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Session 5 PD, Foundations of ACA: Part 1

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Medical loss ratios (MLR)

- ACA requires health plans “to spend a set percentage of premium dollars on health care services and activities to improve health care quality.”
- Plans must file an MLR report annually with Health and Human Services (HHS)
- Plans must rebate a portion of the health insurance premiums received if its MLR does not meet the MLR standard
  - 85% for plans in the large group market
  - 80% for plans in the individual and small group markets
- Effective for coverage in 2011; initial rebates provided in 2012

1Centers for Medicare and Medicaid Services CMS. Medical loss ratio (MLR) rebate notice instructions. May 16, 2012.
What is a health exchange?

- Marketplace for qualified health plans (QHP)
  - Plans must meet minimum federal requirements
  - Initially serving the individual and small employer markets only
  - CBO estimates will cover 24 million lives by 2019
- Competition among QHPs
  - Compete on price, network, customer service
  - Benefits are fully comparable
  - Exchanges will rank plans based on quality and price
- Risk mitigation programs
  - Three “Rs”
  - Interaction
  - Coordination

Exchange structure

- State-Based Exchange
  - Government agency or non-profit organization
  - Clearinghouse: contract with all qualified health plans, or
  - Active purchaser: contract with selected health plans and/or negotiate premium prices with health plans
- Federal Exchange (federally-facilitated Exchange)
  - If state unable / unwilling to set up an Exchange
  - HHS performs all exchange functions
- Partnership Exchange
  - Some Exchange functions performed by State and some by HHS
- individual and small business (SHOP) Exchanges
Main Exchange Functions

- Certify health plans
  - Meet requirements for marketing, provider choice, clinical measures
- Provide standardized health plan comparative information and format for enrollment
- Calculate cost of coverage after premium tax credit and cost sharing reductions
- Rate plans based on quality and price
- Coordinate enrollment procedures with Medicaid
- Navigators and In-Person Assisters (IPAs)
  - Outreach, consumer education, application assistance
- Examine premium increases
Purpose of Risk Mitigation

- Address ACA's fundamental changes to healthcare financing
- Provide premium stabilization
- Mitigate potential impact of adverse selection
- Protect the availability of health plan choice for consumers

Risk Mitigation Programs in ACA

- Three Risk Mitigation Programs ("Rs"):
  - Risk Adjustment (Permanent Program)
  - Reinsurance (Temporary Program)
  - Risk Corridors (Temporary Program)
BIG PICTURE
Interaction of Risk Mitigation Programs

- Reinsurance
- Risk Adjusters
- Risk Corridor

BIG PICTURE
Interaction of Risk Mitigation Programs and Premium Rate Setting

- Reinsurance
- Risk Adjusters
- Risk Corridor
- Premium Rates and Rate Structure by Plan
- Plan Design
**Big Picture:** Interaction of Risk Mitigation Programs, Premium Rate Setting, and MLR Rebate Calculations

- **Reinsurance**
- **Risk Adjusters**
- **Risk Corridor**
- **Premium Rates and Rate Structure by Plan**
- **Plan Design**
- **MLR All Plans in Market**
- **Rebates**

**Risk Adjustment**

- Optionally state-based (if state Exchange) or Federal model
- Separate risk adjustment for each risk pool:
  - Individual
  - Small group
  - Catastrophic
- Permanent program – 2014 and thereafter
- Compensates plans with disproportionately high-risk populations
  - Across non-grandfather products in and out of the Exchange
Federal Risk Adjustment Methodology

- Default if State does not set up Exchange or alternative risk adjustment methodology
- Funds transfer takes place across metal levels within a risk adjustment pool
- Must be completed by June 30 of the following year

Risk Adjustment Implications

- Creates cross subsidies across carriers within the State
  - Carrier’s average risk score is compared to State’s average
    - Average risk score < State average, carrier makes a payment
    - Average risk score > State average, carrier receives a payment
    - Zero sum game in the market
- Direct impact: low risk plans subsidize high risk plans
- Indirect impact: not zero sum gain at the carrier level
  - Strategic considerations for product development
  - Decisions on network design and provider contract
Transitional Reinsurance

