OLIVER WYMAN

AFFORDABILITY AND ACCESSIBILITY OF HEALTH INSURANCE IN ALASKA

Prepared for the Alaska Division of Insurance

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1.   EXECUTIVE SUMMARY

The State of Alaska has one of the highest per capita health care costs in the nation.[1] Higher costs in Alaska are driven by many factors, ranging from the small, geographically dispersed population to limited numbers of medical providers, especially in more remote areas. Higher health care costs in turn lead to higher premium rates for private health insurance. Oliver Wyman Actuarial Consulting, Inc. was engaged by the Alaska Division of Insurance to perform a study related to affordability and accessibility of health insurance in Alaska, funded by a Federal grant under the "State Flexibility to Stabilize the Market Grant Program."

Our analyses included an overview of the Alaska health insurance market landscape, the uninsured population, the provider landscape in Alaska and how it has changed over the past two decades, the level of hospital cost shifting that occurred both prior to and after implementation of the major provisions of the Affordable Care Act (ACA), and the impact various policy options would be expected to have on premium and enrollment, along with the cost to the State to implement them.

To conduct our analyses, we relied on numerous data sources, including information from Centers for Medicare and Medicaid Services (CMS) and the U.S. Census Bureau's American Community Survey (ACS), the Health and Human Services (HHS) Health Resources & Services Administration's (HRSA) Area Health Resources Files (AHRF), among others. Additionally, a data call was sent to insurers offering health insurance coverage in Alaska to collect detailed information pertaining to their enrollees. These data included membership and premium information for the time period beginning in 2017 through the middle of 2019.

Alaska's health insurance market has experienced many changes since the implementation of the ACA. The most significant changes have occurred in the individual market, with the introduction of guaranteed issue of coverage, premium tax credits, adjusted community rating rules, the introduction and effective removal of the individual mandate, and the termination of Federal funding for cost sharing reduction (CSR) subsidies. The Medicaid market has also been impacted materially due to the expansion of Medicaid eligibility to cover all individuals with household incomes up to 138% of Alaska's Federal Poverty Level (FPL), which occurred effective September 1, 2015. On the other hand, the large group market has been somewhat immune to the changes under the ACA relative to the other commercial markets given the comprehensive nature and prior availability of large group employer coverage.

Market Composition

For 2017, the United States Census Bureau reported that the population of Alaska was approximately 740,000 individuals. We estimate that over 40% of that population was covered under group health insurance policies. Enrollees in government programs made up the next largest segment, with approximately 26% of residents enrolled in Medicaid, 10% enrolled in Medicare, and 5% enrolled in Indian Health Services (IHS). Of the remaining 114,000 residents, we estimate that the number enrolled in comprehensive major medical policies through the individual market was less than one third of the volume of uninsured individuals (i.e., ~19,000 vs. ~67,000, respectively), while ~28,000 were enrolled only in various other coverage types such as military and student health.

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[1] Centers for Medicare and Medicaid Services. *State Health Expenditure Accounts by Residence Location Highlights.* CMS.gov, November 21, 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.

Since 2017, notable shifts in enrollment by market segment have occurred. Average monthly membership in the group market has decreased approximately 2% each year, from ~321,000 to ~307,000, with large group accounting for roughly 95% of the total membership volume each year. Average monthly membership in the individual market decreased by about 2% between 2017 and 2019 from ~19,000 to ~18,000. Based on our review, the decrease in individual market enrollment occurred largely between 2018 and 2019, and may be in part due to the individual mandate penalty being reduced to $0 effective January 1, 2019. Enrollment increases in each of Medicaid (from ~196,000 to ~217,000 in 2017 and 2019, respectively) and Medicare (from ~75,000 to ~82,000 in 2017 and 2019, respectively) contributed to a reduction in the number of uninsured individuals.

Uninsured Population

For our review of Alaska's uninsured population, we excluded the population of individuals over the age of 64, as almost everyone in this demographic is eligible for Medicare. Additionally, the "insured" population is defined as (1) individuals who have some type of health insurance coverage (e.g., Medicare, Medicaid, coverage through an employer, IHS, etc.) or (2) reported having a household income at or below 138% FPL, as they would be eligible for Medicaid. When using this methodology, the overall uninsured rate in Alaska in 2018 is calculated to be equal to approximately 5.0%. Additional key observations included:

- *Males* – Males tend to have higher uninsured rates than females, with males making up nearly 60% of Alaska's uninsured population in 2018.

- *Single Adult Households* – Single adult households (i.e., one adult or one adult with child(ren)) made up roughly 70% of the uninsured population in Alaska in 2018 and had the highest average uninsured rate among the family structures (9.2% and 7.4%, respectively).

- *Lower Household Incomes* – Individuals who reside in households with income levels between 139-200% FPL had an average uninsured rate equal to about 12.1% in 2018 and made up approximately 30% of Alaska's overall uninsured population.

- *Employment* – Over 85% of Alaska's uninsured population between the ages of 18-64 in 2018 was employed.

- *Ethnicity* – Those individuals identifying as Alaska Native or American Indian had a very low uninsured rate (i.e., 0.4%) due to the availability of IHS; this segment of the population made up approximately 16% of Alaska's total population but only 1% of the uninsured population.

- *Industry* – The three industry groupings which contain a number of tourism related jobs (arts/entertainment/recreation, fishing/hunting/trapping, and retail trade) each had higher than average uninsured rates (14.3%, 7.1%, and 10.0%, respectively)*.*

Provider Analysis

Our analysis of the provider landscape, and how it has changed over time, examined estimates of the number of physicians, hospital facilities, and other facilities per capita.[2] The information was summarized longitudinally and by geographic area in Alaska, and compared with both statewide and

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[2] To ensure compliance with the AHRF data use license agreement, Oliver Wyman requested and received permission from the HRSA to summarize the AHRF on behalf of the State of Alaska.

nationwide estimates.[3] The geographic areas were defined by borough and census area based on guidance from the Division, with each geographic area defined according to Map 1.1, shown below. Due to the relatively small population base in some geographic areas, there may be volatility in the results for some geographic areas.

Map 1.1
Geographic Area Definitions for Provider Analysis
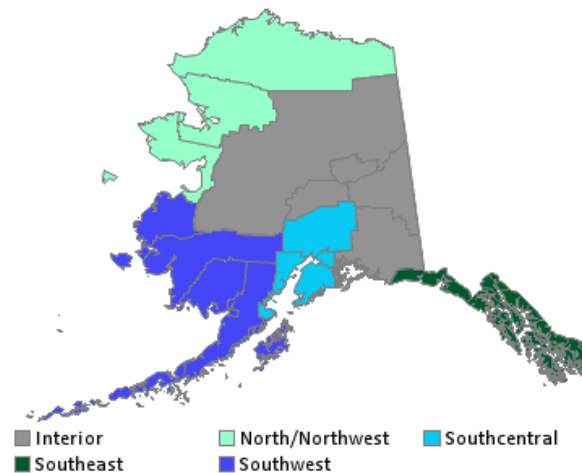
- The North/Northwest and Southwest geographic areas are consistently underserved when compared to other geographic areas of the State and nationwide data.

- The number of non-primary care physicians per 100,000 residents in Alaska is generally lower relative to the rest of the nation.

- The number of hospital facilities per 100,000 residents is generally higher in Alaska relative to the rest of the nation; however, the number of hospital beds per 100,000 residents is generally lower in Alaska relative to the rest of the nation.

- There are generally fewer skilled nursing facilities, home health agencies, and hospices per 100,000 residents in Alaska relative to the rest of the nation.

- There are generally more ambulatory surgical centers per 100,000 residents in Alaska relative to the rest of the nation.

- The number of community health centers per 100,000 residents is significantly higher in the less populous geographic areas of Alaska.

Hospital Cost Shifting

According to Health Affairs, cost shifting occurs when a hospital increases its price for some payers (to a level that is above cost) in order to compensate for shortfalls in reimbursement received from other

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[3] Nationwide statistics represent data for the lower 48 states, including the District of Columbia.

payers (who are paying below cost), to ensure that they collect enough revenue in total to cover their operating expenses.[4] Using information from the Medicare Cost Reports we estimated the extent to which cost shifting may have occurred among hospitals[5] in Alaska, both prior to the expansion of Medicaid and implementation of the major provisions of the ACA (e.g., guarantee issue, premium subsidies), and once these major policy changes were implemented. Please note that this analysis only captures the impact of cost shifting from these fifteen hospitals; the impact of the seven tribal hospitals and other sectors of the Alaska health care system (e.g., professional or ancillary services) were not included in the analysis.

Table 1.1 shows payments, costs, and the ratio of payments to costs for hospitals by payer type in Federal Fiscal Year 2013 (FY 2013) and FY 2018. Given the significant presence of tribal hospitals in Alaska, particularly in the less populous rural areas, the amount of uncompensated care provided in Alaska is understated, and this understatement may potentially be significant.

Table 1.1
Payments and Cost for Hospitals in Alaska (in $ Millions)

	FY 2013				FY 2018			
	Payments	Cost	Surplus/ (Shortfall)	Payments/ Cost Ratio	Payments	Cost	Surplus/ (Shortfall)	Payments/ Cost Ratio
Private Payer/ Other	1,108	845	263	1.312	1,221	889	332	1.374
Medicare	299	338	(39)	0.885	415	449	(34)	0.924
Medicaid/Other Government	221	218	3	1.012	351	339	12	1.036
Uncompensated Care	0	94	(94)	N/A	0	57	(57)	N/A
Total	1,628	1,496	133	1.089	1,987	1,733	254	1.146

A number of observations can be made from the information in Table 1.1:

- Payments from private payers to hospitals significantly exceeded costs for those services, and the ratio of payments to costs increased slightly between FY 2013 and FY 2018.

- While payments received by hospitals from Medicare were less than the amount needed to cover costs in both periods, payments covered a larger portion of costs in FY 2018 than they did in FY 2013.

- Medicaid payments covered hospitals' costs in both FY 2013 and FY 2018.

- Uncompensated care provided by hospitals decreased significantly between FY 2013 and FY 2018, from $94 million to $57 million. This is a direct result of fewer uninsured individuals due to the expansion of Medicaid eligibility and the introduction of premium subsidies in the individual ACA market.

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[4] Dobson, DaVanzo, and Sen (2006). *The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications*. Health Affairs Vol. 25, No. 1. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.1.22.

[5] Hospitals operating by Native health organizations are not required to file Schedule S-10, which is where charity care and bad debt are reported. Therefore, hospitals operated by Native health organizations have not been included in the analyses.

- The decrease in uncompensated care, combined with increased payments relative to costs for services covered by private payers and Medicare, led to an increase in hospitals' overall payment-to-cost ratio between FY 2013 and FY 2018, with payments exceeding costs by 8.9% in FY 2013 and payments exceeding costs by 14.6% in FY 2018.

Policy Options

Increasing access to affordable health care coverage is vital to attracting a broad base of individuals that elect coverage, and the success of the health insurance markets. Focusing on the individual and small group markets, we developed a baseline scenario that reflects current statutes and regulations at both the state and Federal level, as well as Alaska's currently approved Section 1332 Waiver for a reinsurance program in the individual ACA market. Under the baseline scenario we expect that in 2020 there will be approximately 16,700 Alaskans enrolled in the individual ACA market, 1,800 Alaskans enrolled in the individual non-ACA market, and 14,200 Alaskans enrolled in the small group ACA market. We then analyzed the impact that various policy changes, if implemented, would be expected to have on enrollment and premium rates in the individual and small group ACA markets in Alaska, as well as the potential cost to the State.

To assess how the policy changes might impact the markets, we used the Oliver Wyman Healthcare Reform Microsimulation Model (HRM Model) along with data received through a carrier data call. The HRM Model is a leading edge tool that captures the flow of individuals across various health insurance markets based on their economic purchasing decisions, and integrates the results with actuarial modeling designed to assess the impact that various policy changes are expected to have on the health insurance markets.

- **Merging the Individual and Small Group ACA Markets into a Single Risk Pool** – Under this scenario it was assumed that insurers participating in the individual and small group ACA markets offer the same benefit plans to individuals and families as they would offer to small employers, at the same premium rates. However, only those individuals and families with incomes at or below 400% FPL not enrolling as part of a small employer group would be eligible for premium subsidies.

  In the baseline, premium rates in the individual ACA market are 17% lower than premium rates in the small group ACA market in 2020. If the individual and small group ACA markets in Alaska were merged, premium rates in the individual ACA market prior to the application of any subsidies would be expected to increase by approximately 9%, whereas premium rates in the small group ACA market would be expected to decrease by approximately 9%. Roughly 80% of individual ACA market enrollees in Alaska receive premium subsidies and would be largely immune from these premium changes. In total, merging the markets would be expected to result in an increase of roughly 300 enrollees in ACA enrollment, relative to the baseline, comprised of an expected decreased of 200 enrollees in the individual ACA market and an expected increase of 500 enrollees in the small group ACA market.

  We also examined the impact that merging the individual and small group ACA markets would have had on Alaska's approved Section 1332 Waiver and estimate Federal pass-through savings would have been approximately $29 million lower, with most of the additional cost being borne by the State.

- **Extending Premium Subsidies to Income Ranges Above 400% FPL** – In order to assess the potential impact in Alaska of addressing the current "subsidy cliff," we modeled three alternate premium subsidy structures, each of which extends premium subsidies to income ranges above 400% FPL. A summary of the Applicable Percentages[6] that were modeled, expressed as percentages of household income in relation to FPL, are shown in Table 1.2 below.

Table 1.2
Summary of Alternate Subsidy Structures Expanding Premium Subsidies

	Applicable Percentages by FPL							
	133%	**150%**	**200%**	**250%**	**300%**	**400%**	**500%**	**600%**
Baseline	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%	N/A	N/A
Scenario 1*	3.09%	4.12%	6.49%	8.29%	10.00%	12.00%	15.00%	N/A
Scenario 2	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%	12.39%	15.00%
Scenario 3**	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%	9.78%	9.78%

* In Scenario 1, the maximum premium amount for individuals and families with household incomes between 250% and 300% FPL was assumed to not change relative to the baseline scenario. For purposes of determining the maximum premium amount for households with incomes between 250% and 300% FPL, a factor of 9.78% of household income was used for a household with an income of 300% FPL instead of a factor of 10.00% of household income, as shown in the table above.
** In Scenario 3, the maximum premium amount of 9.78% of household income also applies to individuals and families with household incomes above 600% FPL.

Table 1.3 summarizes projected enrollment and average premium rates PMPM under the baseline scenario and for each alternate scenario, as well as expected morbidity improvement for each alternate scenario relative to the baseline scenario. Under each scenario, enrollment is projected to increase relative to the baseline, and new enrollees are on average healthier than the individual ACA market population in the baseline scenario.

Table 1.3
Enrollment, Average Premium PMPM, and Anticipated Morbidity Improvement

	Baseline	Scenario 1	Scenario 2	Scenario 3
ACA Enrollees	16,670	16,937	17,291	17,538
Average Premium Rate PMPM	$739	$718	$726	$718
Anticipated Morbidity Improvement	N/A	0.6%	1.5%	2.0%

Table 1.4 summarizes the projected number of subsidized enrollees, the average premium subsidy PMPM, and the total premium subsidy expenditure under the baseline scenario and for each alternate scenario. Total premium subsidy expenditures are projected to increase under each scenario relative to the baseline scenario, reflecting a net cost to the State. However, it should be

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[6] Individuals and families eligible for premium subsidies pay a specified percentage of their household income, known as the Applicable Percentage, for the second lowest cost silver plan available to them through the FFM. The Federal government provides a premium subsidy for any premium amount above the Applicable Percentage of household income.

noted that any increase in enrollment as a result of increasing the availability of premium subsidies could have an impact on the Federal pass-through funding for the existing Section 1332 Waiver.[7]

Table 1.4
Subsidized Enrollment and Premium Subsidy Expenditures

	Baseline	Scenario 1	Scenario 2	Scenario 3
ACA Subsidized Enrollees	13,112	14,169	15,209	16,470
Average Premium Subsidy PMPM	$672	$637	$609	$575
Total Premium Subsidies (in millions)	$105.8	$108.3	$111.2	$113.7
Change in Total Premium Subsidies (in millions)		$2.5	$5.4	$8.0

- **Varying Premium Subsidies by Age** – We modeled two alternate premium subsidy structures, each of which increases premium subsidies for individuals under the age of 64. A summary of the Applicable Percentages for each of the alternate premium subsidy structures modeled are shown in Table 1.5. Under each alternate scenario, the Applicable Percentage used to determine the premium subsidy for a household was based on the oldest eligible individual in the household, and Applicable Percentages were interpolated for households where the oldest age falls in between those shown in Table 1.5. For example, the applicable percentage under Scenario 4 for a household with an income of 250% FPL where the oldest eligible person in the household is age 45 would be 7.29% (= 6.49% + (45-21)/(64-21) x (8.29%-6.49%)).

Table 1.5
Age and Income Based Premium Subsidies Scenarios

Scenario	Age	Applicable Percentages by Age and FPL					
		133%	150%	200%	250%	300%	400%
4	21 and Under	3.09%	4.12%	6.49%	6.49%	6.49%	6.49%
	64*	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%
5	21 and Under	3.09%	4.12%	4.12%	4.12%	4.12%	4.12%
	64*	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%

*This also represents the baseline scenario

Table 1.6 summarizes projected enrollment and average premium rates PMPM under the baseline and for each alternate scenario. Under each alternate scenario, membership increases slightly and average premium rates are projected to increase, in part due to enrollees selecting richer benefit levels in response to higher subsidies. Since enrollment does not increase materially under each alternate scenario relative to the baseline scenario, no morbidity improvement is projected.

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[7] An analysis of the impact on the State's existing Section 1332 Waiver was outside the scope of this project.

Table 1.6
Summary of Enrollment, Average Premium PMPM, and Anticipated Morbidity Improvement

	Baseline	Scenario 4	Scenario 5
ACA Enrollees	16,670	16,681	16,788
Average Premium Rate PMPM	$739	$765	$770
Anticipated Morbidity Improvement	N/A	0.0%	0.0%

It should be noted that, with the exception of the merged individual and small group ACA market scenario, the policy options modeled would likely require changes to be made to the eligibility and subsidy calculations when applying for coverage through the Exchange. Additionally, some policy options modeled may require a State-Based Exchange in order to be implemented. This would represent an additional cost to the State. However, quantification of these potential costs was outside the scope of this project.

Table 1.7 summarizes the projected number of subsidized enrollees, the average premium subsidy PMPM, and the total premium subsidy expenditure under the baseline scenario and for each alternate scenario. Total premium subsidy expenditures are projected to increase under each scenario relative to the baseline scenario, reflecting a net cost to the State.

Table 1.7
Summary of Subsidized Enrollment and Premium Subsidy Expenditures

	Baseline	Scenario 4	Scenario 5
ACA Subsidized Enrollees	13,112	13,124	13,231
Average Premium Subsidy PMPM	$672	$700	$736
Total Premium Subsidies (in millions)	$105.8	$110.3	$116.8
Change in Total Premium Subsidies (in millions)		$4.5	$11.0

2.   INTRODUCTION

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was engaged by the Alaska Division of Insurance (the Division) to perform an assessment of the health insurance markets in Alaska. This work was funded by a Federal grant under the "State Flexibility to Stabilize the Market Grant Program."

In the following sections, we provide a detailed summary of key characteristics of Alaska's health insurance markets, its provider landscape, and its uninsured population, along with the results of actuarial and economic modeling that was performed. Below is an outline of the specific information presented:

- An overview of Alaska's health insurance markets, including an overview of enrollment by coverage type and detailed enrollment information for select characteristics of the population (e.g., enrollment by age and gender)

- An overview of Health Care Sharing Ministries (HCSMs) in Alaska, including estimates of enrollment and information on member contribution levels

- A thorough analysis of Alaska's uninsured population in 2018, including uninsured rates and distributions of the uninsured for select characteristics in 2018

- A high level analysis of potential hospital cost shifting among payers, including a review of changes in uncompensated care

- A review of the provider landscape in Alaska and how it has changed over time by provider type, facility type, and region

- Actuarial and economic analysis of several policy options that could be available to the State, including merging its individual and small group markets, modifying premium subsidies and expanding them to individuals with incomes above 400% of the Federal Poverty Level (FPL), and varying premium subsidies by age

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

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

3.   DATA SOURCES AND RELIANCE

In completing our analysis, we reviewed information from a variety of sources in assessing the current state of Alaska's health insurance and provider markets, including information from the Centers for Medicare and Medicaid Services (CMS), the U.S. Census Bureau's American Community Survey (ACS), the Health and Human Services' (HHS) Health Resources & Services Administration's (HRSA) Area Health Resources Files (AHRF), among others. Additionally, a data call was sent to insurers offering health insurance coverage in Alaska to collect detailed information pertaining to their enrollees. These data included membership and premium information for the time period beginning in January 2017 and ending June of 2019.

It is important to note that the information from the data call served as the primary basis for developing our health insurance market population estimates. A description of each of the specific data sources used in analyzing Alaska's insurance and provider markets is summarized below:

- Overall distributions by health insurance coverage type and enrollment by coverage types were based on U.S. Census Bureau statistics, the Medicare Enrollment Dashboard published by CMS,[8] Medicaid data published by the Alaska Department of Health and Social Services and CMS, ACS data, and information from the insurer data call

- Uninsured rates, population demographic information, and median household incomes were based on ACS data

- Enrollment and premium information for HCSMs were provided in response to the Division's request for audited financial statements, application and guideline materials, enrollment information, and contribution information from four qualifying HCSMs in Alaska

- CMS hospital cost reports and manuals were used to estimate hospital cost shifting and determine the levels of uncompensated care associated with services performed by Alaska hospitals

- Information from the AHRF published by the HRSA to examine changes in the number of health care professionals and facilities at the regional level. The AHRF is a compilation of data from a variety of sources, and includes data from the American Medical Association, the American Hospital Association, and the U.S. Census Bureau

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

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[8] Centers for Medicare and Medicaid Services. *Medicare Enrollment Dashboard.* CMS.gov, March 2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html.

4.   OVERVIEW OF ALASKA'S HEALTH INSURANCE MARKETS

Alaska's health insurance markets have changed significantly over the course of the last several years, with the individual market, Medicaid, and uninsured segments experiencing the most significant changes. The implementation of several key provisions of the Affordable Care Act (ACA) in 2014 resulted in the introduction of guaranteed issue of coverage, premium tax credits, and adjusted community rating rules in the individual market. In September of 2015, Alaska expanded Medicaid to cover most individuals with incomes below 138% FPL, which resulted in a significant increase in Medicaid enrollment. The group markets were less impacted by the changes under the ACA relative to the other commercial markets.

In recent years, the individual market in Alaska has faced significant challenges. Premium rates increased dramatically between 2014 and 2017; Moda Health Plan, Inc. exited the individual market at the end of 2016 due to financial constraints; Federal funding for cost sharing reduction (CSR) subsidies was eliminated in the fall of 2017; and the individual mandate penalty was eliminated for calendar year 2019 and beyond.

Chart 4.1 summarizes enrollment by health insurance coverage type for the period 2016 through 2019. The individual market includes those enrolled in ACA, grandfathered and transitional plans. The group market includes both small and large groups, fully-insured and self-insured groups. The small group market includes ACA, grandfathered and transitional plans. The Medicaid and Medicare markets include individuals enrolled in each respective government program; individuals enrolled in both Medicaid and Medicare (i.e., Dual Eligibles) are categorized as being enrolled in Medicaid in Chart 1. Indian Health Service (IHS) represents non-elderly individuals who are eligible to utilize IHS providers and have no other form of health care coverage. The Other category consists of non-elderly individuals covered under government programs other than Medicare and Medicaid (e.g., military coverage).

Chart 4.1
Estimated Average Enrollment by Health Insurance Coverage Type (in 1,000s)
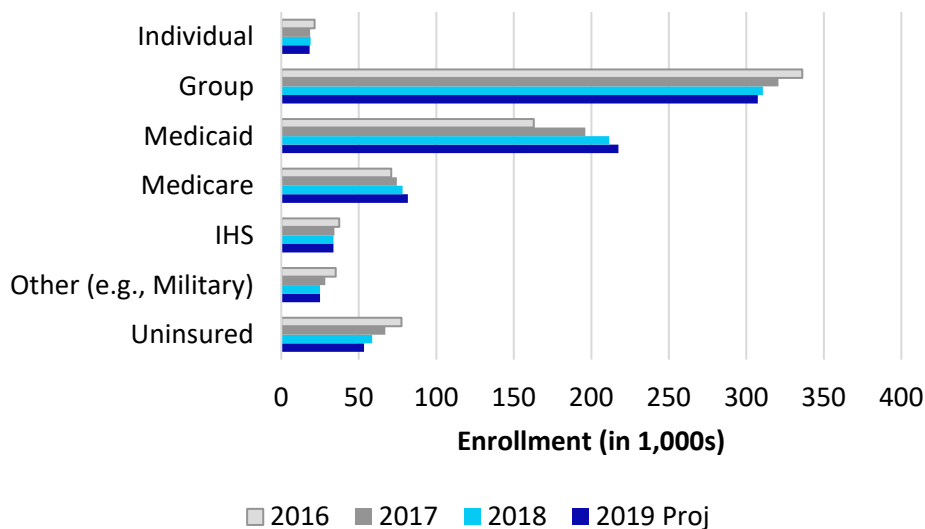
Sources: Insurer data call responses, Census data, ACS data, CMS enrollment files, Kaiser Family Foundation data, MEPS data, MLR reports, and Supplemental Health Care Exhibit data

Key takeaways include:

- Enrollment in the individual market in Alaska decreased slightly from 22,000 enrollees in 2016 to 18,000 enrollees in 2019. The reduction in individual market coverage was driven by Medicaid expansion and a reduction in individuals enrolled in transitional and grandfathered coverage.

- In the Alaska group market, enrollment decreased by 29,000 enrollees from 336,000 in 2016 to 307,000 in 2019. The reduction in group market coverage was likely attributable to an overall aging of the group market (i.e., some enrollees transitioned to Medicare) and the expansion of Medicaid.

- The Medicaid population grew from 163,000 enrollees in 2016 to 217,000 enrollees in 2019. A majority of the increase in the Medicaid population is attributable to Alaska electing to expand Medicaid coverage to most adults with family incomes under 138% FPL, which was effective September 1, 2015. In our experience, it is not uncommon for there to be a lag in Medicaid enrollment relative to the effective date of an expansion in Medicaid eligibility. This is generally attributed to a lag in outreach activities and potential backlogs in processing applications.

- Medicare enrollment in Alaska increased by 11,000 enrollees between 2016 and 2019. The growth in Medicare enrollment is consistent with the overall aging of the population.

- The number of individuals covered only by IHS has remained stable for the last few years, experiencing a slight decrease between 2016 and 2017, and then holding steady at 4.6% of the population from 2017 to 2019. It should be noted that IHS is not considered to be insurance by the U.S. Census Bureau. However, in Alaska, IHS and tribal entities are believed to provide more comprehensive health care relative to the rest of the nation.

- The uninsured population, excluding the population covered by IHS, decreased from 10.5% of the population in 2016 to a projected 7.2% of the population in 2019.[9]

It should be noted that throughout this section of the report, some information for 2019 is stated on a projected basis (2019 Proj), while other information is stated on a year-to-date basis (2019 YTD). Any information shown on a 2019 YTD basis represents actual information through June 2019. Any information shown on a 2019 Proj basis represents our best estimate of projected enrollment for calendar year 2019. Additionally, it should be noted that detailed information pertaining to the commercial markets was only available from 2017 through 2019; a more detailed view of the commercial markets was not available for 2016.

4.1.   Individual Market

The Alaska individual market has experienced several significant changes since 2014 as a result of the implementation of the ACA. Guaranteed issue, premium tax credits, essential health benefits (EHBs), and an individual mandate were introduced, and insurers were required to adhere to new adjusted community rating restrictions and actuarial value requirements (e.g., metallic levels). Between 2014 and 2016, premium rates increased significantly in the Alaska individual ACA market. At the end of 2016, the largest insurer in the individual market, Moda Health Plan, Inc., exited the market due to steep financial

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[9] The uninsured population represents individuals with no health care coverage and includes individuals who may be eligible for Medicaid or Medicare but are not enrolled. Note that this presentation of the uninsured population is not consistent with the presentation of the uninsured population in Section 7 of this report.

losses. In 2017, the State introduced the Alaska Reinsurance Program (ARP) in an effort to stabilize and reduce premium rates in the individual ACA market.

Since 2017, the individual market has continued to face challenges. Federal funding for CSR subsidies was eliminated in the fall of 2017, and the individual mandate was removed beginning in 2019. However, despite these changes, overall enrollment in the Alaska individual market has remained fairly stable and premium rates in the individual ACA market have decreased significantly, in large part due to the introduction of the ARP and premium rate corrections.

In this section we examine the current state of the Alaska individual market. We first provide an overview of enrollment in the individual market. We then analyze various characteristics of Alaska's individual market enrollees (e.g., geographic mix, demographic mix, average benefit levels, etc.) to summarize the basic characteristics of the population that has taken up coverage in the individual market and how the individual market population has changed in recent years.

4.1.1.   Overview of the Individual Market

Enrollment in the Alaska individual market remained relatively stable between 2017 and 2019. As shown in Chart 4.2, enrollment in the individual market increased slightly in 2018 but is projected to decrease slightly in 2019.

Chart 4.2
Estimated Average Annual Individual Market Enrollment (in 1,000s)
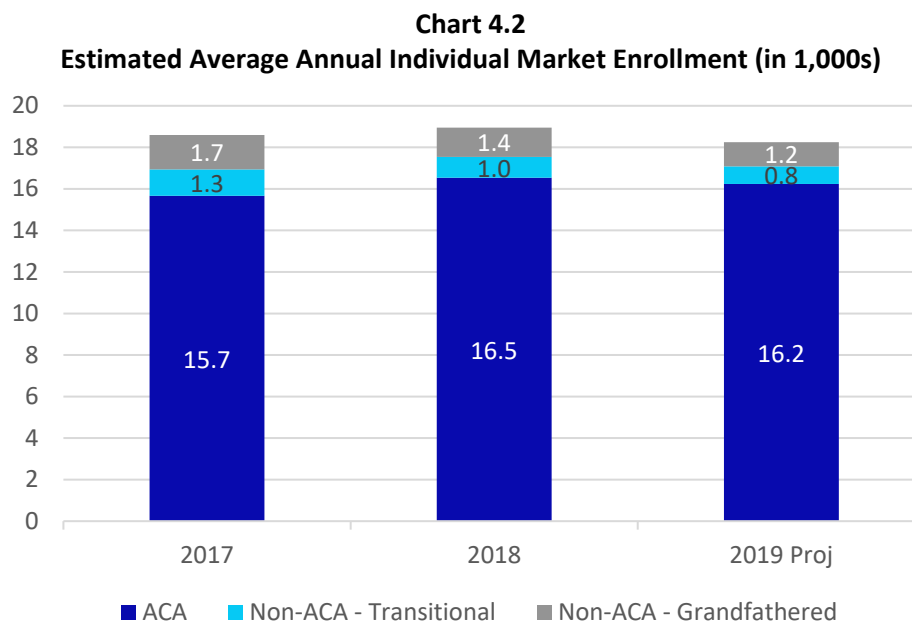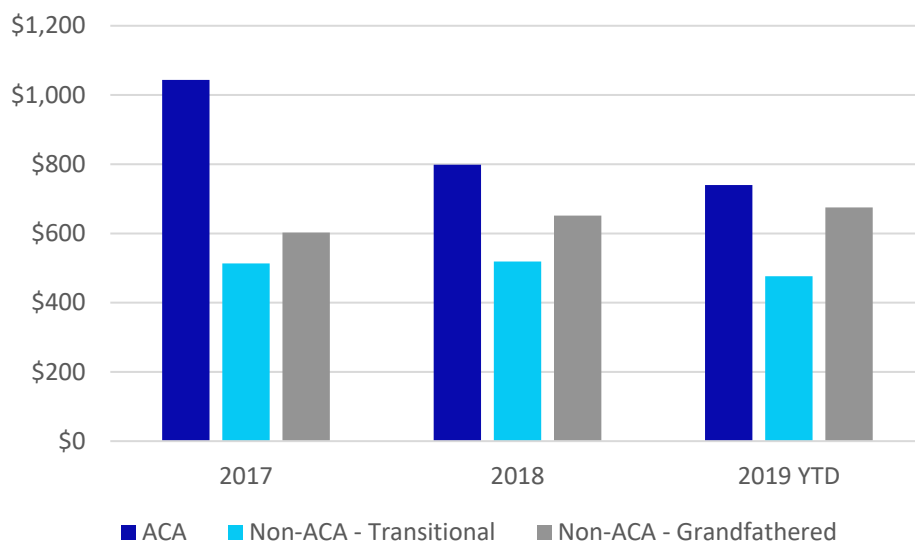

Source: Insurer data call responses

The non-ACA market segment has been a closed block (i.e., no new policies can be issued) since the end of 2013, so we would expect enrollment in individual non-ACA plans to decrease over time as individuals and families gradually transition to other coverage types (e.g., age into Medicare, begin working for an employer that offers health insurance coverage, etc.) or choose to become uninsured. Between 2017 and 2019, the proportion of all individual market enrollees that were enrolled in the ACA market segment has increased from 84.2% to 89.0%, with some non-ACA enrollees believed to have migrated to

ACA coverage and some uninsured individuals believed to have entered or re-entered the individual market.

