	$29	$46	$66	$292
25	$9	$14	$29	$46	$66	$293
26	$9	$14	$30	$47	$67	$299
27	$10	$14	$30	$49	$69	$306
28	$10	$15	$32	$50	$71	$317
29	$10	$15	$32	$52	$73	$326
30	$10	$16	$33	$53	$74	$331
31	$11	$16	$34	$54	$76	$338
32	$11	$16	$34	$55	$78	$345
33	$11	$17	$35	$55	$79	$349
34	$11	$17	$35	$56	$80	$354
35	$11	$17	$35	$57	$80	$356
36	$11	$17	$36	$57	$81	$359
37	$11	$17	$36	$57	$81	$361
38	$11	$17	$36	$58	$82	$363
39	$12	$17	$37	$58	$83	$368
40	$12	$18	$37	$59	$84	$373

	ISM Net Rates					
	133%-150%	150%-200%	200%-250%	250%-300%	300%-400%	>400%
41	$12	$18	$38	$60	$85	$380
42	$12	$18	$38	$61	$87	$386
43	$12	$19	$39	$63	$89	$396
44	$13	$19	$41	$65	$92	$407
45	$13	$20	$42	$67	$95	$421
46	$14	$21	$44	$69	$98	$438
47	$14	$22	$45	$72	$102	$456
48	$15	$23	$47	$76	$107	$477
49	$16	$24	$49	$79	$112	$498
50	$16	$25	$52	$83	$117	$521
51	$17	$26	$54	$86	$122	$544
52	$18	$27	$57	$90	$128	$569
53	$19	$28	$59	$94	$134	$595
54	$20	$29	$62	$99	$140	$623
55	$20	$31	$65	$103	$146	$650
56	$21	$32	$68	$108	$153	$680
57	$22	$34	$71	$113	$160	$711
58	$23	$35	$74	$118	$167	$743
59	$24	$36	$76	$121	$171	$759
60	$25	$37	$79	$126	$178	$792
61	$26	$39	$82	$130	$184	$820
62	$26	$40	$83	$133	$188	$838
63	$27	$41	$86	$137	$194	$861
64 and Older	$28	$41	$87	$139	$197	$875

Appendix E – Reliance Letter

NovaRest
ACTUARIAL CONSULTING

August 9, 2017

Commissioner Doug Ommen
Iowa Insurance Division
Two Ruan Center
601 Locust Street, 4th Floor
Des Moines, Iowa 50309-3738

Subject: Statement Regarding Accuracy of Data and Reliance on Assumptions Provided for the Actuarial Review of Medica Insurance Company Proposed 2018 Individual Health Insurance Rates and Analysis of Effect of Proposed Rates on Iowa Stopgap Measure

Dear Commissioner Ommen:

We are providing this report solely to communicate our analysis of the proposed 2018 Iowa individual ACA-compliant health insurance rates, as filed by Medica Insurance Company (Medica Rate Filing) as filed on August 4, 2017 and the effect of the Iowa Stopgap Measure (ISM), as proposed to the Centers for Medicare and Medicaid Services. Distribution of this report to parties other than the Iowa Insurance Division by us or any other party does not constitute advice from or by us to those parties. The reliance of parties other than the Iowa Insurance Division on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our opinion, we made use of information provided by the Iowa Insurance Division and Iowa carriers without independent investigation or verification (see list attached). If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on the data provided by the company without independent investigation or verification, we have reviewed the information for consistency and reasonableness. Where we found the data to be inconsistent or unreasonable we have requested clarification.

The actuarial methodologies utilized in order to arrive at our opinion were those which were considered generally accepted within the industry.

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

8/7/2017
Date

Donna C. Novak
Signature

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 tel: 520-908-7246 - fax: 772-673-0318 NovaRest.com

List of Data Sources and Assumptions Provided

1. Distribution - IA.XLSX
2. Gundersen_Regions.xlsx
3. IA Stopgap Survey - GRIC.xls
4. IA Stopgap Survey - UHCLIC.xls
5. IA Stopgap Survey - UnitedHealthcare of the Midlands.xlsx
6. NovaRest - Carrier Questions - 2017.07.11 - Question 4.xlsx
7. NovaRest - Carrier Questions - 2017.07.11 - Question 6.xlsx
8. NovaRest - Carrier Questions - 2017.07.12 - SEPs.xlsx
9. NovaRest Iowa Responses 20170713 (002).xlsx
10. NovaRest_Iowa Carrier Questions - GRIC.doc
11. NovaRest_Iowa Carrier Questions - UHCLIC.doc
12. NovaRest_Iowa Carrier Questions.doc
13. NovaRest_Iowa Carrier Questions_Wellmark Response.doc
14. Response to Data Request Dated 2017.07.11 v2.pdf
15. Response to Data Request Dated 2017.07.11.pdf
16. Response to Data Request Dated 2017.07.11.xlsx
17. Medica 2018 individual market rate filing
18. Aetna 2017 individual market rate filing
19. Wellmark 2017 individual market rate filing
20. Medica 2017 individual market rate filing
21. March 2017 Carrier Survey