- State-based
- Individual market only
  - Decreasing each year ($10b, $6b, $4b)
- Paid for by contributions collected from all commercial, major medical insurance (large, small, and individual)
  - Affects all health insurers and self-insured employer coverage
- 2014 per capita contribution rate is $5.25 per month
- Included in the premium rates for all commercial business

Transitional Reinsurance Implications

- For 2014:
  - Attachment point: $60,000
  - Reinsurance cap: $250,000
  - Coinsurance: 80%
- Payments will be made based on the need for reinsurance payments, regardless of where the contribution was collected
- HHS will adjust payments on a uniform pro-rata basis if payment requests exceed contributions
  - Funding set to last three years, actual length depends on claims
Risk Corridor

- Federally run program for qualified health plans
  - Federal government will share in profits or losses from inaccurate pricing
- Individual and small group markets
- Allowable costs compared to target costs
  - Within +/- 3% of target costs – no adjustment
  - Next 5% (92% - 108%) – 50% sharing
  - Next 5% (87% - 113%) – 2.5% of target, plus 80% of amounts <92% or >108%

Risk Corridor Implications

- Applies after reinsurance and risk adjustment
- Insurer implications
  - Need to understand/replicate calculations
  - Likely to require documentation of gain or loss
  - Must be included as part of MLR, what happens if an amount is disputed
  - Depending upon the results, audits may be required
- Previous program in Medicare Advantage when regional PPOs were introduced, similar wording/percentages
What does risk mitigation mean for pricing?

- Medical loss ratio (MLR) requirements limit returns at the global level
- Price will be a primary driver in the Exchange
- How to lower price?
  - Narrow networks
  - Tiered products
- Exchange will monitor for:
  - Discriminatory benefit design
  - Meaningful differences across plans within a carrier
Topics (only discussing **bold** items)

1. Rating/Market rules - “Fair Health”
2. Rate Review
3. Actuarial value determination and general rules
4. The 3Rs: Risk adjustment, Reinsurance, and Risk corridors
5. Exchanges
6. Market Impact
7. Catastrophic Plans
8. Individual Premium subsidies
9. Cost-sharing subsidies
10. Medical Loss Ratio
11. Essential health benefits
12. SHOP Subsidies
13. Employer/Individual Mandates
14. Strategic Considerations
15. Timelines for plan years 2014 and 2015
Rating Rules: Applicability

- Individual and Small Group Markets
- Grandfathered and self-funded plans excluded
- Large Group excluded unless State includes with small group (2017+ only)
- Effective renewal date on or after 1/1/2014

Rating Rules: Guaranteed Available

- Individual and Small Group
  - Open enrollment period
    - Initial: 10/1/13-3/31/14
    - Subsequent Years "y": 10/1/y-1 - 12/7/y-1
  - Individual
    - Rate Development once per year
  - Small Group
    - Quarterly rates acceptable
    - Enrollment throughout year, but can require:
      - Employer Contribution rules
      - Minimum participation rules
Rating Rules: Fair Health Insurance Premiums

Allowed factors
- Benefits – not necessarily aligned with “actuarial value”
- Age (3:1 for adults) – prescribed factors
- Tobacco use (1.5:1)
- Geography

Factors not allowed
- Health status
- Claims experience
- Gender
- Industry
- Small group size

Rating Rules: Fair Health Insurance Premiums

Age
- 3:1 for adults (21+)
- Age bands
  - 1 band ages 0-20, 1-year age bands from 21-63, 1 band ages 64 and older
- Uniform age bands and age curve
- Males 20-24 factors generally 2x prior
- State-established with federal default
- Ceiling of 3 child dependents < age 21

Tobacco use
- 1.5:1
- Can vary by age
- Wellness program – same rules in effect
- Adverse selection vs. ability to capture information
- Applied at individual level
Rating Rules: Single Risk Pool