Chart 4.3 presented below summarizes the differences in average premium rates per member per month (PMPM) by individual market segment between 2017 and 2019.

Chart 4.3
Estimated Average Individual Market Premium Rate PMPM by Market Segment
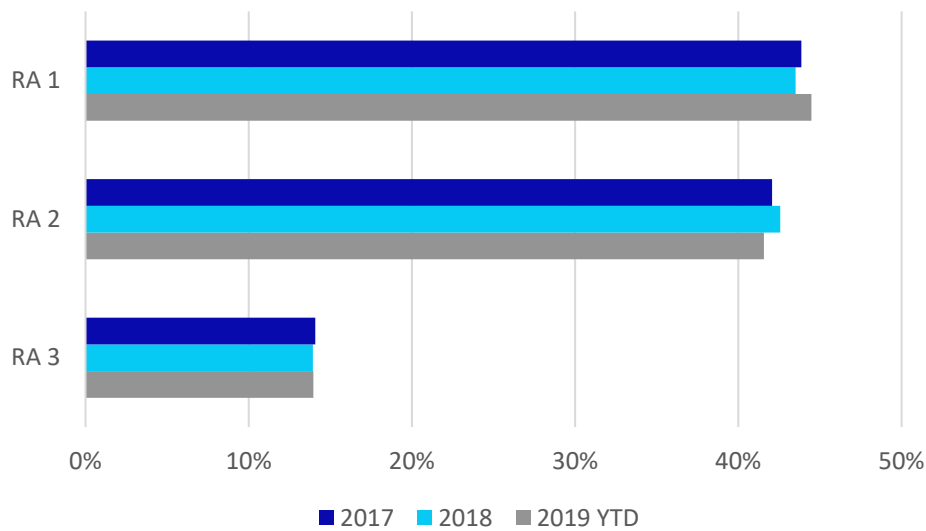

Source: Insurer data call responses

Average ACA premium rates PMPM experienced a sharp decline between 2017 and 2018, despite the 2018 rates reflecting a load to account for the cost associated with CSR subsidies no longer being funded by the Federal government, commonly referred to as "silver loading." This was followed by a less significant decrease in 2019. The decrease in average premium rates PMPM observed in 2018 was a result of better than expected experience.[10] The average transitional premium rate PMPM has remained relatively stable over the course of the last three years, while the average grandfathered premium rate PMPM has risen moderately each year. Despite the drop in average ACA premium rates PMPM, they remain higher than their non-ACA counterparts. It is important to note that the average premium rate PMPM for each market segment is influenced by changes in geographic mix, demographic mix, benefit levels, and for ACA plans, "silver loading."

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[10] Calendar year 2017 premium rates were developed using calendar year 2015 experience. Given the changes occurring in the market at the time the 2017 premium rates were being developed (e.g., the expansion of Medicaid, the exit of Moda Health Plan, Inc. from the individual market, the introduction of the Alaska Reinsurance program, etc.), there was significant uncertainty regarding how the Alaska individual market would evolve in 2017. The assumptions underlying the 2017 premium rates were not emerging as expected at the time the 2018 rates were developed, which resulted in a rate correction for calendar year 2018.

4.1.2.   Geographic Characteristics

Charts 4.4 and 4.5 summarize the distribution of individual ACA and non-ACA market enrollees, respectively, in Alaska by rating area.[11] The majority of individual market enrollees are located in Rating Areas 1 and 2 (i.e., southwest/southcentral Alaska and the interior/North Slope, respectively; Rating Area 3 represents the southeastern portion of the State). Since 2017, the distribution of individual market enrollees by rating area has not changed significantly. Additionally, little change in the overall distribution is observed between 2017 and 2019 when examining the enrollment separately for the ACA and non-ACA market segments.
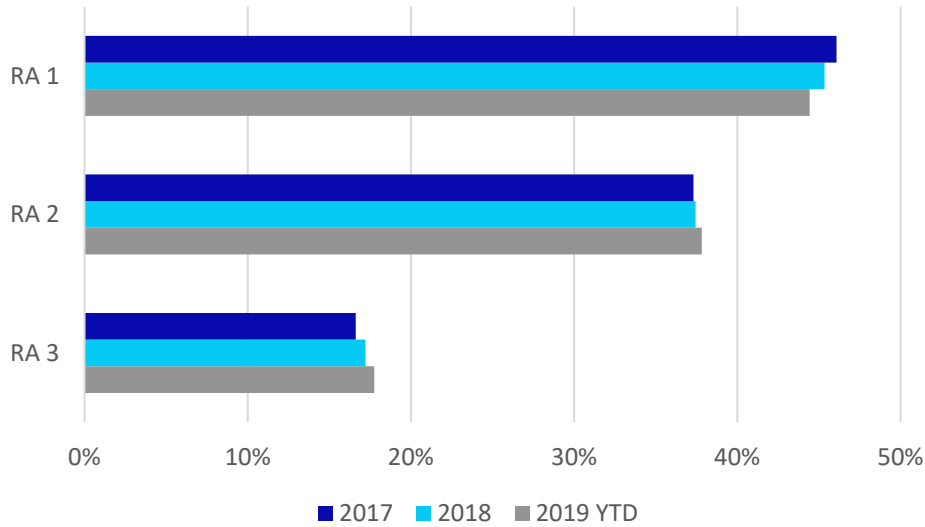
Chart 4.4
Estimated Distribution of Individual ACA Enrollees by Rating Area

Sources: Insurer data call responses

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[11] Rating Areas in Alaska are defined by three-digit ZIP Code. Rating Area 1 corresponds to three-digit ZIP Code 995; Rating Area 2 corresponds to three-digit ZIP Codes 996 and 997; Rating Area 3 corresponds to three-digit ZIP Codes 998 and 999.

Chart 4.5
Estimated Distribution of Individual Non-ACA Enrollees by Rating Area
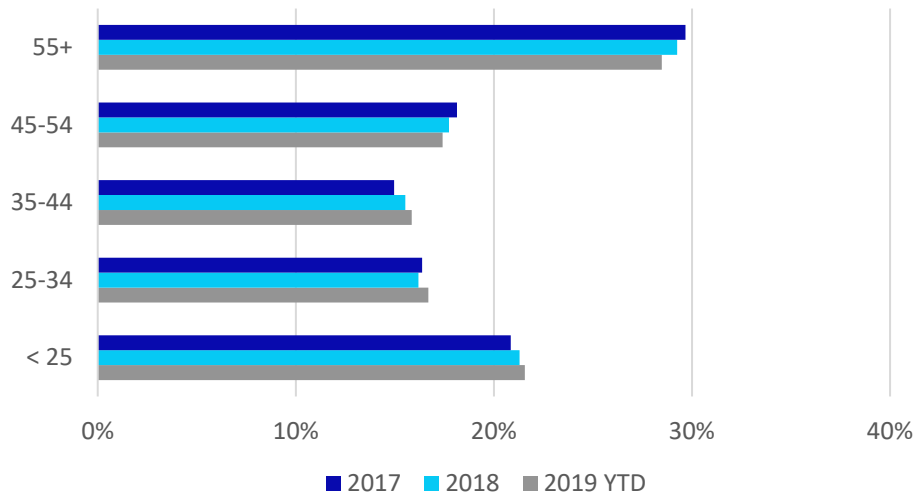

Source: Insurer data call responses

4.1.3. Demographic Characteristics

Chart 4.6 summarizes the distribution of individual market enrollees by age range. Approximately 30% of individual market enrollees are age 55 and older, while over 20% of the market is under the age of 25. The age distribution has become slightly younger since 2017, which is the opposite of what occurred nationally during this period. Changes in the distribution of individual market enrollees by age may indicate families represent a greater proportion of total individual market enrollment in 2019 relative to 2017.

Chart 4.6
Estimated Distribution of Individual Market Enrollees by Age Range

Source: Insurer data call responses

Chart 4.7 shows a comparison of the age distribution of 2019 individual market enrollees, through June of 2019, for individual ACA and non-ACA market enrollees. A larger proportion of individual non-ACA market enrollees fall into both the oldest and youngest age ranges, while the proportion of individual ACA market enrollees is significantly greater than the proportion of individual non-ACA market enrollees between the ages of 25 and 44.
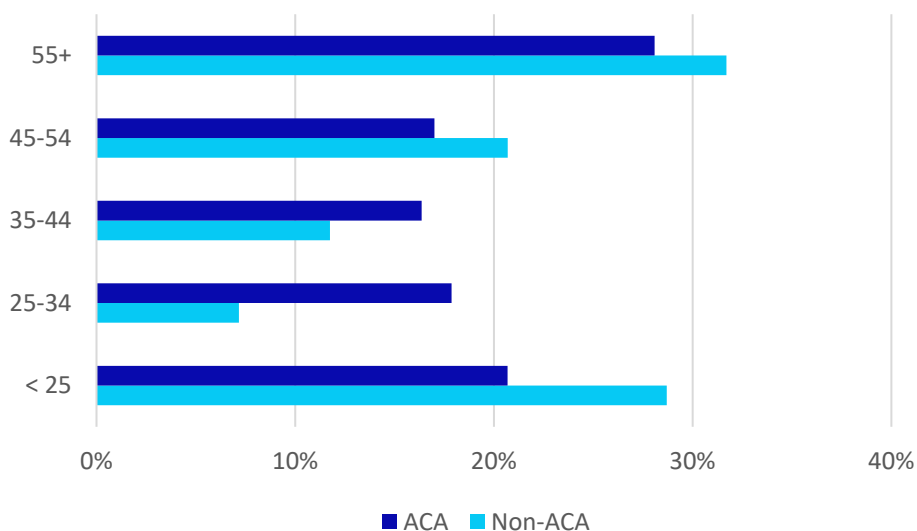
Chart 4.7
Estimated Distribution of 2019 YTD Individual Market Enrollees by Age Range

Source: Insurer data call responses

While not shown, information from the insurer data call shows 52.6% of individual ACA market enrollees in 2019 were female, compared to 50.4% of individual non-ACA market enrollees being female. Additionally, ACA plans may offer more comprehensive benefits (e.g., include maternity coverage) relative to non-ACA plans.

4.1.4.   Income Characteristics

The distribution of individual ACA market enrollees by income range in relation to FPL is shown in Chart 4.8.[12] The proportion of individual ACA market enrollees has shifted from 2017 to 2019, with a greater proportion of individual ACA market enrollees having incomes at or above 300% FPL. A reduction in premium rates in the individual ACA market may have encouraged some uninsured individuals who are not subsidy eligible to take up coverage. Additionally, some individual non-ACA market enrollees may have transitioned to the individual ACA market since the premium differential between individual ACA and individual non-ACA plans has narrowed considerably since 2017.[13]

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[12] Income information for individual Non-ACA enrollees was not available. Therefore, the analysis was limited to individual ACA enrollees.

[13] Most individual non-ACA enrollees are not believed to be eligible for premium subsidies in the individual ACA market, since the presence of premium subsidies through the Exchange encouraged non-ACA enrollees with incomes at or below 400% FPL to switch to individual ACA coverage.

Chart 4.8
Estimated Distribution of Individual ACA Enrollees by FPL
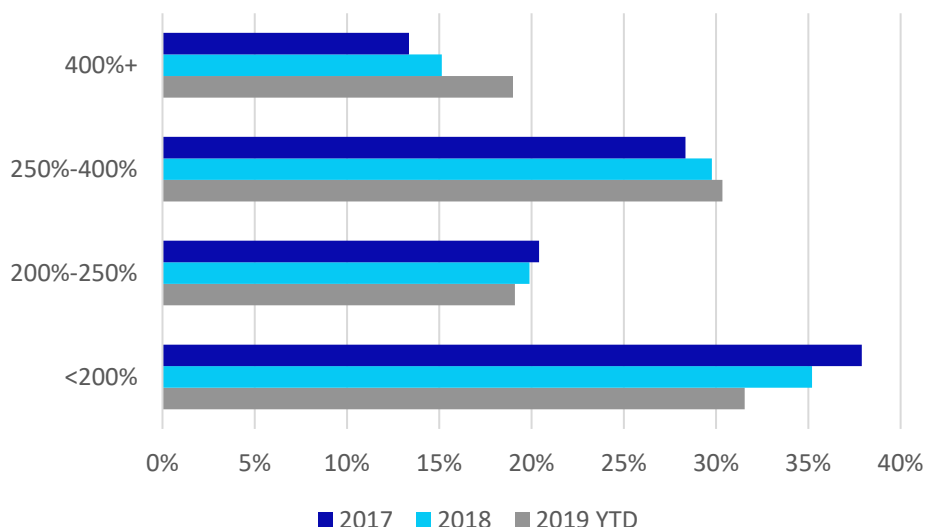
Sources: Insurer data call responses and Marketplace Public Use Files (PUFs)

Table 4.1 provides an overview of the proportion of individual ACA market enrollees receiving premium subsidies, by year.

Table 4.1
Summary of Individual ACA Market Enrollees Receiving Premium Subsidies

	2017	2018	2019 YTD
Percent of Individual ACA Market Enrollees Receiving Premium Subsidies	86.6%	84.9%	81.0%
Average Premium Rate PMPM for Individuals Receiving Premium Subsidies	$1,058	$811	$761
Average Premium Subsidy PMPM for Individuals Receiving Premium Subsidies	$968	$727	$669

Sources: Insurer data call responses and Marketplace PUFs

Approximately 81.0% of individual ACA market enrollees received premium subsidies in 2019 YTD, which represents a 5.6 percentage-point decrease from 2017 levels. The average premium rate PMPM for individuals receiving premium subsidies and the corresponding average premium subsidy PMPM decreased significantly in 2018 relative to 2017, and decreased further in 2019 YTD, as a result of premium rate decreases observed in the individual ACA market. Additionally, premium subsidies as a percentage of the total premium rate associated with individuals receiving premium subsidies decreased from 91.5% (i.e., $968 divided by $1,058) to 87.9% (i.e., $669 divided by $761) between 2017 and 2019 YTD. Please note, the average premium rates and premium subsidy amounts PMPM shown have not been normalized for differences in age, benefits, or income mix among individuals receiving premium subsidies.

4.1.5.   Benefit Characteristics

Table 4.2 summarizes the distribution of individual ACA market enrollees by metal level for 2017 through 2019 YTD. The distribution of enrollees by metal level shifted significantly between 2017 and

2019 YTD with a lower proportion of enrollees selecting silver-level coverage in 2019 YTD relative to 2017. The majority of these enrollees moved from silver-level coverage to gold-level coverage. Premera was the sole individual ACA insurer in Alaska from 2017 to 2019. Premium rates for the gold plan offered by Premera were lower than premium rates for both silver plans offered by Premera on the Exchange in 2018 and 2019 due to silver plans offered by Premera reflecting "silver loading." "Silver loading" increases premium subsidies for an enrollee, which generally enables enrollees to purchase plans with a base premium rate (i.e., prior to the consideration of any premium subsidies) that is lower than the second lowest cost silver plan at a lower cost than they otherwise would be able to in the absence of "silver loading."

Table 4.2
Distribution of Individual ACA Market Enrollees by Metal Level

| Metal Level	2017	2018	2019 YTD
Bronze	49.6%	51.1%	49.7%
Silver	44.0%	38.8%	22.6%
Base Silver	8.5%	6.6%	3.1%
73% CSR Silver	8.0%	6.3%	2.4%
87% CSR Silver	16.0%	15.1%	9.8%
94% CSR Silver	11.5%	10.8%	7.3%
Gold	2.7%	5.7%	23.0%
Limited Cost Share	2.7%	3.0%	3.2%
Zero Cost Share	0.9%	1.3%	1.5%

Source: Insurer data call responses

Individuals with incomes under 250% FPL are eligible to enroll in a silver plan CSR variant through the Exchange.[14] While they may choose to enroll in any other non-catastrophic plan available through the Exchange and still receive a premium subsidy, doing so would result in them forfeiting CSR subsidies. As shown in Chart 4.9, the proportion of individual ACA enrollees eligible to enroll in CSR plans decreased between 2017 and 2019, likely due to an increase in non-subsidized enrollment. Additionally, the proportion of individual ACA enrollees eligible to enroll in CSR plans that actually enrolled in CSR plans remained steady in 2018 relative to 2017 but decreased significantly in 2019. This shift is likely being driven by the presence of "silver loading" among silver plans on the Exchange, as some CSR eligible individuals chose to enroll in a gold plan at a lower cost relative to the second lowest cost silver plan available on the Exchange.

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[14] Silver CSR variant plans provide reduced cost sharing for silver coverage.

Chart 4.9
Estimated Proportion of Individual ACA Enrollees Eligible for and Enrolling in CSR Plans
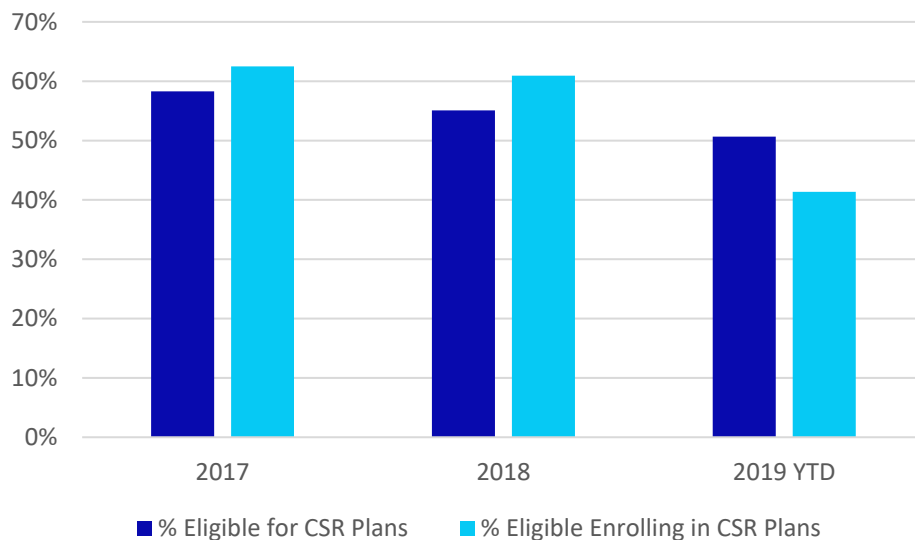
Sources: Insurer data call responses and open enrollment reports

4.2.   Small Group Market

The ACA required small group[15] insurers to adhere to the same adjusted community rating rules, metallic level requirements, and EHB requirements that apply in the individual market. However, unlike the individual market, guaranteed issue and limitations on underwriting the morbidity characteristics of a given group applied to the small group market prior to the passage of the ACA, dampening the impact of the changes mandated by the ACA relative to the individual market. Some of the largest changes from the ACA that affected the small group market included capping member out-of-pocket medical expenditures, the elimination of pre-existing condition exclusions, the elimination of dollar caps on annual benefits, and the elimination of rating by industry, group size, and morbidity.

In this section we examine the current state of the Alaska small group market. We first provide an overview of enrollment in the small group market. We then analyze various characteristics of Alaska's small group market enrollees (e.g., geographic mix, demographic mix, etc.) to summarize the basic characteristics of the population that has taken up coverage in the small group market and how the small group market population has changed in recent years.

Please note, some of the information available for individual market enrollees is not available for small group enrollees, and therefore, could not be summarized. Additionally, it should be noted that our analysis of the small group market is limited to fully-insured small group enrollees. Based on our discussions with the Division, self-funding and level-funding is not believed to be widely prevalent in the Alaska small group market.

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[15] Small groups are defined as employers with 50 or fewer employees.

4.2.1.   Overview of the Small Group Market

Chart 4.10 summarizes the enrollment in the Alaska small group market from 2017 through 2019. Enrollment has decreased each year between 2017 and 2019, which is consistent with small group enrollment trends being observed nationwide. Premera terminated transitional plans at the end of 2018, resulting in a drop in non-ACA enrollment and an increase in ACA enrollment.

Chart 4.10
**Estimated Average Annual Small Group Market Enrollment (in 1,000s)**
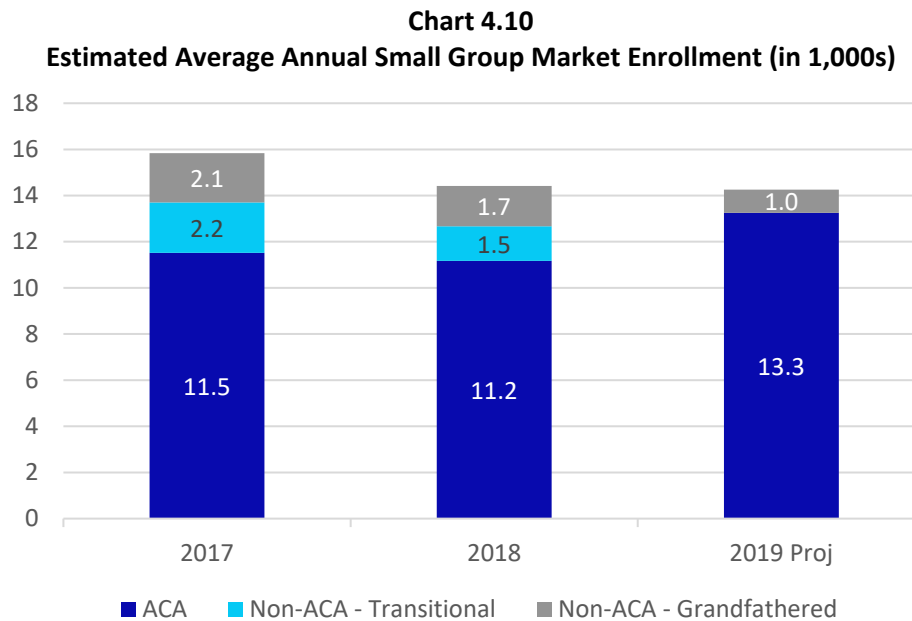
Source: Insurer data call responses

The reduction in small group enrollment is likely attributable to fewer small groups offering coverage to their employees. Small group employers are not subject to the employer mandate, and given the presence of guaranteed issue and premium tax credits in the individual market, some small employers may have determined their employees were better off receiving subsidized coverage though the Exchange in return for higher wages, using the cash savings associated with not providing health insurance coverage as a mechanism to fund increased wages. Additionally, the ACA's small employer tax credit was meant to encourage eligible employers with fewer than 25 full-time equivalent employees to offer coverage, but only a small portion of small employers have utilized the credit. Small employers view the administrative burdens and requirements associated with receiving the credit as outweighing the savings.[16]

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[16] Stephen Miller. *"ACA's Small Business Tax Credit Goes Largely Unused."* March 29, 2016. Accessed April 2, 2020. https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/small-biz-tax-credit.aspx

Chart 4.11 summarizes the average premium rates PMPM by small group market segment between 2017 and 2019 YTD.

Chart 4.11
**Estimated Average Small Group Premium Rate PMPM by Market Segment**
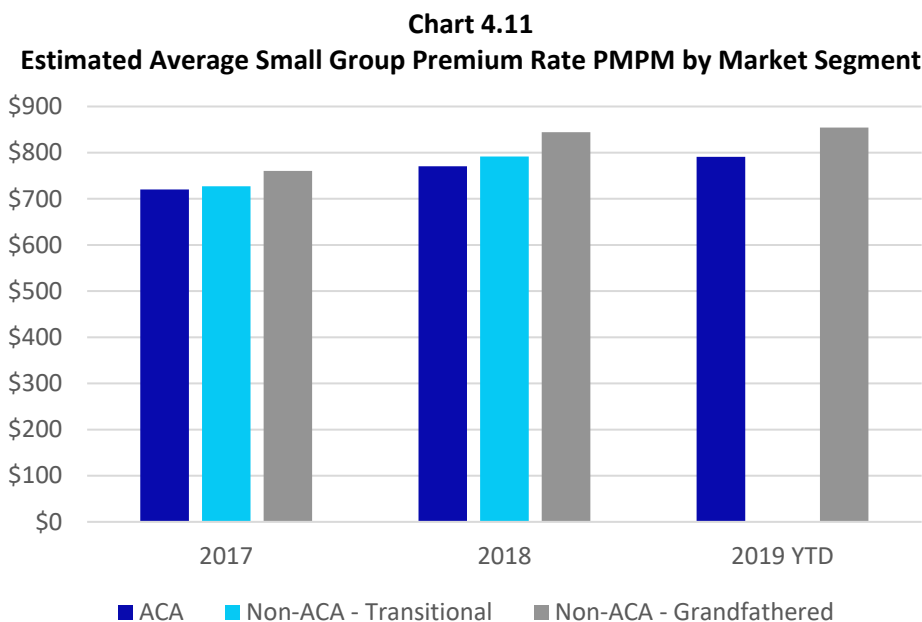
Source: Insurer data call responses

Chart 4.11 demonstrates that the average premium rate PMPM for each market segment increased between 2017 and 2019. ACA premiums were lower than their non-ACA counterparts in all years, contributing to the high percentage of the small group enrollees choosing ACA plans. However, it is not clear how average benefit levels compare between the small group ACA and non-ACA market segments. Additionally, the average premium rate PMPM for each market segment is being influenced by differences in geographic mix and demographic mix.

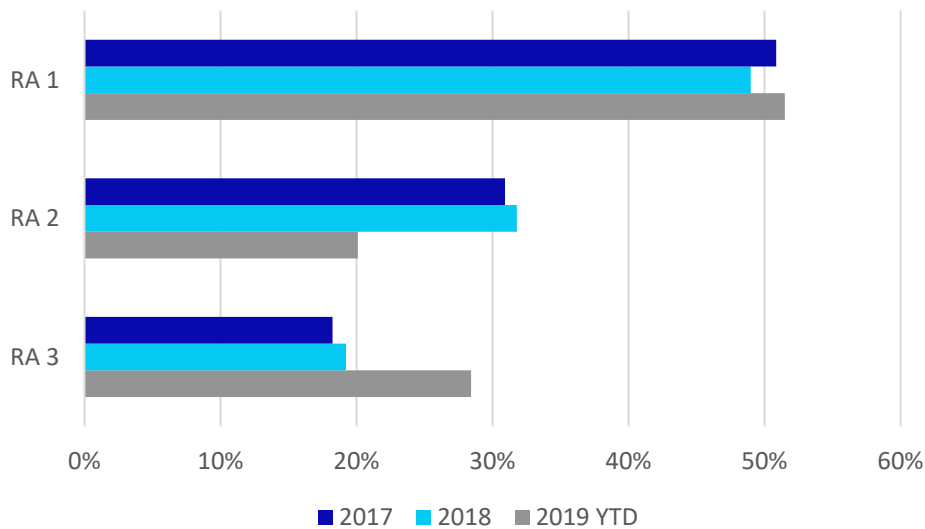### 4.2.2.   Geographic Characteristics

Charts 4.12 and 4.13 summarize the distribution of small group ACA and non-ACA enrollees, respectively, in Alaska by rating area. Similar to the individual market, a majority of small group market enrollees are located in Rating Areas 1 and 2 (i.e., southwest/southcentral Alaska and the interior/North Slope, respectively; Rating Area 3 represents the southeastern portion of the State). Since 2017, the distribution of small group ACA enrollees by region has not changed significantly. While a shift in membership from Rating Area 2 to Rating Area 3 for the non-ACA market was observed in 2019, this shift was likely attributable to Premera choosing to terminate transitional plans at the end of 2018, and approximately half of all small group non-ACA enrollees were enrolled in transitional plans in 2018.

Chart 4.12
Estimated Distribution of Small Group ACA Enrollees by Rating Area
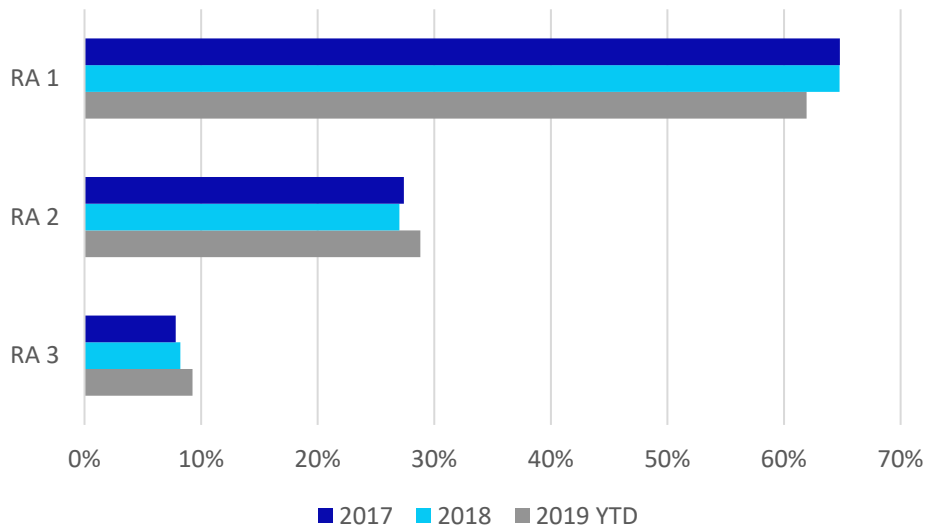
Source: Insurer data call responses

Chart 4.13
Estimated Distribution of Small Group Non-ACA Enrollees by Rating Area

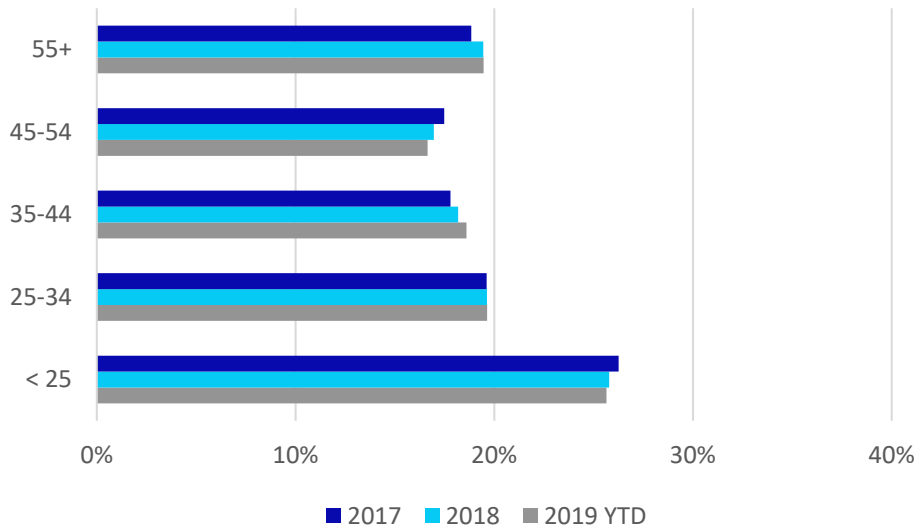Source: Insurer data call responses

4.2.3.   Demographic Characteristics

Chart 4.14 summarizes the distribution of small group enrollees by age group from 2017 through 2019 YTD. While slight changes in the distribution of small group enrollees by age were observed (e.g., a slight decrease in the proportion of small group enrollees under the age of 25), no significant shifts were observed.

Chart 4.14
Estimated Distribution of Small Group Market Enrollees by Age Range

Chart 4.15 shows the age distribution of 2019 YTD small group market enrollees, split by plan type (i.e., ACA and non-ACA). The age distribution is fairly consistent between ACA and non-ACA enrollees in the small group market.

Chart 4.15
Estimated Distribution of 2019 YTD Small Group Market Enrollees by Age Range
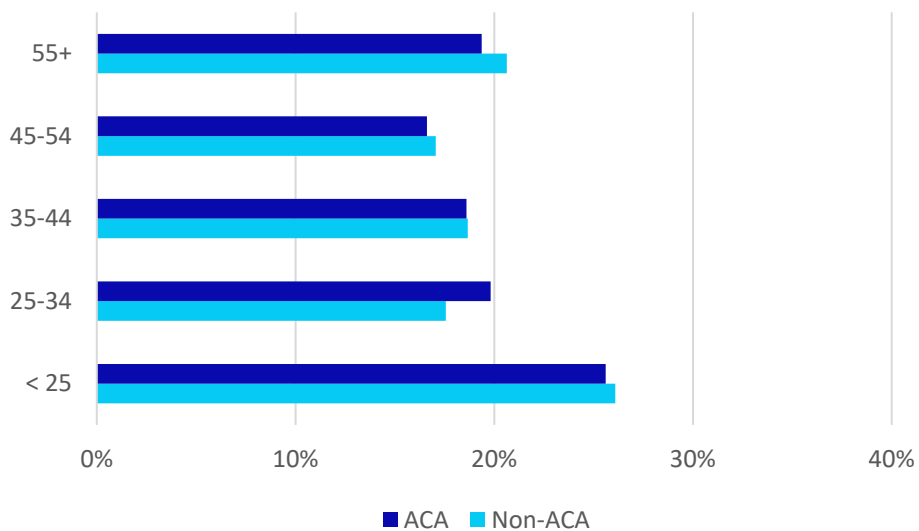
While not shown, information from the insurer data call shows 53.3% of small group ACA market enrollees in 2019 were female compared to 46.7% of small group non-ACA market enrollees being

female. The difference in gender mix between small group ACA and non-ACA enrollees is likely driven by differences in the allowable rate variation by gender between the two plan types. Premium rates for ACA products cannot vary by gender whereas premium rates for non-ACA plans are allowed to vary by gender.

4.2.4.   Benefit Characteristics

Chart 4.16 summarizes the distribution of small group ACA enrollees by metal level from 2017 through 2019 YTD. The distribution of enrollment by metal level has changed since 2017, with a greater proportion of small group enrollees in gold plans and a lower proportion of enrollees in bronze and silver plans in 2018 and 2019 YTD. The average observed premium rate PMPM by metal level decreased for gold enrollees from 2017 to 2019, while increases in the average premium rate PMPM for bronze and silver enrollees were observed. These changes in premium rates, combined with small groups transitioning from non-ACA plans which may feature richer than average benefit levels relative to ACA plans, are likely contributing to an increase in the distribution of small group enrollees in gold plans.
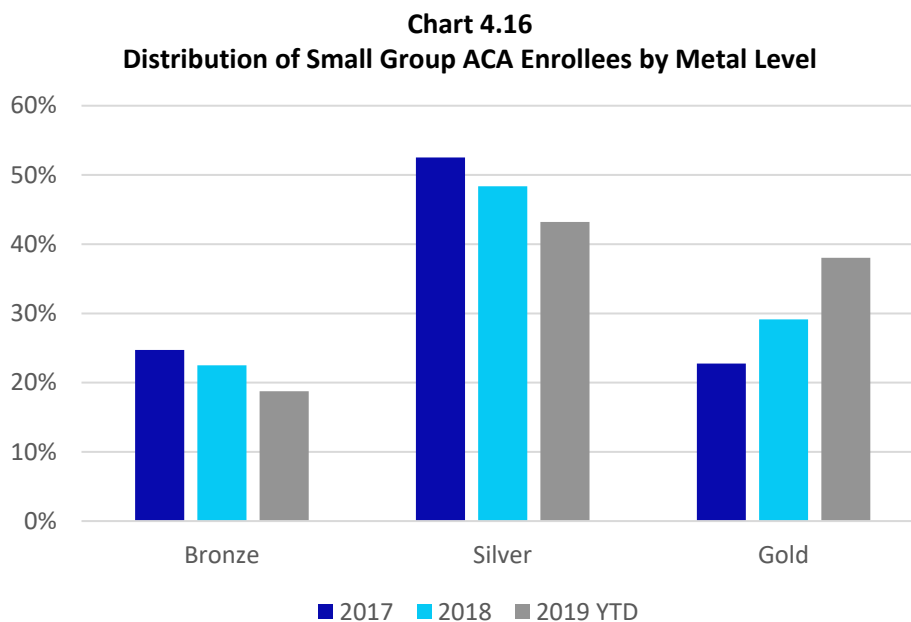
Chart 4.16
Distribution of Small Group ACA Enrollees by Metal Level

Source: Insurer data call responses

4.3.   Large Group Market

Consistent with the small group market, some of the largest changes from the ACA that affected the large group[17] market included the requirement to cover dependents up to the age of 26, the elimination of pre-existing condition exclusions, and the elimination of dollar caps on annual benefits. Additionally, one of the more significant provisions of the ACA that affected large group employers was the mandate that large group employers offer affordable coverage to their employees. However, most large group employers offered coverage to employees prior to the passage of the ACA. Therefore, the ACA's impact

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[17] Large groups are defined as employers with more than 50 employees.

on the large group market was more moderate relative to its impact on the individual and small group markets.

In this section we examine the current state of the Alaska large group market. We first provide an overview of enrollment in the large group market. We then analyze various characteristics of Alaska's large group enrollees. However, it should be noted that information for the large group market is more limited relative to the individual and small group markets, and therefore, less information is summarized.

### 4.3.1.   Overview of the Large Group Market

Chart 4.17 summarizes enrollment in the Alaska large group market. Total enrollment in the large group market did not change materially between 2017 and 2019, although enrollment in the self-insured market has decreased since 2017. Self-funding is widely prevalent in the large group market, and while self-funded groups are still required to comply with most of the benefit and cost sharing requirements under the ACA, self-funded groups are exempt from some of the ACA's fees and taxes.

Chart 4.17
Average Annual Large Group Enrollment (in 1,000s)
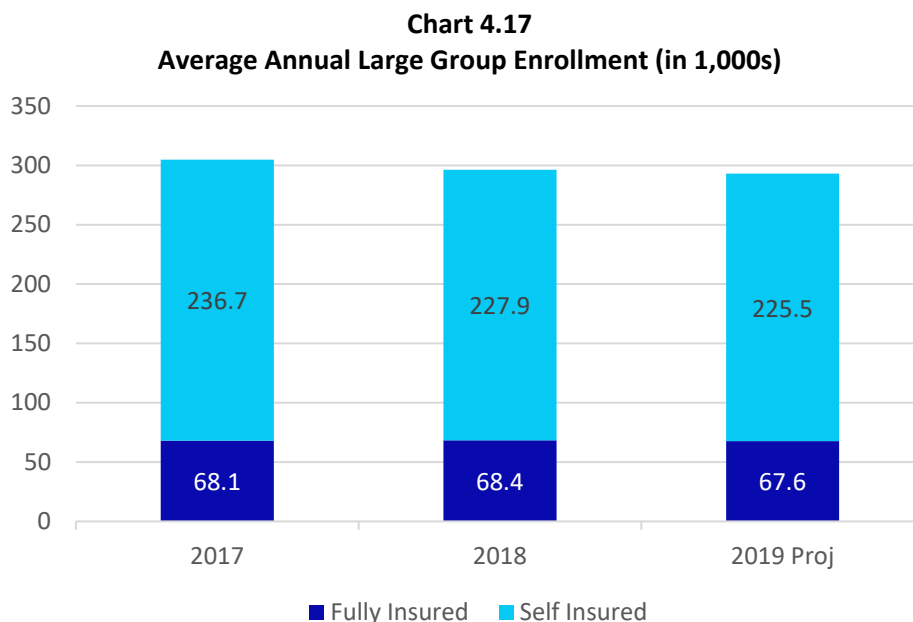
Sources: Insurer data call responses, MLR reports, and MEPS

Chart 4.18 summarizes the average premium rates PMPM for the large group fully-insured market segment between 2017 and 2019 YTD, excluding individuals with coverage through the Federal Employees Health Benefit Program (FEHBP). Average premiums PMPM increased more modestly in 2019 YTD relative to the change in average premiums PMPM from 2017 to 2018. Additionally, the average premium rate PMPM for each year is being influenced by differences in geographic mix, demographic mix, and benefits. However, given the stability of the large group fully-insured, we do not believe these differences are significant.

Chart 4.18
Estimated Average Large Group Fully-Insured Premium Rate PMPM
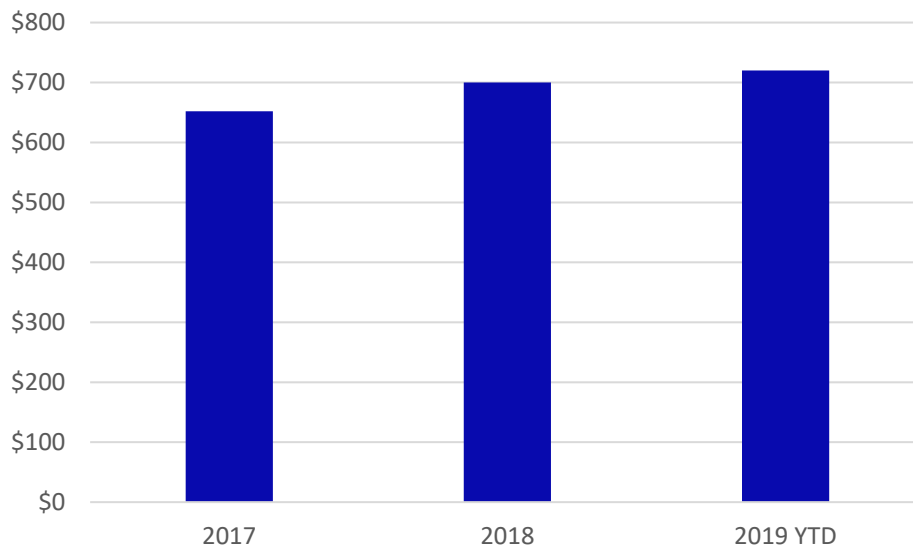
Source: Insurer data call responses

4.3.2.   Demographic Characteristics

Chart 4.19 summarizes the distribution of large group enrollees (excluding FEHBP enrollees) in Alaska by age group. The chart shows that the large group market has aged slightly between 2017 and 2019, with a slight decrease in the proportion of large group fully-insured enrollees under the age of 25 and a slight increase in the proportion of large group fully-insured enrollees between the ages of 35 and 44 and age 55 and older. While the data underlying Chart 4.19 is based on large group fully-insured data, we believe this information is likely representative of the entire large group market; demographic data of self-funded enrollees was unavailable. While not shown in the chart below, approximately 47.6% of large group fully-insured enrollees were females in 2019 YTD, down slightly from 48.2% in 2017.

Chart 4.19
Estimated Distribution of Large Group Fully-Insured Market Enrollees by Age Range
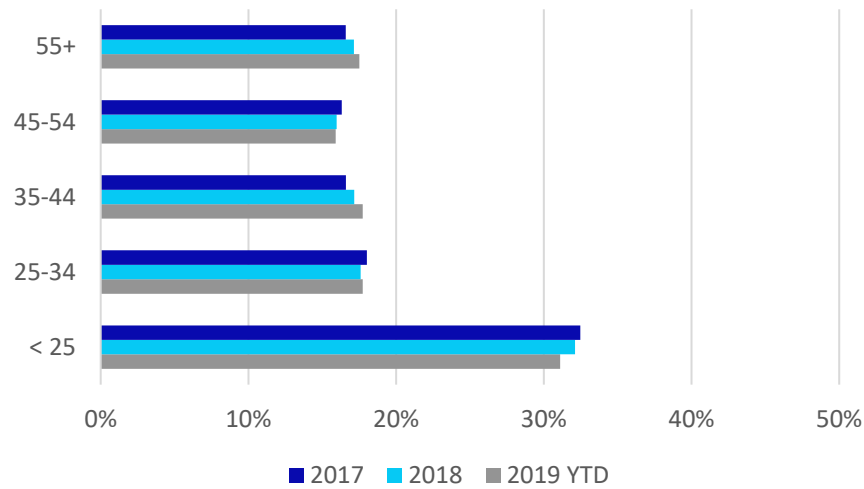
Source: Insurer data call responses (Data provided by Cigna was included in the enrollment estimates)

4.3.3.   Group Size

Chart 4.20 summarizes the distribution of large group fully-insured enrollees by group size (excluding FEHBP enrollees). The chart shows that the distribution of enrollment by group size has fluctuated from year to year, with a slight increase in the 1,000+ group size in 2019. However, this increase is likely attributable to one or two groups. Please note that data provided by one insurer was not included since the enrollment data was not separated by group size.

Chart 4.20
Estimated Distribution of Large Group Fully-Insured Enrollees by Group Size
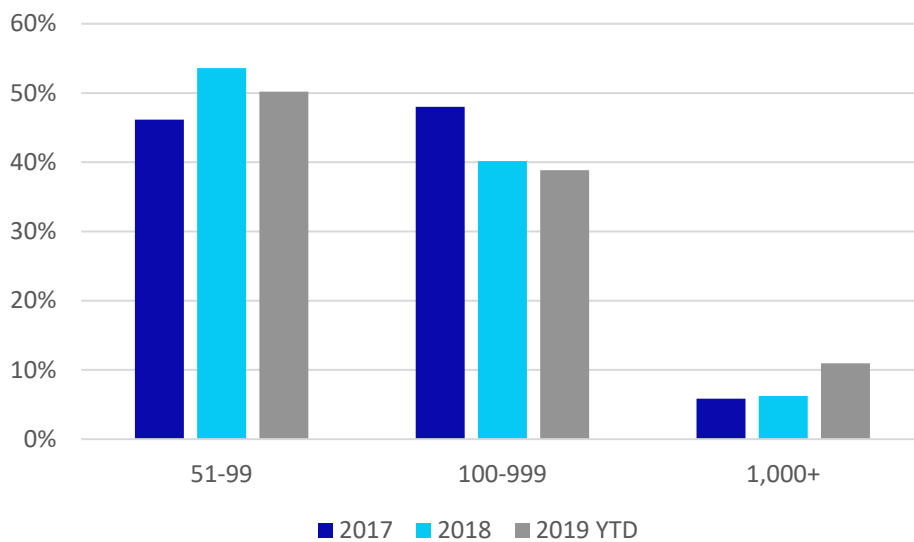
Source: Insurer data call responses

4.4.   Health Care Sharing Ministries

An alternative coverage type that we collected information on for this report is coverage issued through HCSM. A HCSM is an organization whose members "share a common set of ethical or religious beliefs and share medical expenses among themselves in accordance with those beliefs and without regard to the state in which a member resides or is employed."[18] While not traditional insurance, HCSMs collect contributions (a premium equivalent metric) from members and use those contributions to pay for the medical costs of all members. HCSMs tend to avoid using insurance terms, but they generally contain features that resemble health insurance, including the use of provider networks, defined benefits and cost sharing, preauthorization for procedures and prescription drugs, and claims processing.

However, HCSMs differ from traditional insurance in a number of important ways. HCSMs are not considered insurance, and they are not regulated in the same manner as insurance companies in Alaska. Additionally, they are not required to abide by the regulations of the ACA, which means HCSMs may rate by health status or deny coverage due to health status, deny coverage of pre-existing conditions, impose annual or lifetime benefit maximums, or only cover select services (e.g., inpatient and outpatient services only). This flexibility allows HCSMs to offer coverage at member contribution levels that are significantly lower relative to premium rates observed in the individual and employer markets in Alaska. HCSMs may also require members to be active participants of the ministry and maintain a lifestyle that is consistent with the religious beliefs of the organization (e.g., refrain from tobacco use, refrain from excess alcohol consumption). Given HCSMs' significant differences from traditional insurance, individuals who are solely covered by an HCSM may be considered uninsured.

For this analysis and report, the Division requested audited financial statements, application and guideline materials, enrollment information, and contribution information from four qualifying HCSMs in Alaska. Based on the information provided, we estimate average monthly member contributions for HCSMs in 2019 were between $100 and $200, which is significantly lower than the estimated average monthly premium rate PMPM in the 2019 individual ACA market of $740.

Chart 4.21 summarizes total enrollment in HCSMs between 2016 and projected 2019. The chart shows that enrollment in this type of coverage is relatively small but has been increasing over time. Given the growth, this alternative coverage could be an area for further review in coming years. It should be noted that some HCSMs reported household counts instead of membership counts; household counts were converted to membership counts, where necessary, using the average number of members per household as reported by the HCSMs providing both membership and household counts.

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[18] I.R.C. § 5000A.

Chart 4.21
Estimated Enrollment in Health Care Sharing Ministries (in 1,000s)
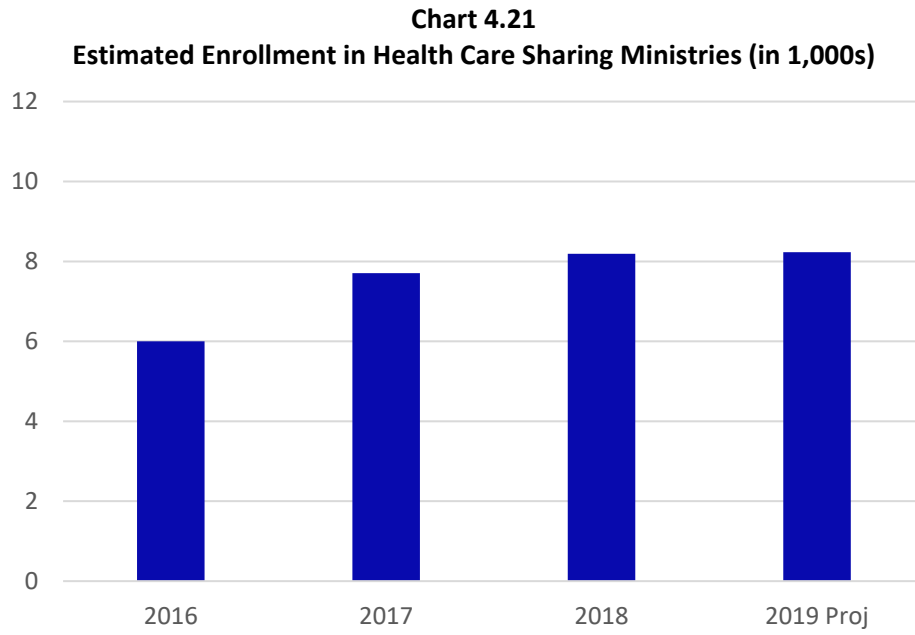
Source: HCSM data call responses

5.   ANALYSIS OF THE UNINSURED POPULATION IN ALASKA

For our review of Alaska's uninsured population, we utilized detailed 2018 ACS data made available by the U.S. Census Bureau. Per the request of the Division, this analysis excludes the population of individuals over the age of 64. Additionally, per the request of the Division, the "insured" population was defined as those individuals who either (1) answered "yes" to having some type of health insurance coverage (e.g., Medicare, Medicaid, coverage through an employer, IHS, etc.) when asked through the survey,[19] or (2) reported having a household income at or below 138% of Alaska's FPL. To the extent any additional modifications have been made to the underlying population for a reported category, those modifications are documented.

In this section, we summarize estimates of uninsured rates as well as distributions of the Alaskan uninsured and total populations by various characteristics (e.g., demographic mix, socioeconomic mix) of Alaskan residents. [20] When we refer to uninsured rates, we are referring to the number of uninsured individuals as a percentage of the total number of individuals within a specified category (e.g., female, age 26-34). When we refer to distributions of the uninsured and total Alaskan populations, we are looking only at individuals who are either uninsured or in the total population studied and how those respective populations are distributed across a specific set of characteristics (e.g., age, gender).

5.1.   Key Findings and Observations

Key findings and observations from our analysis of Alaska's uninsured population include the following:

- **Overall Uninsured Rate** – When using the population and methodology described as the basis for this analysis, the overall uninsured rate in Alaska in 2018 is calculated to be approximately 5.0%.

- **Geographic Area** –Of the geographic areas which were analyzed, the highest uninsured rates were observed in the Anchorage area with a 5.7% uninsured rate in Anchorage North and a 6.0% uninsured rate in Anchorage South. The lowest uninsured rates were observed in the Fairbanks-Juneau-Ketchikan area and Rural Alaska area with uninsured rates equal to 3.5% and 4.4%, respectively.

- **Demographics** – In general, males tend to have higher uninsured rates than females, with males making up nearly 60% of Alaska's uninsured population in 2018. Specifically, males in the age ranges of 26-34 and 35-54 had significantly higher uninsured rates (8.5% and 9.2%, respectively) when compared to other demographic segments. For females, the highest uninsured rate was observed in the age range of 35-54 (5.9%).

- **Family Structure** – Adults residing in households with only one adult (i.e., one adult or one adult with child(ren)) made up approximately 69% of the uninsured population in Alaska in 2018 and had high average uninsured rates (9.2% and 7.4%, respectively) relative to adults residing in households with two adults (4.8% when two adults or 3.3% when two adults with child(ren)).

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[19] United States Census Bureau. *Why We Ask Questions About…Health Insurance Coverage*. Census.gov. https://www.census.gov/acs/www/about/why-we-ask-each-question/health/.

[20] The total population is equal to the sum of the Alaskan uninsured and insured populations, excluding individuals over the age of 64

- **Household Income** – Uninsured rates in Alaska in 2018 are highly correlated with household income levels. In general, at household income levels above 138% FPL, those individuals who had the lowest income levels had the highest average uninsured rates. As an example, those individuals who reside in households with income levels between 139-200% FPL had an average uninsured rate equal to about 12.1%, while those individuals who reside in households with income levels higher than 600% FPL had an average uninsured rate equal to about 2.4%. Over 30% of Alaska's uninsured population reported that they had household incomes between 139% and 200% FPL and over 75% of Alaska's uninsured population reported that they had household incomes below 400% FPL.

- **Education Level -** Uninsured rates among adults decrease as an individual's education level increases. While those adults with a bachelor's degree or higher made up approximately 26.1% of the total population between the ages of 18-64, they made up only 13.4% of the uninsured population for that age range. On the other hand, those adults who graduated from high school but have no college experience made up about 25.3% of the population between the ages of 18-64, but account for 38.9% of the uninsured population for that age range.

- **Employment** – Over 85% of Alaska's uninsured population between the ages of 18-64 in 2018 was employed.

- **Class of Worker** – Government employees had a very low uninsured rate equal to only 1.2%. While government employees made up 26.7% of the total adult population between the ages of 18-64, that segment represented only 5.3% of the uninsured adult population for that same age range.

- **Industry** – The three industry groupings which contain a number of tourism related jobs, arts/entertainment/recreation, fishing/hunting/trapping, and retail trade, each had higher than average uninsured rates of 14.3%, 7.1%, and 10.0%, respectively.

- **Ethnicity** – Those individuals identifying as Alaska Native or American Indian had a very low uninsured rate (i.e., 0.4%) due to the availability of IHS; this segment of the population made up approximately 16% of Alaska's total population but only 1% of the uninsured population.

5.2.   Detailed Characteristics of the Uninsured Population

When using the population and methodology described above as the basis for this analysis, the overall uninsured rate in Alaska in 2018 is calculated to be approximately 5.0%. For comparison purposes, the U.S. Census Bureau estimates the 2018 uninsured rate in Alaska for the population under the age of 65 to be 14.3%.[21] The primary difference between these two estimates (i.e., 5.0% and 14.3%) is that the U.S. Census Bureau defines the "insured" population as being only those individuals who answered "yes" to having some type of health insurance coverage when asked, and does not consider those individuals whose only reported health coverage is IHS as being insured.[22] Given that, there are a number of individuals who have either reported IHS as being their only source of health coverage or who reported having a household income at or below 138% of Alaska's FPL which are considered to be

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[21] United State Census Bureau. *QuickFacts Alaska*. Census.gov. Accessed April 9, 2020. https://www.census.gov/quickfacts/fact/table/AK/HEA775218

[22] American Community Survey. *American Community Survey and Puerto Rico Community Survey 2017 Subject Definitions*, p. 73. https://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2017_ACSSubjectDefinitions.pdf.

"insured" for this analysis but who are not considered to be insured in the U.S. Census Bureau's estimate.

5.2.1.   Geographic Area

For this section, geographic areas in Alaska are defined to be consistent with the Public Use Microdata Areas (PUMAs) which have been developed by the U.S. Census Bureau and represent the most granular geographic segmentation available within the ACS data.[23] Map 5.1 provides a breakdown showing how the U.S. Census Bureau's PUMAs are organized in the State of Alaska.

Map 5.1
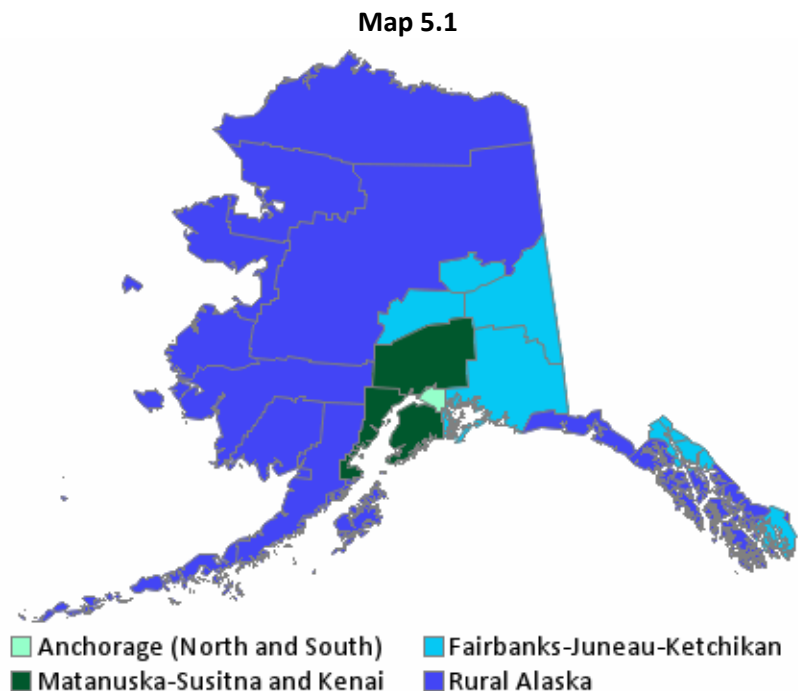
Chart 5.1 displays the estimated 2018 uninsured rates by geographic area, with Anchorage North and Anchorage South reported separately. As shown, the lowest uninsured rate was observed in the Fairbanks-Juneau-Ketchikan area (3.5%). The highest uninsured rate was observed in the Anchorage South region (6.0%), although results between Anchorage North and Anchorage South were largely similar.

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[23] PUMAs are geographic areas defined by the U.S. Census Bureau for statistical reporting purposes. Each PUMA contains between 100,000 and 200,000 residents. The definition for PUMAs in Alaska can be found on the U.S. Census Bureau's website: https://www.census.gov/geographies/reference-maps/2010/geo/2010-pumas/alaska.html.

Chart 5.1
2018 Uninsured Rates by Geographic Area
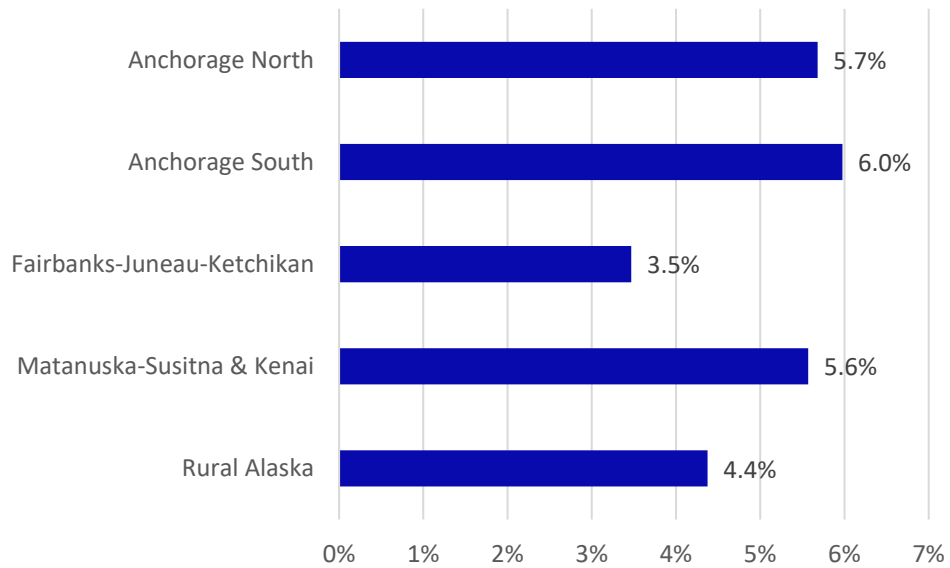
Chart 5.2 provides the distribution of the Alaskan uninsured and total populations by geographic area. In general, the distribution of the uninsured population follows that of the total population fairly closely, with the exception of the Fairbanks-Juneau-Ketchikan area where a more significant difference was observed between the percentage of the uninsured population that resides there (15.7%) and the percentage of the total population that resides there (22.8%).

Chart 5.2
2018 Population Distributions by Geographic Area
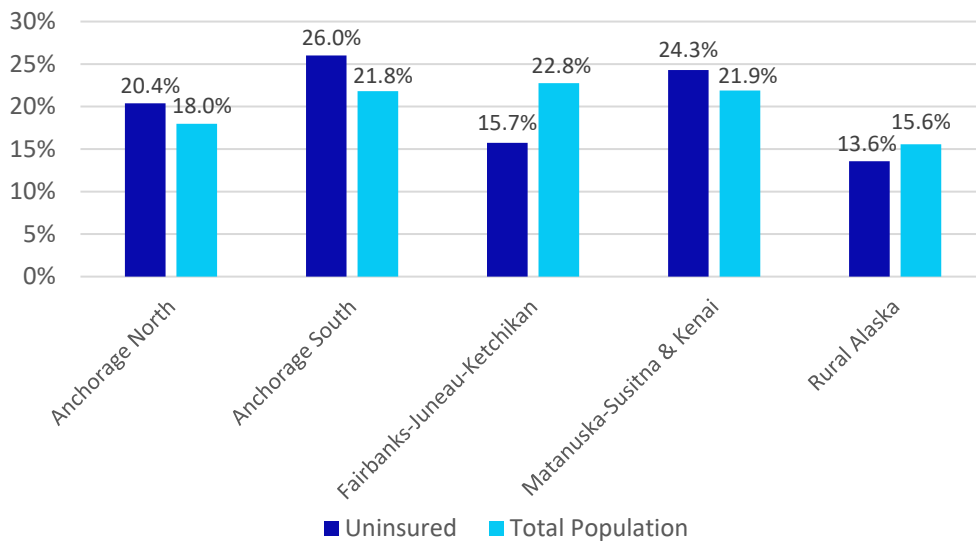
5.2.2.   Age and Gender

Chart 5.3 displays the estimated 2018 uninsured rates by age range. The highest observed uninsured rate is for the 35-54 age range (7.7%). For those in the 35-54 age range, this result (i.e., having a relatively high uninsured rate) is likely driven by the fact that (1) younger individuals in this segment are generally in better health and less risk averse than older populations, and so may not seek out health insurance coverage as readily as older age groups, and (2) individuals in this segment, on average, have income levels that make them less likely to qualify for Medicaid than individuals in younger age groups (e.g., 36.5% of the individuals in the 26-34 age group have household incomes at or below 138% compared to only 16.6% of the individuals in the 35-54 age group). The lowest uninsured rate (1.8%) is seen in children under the age of 18. This result is not unexpected given that children may be covered under an insured parent and may also have an opportunity to be covered under Alaska's Denali KidCare program, depending on income eligibility.

Chart 5.3
2018 Uninsured Rate by Age Range
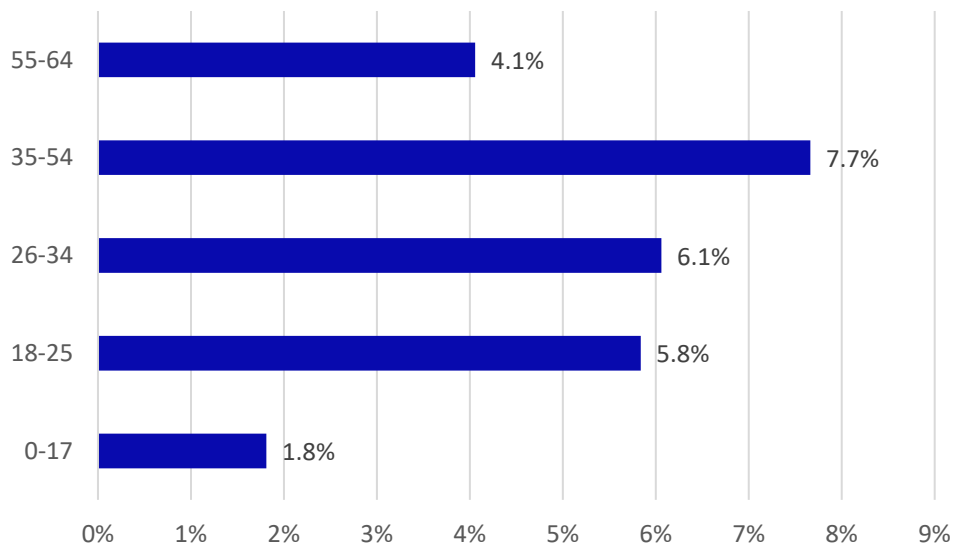
Chart 5.4 provides the distribution of the Alaskan uninsured and total populations by age range. Overall, the 35-54 age group made up a more significant portion of the uninsured population than the total population, while the opposite is true for the 0-17 age group. These results are consistent with that which would be expected based on the uninsured rates observed in Chart 5.3.

Chart 5.4
2018 Population Distributions by Age Range
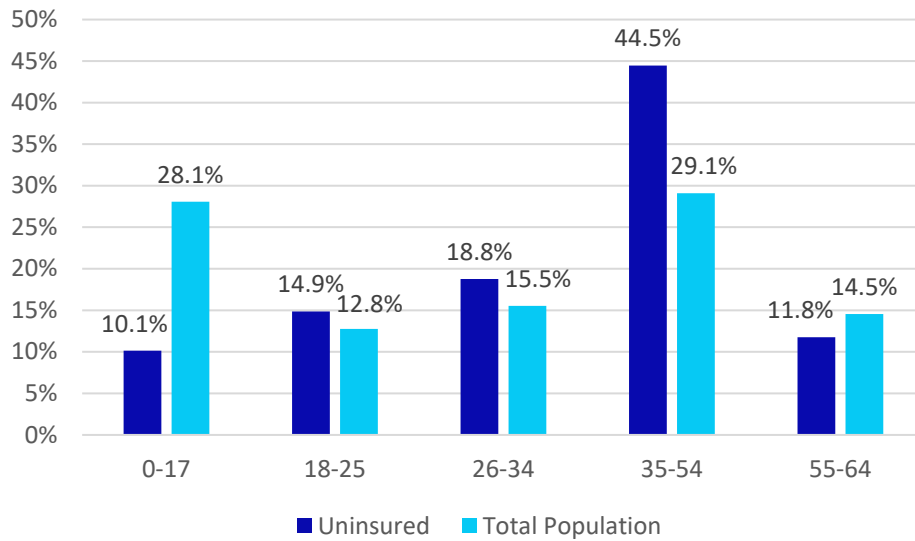
Chart 5.5 displays the estimated 2018 uninsured rates by gender, and Chart 5.6 provides the distribution of the Alaskan uninsured and total populations by gender. Overall, males were more likely to be uninsured than females and made up nearly 60% of the uninsured population in 2018.

Chart 5.5
2018 Uninsured Rates by Gender

Chart 5.6
2018 Population Distributions by Gender
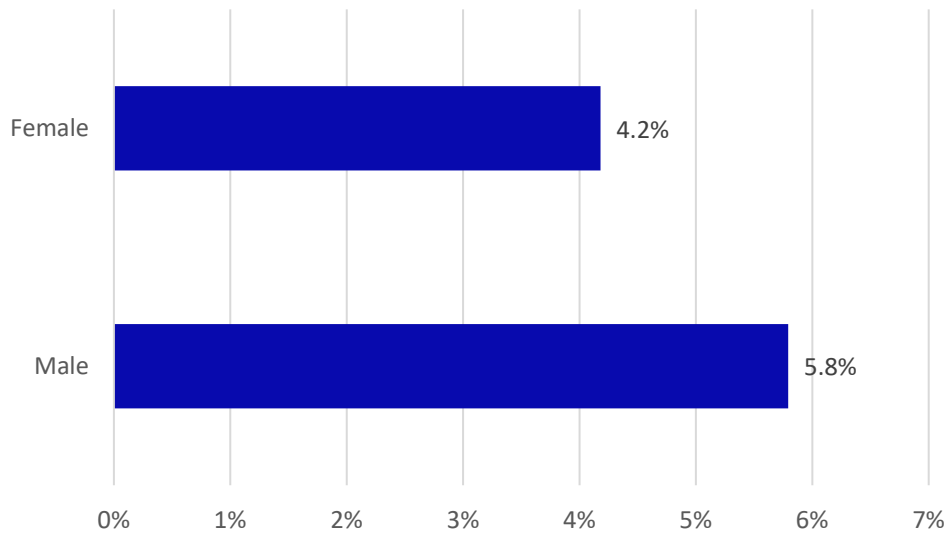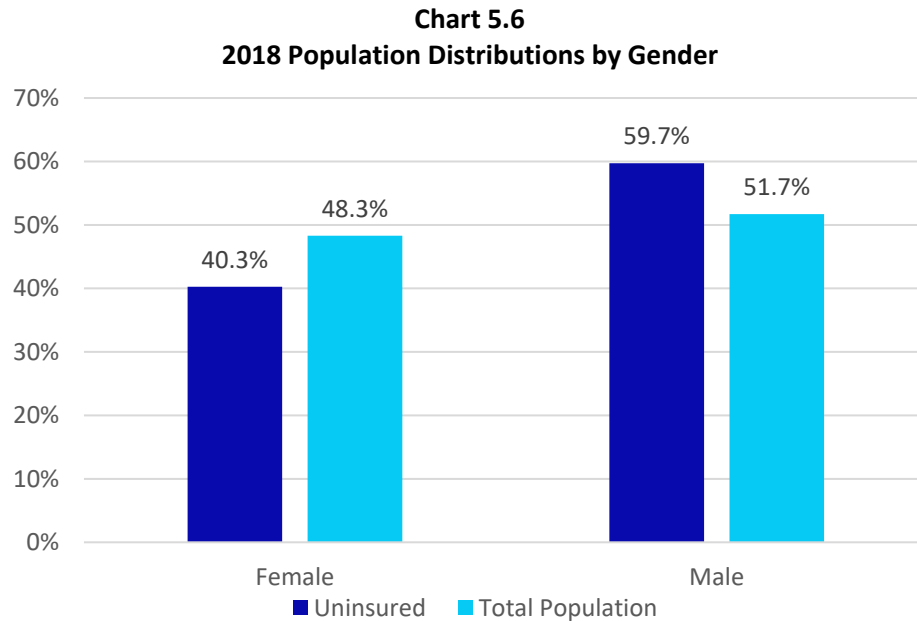
Chart 5.7 displays the estimated 2018 uninsured rates split by each age range and gender combination. As shown in Chart 5.7, male uninsured rates are higher than female uninsured rates in every age group except for the 0-17 and 55-64 age ranges. The largest difference between gender occurs in the 26-34 and 35-54 age ranges, with males in those age groups being significantly more likely to be uninsured than females. Some of this disparity could be driven in part by the fact that females of child bearing age may be more likely to purchase coverage than males of the same age. Additionally, females who have household incomes at or below 200% FPL who become pregnant may be eligible for medical assistance through the Denali KidCare program.[24]

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[24] Alaska Department of Health and Social Services. *MAGI Medicaid Eligibility Standards.* dhss.alaska.gov, March 2020. Accessed February 6, 2020. http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf.

Chart 5.7
2018 Uninsured Rates by Age and Gender
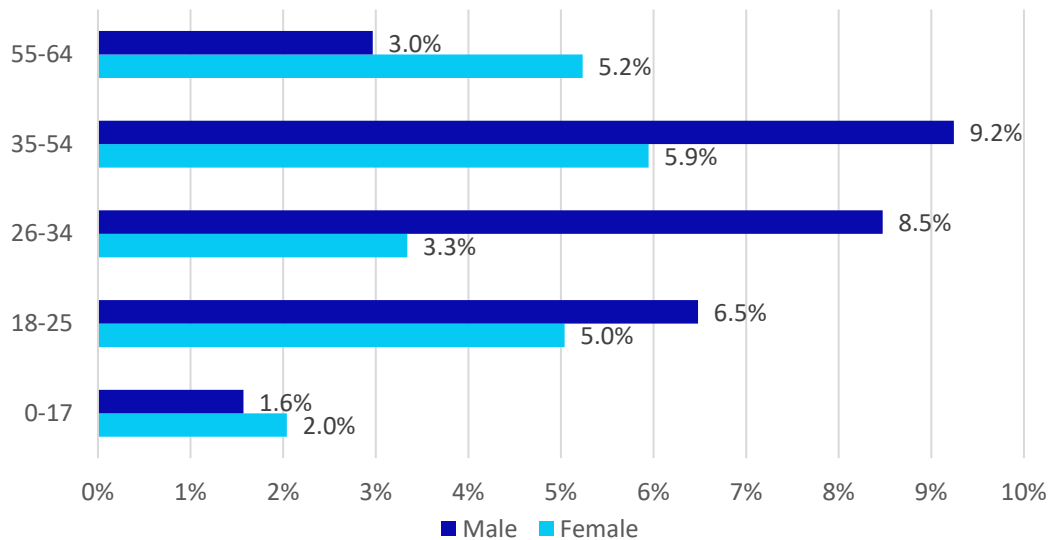
5.2.3.   Family Structure (Ages 18 – 64 Only)

The figures in Charts 5.8 and 5.9, in addition to excluding individuals over the age of 64, reflect results for the adult population only (i.e., the data additionally excludes individuals under the age of 18).

Chart 5.8 displays the estimated 2018 uninsured rates by family structure, showing that adults who do not have a spouse were much more likely to be uninsured than those who do have a spouse. This may be in part due to households with two adults having a higher probability of at least one individual being offered comprehensive major medical insurance through their employer.

Chart 5.8
2018 Uninsured Rates by Family Structure
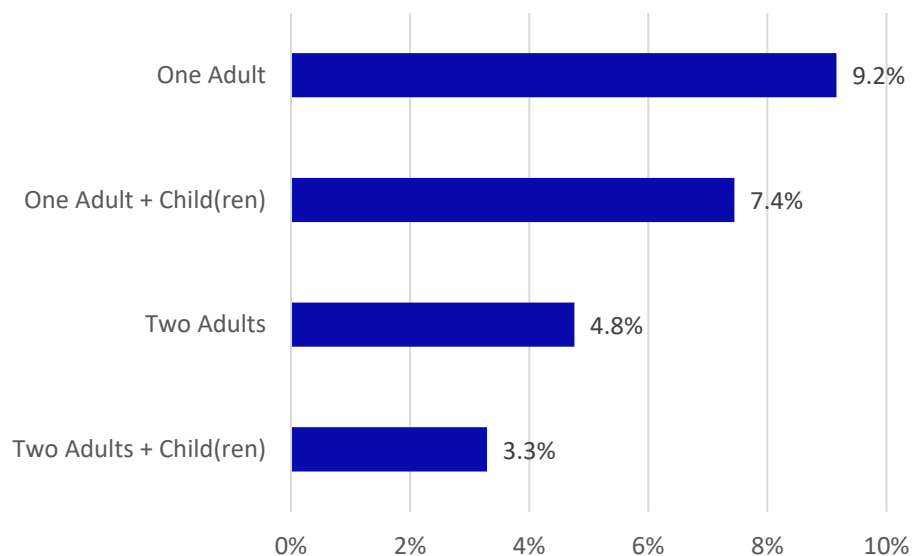
Chart 5.9 provides the distribution of the Alaskan uninsured and total adult populations by family structure. The chart shows that while households with one adult and no child(ren) made up about 40% of the total adult population, they made up more than half of the uninsured adult population.

Chart 5.9
2018 Population Distributions by Family Structure
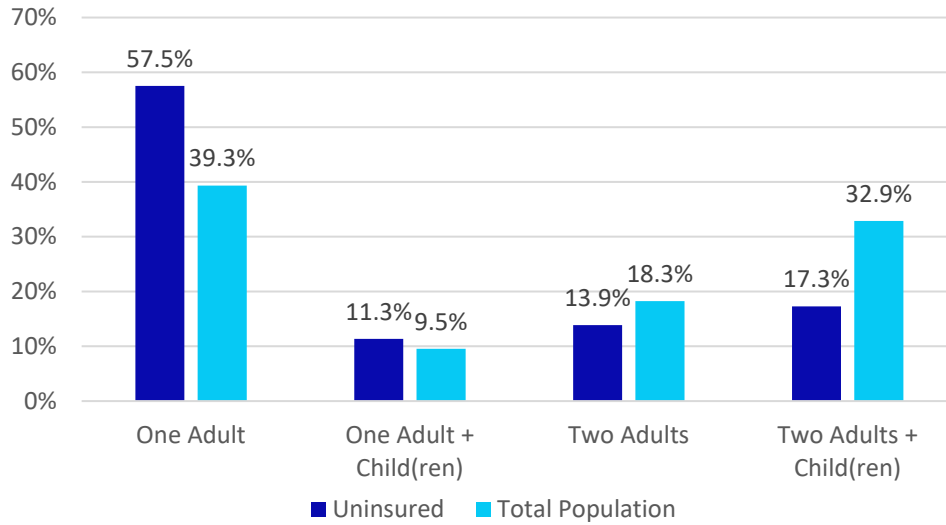
5.2.4.   Household Income

The charts in this section summarize Alaska's uninsured population by household income ranges, shown as a percentage of FPL. First, Table 5.1 below provides an example of 2018 household income values at specified FPLs for a single person household, a two-person household, and a four-person household in order to provide some reference around the magnitude of household incomes at different FPL levels.

Table 5.1

Household Income at Various 2018 FPL Levels in Alaska

	Single Person Household	Two Person Household	Four Person Household
100% FPL	$15,180	$20,580	$31,380
138% FPL	$20,948	$28,400	$43,304
200% FPL	$30,360	$41,160	$62,760
300% FPL	$45,540	$61,740	$94,140
600% FPL	$91,080	$123,480	$188,280

Chart 5.10 displays the estimated 2018 uninsured rate by household income range, shown as a percentage of FPL.[25] In general, the probability of being uninsured decreases as income increases, with the highest uninsured rates observed among households with the lowest incomes. Even with the expansion of Medicaid, the availability of Denali KidCare, and the introduction of premium tax credits to assist families with lower incomes under the ACA, uninsured rates for the cohort with household incomes in the 139-200% FPL range were significantly higher than those at higher income levels.

Chart 5.10
2018 Uninsured Rates by Income Range as a % of FPL

Income Range	Uninsured Rate
139%-200%	12.1%
201%-250%	8.1%
251%-300%	7.5%
301%-400%	8.3%
401%-600%	5.1%
601%+	2.4%
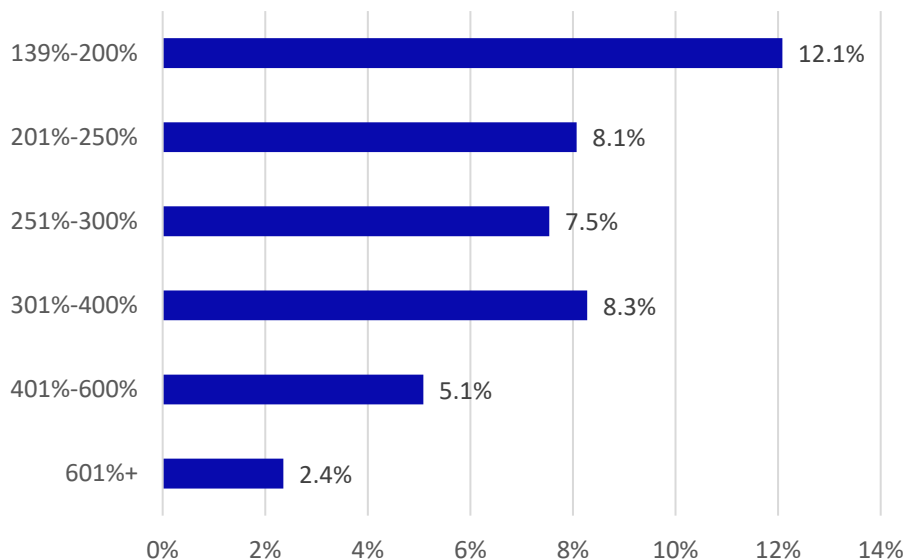
Chart 5.11 provides the distribution of the Alaskan uninsured and total populations by household income range. As shown, individuals residing in households that have income levels equal to 601% FPL or greater made up approximately 16% of the total population but only about 7% of the uninsured population. Conversely, approximately 31% of all uninsured individuals in 2018 had household incomes between 139-200% FPL while individuals in that income range only made up approximately 13% of the total population. Potential reasons for why such a large percentage of the lower income population remains uninsured may include that these individuals weren't aware they were eligible for subsidized coverage with reduced cost sharing requirements under the ACA, didn't want to hassle with the required paperwork and the need to provide proof of income, or didn't have enough discretionary income to purchase health insurance coverage even with the financial assistance that is available (e.g., Federal premium subsidies, employer contributions) to them.

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[25] Household incomes at or below 138% FPL are not shown as, per the request of the Division, the entire population with household incomes in that income range is being assigned as "insured." Therefore, the uninsured rate for households in that income range is assumed to be 0.0%.

Chart 5.11
2018 Population Distributions by Income Range as a % of FPL
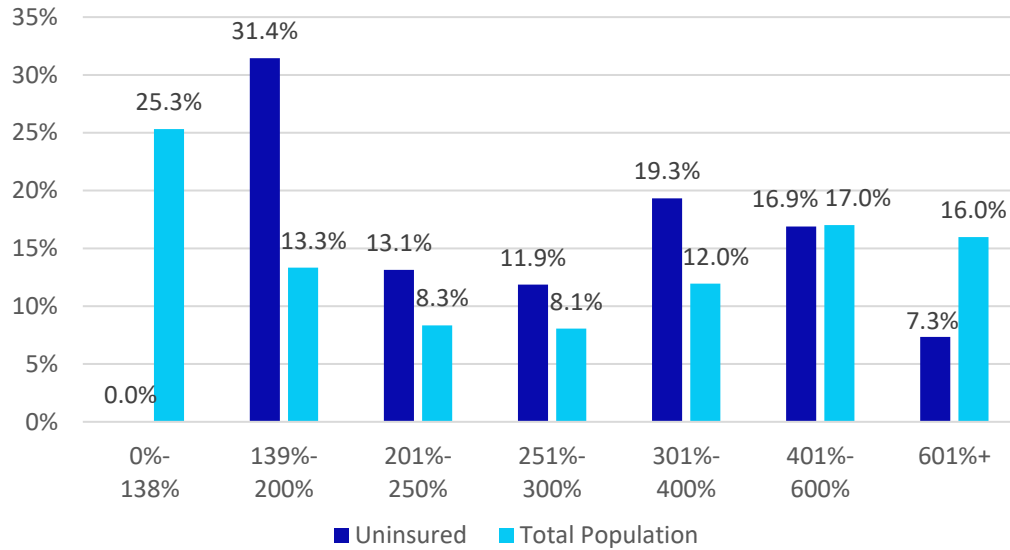
5.2.5.   Education Level (Ages 18 – 64 Only)

The figures in Charts 5.12 and 5.13, in addition to excluding individuals over the age of 64, reflect results for the adult population only (i.e., the data additionally excludes individuals under the age of 18).

Chart 5.12 displays the estimated 2018 uninsured rates by education level, and shows that, in general, uninsured rates among adults decrease as an individual's education level increases. A large reason for this may be due to the fact that the segment of the population with a higher education level was more likely to be employed, work for an employer that offers comprehensive health insurance coverage and have disposable income at a level where they feel they can afford insurance coverage.

Interestingly, the uninsured population in Alaska with at least some college experience (including college graduates) had an 82% employment rate while the uninsured population in Alaska that does not have any college experience had an employment rate of 91%. This indicates that those uninsured individuals without any college experience were more likely to be employed than those uninsured individuals who did have college experience; however, this also indicates that the uninsured population without any college experience may have been more likely to be employed in industries and jobs which did not offer health coverage to their employees or had income levels which did not support the ability to purchase health coverage regardless of whether it was offered by their employer.

Chart 5.12
2018 Uninsured Rates by Education Level

Education Level	Uninsured Rate
< High School	8.1%
HS Grad	9.6%
GED	6.2%
Some College	6.2%
Associate's	4.2%
Bachelor's +	3.2%

The distribution of the Alaskan uninsured and total adult populations by education level is provided in Chart 5.13. While those individuals with a bachelor's degree or higher made up approximately 26.1% of the total adult population, they made up only 13.4% of the adult uninsured population. On the other hand, those individuals who graduated from high school but have no college experience made up about 25.3% of the adult population in Alaska but accounted for 38.9% of the adult uninsured population.

Chart 5.13
2018 Population Distributions by Education Level

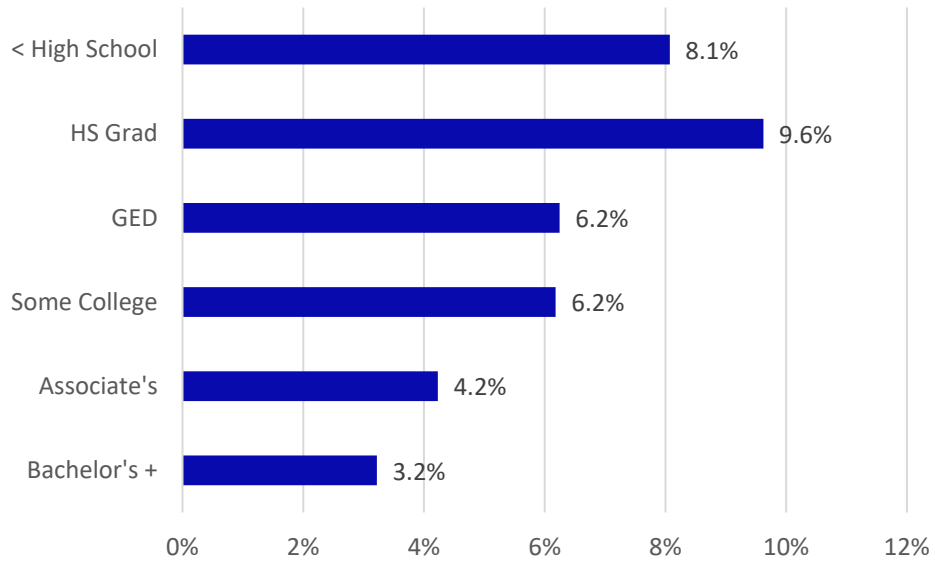| Education Level	Uninsured	Total Population
< High School	8.4%	6.5%
HS Grad	38.9%	25.3%
GED	5.5%	5.6%
Some College	28.9%	29.3%
Associate's	4.8%	7.2%
Bachelor's +	13.4%	26.1%

47
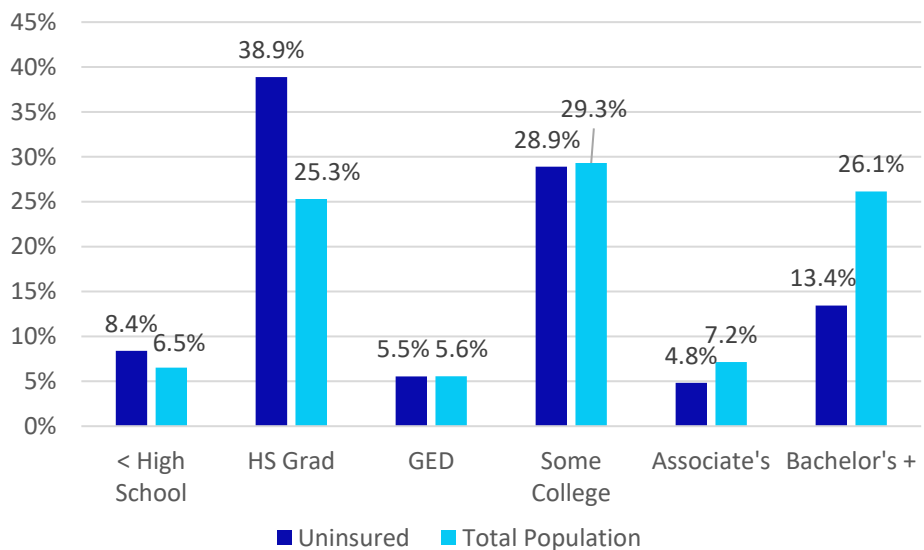
5.2.6.   Employment Status (Ages 18 – 64 Only)

The figures in Charts 5.14 and 5.15, in addition to excluding individuals over the age of 64, reflect results for the adult population only (i.e., the data additionally excludes individuals under the age of 18).

Chart 5.14 displays the estimated 2018 uninsured rates by employment status. For this chart, individuals were categorized into three work status categories: (1) part of the workforce and employed, (2) part of the workforce but unemployed, and (3) not part of the workforce. An individual was classified as part of the workforce but unemployed if they reported that they were actively seeking employment but did not currently have a job. An individual was considered not in the workforce if they reported they were unemployed but were not actively seeking employment (e.g., early retirees, individuals raising dependents, individuals in school).

Interestingly, adults who are considered to be part of the workforce and employed had a higher uninsured rate than adults who were either part of the workforce and unemployed or who were not in the workforce at all. We analyzed these results further and found that, as shown in Table 5.2 immediately below Chart 5.14, a significant portion of the adult population that was not employed resided in households with income levels that fall at or below 138% FPL. Given that this analysis assumes all individuals with household incomes at or below 138% FPL are "insured," this appears to be the key factor which is driving the calculated uninsured rates for the two specified populations to be lower than the employed segment of the population.

One additional item we wanted to highlight is that, in analyzing the above-noted results further, we found that the uninsured rate for employed adults who had household incomes between 139-200% FPL was approximately 20.0% while the uninsured rate for employed adults who had household incomes above 200% FPL was approximately 6.7%. This is noteworthy in that it demonstrates that the disparity in uninsured rates by income level shown in Chart 10 is even greater when isolated to employed adults.

Chart 5.14
2018 Uninsured Rates by Employment Status
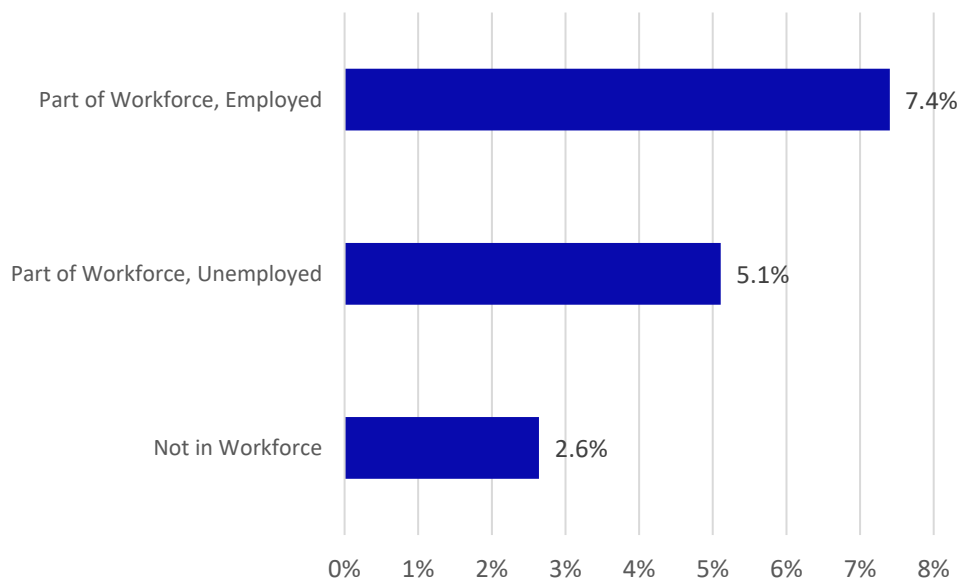
Table 5.2

Alaska - 2018 Employment Status
Distribution of Total Population by FPL Level

Income	Part of Workforce, Employed	Part of Workforce, Unemployed	Not in Workforce
0% - 138% FPL	15.4%	60.0%	52.1%
139% - 200% FPL	12.9%	13.8%	11.3%
201% - 400% FPL	30.2%	14.2%	19.0%
401+% FPL	41.5%	12.1%	17.6%

The distribution of the Alaskan uninsured and total adult populations by employment status are provided in Chart 5.15.

Chart 5.15
2018 Population Distributions by Employment Status
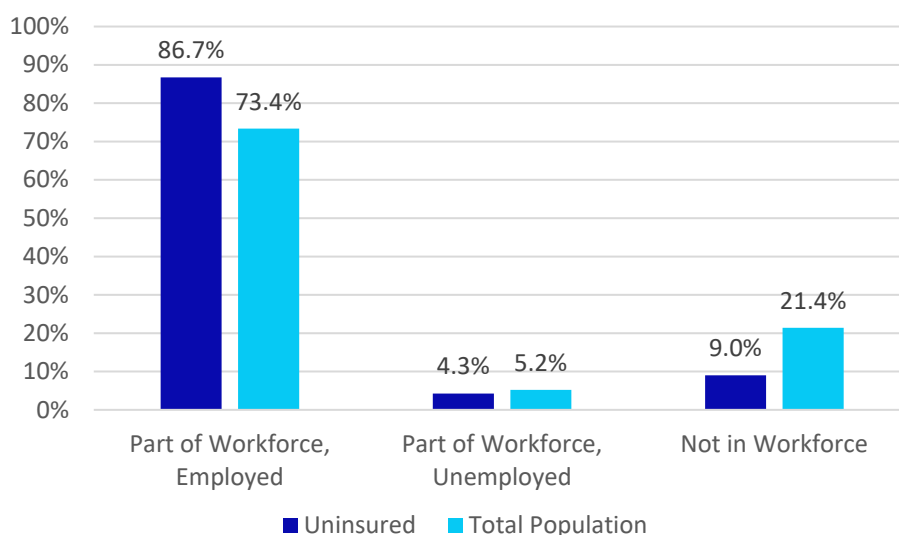
5.2.7.   Class of Worker (Ages 18 – 64 Only)

The figures in Charts 5.16 and 5.17, in addition to excluding individuals over the age of 64, reflect results for the adult population only (i.e., the data additionally excludes individuals under the age of 18).

Chart 5.16 displays the estimated 2018 uninsured rates by class of worker. Within the ACS data, class of worker refers to the job that an individual either currently has or, if they are currently unemployed or not in the workforce, their most recent job within the last five years. Chart 5.16 shows that, of those adults who have worked in the last five years, the individuals who are or were considered to be government employees had the lowest uninsured rates by a significant margin (i.e., relative to other classes of worker) while the self-employed populations had the highest uninsured rates. One reason self-employed individuals may have had higher uninsured rates could be related to the fact that many of them are required to purchase their own health coverage directly (as opposed to having their health

insurance coverage purchased through a larger employer and partially subsidized through employer contributions).

Chart 5.16
2018 Uninsured Rates by Class of Worker

The distribution of Alaskan uninsured adults and the distribution of the total adult population by class of worker is provided in Chart 5.17. As shown, about 61% of uninsured adult individuals work(ed) for private for-profit entities. Additionally, while government employees made up over 25% of the total adult population, that segment represented only 5.3% of the uninsured adult population. Conversely, while self-employed individuals made up approximately 8% of the total adult population, they represented almost 22% of the uninsured adult population.

Chart 5.17
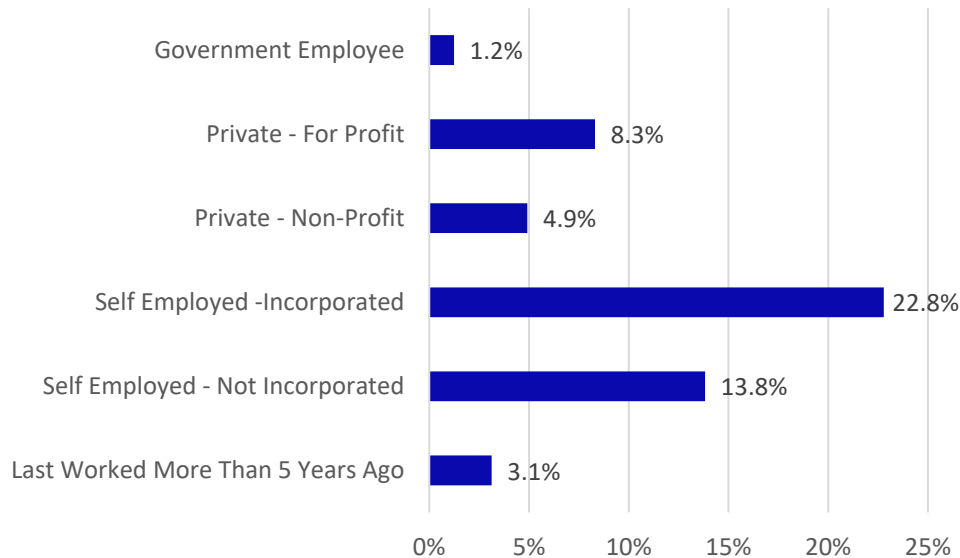**2018 Population Distributions by Class of Worker**
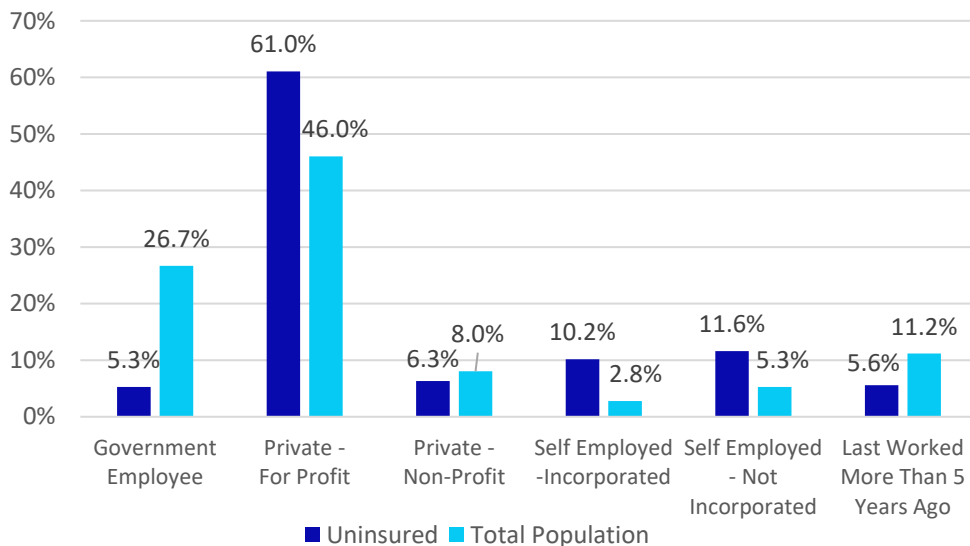
5.2.8.   Industry (Ages 18 – 64 Only)

The figures in Charts 5.18 and 5.19, in addition to excluding individuals over the age of 64, reflect results for the adult population only (i.e., the data additionally excludes individuals under the age of 18).

Chart 5.18 displays the estimated 2018 uninsured rates by industry. Within the ACS data, industry refers to the industry that an individual either currently has or, if they are currently unemployed or not in the workforce, their most recent industry worked in within the last five years. Individuals included in the "None" category are those who have either never worked or who have not been employed within that last five years. In this section, in addition to the modifications we made to the underlying population at the request of the Division, we have also removed those individuals under the age of 18 from the analysis.

As shown in Chart 5.18, the arts/entertainment/recreation/food service and wholesale trade industries had the highest uninsured rates out of all industries at 14.3% and 13.7%, respectively. Nearly 60% of the uninsured adult population in the arts/entertainment/recreation/food service industry are individuals between the ages of 35 and 54; we previously saw that this age group had the highest uninsured rate among all age ranges.

Additionally, we note that the three industry groupings which likely contain the most tourism related jobs, arts/entertainment/recreation/food service, fishing/hunting/trapping, and retail trade, each had higher than average uninsured rates of 14.3%, 7.1%, and 10.0%, respectively. One reason for this could be that employees working in tourism related industries can tend to be more seasonal or part-time in nature and, therefore, have both lower incomes as well as be less likely to be offered comprehensive insurance coverage by their employer.

Chart 5.18
2018 Uninsured Rates by Industry

Industry	Uninsured Rate
Agriculture, Other	5.3%
Arts/ Ent/ Rec/ Food Service	14.3%
Construction	10.8%
Edu Serv/ Health Care	4.3%
Finance/ Insurance	5.0%
Fishing/ Hunting/ Trapping	7.1%
Information	4.6%
Manufacturing	10.1%
Mining/ Quarrying/ Extraction	6.6%
Other, Not Public Admin	7.4%
Professional/ Scientific	8.8%
Public Admin/ Military	0.7%
Retail Trade	10.0%
Trans/ Ware/ Utilities	3.2%
Unemployed	11.1%
Wholesale Trade	13.7%
None	2.2%

Chart 5.19 provides the distribution of the Alaskan uninsured and total adult populations by industry. We note that while the adults in the wholesale trade industry had a high uninsured rate, only approximately 1% of Alaska's total adult population and 3% of Alaska's uninsured adult population

worked in this industry. Regarding the arts/entertainment/recreation/food service industry, the adults in that industry made up approximately 8% of Alaska's total adult population but 19% of its uninsured adult population.

Chart 5.19
2018 Population Distribution by Industry
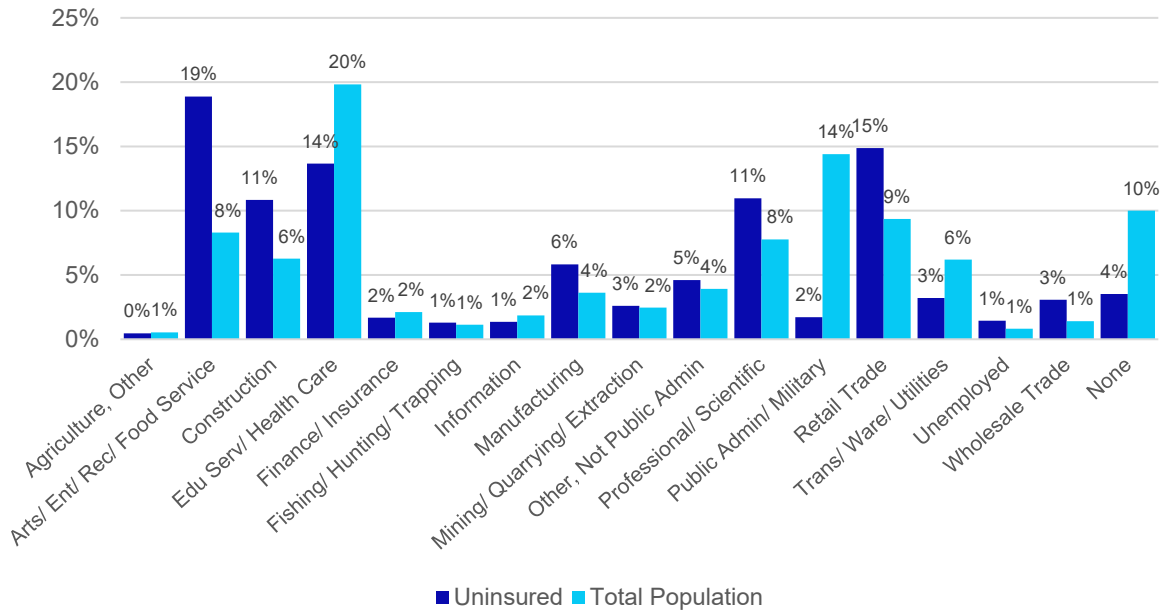
5.2.9.   Primary Language Spoken

Chart 5.20 displays the estimated 2018 uninsured rates by primary language spoken. In reviewing the uninsured population by primary language spoken, the Tagalog speaking population had the highest uninsured rate at 8.6%. The lowest uninsured rate was observed among those in the "Alaska Native & Other North American Languages" category with a rate of 1.3%. This result is being driven by the fact that a majority of this population reported being eligible for coverage through IHS.

Chart 5.20
2018 Uninsured Rates by Primary Language Spoken

Primary Language	Uninsured Rate
Alaska Native & Other North American Languages	1.3%
English	4.9%
Spanish	6.8%
Tagalog	8.6%
Other	6.8%
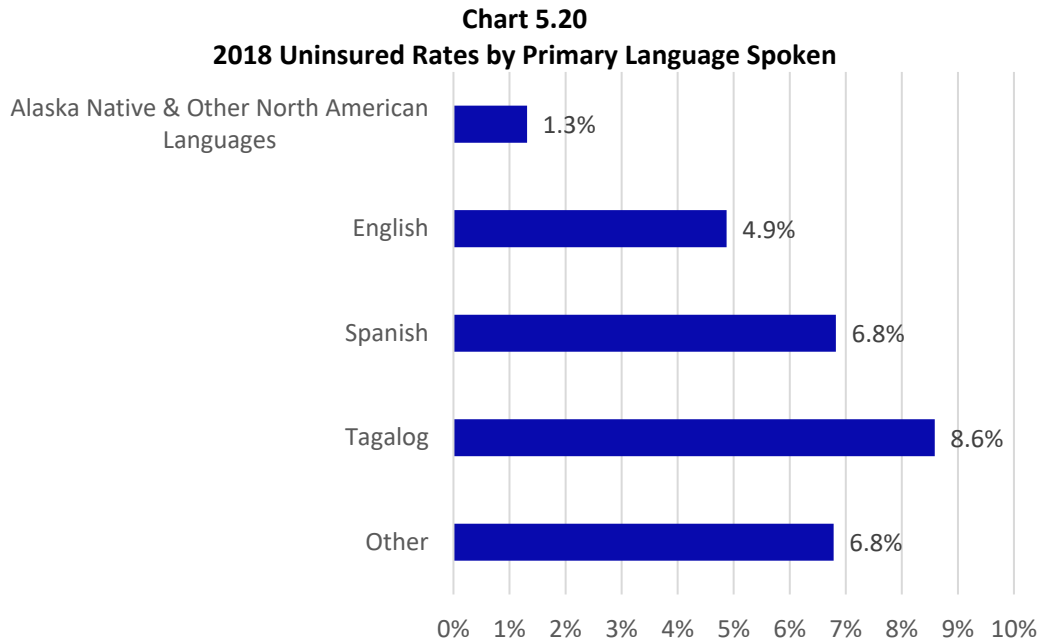
Chart 5.21 provides the 2018 distribution of the Alaskan uninsured and total populations by primary language spoken. While we saw the highest uninsured rate among those who speak Tagalog, we see that these individuals made up a relatively small percentage of the uninsured and total populations (approximately 3% and 2%, respectively).

Chart 5.21
2018 Population Distributions by Primary Language Spoke

Primary Language	Uninsured	Total Population
Alaska Native & Other North American Languages	0.9%	3.3%
English	82.6%	85.0%
Spanish	5.4%	3.9%
Tagalog	3.4%	2.0%
Other	7.7%	5.7%
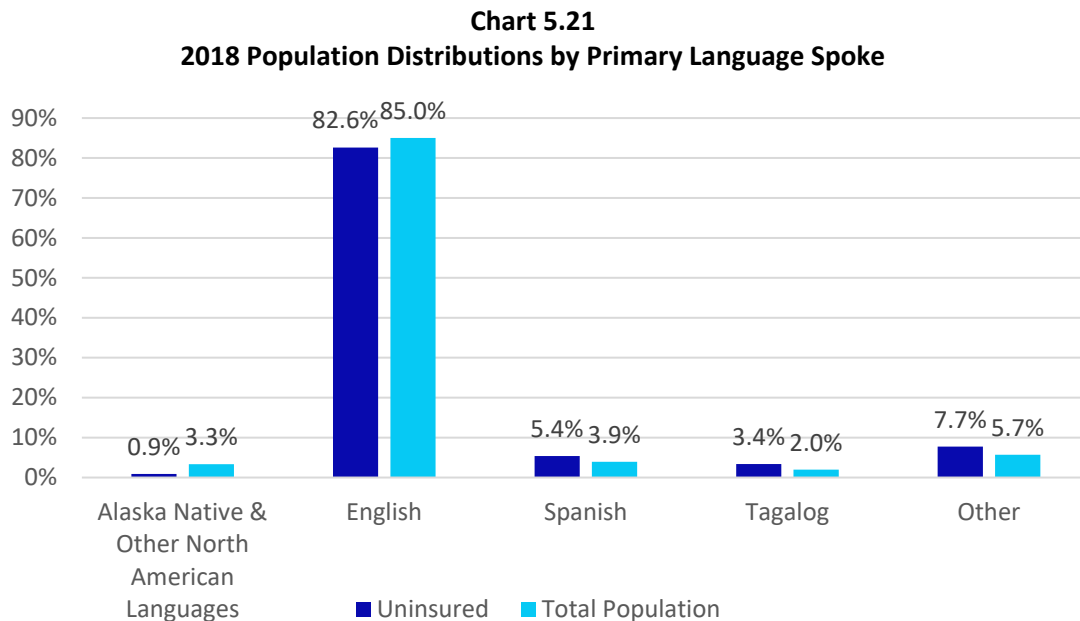
5.2.10.   Ethnicity

Chart 5.22 displays the estimated 2018 uninsured rates by ethnicity. As shown, the highest uninsured rate among ethnicities was in the African American segment, where 11.4% of the population within that segment reported not having health insurance coverage. Individuals who identify as Alaska Native or American Indian had a very low uninsured rate, driven by the availability of IHS to a majority of that segment of the population.

Chart 5.22
2018 Uninsured Rates by Ethnicity

Ethnicity	Uninsured Rate
African American	11.4%
Alaska Native or American Indian	0.4%
Asian	8.0%
Two or More	2.0%
White	5.9%
Other	6.9%
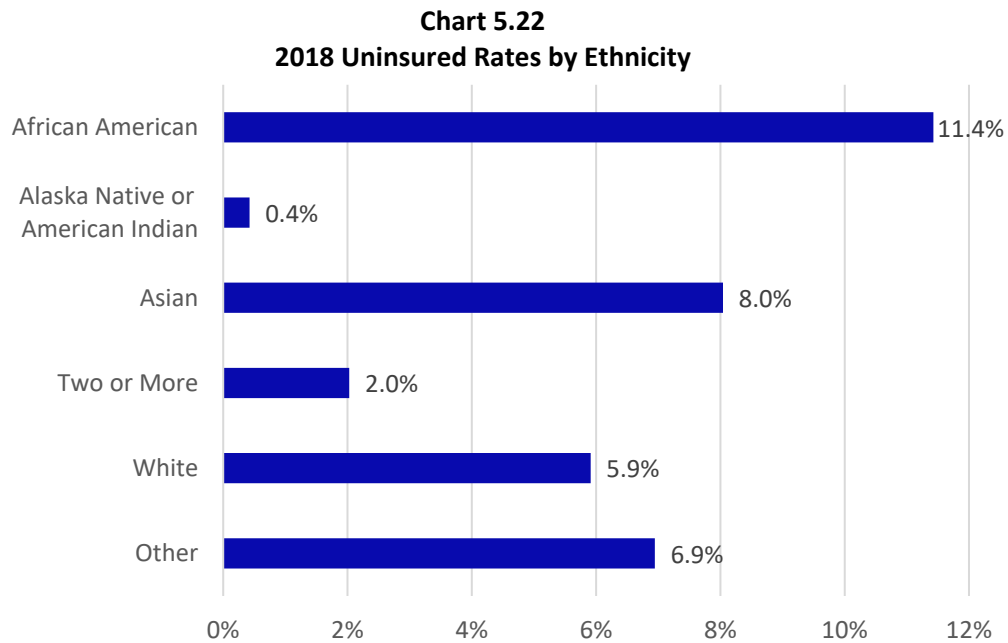
Chart 5.23 provides the 2018 distribution of the Alaskan uninsured and total populations by ethnicity. In this chart, we see that while the African American population had the highest uninsured rate, those who identify as African American accounted for only about 3% of the total population. Those individuals identifying as Alaska Native or American Indian made up approximately 16% of Alaska's total population but only 1% of the State's uninsured population.

Chart 5.23
2018 Population Distributions by Ethnicity

Ethnicity	Uninsured	Total Population
African American	7.5%	3.3%
Alaska Native or American Indian	1.4%	16.2%
Asian	9.8%	6.1%
Two or More	3.6%	9.0%
White	73.9%	62.7%
Other	3.8%	2.8%

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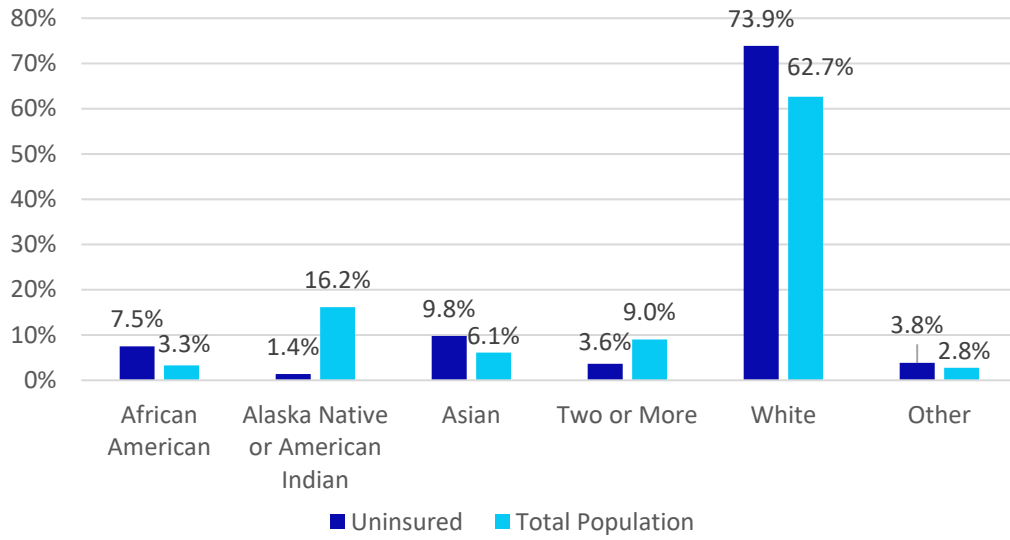
6.   THE ALASKA PROVIDER LANDSCAPE

Oliver Wyman's view of the Alaska provider landscape is based on information from the AHRF published by the HHS' HRSA.[26] The AHRF summarizes the number of health care professionals and facilities, hospital utilization and expenditures, and characteristics of the general population at the borough-level. The AHRF is a compilation of data from a variety of sources, and includes data from the American Medical Association, the American Hospital Association, and the U.S. Census Bureau.

In this section, we summarize estimates of the number of physicians, hospital facilities, and other facilities per capita.[27] The information is presented longitudinally, but the time periods for which the data elements are summarized differ due to differences in the availability of the various data sources. Additionally, in some cases the data sources for a given data element are not consistent over time (e.g., data pertaining to physician counts is based on information from the American Medical Association for some data points and the American Osteopathic Association for other data points).

The information has been summarized by geographic area in Alaska. The geographic areas in Alaska are defined by borough and census area based on guidance from the Division, with each geographic area defined according to Map 6.1, shown below. Due to the relatively small population base in some geographic areas, particularly the North/Northwest and Southwest regions, there may be volatility in the results for some geographic areas. For comparison purposes, we have also summarized each data element on both a statewide and nationwide basis.[28] Please note the geographic area definitions in this section differ from those defined by the U.S. Census Bureau and used in the prior section.

Map 6.1
Geographic Area Definitions for Provider Analysis

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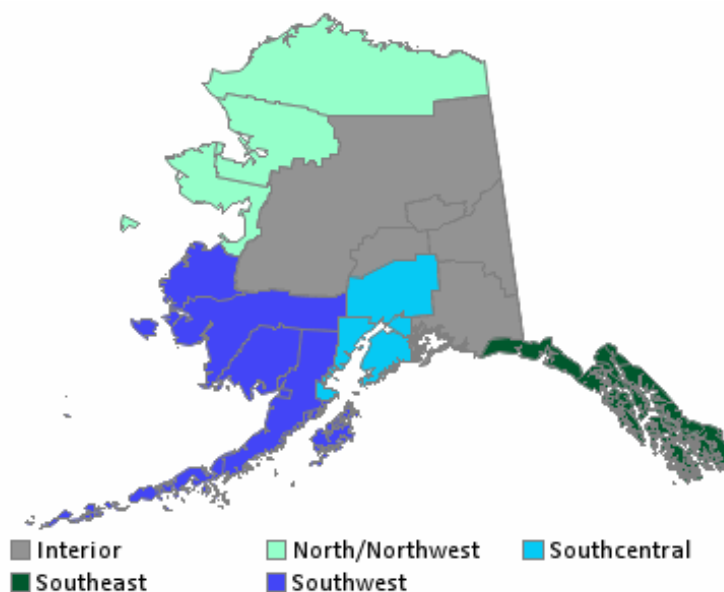
[26] Data from the 2011 and 2019 AHRF was included in our analysis. Oliver Wyman submitted a request to the HRSA to access datasets predating the 2011 AHRF, but the information was not received as of February 28, 2020.

[27] To ensure compliance with the AHRF data use license agreement, Oliver Wyman requested and received permission from the HRSA to summarize the AHRF on behalf of the State of Alaska.

[28] Nationwide statistics represent data for the lower 48 states, including the District of Columbia.

We note that our characterization of the data is dependent on the documentation made available by the HRSA. If we have misinterpreted the limited documentation that is made available or if the information we utilized is inaccurate, our findings and conclusions may need to be revised.

6.1.   Key Findings and Observations

Key findings and observations from our analysis of the Alaska provider landscape include the following:

- The North/Northwest and Southwest geographic areas are consistently underserved when compared to other geographic areas of the State and nationwide data. The number of physicians per 100,000 residents is significantly lower relative to the State, particularly among non-primary care physicians involved in patient care. Additionally, the North/Northwest and Southwest geographic areas of Alaska have no home health agencies, hospices, or ambulatory surgical centers. However, it should be noted that the number of community health centers per 100,000 residents is significantly higher in these geographic areas relative to the State.

- While the number of primary care physicians[29] per 100,000 residents in Alaska is consistent with the rest of the nation, the number of non-primary care physicians per 100,000 residents in Alaska is generally lower relative to the rest of the nation.

- The number of hospital facilities per 100,000 residents is generally higher in Alaska relative to the rest of the nation, but since the average number of beds per hospital facility is generally lower in Alaska relative to the rest of the nation, the number of hospital beds per 100,000 residents is generally lower in Alaska relative to the rest of the nation.

- There are generally fewer skilled nursing facilities, home health agencies, and hospices per 100,000 residents in Alaska relative to the rest of the nation.

- There are generally more ambulatory surgical centers per 100,000 residents in Alaska relative to the rest of the nation.

- The number of community health centers per 100,000 residents is significantly higher in the less populous geographic areas of Alaska.

6.2.   Physician Analysis

In this section, we present estimates of the number of physicians in Alaska. The physician analysis was limited to active, non-Federal physicians and split between doctors of medicine (MDs) and doctors of osteopathy (DOs) due to differences in the availability of the data for MDs and DOs for earlier time periods. Active physicians exclude physicians who are retired, semiretired, working part-time, or temporarily not in practice. Non-Federal physicians represent physicians not employed full-time by the Federal government.

Chart 6.1 presents the number of MDs per 100,000 residents by year. The number of MDs per 100,000 residents in Alaska has consistently been significantly lower relative to the number of MDs per 100,000 residents nationwide over the period 1990 to 2017. The number of MDs per 100,000 residents was

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[29] Physicians are defined as active non-federal physicians, described further in Section 6.2 of the report.

relatively similar by geographic area within Alaska in 1995 but has become significantly different by 2017. The Southcentral geographic area of Alaska has the highest number of MDs per 100,000 residents, whereas the less populous Southwest and North/Northwest geographic areas have significantly fewer MDs per 100,000 residents.

Chart 6.1
MDs Per 100,000 Residents by Year
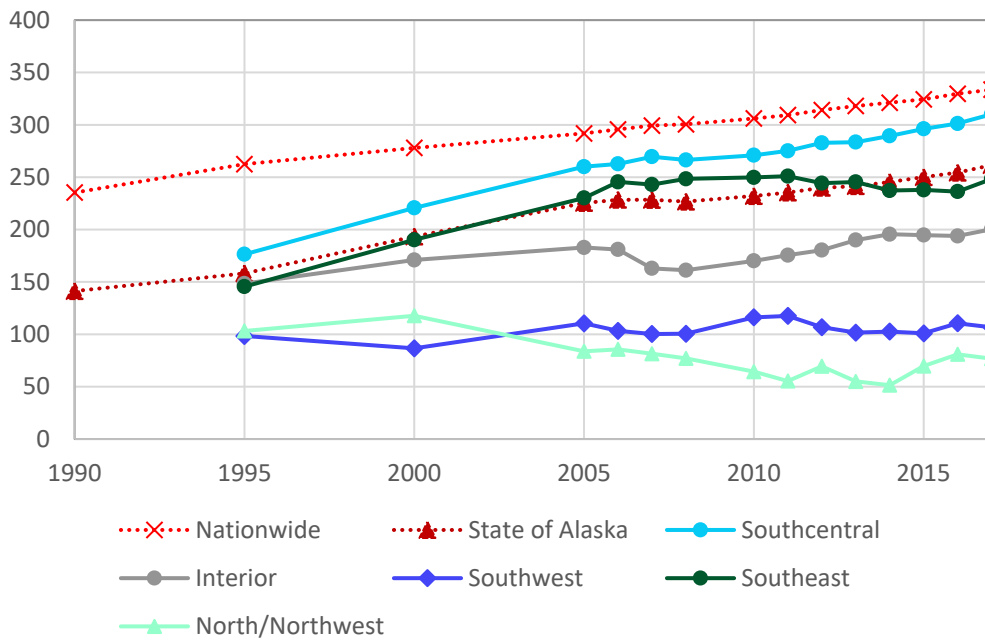
Chart 6.2 presents the number of DOs per 100,000 residents by year. Following a pattern similar to MDs, the number of DOs per 100,000 residents was relatively similar by geographic area within Alaska in 1998 but became significantly different by 2017. The number of DOs per 100,000 residents in Alaska has exceeded the number of DOs per 100,000 residents nationwide in recent years due to significant increases in the number of DOs per 100,000 residents in the Southcentral and Interior geographic areas of Alaska. It should be noted that DOs make up a significantly smaller proportion of total physicians relative to MDs., which results in the total number of physicians (i.e., MDs and DOs combined) per 100,000 residents being lower in Alaska relative to the rest of the nation.

Chart 6.2
DOs Per 100,000 Residents by Year
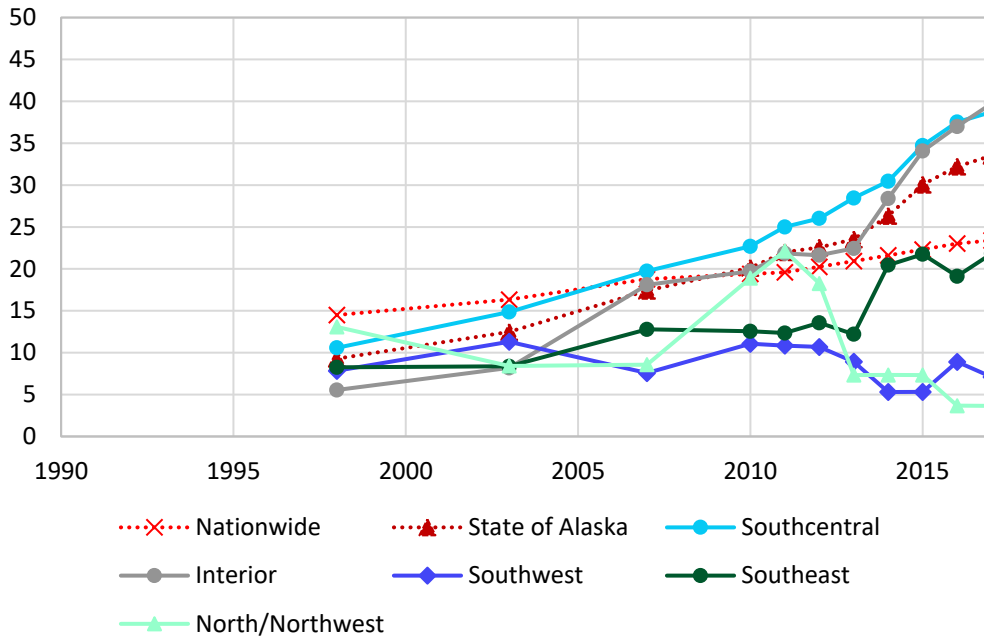
6.2.1. Physicians Involved in Patient Care

Charts 6.3 and 6.4 present the number of MDs and DOs, respectively, involved in patient care (i.e., hospital residents and physicians practicing in an office or hospital setting) per 100,000 residents.[30] The number of MDs involved in patient care per 100,000 residents in Southcentral Alaska is similar to the number of MDs involved in patient care per 100,000 residents nationwide, and has been since 2005. However, for the other geographic areas in Alaska, the number of MDs involved in patient care per 100,000 residents is significantly lower and has either remained the same or decreased slightly since 2005.

The number of DOs involved in patient care per 100,000 residents statewide has exceeded the number of DOs involved in patient care per 100,000 residents nationwide due to significant increases in the Southcentral and Interior geographic areas of Alaska. The number of DOs involved in patient care per 100,000 residents is significant lower in the Southwest and North/Northwest geographic areas of Alaska.

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[30] Most physicians are involved in patient care. In 2017, approximately 93% of physicians were involved in patient care.

Chart 6.3
MDs Involved in Patient Care Per 100,000 Residents by Year

Legend: Nationwide, State of Alaska, Southcentral, Interior, Southwest, Southeast, North/Northwest

Chart 6.4
DOs Involved in Patient Care Per 100,000 Residents by Year

Legend: Nationwide, State of Alaska, Southcentral, Interior, Southwest, Southeast, North/Northwest
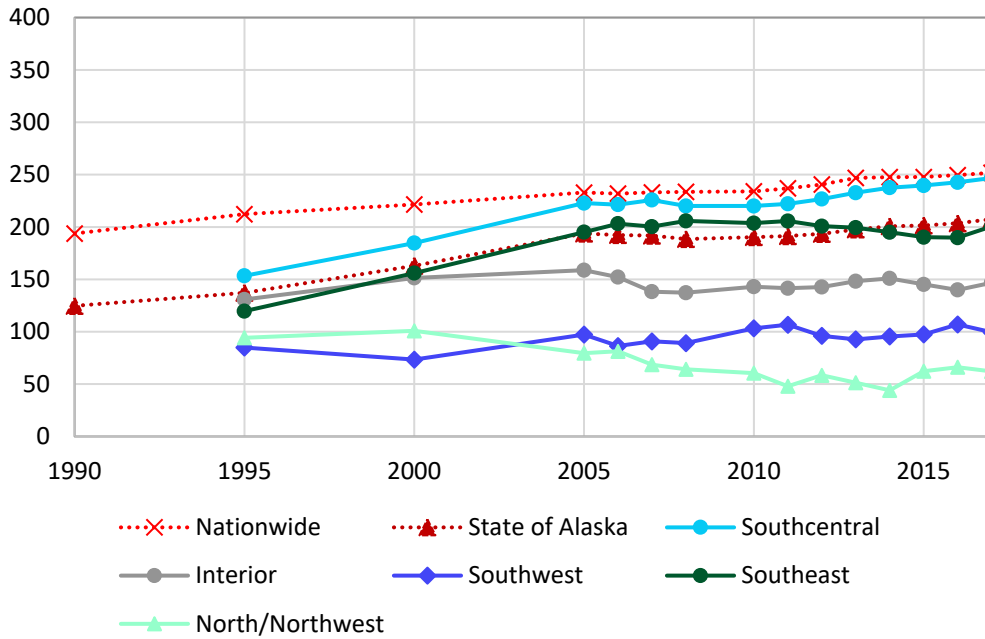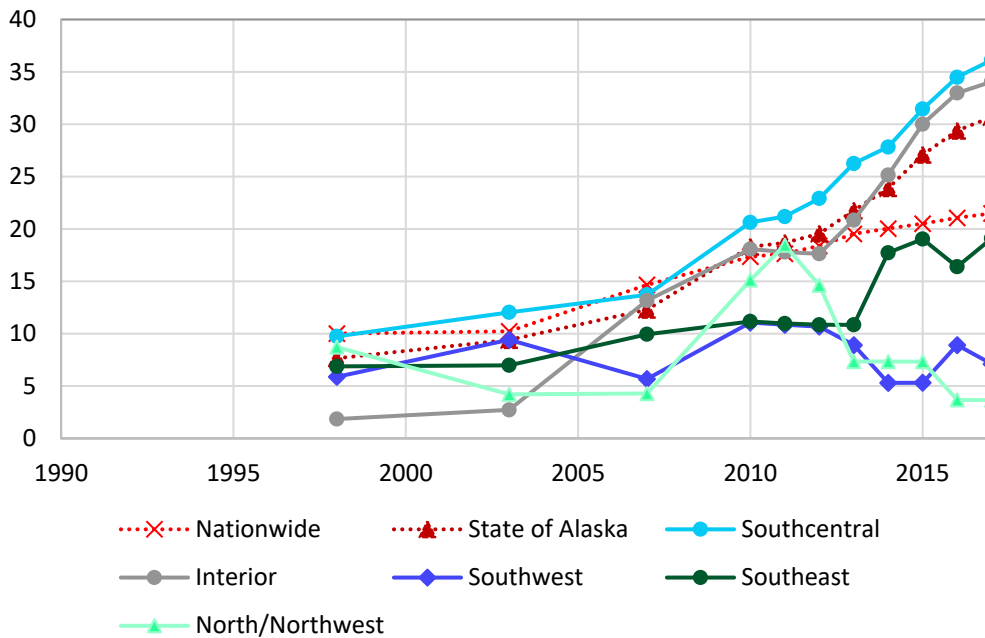
6.2.2. Physicians Not Involved in Patient Care

Charts 6.5 and 6.6 present the number of MDs and DOs, respectively, not involved in patient care (e.g., physicians working in an administrative, research, or teaching position) per 100,000 residents. The number of MDs not involved in patient care per 100,000 residents has been consistently lower in Alaska relative to the rest of the nation. This is likely, at least in part, due to a greater prevalence of academic medical centers and teaching hospitals per 100,000 residents in other parts of the nation.

The number of DOs not involved in patient care per 100,000 residents is slightly higher in Alaska relative to the rest of the nation. However, there is significant variation in this relationship by geographic area and year.

The results by geographic area show significant variation due to the relatively low volumes of physicians not involved in patient care.

Chart 6.5
MDs Not Involved in Patient Care Per 100,000 Residents by Year

Chart 6.6
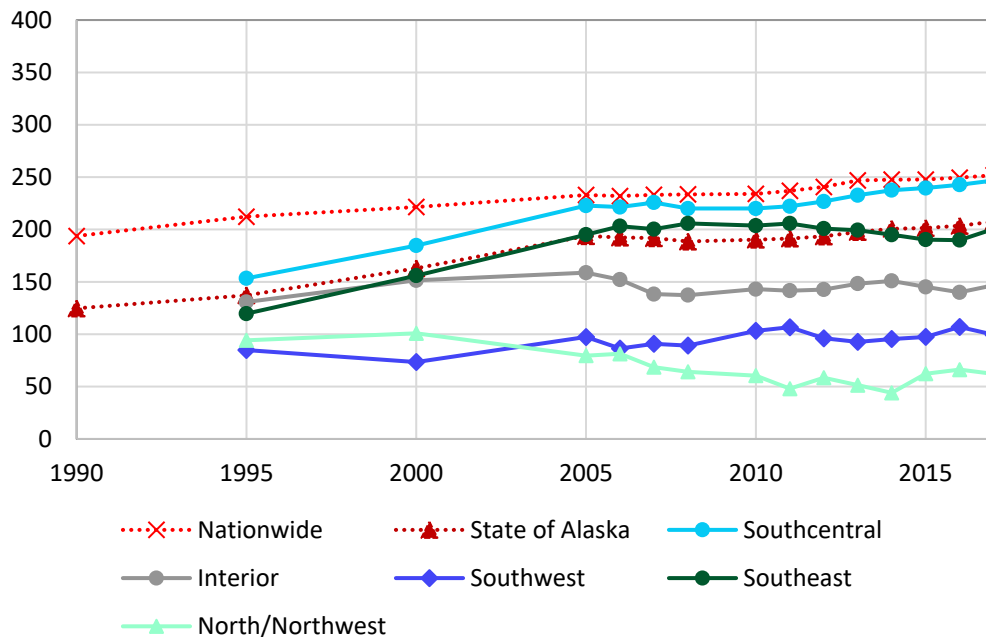**DOs Not Involved in Patient Care Per 100,000 Residents by Year**
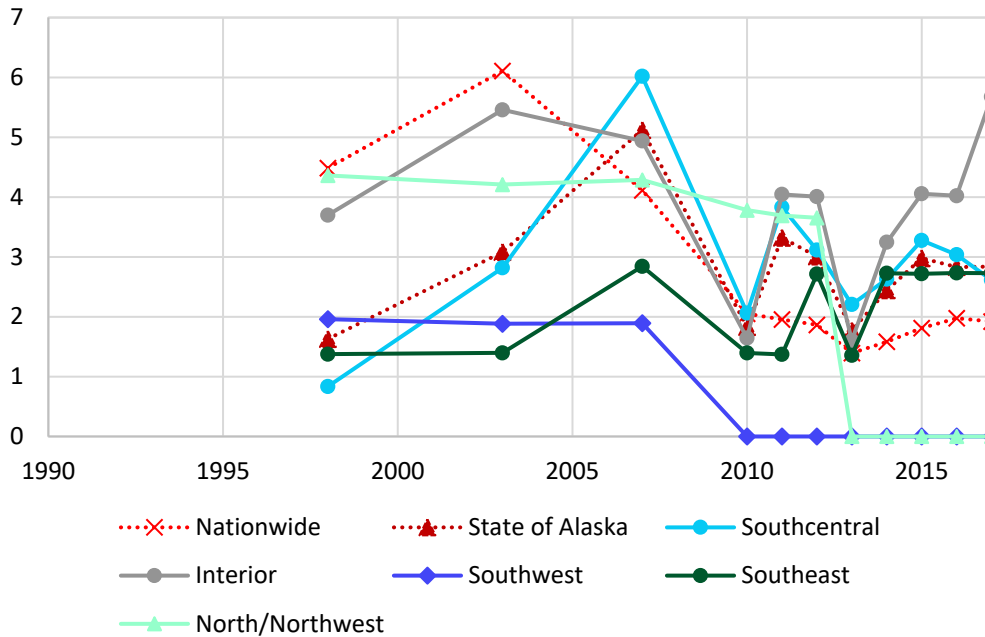
While the number of MDs working in an administrative, teaching, or research position could be summarized, the results are volatile by geographic area. Additionally, the information is not available for DOs. In 2010, approximately 1.5% of MDs in Alaska identified themselves as being in an administrative position which is comparable to the rest of the nation (1.5%). By 2017, 1.1% of MDs. in Alaska identified themselves as being in an administrative position, which is similar to the rest of the nation (1.2%).

6.2.3. Physicians by Provider Specialty Grouping

Physicians involved in patient care were categorized into one of three provider specialty groups: primary care, special specialists, and other specialists. Primary care includes the general family medicine, general practice, general internal medicine, and general pediatrics specialties. Special specialists include the allergy, anesthesiology, cardiology, emergency medicine, neurology, pathology, psychiatry, radiology, and radiology oncology specialties. Other specialists represent all other provider specialties not included in the primary care and special specialist categories.

Charts 6.7 and 6.8 present the number of primary care MDs and DOs., respectively, per 100,000 residents. The number of primary care MDs and DOs is lowest in the North/Northwest geographic area of Alaska. However, in many geographic areas, the number of primary care MDs and DOs per 100,000 residents is similar to or higher than the number of primary care physicians per 100,000 residents nationwide.

Chart 6.7
Primary Care MDs Per 100,000 Residents by Year
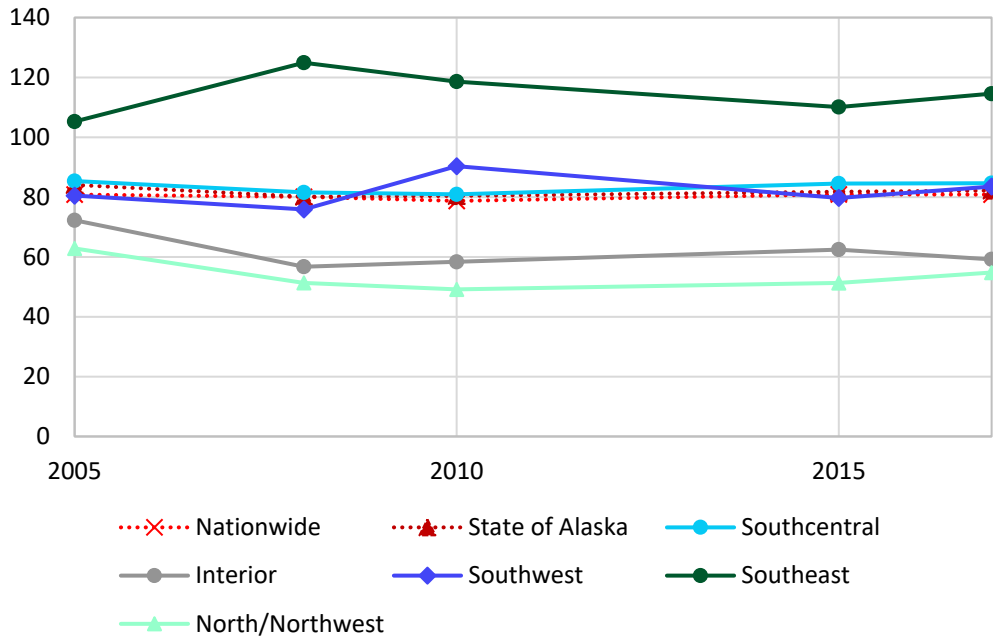
Chart 6.8
Primary Care DOs Per 100,000 Residents by Year
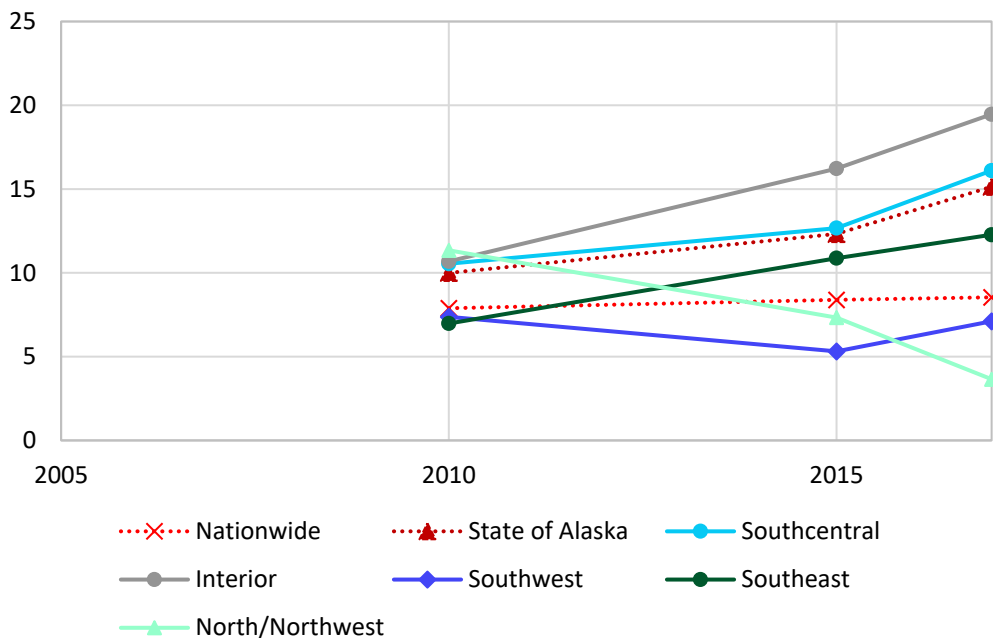
Charts 6.9 and 6.10 present the number of MDs for the special specialists and the other specialists groupings. The data for DOs could not be summarized since the data was not available to identify special specialists in the same manner as MDs. While the number of MDs per 100,000 residents for the special

specialists and other specialists groupings in Southcentral Alaska are similar to the rest of the nation, there are fewer MDs per 100,000 residents in these specialty groupings in the remaining geographic areas of Alaska, particularly in the Southwest and North/Northwest geographic areas.

Chart 6.9
Special Specialist MDs per 100,000 Residents by Year
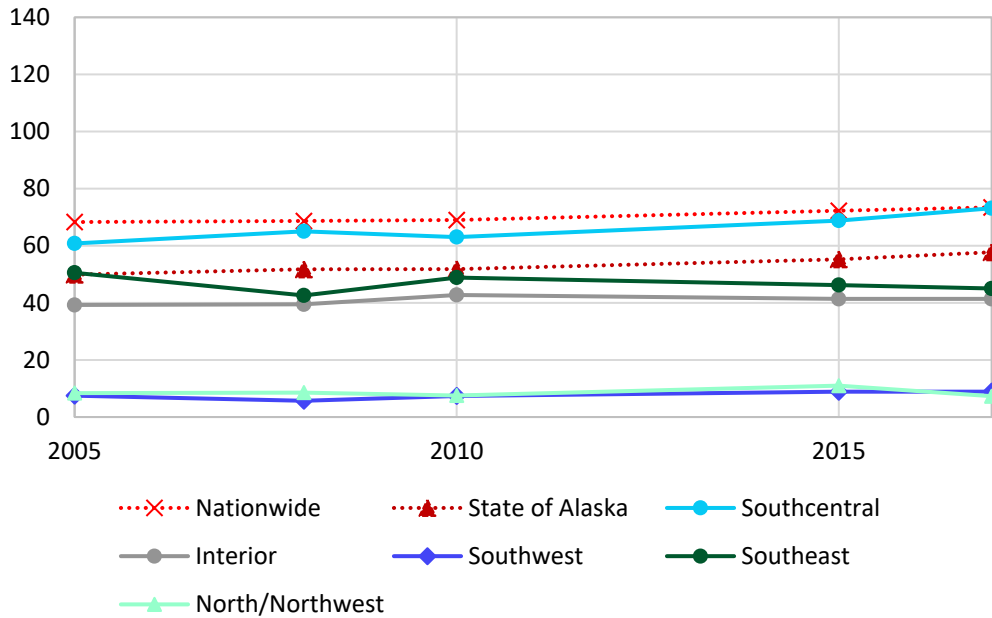
Chart 6.10
Other Specialist MDs per 100,000 Residents by Year
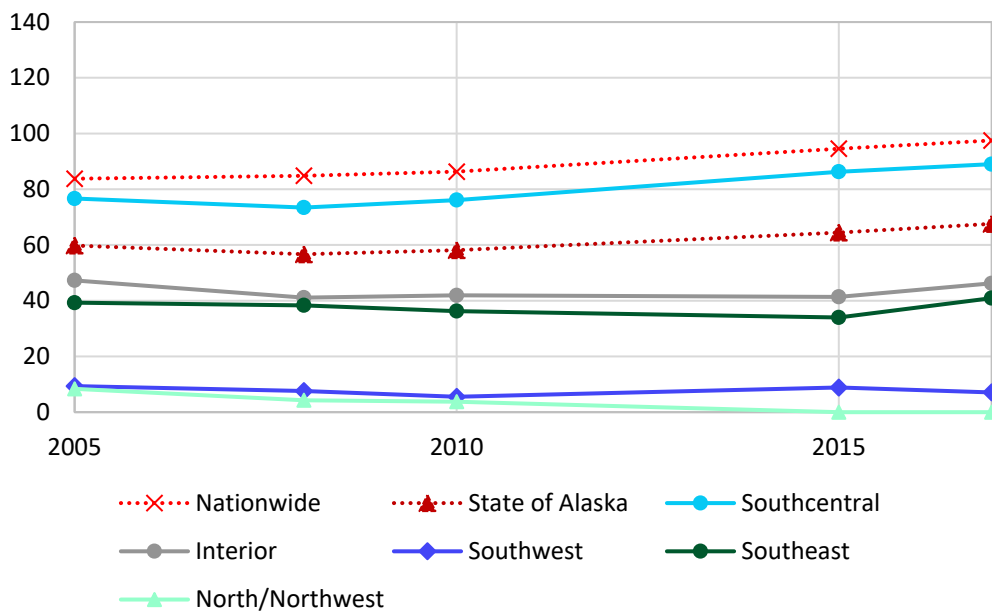
6.3.   Facility Analysis

In this section, we present estimates of the number of facilities in Alaska. Data pertaining to hospitals is based on information from the American Hospital Association. Data pertaining to other health care facilities is based on information from the Center for Medicare and Medicaid Services' (CMS) Quality Improvement Evaluation System database and CMS' Online Survey and Certification Reporting System; only Medicare-certified facilities are reflected. It should be noted that some facilities may have multiple designations (e.g., a hospital identified as a Federally Qualified Health Center (FQHC)).

6.3.1. Hospital Facilities

Charts 6.11 and 6.12 present the number of hospital facilities and hospital beds per 100,000 residents in Alaska, respectively. While the number of hospital facilities per 100,000 residents in every geographic area is higher in Alaska relative to the rest of the nation, the average number of beds per hospital facility is lower. As shown in Chart 6.12, the number of hospital beds per 100,000 residents in Alaska in recent years is lower in most geographic areas, except for the Southcentral and Southeast geographic areas, relative to the rest of the nation.

Chart 6.11
Hospital Facilities Per 100,000 Residents
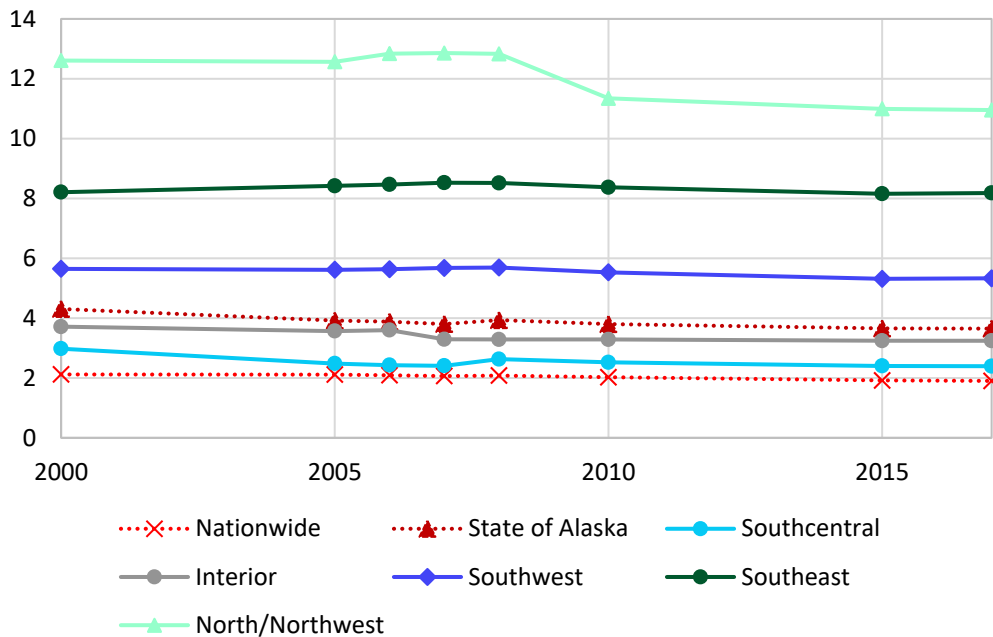
Chart 6.12
Hospital Beds Per 100,000 Residents
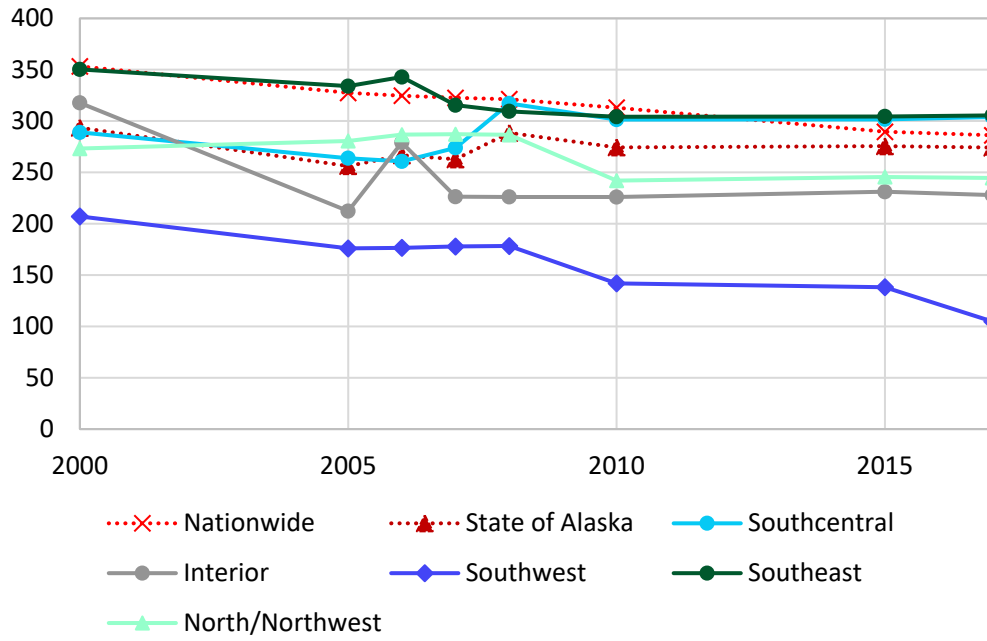
6.3.2. Skilled Nursing Facilities

Chart 6.13 presents the number of skilled nursing facilities per 100,000 residents. Overall, the number of skilled nursing facilities per 100,000 residents has increased slightly over time in Alaska, whereas nationwide the number of skilled nursing facilities per 100,000 residents has decreased slightly. The large increases observed in the North/Northwest and Southeast geographic areas of Alaska are the result of there being a low number of skilled nursing facilities in those geographic areas, and the number of facilities in each geographic area increasing by one.

Chart 6.13
Skilled Nursing Facilities Per 100,000 Residents
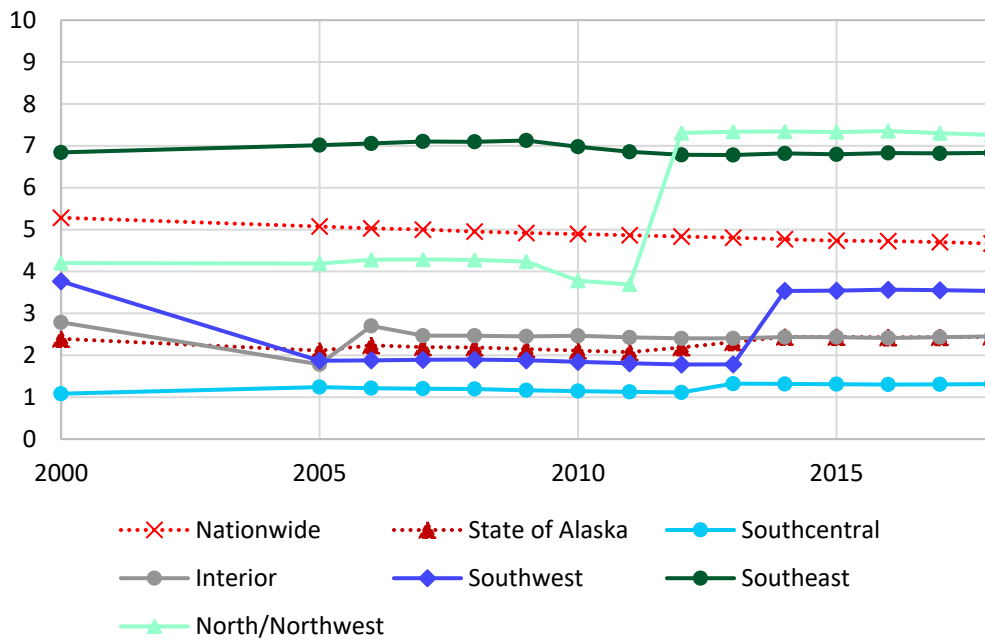
6.3.3. Home Health Agencies

Chart 6.14 summarizes the number of home health agencies per 100,000 residents. The number of home health agencies per 100,000 residents has generally decreased in Alaska since 2005, whereas nationwide, the number of home health agencies per 100,000 residents has generally increased. No home health agencies were reported in the Southwest and North/Northwest geographic areas of Alaska in 2017.

Chart 6.14
Home Health Agencies Per 100,000 Residents
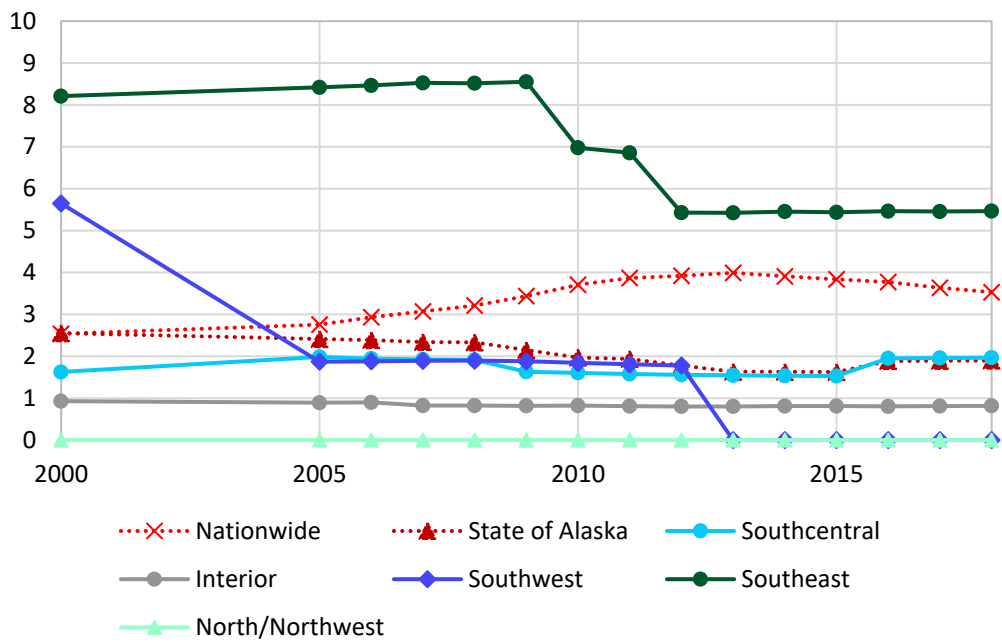
6.3.4. Hospice Facilities

Chart 6.15 summarizes the number of hospice facilities per 100,000 residents. Since 2010, the number of hospice facilities per 100,000 residents has increased in Alaska, consistent with nationwide trends. No hospices were reported in the Southwest and North/Northwest geographic areas of Alaska in 2017.

Chart 6.15
Hospice Facilities Per 100,000 Residents
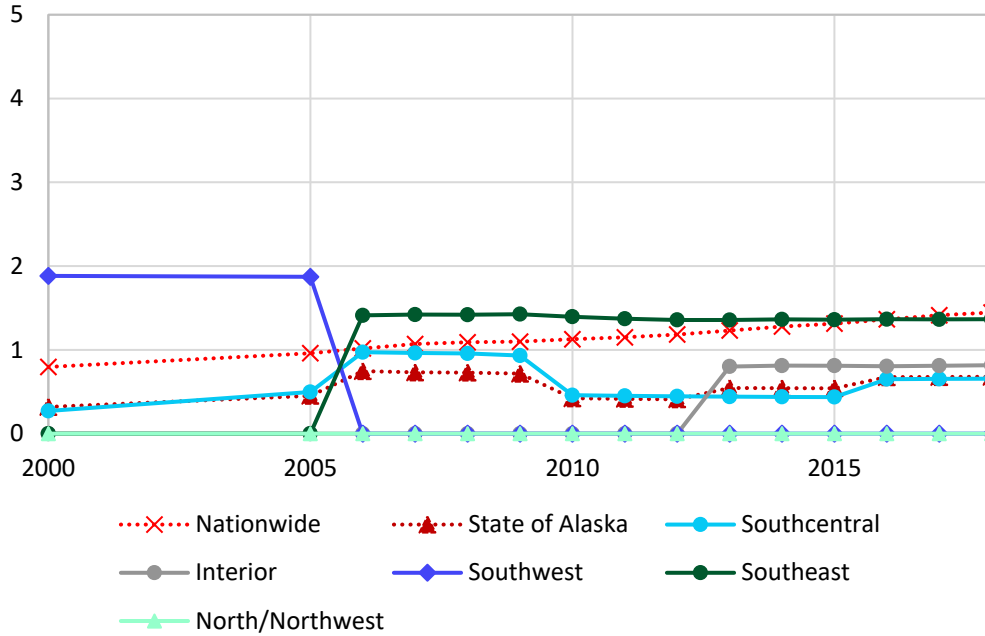
6.3.5. Ambulatory Surgical Centers

Chart 6.16 presents the number of ambulatory surgical centers per 100,000 residents. The number of ambulatory surgical centers per 100,000 residents has increased in Alaska since 2010, whereas nationwide the number of ambulatory surgical centers per 100,000 residents not changed materially over the same time period. No ambulatory surgical centers were reported in the North/Northwest and Southwest geographic areas of Alaska in 2017.

Chart 6.16
Ambulatory Surgical Centers Per 100,000 Residents
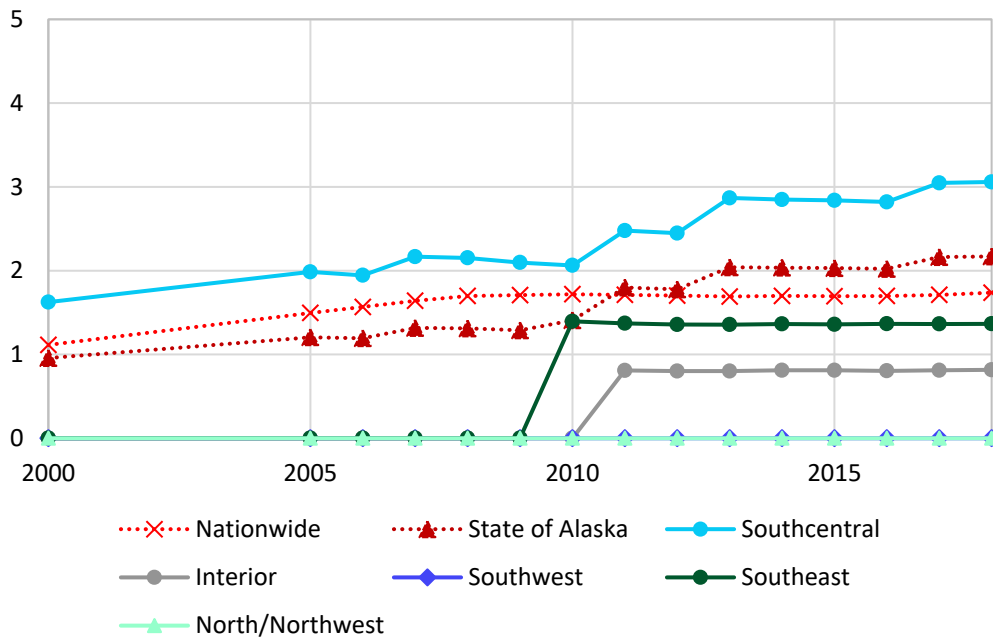
6.3.6. Community Health Centers

According to the AHRF documentation, "Community Health Centers are Health Center Program grantees that receive funding to target a generally underserved community or population." Based on information from the Congressional Research Service, "All federal Health Center Program grantees may be designated as federally qualified health centers (FQHC)."[31] Data pertaining to community health centers is not available in the 2011 and 2019 AHRF datasets prior to 2013, and while the AHRF includes information on FQHCs prior to 2013, only a subset of FQHCs appear to be reflected in the data.[32]

Chart 6.17 presents the number of community health centers per 100,000 residents and does not reflect information for FQHCs prior to 2013. As shown in Chart 6.17, the number of community health centers per 100,000 residents is significantly higher in Alaska relative to the rest of the nation. This is likely driven by Alaska being less populous than the rest of the nation, and in our experience, less populous and rural areas tend to be more frequently identified as medically underserved areas, relative to urban areas.

Chart 6.17
Community Health Centers Per 100,000 Residents

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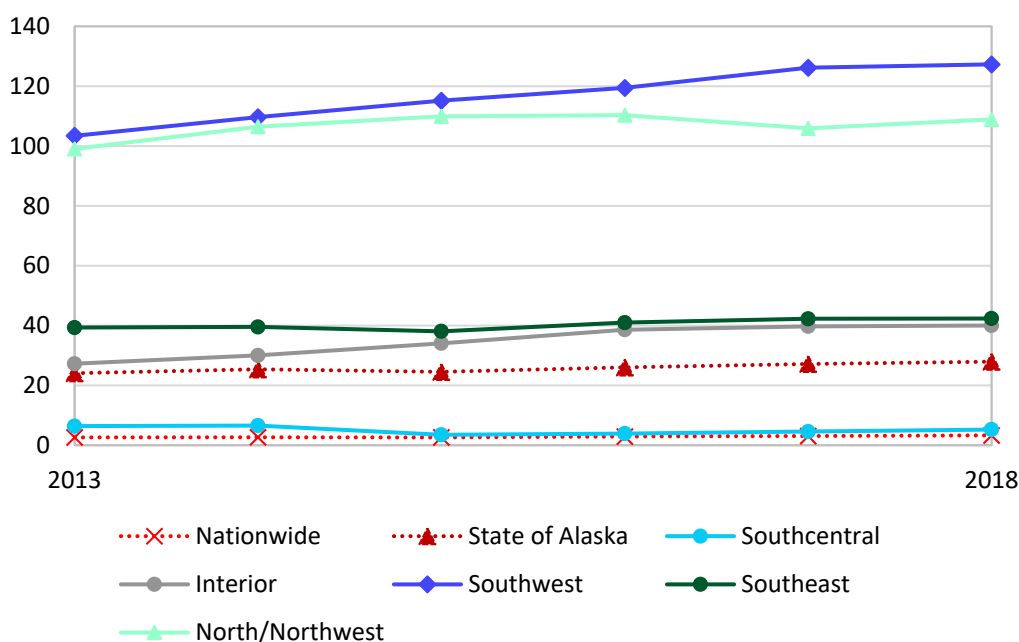
[31] Congressional Research Service. *Federal Health Centers: An Overview.* CRS.gov, May 19, 2017. https://fas.org/sgp/crs/misc/R43937.pdf.

[32] According to the AHRF documentation, FQHCs are identified based on Health Care Financing Administration (HCFA) category of provider whereas community health centers appear to capture most FQHCs in Alaska.

7. HOSPITAL COST SHIFTING

According to Health Affairs, cost shifting occurs when a hospital increases its price for some payers (to a level that is above cost) in order to compensate for shortfalls in reimbursement received from other payers (who are paying below cost), to ensure that they collect enough revenue in total to cover their operating expenses.[33] Reimbursement shortfalls are typically driven by lower reimbursement levels from public payers (e.g., Medicare), and uncompensated care. While providers may be able to offset some of this shortfall through increased efficiency, at some point additional reductions in services may begin to compromise the quality of care.

In this section, information from the Medicare Cost Reports as reported to the Healthcare Cost Report Information System[34] was summarized to estimate the level of cost shifting that may have occurred among non-tribal hospitals[35] in Alaska in Fiscal Year 2013 (FY 2013) and FY 2018. FY 2013 provides a view of cost shifting that occurred prior to the expansion of Medicaid and the implementation of the major provisions of the ACA (e.g., guarantee issue, premium subsidies). The most recent publicly available Medicare Cost Reports are for FY 2018. The analysis compares payments and costs by payer type, along with uncompensated care, for fifteen non-tribal hospitals for each fiscal year.[36] Please note that our analysis only captures the impact of cost shifting from these fifteen hospitals; the impact from tribal hospitals or other sectors of the Alaskan health care system (e.g., professional or ancillary services) are not included in the analysis.

Uncompensated care is typically the largest driver of hospital cost shifting, and is an overall measure of care provided by hospitals for which no payment was received from the patient or a payer. CMS defines uncompensated care as charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients that do not meet the hospital's charity care policy, discounts given to uninsured patients that do not meet the hospital's financial assistance policy, or bad debt reimbursed by Medicare.[37] A hospital incurs bad debt when it cannot obtain reimbursement for care provided.[38] The Emergency Medical Treatment and Labor Act (EMTALA) requires that hospitals treat individuals that present themselves in the emergency department, including providing emergency care and hospitalization if required, regardless of their ability to pay. EMTALA includes both care provided in the emergency room, as well hospitalization, if required. Services provided under EMTALA can represent a significant portion of a hospital's bad debt.

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[33] Dobson, DaVanzo, and Sen (2006). *The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications.* Health Affairs Vol. 25, No. 1 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.1.22

[34] Centers for Medicare and Medicaid Services. Cost Reports. CMS.gov, January 21, 2019. Accessed March 31, 2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports

[35] Hospitals operated by Native health organizations are not required to file Schedule S-10 which is where charity care and bad debt are reported. Therefore, hospitals operated by Native health organizations have not been included in the analyses.

[36] The following hospitals were included in the analysis: Alaska Regional Hospital, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Fairbanks Memorial, Ketchikan Medical Center, Mat-Su Regional Medical Center, Petersburg Medical Center, Providence Kodiak Island Medical Center, Providence Alaska Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, and Wrangell Medical Center.

[37] Centers for Medicare and Medicaid Services. *Chapter 40 Hospital and Hospital Health Care Complex Cost Report (Form CMS-2552-10).* CMS.gov. Accessed April 9, 2020. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html.

[38] American Hospital Association. *Fact Sheet: Uncompensated Hospital Care Cost.* aha.org, January 2020. Accessed March 31, 2020. https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost

Higher payments from private payers can exceed a hospital's costs for delivering care to those patients by a considerable amount, allowing the excess to finance Medicare and Medicaid underpayments, as well as uncompensated care. Table 7.1 shows payments, costs, and the ratio of payments to costs (payment-to-cost ratio) for hospitals by payer type in FY 2013 and FY 2018. Given the significant presence of tribal hospitals in Alaska, particularly in the less populous rural areas, the amount of uncompensated care provided in Alaska is understated, and this understatement may potentially be significant.

Table 7.1
Payments and Costs for Hospitals in Alaska (in $ Millions)

	FY 2013				FY 2018			
	Payments	**Costs**	**Surplus/ (Shortfall)**	**Payments/ Costs**	**Payments**	**Costs**	**Surplus/ (Shortfall)**	**Payments/ Costs**
Private Payer/ Other	1,108	845	263	1.312	1,221	889	332	1.374
Medicare	299	338	(39)	0.885	415	449	(34)	0.924
Medicaid/Other Government	221	218	3	1.012	351	339	12	1.036
Uncompensated Care	0	94	(94)	N/A	0	57	(57)	N/A
Total	1,628	1,496	133	1.089	1,987	1,733	254	1.146

A number of observations can be made from the information in Table 7.1:

- Payments from private payers to hospitals significantly exceeded costs for those services, and the ratio of payments to costs increased slightly between FY 2013 and FY 2018.

- While payments received by hospitals from Medicare were less than the amount needed to cover costs in both periods, payments covered a larger portion of costs in FY 2018 than they did in FY 2013.

- Medicaid payments covered hospitals' costs in both FY 2013 and FY 2018.

- Uncompensated care provided by hospitals decreased significantly between FY 2013 and FY 2018, from $94 million to $57 million; this is a direct result of fewer uninsured individuals due to expansion of Medicaid eligibility in Alaska and the introduction of premium subsidies in the individual ACA market.

- The decrease in uncompensated care, combined with increased payments relative to costs for services covered by private payers, Medicare and Medicaid, led to an increase in hospitals' overall payment-to-cost ratio between FY 2013 and FY 2018, with payments exceeding costs by 8.9% in FY 2013 and payments exceeding costs by 14.6% in FY 2018.

Charts 7.1 and 7.2 provide a pictorial view of the relationship between payments and costs associated with hospitals, for each payer type and year. In each chart, the width of each bar represents the percentage of hospital's total costs represented by that payer type. The height of the bar represents the payment-to-cost ratio. A line has been drawn to correspond with a 1.0 payment-to-cost ratio, indicating the level at which payments equal costs. The portion of a bar that exceeds the line represents payments

received by the hospitals in excess of their costs. For those bars that are below the line, the area by which the bar falls below the line represents the amount by which payments fall short of covering costs.

While hospitals' total costs across all payers grew between FY 2013 and FY 2018, Charts 7.1 and 7.2 show that services covered by private payers represented a smaller percentage of total costs in FY2018 than they did in FY2013. Further, Medicare and Medicaid grew as a percentage of total costs, driven by an aging population in Alaska, and more individuals becoming eligible for Medicaid.

Chart 7.1
FY 2013 Payment-to-Cost Ratio by Payer Type
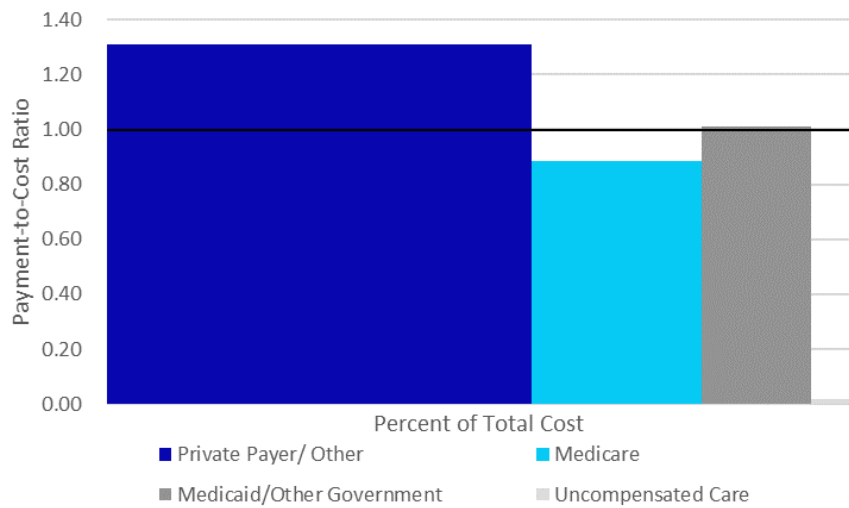
The height of the bar for uncompensated care is zero

Chart 7.2
FY 2018 Payment-to-Cost Ratio by Payer Type
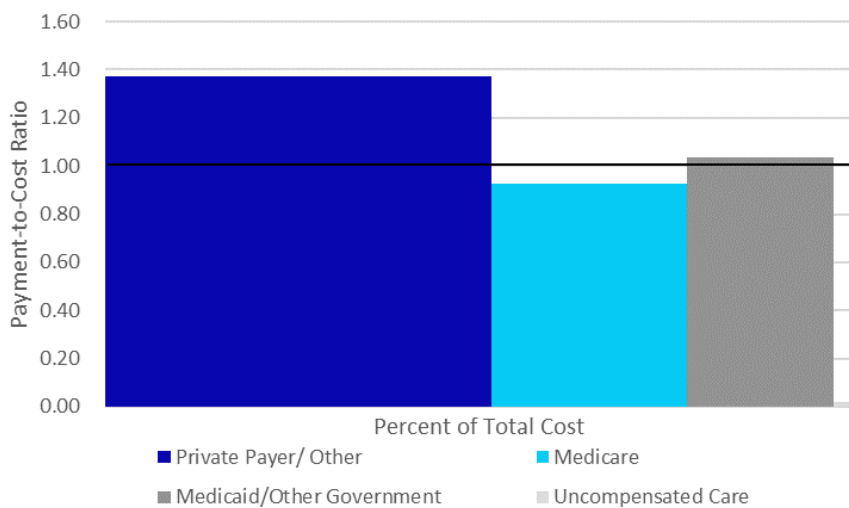
The height of the bar for uncompensated care is zero

Table 7.2 compares the FY 2013 and FY 2018 total uncompensated care for hospitals to the total Alaska population, along with the annual cost of uncompensated care per resident. Uncompensated care per resident decreased 40% over this period.

Table 7.2
Annual Cost of Uncompensated Care per Resident

	FY 2013	FY 2018
Uncompensated Care	$94,407,855	$56,977,960
Alaska Population	737,045	737,438
Uncompensated Care per Resident	$128	$77

8.   ANALYSIS OF ACA MARKET POLICY OPTIONS

Increasing access to affordable health care coverage is vital to attracting a broad base of individuals that elect coverage, and the success of the health insurance markets. As part of our work for the Division, we were asked to analyze the impact that various policy changes, if implemented, may be expected to have on enrollment and premium rates in the individual and small group ACA markets, as well as the potential cost to the State for each policy change. The policy changes that were modeled are as follows:

1.   Merging the individual and small group ACA markets into a single risk pool

2.   Extending premium subsidies in the individual market to income ranges above 400% FPL, and in some cases modifying the Applicable Percentage[39] that higher income individuals currently eligible for subsidies must pay for the second-lowest cost silver plan

3.   Varying by age the Applicable Percentage that a subsidy-eligible individual must pay for the second-lowest cost silver plan in the individual ACA market

To assess how the policy changes described above might be expected to impact the health insurance markets in Alaska, we used the Oliver Wyman Healthcare Reform Microsimulation Model (HRM Model). In this section of the report, we provide an overview of the HRM Model, a description of the scenarios that were modeled, and a summary of the results.

The results, which represent our best estimate based on the information made available for the analysis, reflect point estimates. There is significant uncertainty with respect to future enrollment and premiums in the health insurance markets, and actual experience will likely differ from that which is being modeled in this analysis. As more up-to-date information becomes available, or if the information we utilized is determined to be inaccurate, our findings and conclusions may need to be revised. Should the State wish to explore one of the modeled policy options further, we recommend more refined modeling be completed that utilizes the most recent information available, incorporates feedback from key stakeholders (e.g., insurers, the Federal government, etc.), and performs sensitivity testing around key assumptions.

8.1.   Overview of the Oliver Wyman HRM Model and Data Sources Used

The Oliver Wyman HRM Model was utilized to examine the impact each policy change would have on the health insurance markets in the state of Alaska, relative to the 2020 baseline scenario, if the change had been implemented in 2020. The HRM Model is an economic utility model that captures the flow of individuals across various health insurance markets based on their economic purchasing decisions. It is integrated with actuarial modeling designed to assess the impact that various policy changes are expected to have on the health insurance markets.

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[39] Individuals and families eligible for premium subsidies pay a specified percentage of their household income, known as the Applicable Percentage, for the second lowest cost silver plan available to them through the FFM. The Federal government provides a premium subsidy for any premium amount above the Applicable Percentage of household income.

The population underlying the HRM Model is based on ACS data. The ACS data provides detailed information for each individual in a surveyed household unit, including demographic, socioeconomic, geographic, and employment information. The data also provides information regarding health insurance coverage types. The ACS data was supplemented and synthesized with several other data sources, including information from an insurer data call issued by the Division to all health insurers offering fully-insured coverage in Alaska's individual, small group, or large group markets in 2017, 2018, or 2019.

The insurer data call collected detailed information for each market segment, including premium, claims, and enrollment data from January 2017 through June 2019. This information was used to aid in calibrating the HRM Model. The information from the insurer data call was further augmented with information from a number of other sources (e.g., statutory financial statements, medical loss ratio (MLR) report data, CMS' Open Enrollment Period data, etc.) to validate the insurer data that was provided, and to gather additional information utilized in our modeling but not captured through the insurer data call (e.g., the distribution of individuals enrolling through the federally facilitated marketplace (FFM), by income range).

Health status was assigned to various sub-populations within the HRM Model based on a statistical analysis of self-reported health status obtained from the Current Population Survey (CPS) data. The CPS data includes a self-reported health status indicator as well as fields classifying income, age, gender, geography, coverage type, and other categories. Respondents to the survey classify their health into one of five categories: excellent, very good, good, fair and poor. The model reflects these classifications numerically by assigning a calculated morbidity load to each category.

Information from the Agency for Health Care Research and Quality's Medical Expenditure Panel Survey (MEPS) Insurer/Employer Component was used to simulate the Alaska employer-based market. MEPS identifies key statistics for the employer-based market for every state by group size, including statistics related to health insurance coverage such as employer offer rates, employee take-up rates, and self-funding rates among employers. Individuals in the ACS data identified as working for private employers were categorized into employer group size segments based on the distribution of employees by group size according to MEPS.

The economic utility functions underlying the HRM Model were calibrated such that the calibrated model replicates the known number of individuals in each of the individual, employer-based, and uninsured markets in Alaska for 2017, 2018, and 2019. The various parameters of the HRM Model's utility functions were then further adjusted until the model also projected individual and small group market enrollment in each of 2017, 2018, and 2019 that was consistent with key characteristics of the actual enrollees in each market for each year (e.g., by age range, income range, etc.).

Average claim costs were calibrated and adjusted on an overall basis using information provided in the insurer data call, statutory financial statements, and other public data sources. For 2019 and beyond, claim costs within the HRM Model were trended forward assuming an average annual claims trend rate equal to 9.0%. While this is a higher trend rate than we typically observe in the commercial health insurance markets, we believe trend rates are higher in Alaska relative to the rest of the country based on information from insurer rate filings in Alaska and our prior review of information published by

National Health Expenditure Data (NHED).[40] Member cost sharing and incurred claims were calculated by the HRM Model, with member cost sharing capped at the maximum annual limitation on cost sharing for each year.

Actual lowest-cost premium rates for Alaska's individual and small group ACA markets from 2016 through 2020 were utilized within the HRM Model. Premium data was based on information from insurer rate filings made available by the Division and public use files from data.healthcare.gov. In 2019 and 2020, an off-Exchange only silver plan was available in the Alaska individual ACA market that did not reflect a load to account for the lack of Federal funding for CSR subsidies, often referred to as "silver loading."[41] As a result, we included an off-Exchange only silver plan option in the HRM Model for 2019 and 2020. It should be noted that premium rates in the individual ACA market from 2017 through 2020 reflect the presence of the Alaska Reinsurance Program (ARP). Premium rates for the individual non-ACA and employer-based markets from 2016 through 2020 were estimated using information from the insurer data call, statutory financial statements, insurer rate filings made available by the Division, and other public data sources.

Federal premium subsidies for eligible individual ACA market enrollees were assumed to change each year based on changes in premium rates for the second lowest cost silver plan available in each rating area and changes in the Applicable Percentage Tables as published by the Internal Revenue Service (IRS).

The HRM Model assumes a "steady state" population. This means the overall distribution by income as a percentage of FPL, health status, employer size, and family composition of the population being modeled is not expected to change significantly from year to year. The model also assumes the modeled policy changes will have no significant impact on the number of Alaskans covered under Medicaid, Medicare, or other public programs.

Additional adjustments were applied to the modeled results to reflect anticipated population growth within the state of Alaska, using information from the Alaska Department of Labor and Workforce Development. Lastly, the HRM Model output assumes there will be no significant insurer entries or exits, and there will be no significant legislative changes at the State or Federal level that would impact the insurance markets.

8.2.   Baseline Scenario

In the baseline scenario, separate individual and small group market risk pools are maintained, and the current Federal premium subsidy structure remains in effect. Additionally, the ARP, which was implemented in the individual ACA market in 2017, is modeled to remain in place for 2020.

Chart 8.1 summarizes actual enrollment in the individual market in 2017, 2018, and 2019, along with the projected enrollment for 2020 using the HRM Model, under the baseline scenario.

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[40] State of Alaska Department of Commerce, Community, and Economic Development Division of Insurance. *Alaska 1332 Waiver Application.*
https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033

[41] "Silver loading" refers to the practice of insurers loading the premium rates for silver plans offered through the Exchange to account for the cost associated with CSR subsidies no longer being funded by the Federal government.

Chart 8.1
Average Individual Market Enrollment by Year (in 1,000s)
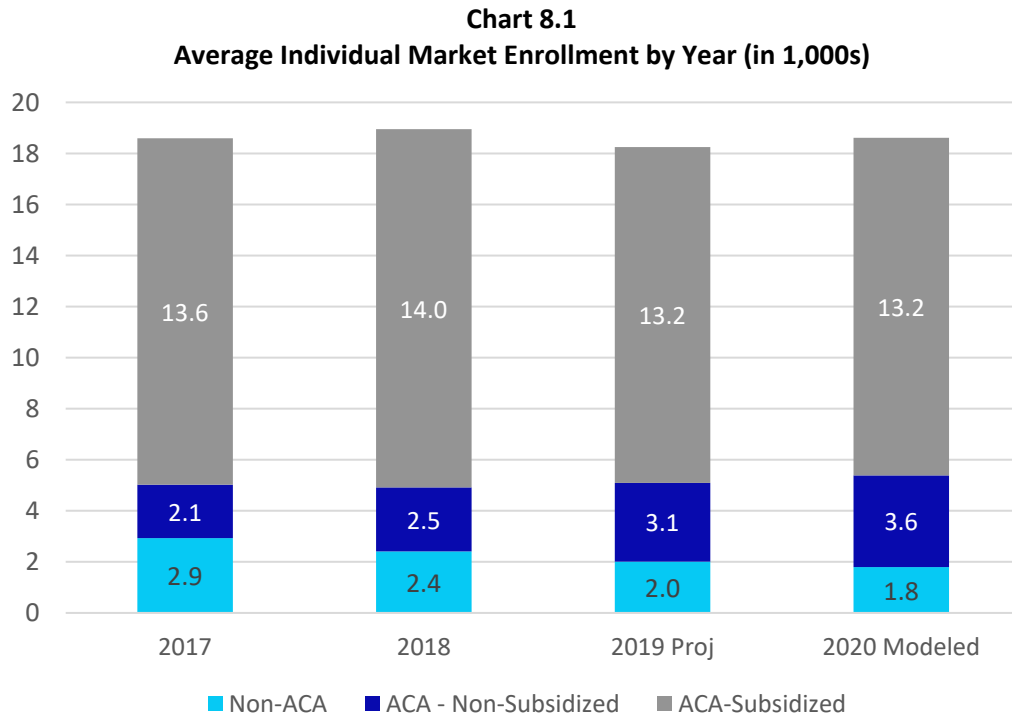
Chart 8.1 shows that enrollment in non-ACA plans has decreased since 2017, whereas enrollment in individual ACA plans for non-subsidized enrollees has increased. Since individual non-ACA plans represent a closed block of policies (i.e., no new policies have been issued since late 2013), we would expect enrollment in individual non-ACA plans to decrease over time as individuals gradually transition to other coverage types (e.g., age into Medicare, begin working for an employer that offers health insurance coverage, migrate to an ACA policy, etc.).

Growth in individual ACA non-subsidized enrollment is likely being driven by a reduction in individual ACA premium rates, resulting in some individual non-ACA enrollees migrating to individual ACA coverage and some uninsured individuals taking up health insurance coverage. The reduction in individual ACA-Subsidized enrollment in 2019 may be due to the elimination of the individual mandate penalty starting in 2019, among other factors. Total enrollment in the individual market has remained relatively stable between 2017 and 2019, and total enrollment for 2020 is projected to be similar to 2019.

Chart 8.2 summarizes actual enrollment in the small group market in 2017, 2018, and 2019, along with the projected enrollment for 2020 using the HRM Model.

Chart 8.2
Average Small Group Market Enrollment by Year (in 1,000s)
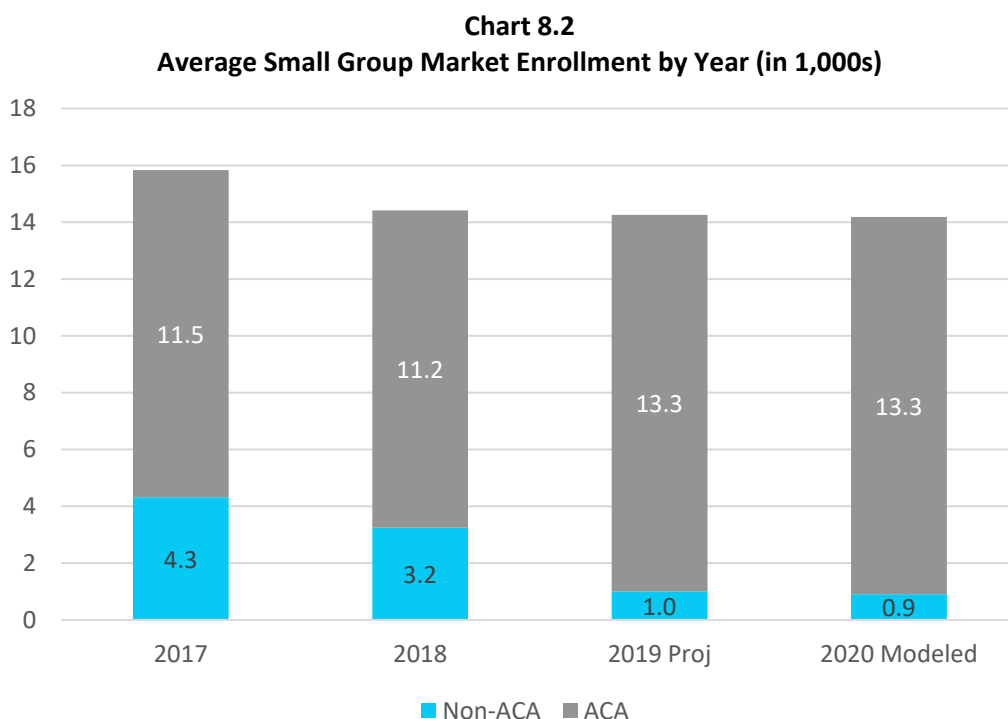
Chart 8.2 shows total enrollment in the small group market decreased from 2017 to 2018, but remained steady from 2018 to 2019, and is projected to remain steady in 2020. However, from 2017 to 2019, a significant decrease in small group non-ACA enrollment was observed, driven by Premera choosing not to renew small group transitional plans. Based on the data, it appears as though most groups previously enrolled in small group transitional coverage migrated to small group ACA plans.

8.3.   Merged Individual and Small Group Market

In the merged market scenario, the individual ACA and small group ACA market risk pools were assumed to be merged into one single risk pool. This means insurers participating in the individual and small group markets were assumed to offer the same benefit plans to individuals and families as they would offer to small employers. This also means that since premium rates would be based on the combined morbidity of both markets, premium rates for a given plan would be the same for both markets. However, only those individuals and families with incomes at or below 400% FPL not enrolling as part of a small employer group would be eligible for premium subsidies. The ARP was assumed to remain in place and authorized to reimburse insurers up to $69 million in claim costs in 2020 in the merged market for enrollees diagnosed with specified high-cost conditions. Additionally, only the ACA risk pools were assumed to be merged; transitional and grandfathered coverages were assumed to remain available to eligible enrollees as separate, unmerged risk pools.

Under the baseline scenario, premium rates in the individual ACA market in 2020 are modeled to be 17% lower than premium rates in the small group ACA market.[42] If the individual and small group ACA

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[42] Due to differences in the rating slopes in each market, the premium rate differential between the individual and small group markets varies by metal level.

markets in Alaska were merged, premium rates in the individual ACA market would be expected to increase by approximately 9%, whereas premium rates in the small group ACA market would be expected to decrease by approximately 9%. However, individual ACA market enrollees currently receiving premium subsidies would be largely sheltered from any premium rate increase associated with merging the individual and small group markets, since subsidies would be expected to increase if premium rates increased in the market.[43] Approximately 81% of individual ACA market enrollees received subsidies in 2019, and 79% are projected to receive premium subsidies in 2020 in the baseline scenario.[44]

Chart 8.3 summarizes the projected enrollment under the baseline and merged market scenarios.

Chart 8.3
Summary of 2020 Enrollment in the Unmerged and Merged Market Scenarios (in 1,000s)
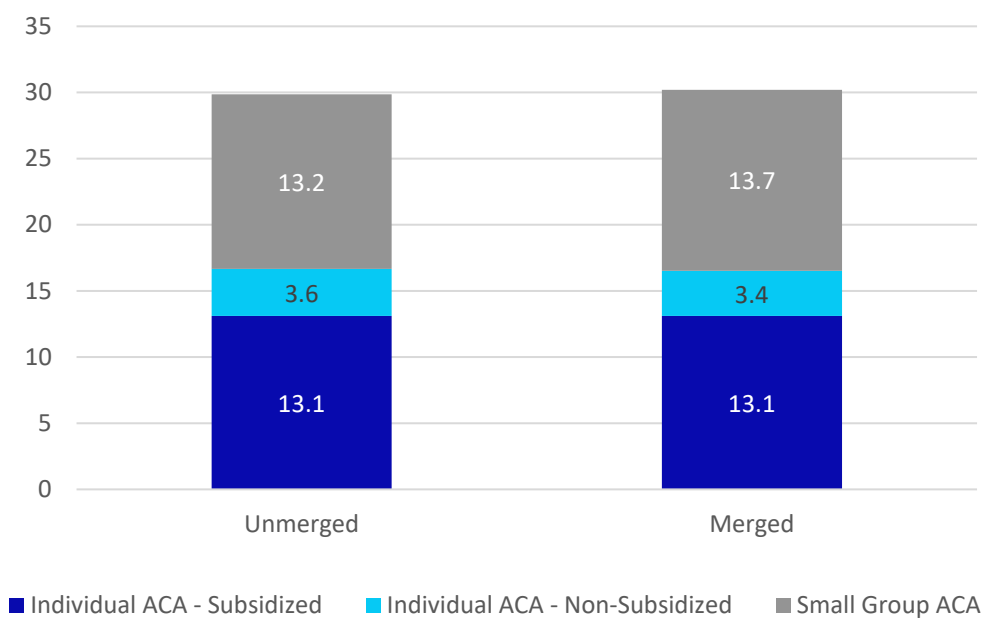
Enrollment in the small group ACA market is projected to increase nearly 4% (roughly 500 enrollees) under a merged market scenario as a greater proportion of employees take up coverage and a small number of employers would be expected to begin offering coverage as a result of lower premiums. However, enrollment in the individual ACA market is projected to decrease 1% (roughly 200 enrollees) as some non-subsidized individual market enrollees would be expected to drop their individual market

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[43] Individuals and families eligible for premium subsidies pay a specified percentage of their household income, known as the Applicable Percentage, for the second lowest cost silver plan available to them through the FFM. The Federal government provides a premium subsidy for any premium amount above the Applicable Percentage of household income. The Applicable Percentage varies by income in relation to FPL, and increases as household income increases, meaning households with higher incomes will pay higher premium rates relative to households with lower incomes. Individuals eligible for Medicaid are not eligible to receive premium subsidies. Additionally, individuals and families with access to affordable health insurance coverage through an employer are not eligible for premium subsidies.

[44] 2019 estimate based on information from the insurers data call; 2020 projected using output from the HRM Model.

coverage when faced with higher premiums. In total, the merged market is projected to result in a 1% increase (roughly 300 enrollees) in ACA enrollment relative to the baseline scenario.

Our modeling shows the average morbidity of the merged market would be similar to the average morbidity of the combined individual and small group ACA markets under the baseline scenario. While overall enrollment would be expected to increase under the merged market relative to the baseline scenario, most of the "new" enrollees are shown to be previously insured in the baseline scenario.

Our modeling assumes a portion of the premium reduction that would be observed in the small group market under a merged market scenario would be passed down to the employee, thereby reducing the employee contribution for health insurance. Some employees working for small group employers that offer health insurance have spouses who work for large group employers that offer health insurance coverage. When the employee contributions decrease in the small group market under the merged market scenario, a small number of households taking coverage in the large group market under the baseline scenario choose to take coverage in the small group market in the merged market because the economic utility becomes more favorable.

Additional consideration should be given to the impact that merging the individual and small group markets would be expected to have on Federal pass-through savings amounts associated with Alaska's current Section 1332 Waiver.[45] The ARP is authorized to reimburse insurers up to $69 million in calendar year 2020. In 2019, the ARP was fully funded by Federal pass-through savings that were generated as a result of reduced premium subsidies produced due to the reinsurance program. In 2020, the ARP is expected to be fully funded with Federal pass-through savings under the baseline scenario.[46] However, under the merged market scenario Federal pass-through savings are projected to be significantly lower as the difference in premium rates for individual ACA enrollees with and without the ARP under a merged market scenario would not be as large relative to the baseline scenario. This is due to the fact that insurers would be required to spread any reinsurance recoveries under the ARP across all enrollees covered in the merged market, both those covered as individuals and families and those covered through small employers.

We estimate that if the individual and small group ACA markets had been merged in 2020, Federal pass-through savings would have been approximately $29 million lower, with most of the additional cost being borne by the State. Additionally, the results of our modeling suggest the net cost to the State may be lower if the individual and small group ACA markets remain unmerged and a separate reinsurance

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[45] The State of Alaska implemented a state-based reinsurance program in calendar year 2017, the ARP, for the individual ACA market. Under the ARP, individual market insurers are allowed to cede the premium and claims of ACA enrollees with specified high cost conditions to the reinsurance program. The State of Alaska submitted and received approval for a Section 1332 Waiver, which went into effect starting in benefit year 2018. Under the approved Section 1332 Waiver, the State is allowed to receive Federal funding for any savings the ARP generates with respect to Federal spending. Since the ARP reduces premiums in the individual ACA market, the program reduces premium subsidies expended by the Federal government, and the premium savings, once offset by other reductions in Federal revenue (e.g., Exchange User Fees), are passed through to the State to help fund the ARP.

[46] Centers for Medicare and Medicaid Services. *2020 Pass-through Funding Estimate.* CMS.gov, January 10, 2020. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-AK-2020.pdf.

program was implemented in the small group market that would reduce small group ACA premium levels to the same premium level under the merged market scenario.[47]

8.3.1. Potential Advantages and Disadvantages of Merging the Individual and Small Group ACA Markets

There are several potential advantages and disadvantages of merging the individual and small group ACA markets. These include but are not limited to the following:

Potential advantages of merging the individual and small group ACA markets

- Premium rates would be expected to decrease approximately 9% for small group ACA enrollees, and subsidized individual market ACA enrollees would be expected to be largely sheltered from any rate increase observed as a result of merging the markets.

- A larger pool is created over which an insurer's costs can be spread, which could lead to greater risk stability; generally, the larger the risk pool, the lower the volatility in claim costs.

- The same products would be required to be sold to both individuals and small groups, which could reduce administrative expenses for insurers as they would need to maintain one product portfolio.

- Individuals that lose small group ACA coverage would be able to maintain their coverage if the same products are offered in the individual ACA market.

- Consumer choice could increase as insurers would be required to participate in both the individual and small group ACA markets; currently, four insurers participate in the small group ACA market, while only two of those insurers participate in the individual ACA market.

Potential disadvantages of merging the individual and small group ACA markets

- Premium rates would be expected to increase for a portion of individual ACA market enrollees, in particular those not eligible for premium subsidies.

- Insurers offering coverage in only one market today (i.e., individual or small group) may decide not to participate if they were required to participate in both markets.

- It may be more difficult to tailor products, customer service, and marketing in a merged market to meet the respective needs of the respective markets.

- Insurers would only be allowed to change rates in the small group market once per year.

- Merging the markets may require changes to administrative systems for insurers.

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[47] If the 2020 small group ACA premiums are reduced approximately 9% relative to the baseline scenario, the estimated program cost to the State would be approximately $13 million. However, the State's cost would be somewhat lower if the average morbidity in the small group ACA market was projected to improve as a result. Costs associated with administering a program to reduce premiums in the small group ACA market were not considered.

- The State's portion of the cost for the ARP would be expected to increase significantly due to lower pass-through savings, since the premium reduction due to the presence of the ARP would need to be spread across both individuals and small groups.

8.4.   Alternate Premium Subsidy Structures

The current Federal premium subsidy structure provides premium subsidies to individuals and families with incomes up to 400% FPL purchasing on-Exchange coverage through the individual ACA market, provided premium rates for the second lowest cost silver plan exceed a specified percentage of household income, known as the Applicable Percentage.[48] Chart 8.4 presents the Applicable Percentages for calendar year 2020.

Chart 8.4
2020 Applicable Percentages
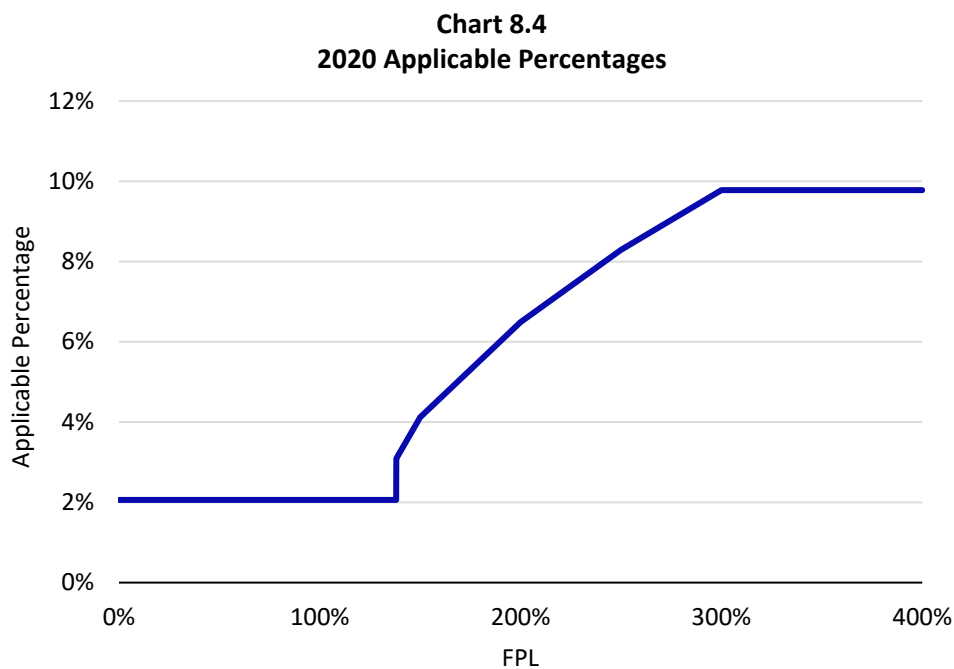
Table 8.1 below presents the income that would be earned by an individual or a family of four at different percentages of the Alaska FPL in 2020, while Table 8.2 presents the maximum subsidized monthly premium those individuals or families would be required to pay.

Table 8.1
Income at Various 2019 FPL Levels in Alaska[49]

	100%	200%	300%	400%
Single	$15,600	$31,200	$46,800	$62,400
Family of Four	$32,190	$64,380	$96,570	$128,760

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[48] The premium subsidy for a given household is equal to the difference between the premium rate for the second lowest cost silver plan available to an enrollee through the FFM and the Applicable Percentage of household income.

[49] Per statute, prior year FPL guidelines are used to determine premium subsidies for a given benefit year since FPL guidelines for a given benefit year are not made available until after the open enrollment period.

Table 8.2
2020 Maximum Subsidized Monthly Premium in Alaska

	100%	200%	300%	400%
Single	$27	$169	$381	$509
Family of Four	$55	$348	$787	$1,049

Under the current Federal premium subsidy structure, there may be significant differences in the premium rate paid by a household with an income at or slightly below 400% FPL versus a household with an income above 400% FPL. This phenomenon is commonly referred to as the "subsidy cliff." For example, a family of four with an income of $128,400 (which is approximately equal to 399% FPL) residing in the Municipality of Anchorage, would pay a monthly premium rate of $1,047, after accounting for a monthly premium subsidy of $454.[50] However, a similar family of four with an income of $129,100 (approximately 401% FPL), would pay a monthly premium rate of $1,501.

8.4.1. Expanding Access to Premium Subsidies to Higher Income Levels

In order to assess the potential impact of reducing the "subsidy cliff," we modeled three alternate premium subsidy structures, each of which extends premium subsidies to income ranges above 400% FPL. A summary of the premium subsidy structures that were modeled, expressed as percentages of household income in relation to FPL, are shown in Table 8.3.

Table 8.3
Summary of Alternate Subsidy Structures Expanding Premium Subsidies

	Applicable Percentages by FPL							
	133%	**150%**	**200%**	**250%**	**300%**	**400%**	**500%**	**600%**
Baseline	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%	N/A	N/A
Scenario 1*	3.09%	4.12%	6.49%	8.29%	10.00%	12.00%	15.00%	N/A
Scenario 2	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%	12.39%	15.00%
Scenario 3**	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%	9.78%	9.78%

* In Scenario 1, the maximum premium amount for individuals and families with household incomes between 250% and 300% FPL was assumed to not change relative to the baseline scenario. For purposes of determining the maximum premium amount for households with incomes between 250% and 300% FPL, a factor of 9.78% of household income was used for a household with an income of 300% FPL instead of a factor of 10.00% of household income, as shown in the table above.
** In Scenario 3, the maximum premium amount of 9.78% of household income also applies to individuals and families with household incomes above 600% FPL.

The baseline scenario represents the current Federal premium subsidy structure, with the percentages shown in Table 8.3 representing the maximum amount individuals and families would pay as a percentage of household income for the second lowest cost silver plan available through the FFM, the

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[50] Premium amounts shown are based on a family of four, consisting of two adults age 40 and two child dependents age 10, residing in the Municipality of Anchorage. The results will vary by age and family composition. Income as a percentage of FPL is expressed in terms of the 2019 FPL guidelines, which are used to determine premium subsidies for benefit year 2020.

plan used to calculate premium subsidy amounts. Scenario 1 generally provides no change to premium subsidies for households with incomes below 400% FPL, relative to the baseline scenario, and introduces premium subsidies for those with incomes between 400% and 500% FPL. Scenario 2 provides more generous premium subsidies for those with incomes above 400% FPL, relative to Scenario 1, and Scenario 3 provides the most generous premium subsidies of all scenarios modeled. For individuals and families with household incomes in-between two income ranges shown in Table 8.3 (e.g., 215% FPL), linear interpolation was used to determine the maximum premium amount an individual or family would pay as a percentage of household income for the second lowest cost silver plan. It should be noted that households with incomes below 133% FPL were not considered to be eligible for premium subsidies since the State of Alaska expanded Medicaid to cover all non-elderly adults with incomes below 133% FPL.[51]

Chart 8.5 summarizes the projected enrollment in the individual ACA market under the baseline and each of the alternate scenarios, segmented between enrollees receiving subsidies and enrollees not receiving subsidies.

Chart 8.5
2020 Individual ACA Market Enrollment (in 1,000s)
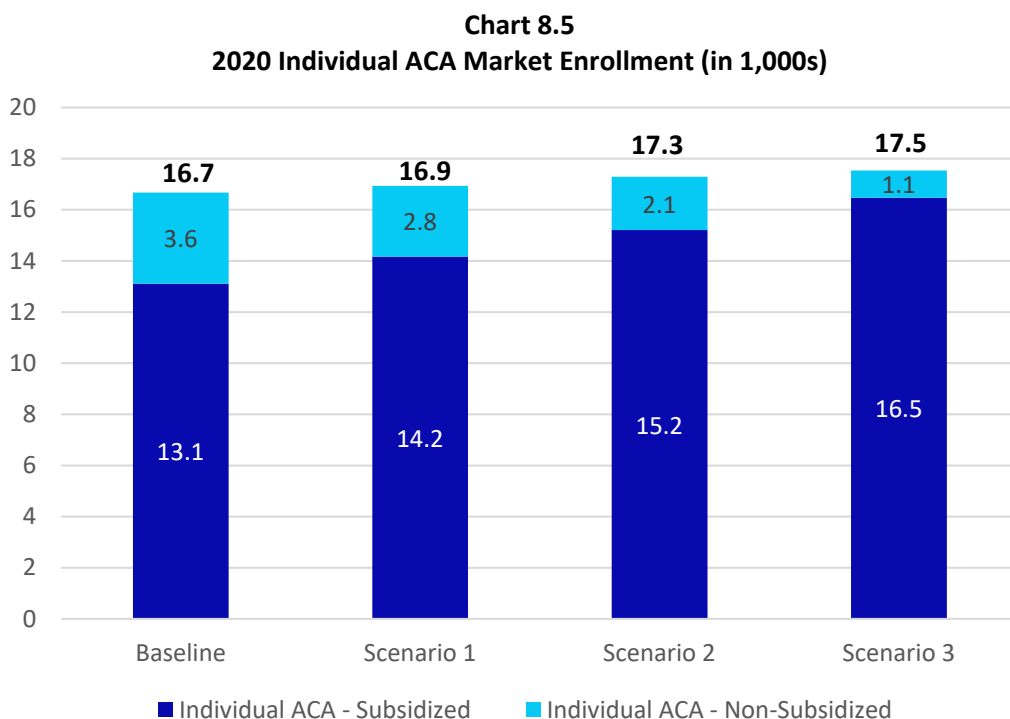
Overall, enrollment is projected to increase under each scenario relative to the baseline scenario, with the number of individuals enrolling in subsidized coverage increasing and the number of individuals enrolling in non-subsidized coverage decreasing as the proportion of the population eligible to receive premium subsidies increases and the proportion of the population not eligible to receive premium

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[51] Some states previously disregarded certain income when determining eligibility for Medicaid (i.e., income disregards). The ACA established a uniform income disregard of 5% of FPL in place of state-specific income disregards to determine whether an individual is eligible for Medicaid. This 5% of FPL income disregard effectively increased the income threshold to determine Medicaid eligibility from 133% FPL to 138% FPL.

subsidies decreases. Additionally, total enrollment is shown to increase as the generosity of premium subsidies increases (e.g., total enrollment under Scenario 2 is higher than Scenario 1).

Chart 8.6 summarizes the projected enrollment in the individual ACA market under the baseline scenario and each of the alternate scenarios, by income range. No income range is projected to be adversely impacted under the modeled scenarios from an enrollment perspective, which is not unexpected for Scenario 2 and Scenario 3 since premium rates, net of premium subsidies, are largely unchanged for individuals currently receiving subsidies and premium subsidies are expanded to households with higher incomes. For Scenario 1, even though households with incomes between 300% and 400% FPL would experience a reduction in premium subsidies, enrollment would not be projected to decrease due to the presence of "silver loading."[52] "Silver loading" increases premium subsidies for an enrollee, which generally enables them to purchase plans with a base premium rate (i.e., premium prior to the consideration of any premium subsidies) that is lower than the second lowest cost silver plan, at a cost lower than they otherwise would be able to. When premium subsidies decrease in Scenario 1 for households with incomes between 300% and 400% FPL, the modeling indicates that many of them would be expected to choose a lower cost premium plan to offset the increase in the net premium that they would have otherwise paid.

Chart 8.6
2020 Individual ACA Market Enrollment by Income Range (in 1,000s)
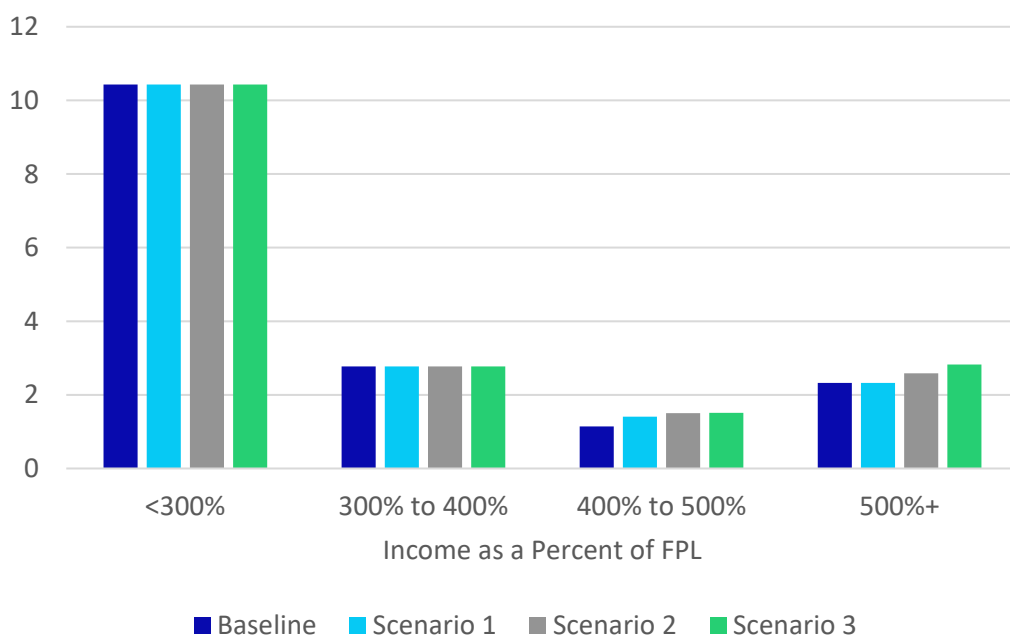
Table 8.4 summarizes projected enrollment and average premium rates PMPM under the baseline scenario and for each alternate scenario, as well as expected morbidity improvement for each alternate scenario relative to the baseline scenario. In Scenario 1, total enrollment in the individual ACA market is projected to increase about 300 enrollees, whereas enrollment in Scenario 2 and Scenario 3 is projected to increase 600 and 900 enrollees, respectively. The individual ACA market enrollees modeled to be

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[52] "Silver loading" refers to the practice of insurers loading the premium rate for silver plans offered through the Exchange to account for the cost associated with CSR subsidies which are no longer being funded by the Federal government.

newly covered in each scenario are on average healthier than the individual ACA market population in the baseline scenario, with the average morbidity improvement increasing as the number of new enrollees modeled increases.

It should be noted that the average premium PMPM is lower under Scenario 1 compared to Scenario 2 due to a proportion of individuals and families with incomes between 300% and 400% FPL being modeled to select a lower cost premium plan in order to offset the reduction in premium subsidies that would occur under Scenario 1.

Table 8.4
Enrollment, Average Premium PMPM, and Anticipated Morbidity Improvement

	Baseline	Scenario 1	Scenario 2	Scenario 3
ACA Enrollees	16,670	16,937	17,291	17,538
Average Premium Rate PMPM	$739	$718	$726	$718
Anticipated Morbidity Improvement	N/A	0.6%	1.5%	2.0%

An improvement in morbidity would result in lower premium rates market-wide as average claim costs PMPM in the individual ACA market are reduced. A decrease in premium rates will reduce the Federal government's expenditures of premium subsidies for households currently receiving premium subsidies, and the difference in premium subsidies for individuals currently receiving premium subsidies could be used to help fund an expansion of premium subsidies to higher income ranges.[53] Table 8.5 summarizes the projected number of subsidized enrollees, the average premium subsidy PMPM, and the total premium subsidy expenditure under the baseline scenario and for each alternate scenario.

Table 8.5
Subsidized Enrollment and Premium Subsidy Expenditures

	Baseline	Scenario 1	Scenario 2	Scenario 3
ACA Subsidized Enrollees	13,112	14,169	15,209	16,470
Average Premium Subsidy PMPM	$672	$637	$609	$575
Total Premium Subsidies (in millions)	$105.8	$108.3	$111.2	$113.7
Change in Total Premium Subsidies (in millions)		$2.5	$5.4	$8.0

Total premium subsidy expenditures are projected to increase under each scenario relative to the baseline scenario. The change in total premium subsidy expenditures relative to the baseline scenario reflect the additional net cost to the State. However, it should be noted that any increase in enrollment as a result of increasing the availability of premium subsidies could have an impact on the Federal pass-through savings for the existing Section 1332 Waiver.[54]

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[53] A Section 1332 Waiver would need to be approved in order to receive Federal pass-through savings produced by changing premium subsidies.

[54] An analysis of the impact on the State's existing Section 1332 Waiver was outside the scope of this project.

8.4.2. Varying Premium Subsidies by Age

As previously noted, the current Federal premium subsidy structure provides premium subsidies to individuals and families with household incomes up to 400% FPL. While the Applicable Percentages vary with income, they do not vary by age. Therefore, since older individuals have higher claim costs, on average, younger individuals may have less financial incentive to take up coverage in the individual ACA market compared to older individuals, even in the presence of premium subsidies. Since premium rates vary by age, and premium subsidies do not, older individuals are more likely to receive premium subsidies relative to younger individuals for a given household income.

We modeled two alternate premium subsidy structures, each of which increases premium subsidies for individuals under the age of 64, relative to the baseline. Individuals age 64 would receive the same premium subsidy as under the baseline scenario. A summary of the Applicable Percentages for each of the alternate premium subsidy structures modeled are shown in Tables 8.6 and 8.7. It should be noted that only households with incomes up to 400% FPL were assumed to be eligible for premium subsidies under these alternate premium subsidy structures (i.e., we did not assume premium subsidies would be extended to income ranges beyond 400% FPL). Additionally, households with incomes below 133% FPL were not considered eligible for premium subsidies.

Table 8.6
Age and Income Based Premium Subsidies – Scenario 4

Applicable Percentages by Age and FPL						
Age	**133%**	**150%**	**200%**	**250%**	**300%**	**400%**
21 and Under	3.09%	4.12%	6.49%	6.49%	6.49%	6.49%
64*	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%

*This also represents the baseline scenario

Table 8.7
**Age and Income Based Premium Subsidies – Scenario 5**

Applicable Percentages by Age and FPL						
Age	**133%**	**150%**	**200%**	**250%**	**300%**	**400%**
21 and Under	3.09%	4.12%	4.12%	4.12%	4.12%	4.12%
64*	3.09%	4.12%	6.49%	8.29%	9.78%	9.78%

*This also represents the baseline scenario

Scenario 4 provides more generous premium subsidies relative to the baseline scenario for individuals under the age of 64 with incomes between 250% and 400% FPL. Scenario 5 provides more generous premium subsidies relative to Scenario 4 for individuals under the age of 64 with incomes between 200% and 400% FPL. Under each alternate scenario, the Applicable Percentage used to determine the premium subsidy for a household was based on the oldest eligible individual in the household. The Applicable Percentages were interpolated for households with incomes and the oldest age in between those shown in the tables above. For example, the applicable percentage under Scenario 4 for a

household with an income of 250% FPL where the oldest eligible person in the household is age 45 would be 7.29% (= 6.49% + (45-21)/(64-21) x (8.29%-6.49%)).

Chart 8.7 summarizes projected enrollment under the baseline and for each alternate scenario, segmented between enrollees receiving subsidies and enrollees not receiving subsidies. Overall, enrollment under Scenario 4 is projected to be similar to enrollment under the baseline scenario, while enrollment is projected to increase approximately 100 enrollees under Scenario 5 relative to the baseline scenario.

Chart 8.7
2020 Individual ACA Market Enrollment (in 1,000s)
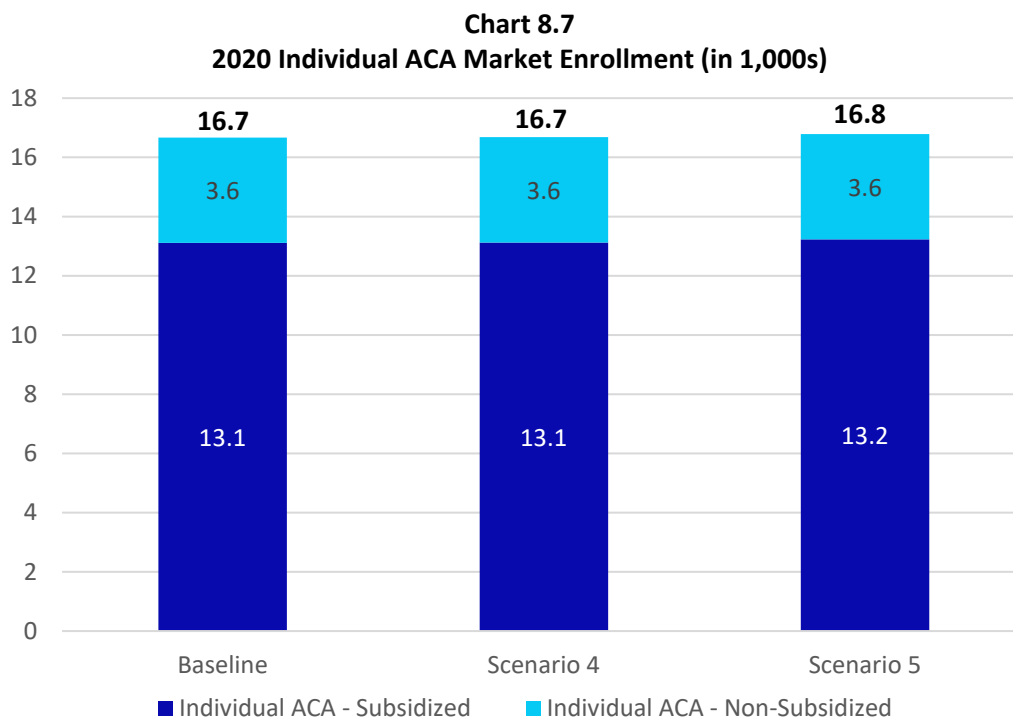
The lack of additional enrollees modeled to enter the individual ACA market, despite an increase in premium subsidies for subsidy-eligible individuals, is likely influenced by two factors. First, the presence of "silver loading" has resulted in an increase in the availability of bronze-level coverage at little or no cost, and it has resulted in subsidy-eligible individuals being able to "buy down" to richer gold benefit levels in the Alaska market.[55] Second, a robust network of IHS providers may either discourage eligible individuals from taking up coverage in the individual ACA market, even with an increase in premium subsidies, or it may have resulted in these individuals being unaware of the recent increase in premium subsidies available to them.

Chart 8.8 summarizes the projected enrollment under the baseline and each scenario by age range. As previously noted, enrollment under Scenario 4 is nearly identical to the baseline scenario, even when broken out by age range. Under Scenario 5, enrollment increases are observed for younger ages ranges, particularly for age ranges 0-24 and 25-34.

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[55] Gold-level coverage is available at a premium rate in the Exchange that is lower than the second lowest cost silver plan.

Chart 8.8
2020 Individual ACA Market Enrollment by Age Range (in 1,000s)
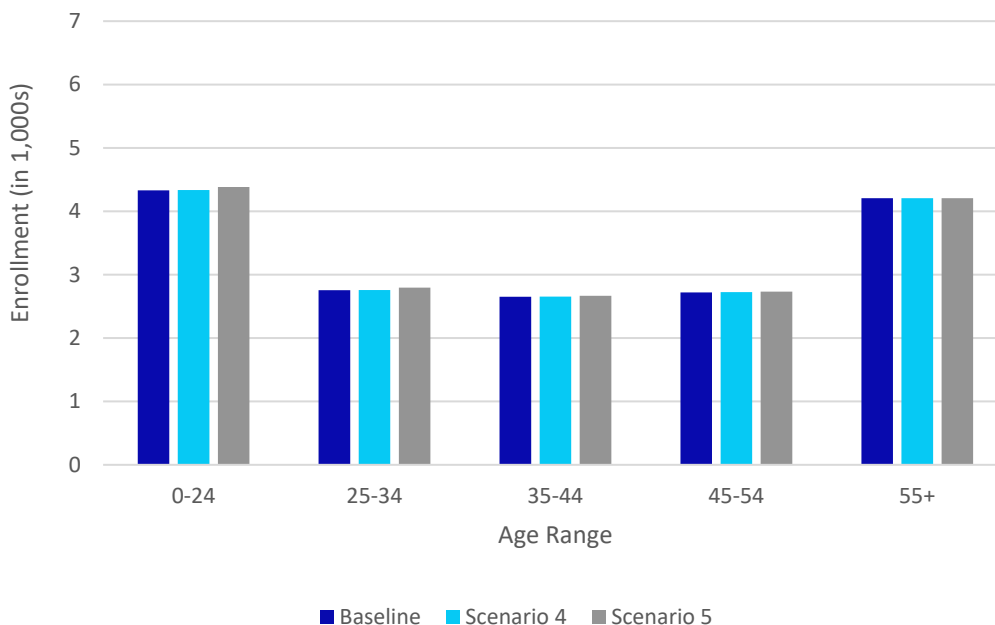

Table 8.8 summarizes projected enrollment and average premium rates PMPM under the baseline and for each alternate scenario as well as expected morbidity improvement for each alternate scenario relative to the baseline scenario.

Table 8.8
Summary of Enrollment, Average Premium PMPM, and Anticipated Morbidity Improvement

	Baseline	Scenario 4	Scenario 5
ACA Enrollees	16,670	16,681	16,788
Average Premium Rate PMPM	$739	$765	$770
Anticipated Morbidity Improvement	N/A	0.0%	0.0%

Under each alternate scenario, average premium rates PMPM are projected to increase, driven by an increase in average premium rates PMPM among subsidized enrollees. Our modeling shows that as premium subsidies increase, a portion of enrollees select richer benefit levels relative to the coverage selected in baseline scenario. Additionally, since enrollment does not increase materially under each alternate scenario relative to the baseline scenario, no morbidity improvement is projected.

Table 8.9 summarizes the projected number of subsidized enrollees, the average premium subsidy PMPM, and the total expected premium subsidy expenditures under the baseline and for each alternate scenario. Additionally, the expected change in total premium subsidies relative to the baseline scenario is shown for each alternate scenario.

Table 8.9
Summary of Subsidized Enrollment and Premium Subsidy Expenditures

	Baseline	Scenario 4	Scenario 5
ACA Subsidized Enrollees	13,112	13,124	13,231
Average Premium Subsidy PMPM	$672	$700	$736
Total Premium Subsidies (in millions)	$105.8	$110.3	$116.8
Change in Total Premium Subsidies (in millions)		$4.5	$11.0

Total premium subsidy expenditures are projected to increase under each alternate scenario, relative to the baseline scenario, with no material increase in enrollment expected and the State bearing the cost associated with the additional premium subsidy amounts.

8.4.3. Potential Advantages and Disadvantages of Changing the Current Premium Subsidy Structure

There are several potential advantages and disadvantages of changing the current premium subsidy structure. These include but are not limited to the following:

Potential advantages of changing the current premium subsidy structure

- Individual ACA market premiums would become more affordable, which would encourage some currently uninsured individuals to take up coverage in the individual ACA market, thereby reducing the number of uninsured.

- Expanding access to premium subsidies to households with incomes above 400% FPL would shield a large portion of existing individual ACA market enrollees from premium increases that exceed annual changes in household incomes, which could create a more stable risk pool.

- If a sufficient number of currently uninsured individuals choose to take up coverage in the individual ACA market as a result of extending premium subsidies to some or all individuals with incomes above 400% FPL, the average morbidity of the individual ACA market would be expected to improve. An improvement in morbidity would be expected to reduce Federal outlays for premium subsidies and could create Federal pass-through savings to fund a portion of the cost of expanding premium subsidies to a broader portion of the population.

Potential disadvantages of changing the current premium subsidy structure

- CMS has indicated a state that wishes to develop its own premium subsidy structure would not be able to use HealthCare.gov as an application portal; therefore, the State would likely need to develop its own application portal and assume responsibility for determining eligibility, payment of subsidies, providing consumer support, etc. However, the state may be able to leverage some back-end functionality of the FFE.[56]

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[56] Centers for Medicare and Medicaid Services. *Section 1332 State Relief and Empowerment Waiver Concepts, State-Specific Premium Assistance (SSPA) Waiver Concept.* CMS.gov, July 15, 2019. Accessed April 9, 2020. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SSPA-Blue-Paper-.pdf

- While the State may be able to leverage the existing Medicaid platform to determine eligibility for premium subsidies, the State would likely incur significant costs to administer the program.

- Increasing premium subsidies for individuals and families with household incomes that currently qualify for income subsidies may not be a cost-effective solution (i.e., a material change in overall enrollment in the individual ACA market is not expected).

- The State would be liable for any increase in premium subsidy expenditures, net of any Federal pass-through savings.

9.   CONCLUSION AND POTENTIAL OPPORTUNITIES

The health insurance markets in Alaska have changed significantly since the passage and implementation of the ACA. Premium subsidies have led to more affordable coverage options for many who are eligible to enroll in the individual ACA market. While premiums increased significantly between 2014 and 2017, the introduction of the ARP in 2017 helped stabilize the individual ACA market in Alaska by bringing significant premium relief to individuals not eligible for premium subsidies. Additionally, Medicaid expansion has substantially increased the number of people covered under Medicaid, which has reduced the number of uninsured and the level of uncompensated care for hospitals.

However, further action may be required to maintain or increase access to affordable health insurance in Alaska. The State of Alaska may consider exploring further the following ideas to assess the impact each could have on the health insurance markets:

Extending premium subsidies in the individual ACA market to households with incomes above 400% FPL: Our modeling shows that expanding premium subsidies in the individual ACA market to households with incomes above 400% FPL could make premiums more affordable in the individual ACA market, on average. Although enrollment is not expected to increase significantly in this scenario, making coverage more affordable through lower premium rates would mean consumers would have more disposable income to spend on other services and consumer goods that could help stimulate the Alaska economy. While this modeling showed that expanding premium subsidies would be expected to increase costs for the State, Federal pass-through savings under the current Section 1332 Waiver have exceeded or are expected to exceed the cost of the ARP in 2019 and 2020, respectively. The State could consider re-filing a Section 1332 Waiver that incorporates the ARP and expands premium subsidies to higher income ranges in order to more closely align Federal pass-through savings with the cost of implementing the State's program under Section 1332 Waiver. It should be noted that if allowed under Section 1332, varying subsidies by age in addition to income is not expected to have a material impact on enrollment in the individual ACA market and could be administratively burdensome, particularly if the State would need to administer a State-based Exchange.

Maintaining separate risk pools in the individual and small group ACA markets and implementing a separate reinsurance program in the small group ACA market: Our modeling shows that implementing a reinsurance program in the small group ACA market would likely be more cost-effective than merging the individual and small group ACA markets into a single risk pool. Merging the individual and small group ACA markets would have a significant negative impact on the amount of Federal pass-through savings expected to be received by the State under its current Section 1332 Waiver. Our modeling shows the cost of a small group ACA reinsurance program would be expected to be less than the expected reduction in Federal pass-through savings if the individual and small group ACA market risk pools were merged, relative to the Federal pass-through savings that would occur if the markets were not merged.[57]

Collaborating with tribal health providers, IHS, and insurers: The State should continue its collaboration with tribal health providers, insurers, and IHS to better understand and improve access to care through tribal providers.

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[57] For this comparison, we assumed that if a reinsurance program was implemented in the small group market, the premium rate reduction would be equivalent to the premium rate reduction that was modeled for small group plans under the merged market scenario.

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Exploring more focused, targeted outreach to uninsured individuals: Many states have very limited, if any, budget available for outreach to uninsured individuals eligible to enroll in the individual ACA market. If funds are available for outreach, understanding the demographic, socioeconomic, and other characteristics of Alaska's current uninsured population may allow the State to adopt more targeted outreach by focusing on individuals that comprise large segments of this population. By targeting efforts toward these segments of the population, the State may be able to maximize the effectiveness of the outreach given the limited resources available for these efforts.

Studying further the relationship between access to care, health outcomes, and premium rates in areas that appear to be underserved relative to the rest of the State and nationally: The analysis appears to indicate that the North/Northwest and Southwest geographic areas are consistently underserved when compared to other geographic areas of the State, and nationwide. In particular, these geographic areas have no home health agencies or ambulatory surgical centers, and the number of physicians per 100,000 residents is significantly lower relative to other regions of the State. Identifying access to care barriers and finding effective solutions to expand access to care may result in improved health outcomes, and improved health outcomes may result in lower claim costs. Lower claim costs, in turn, would result in lower premium rates.

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