- One risk pool for individual market, one for small group
  - Excludes Grandfathered plans
  - Spans Exchange vs. Outside Exchange
  - Rating factors/method with a pool must be the same
    - Therefore, rates inside vs. outside Exchange use same method, but could have different rates for allowable reasons
  - No requirement to offer same plans on and off Exchange
  - Pricing adjustments allowed for:
    - Risk adjustment and reinsurance
    - Product benefit and cost-sharing
    - Network and delivery system

Rating Rules: Price Considerations

- Most effective ways to control pricing will be:
  - Provider Contracting
  - Administrative Expenses
- Provider contracting will be critical to success in the exchanges
- Plan enrollment may be highly skewed based on relative pricing position (premium subsidy leveraging)
- Administrative efficiencies will be more crucial to continued plan success
Rating Rules: Regulatory Fees

- Issuer Fee
  - Exact amount per insurer is unknown
  - Estimated to be about 2-3%
- Exchange User Fee
  - 3.5% in 2014 benefit year; spread across market
  - Intent to align with State-based Exchanges
- Reinsurance Assessment
  - $5.25 PMPM collected annually
- PCORI - $1 PMPY Oct-12, $2 PMPY Oct-13
- Risk Adjustment User Fee
  - <$1.00 PMPY

Rate Review: New State Requirements

- States must have effective review of:
  - Carriers’ ability to estimate rate impact of Federal reinsurance and risk adjustment programs
  - Actuarial value
  - Benefit changes, including EHB
  - Changes in enrollee risk profile and pricing (e.g. age, tobacco use)
Rate Review: What must be filed?

- All rate increases (>0%) must file:
  - Part I – Rate Increase Summary (Excel template)
    - Unified Rate Review Template (URRT)
    - Measures change in index rate (EHB allowed costs)
  - Part III - Rate filing documentation
    - Actuarial Certification
- If rate increase exceeds threshold, must also submit:
  - Part II - Written description justifying the rate increase (intended for consumers).
    - Most significant factors causing rate increase
    - Historical and projected expenses and loss ratios

Rate Review: Part III - Justification for CMS

- Reasonableness of assumptions & validity of historical data underlying the assumptions
- Carrier’s data related to past projections and actual experience
- Impact of medical trend changes by major service categories
- Impact of utilization changes by major service categories
- Impact of cost sharing changes by major service categories
- Impact of benefit changes
- Impact of changes in enrollee risk profile
- Impact of any misestimate of medical trend for prior periods
- Impact of changes in reserve needs
- Impact of changes in admin costs related to programs that improve health care quality
- Impact of changes in enrollee risk profile
- Impact of changes in other admin costs
- Impact of changes in taxes, licensing or regulatory fees
- MLR
- Health Insurance issuer’s capital and surplus
Rate Review: Determination of Unreasonable Rate Increase

- CMS will determine increase to be unreasonable if:
  - (i) Increase is excessive, or
  - (ii) Rate increase is unjustified, or
  - (iii) Rate increase is unfairly discriminatory

- Excessive = unreasonably high in relation to benefits provided
- Unjustified = incomplete/inadequate documentation
- Unfairly Discriminatory = Increase creates differences in rates not permissible or does not reasonably relate to expected cost differences

Market Impact

- Small Group
  - Minimal overall change
  - Disruption in age factors – will impact small groups at extreme ages

- Individual
  - Higher prices, increased market size
  - Same age factor change as small group
  - Richer (EHB) benefits
  - New Enrollees:
    - Guarantee Issue
    - Currently low income uninsured to exchanges
    - High Risk Pool enrollees
Catastrophic Plans

- Available to those under age 30 or who are exempt from mandate to purchase coverage
  - >8% of income compared to EE share of lowest option; if group not available, lowest ind. Bronze after subsidy
- Provides catastrophic coverage set at HSA current law levels, except preventive covered 100%
- Individual Market Only
- Must cover EHB after deductible reached
- Deductible = MOOP for HSAs, as defined by IRS
- Deductible does not apply to first three PCP Visits

Individual Premium Subsidies
a.k.a. Advanced Tax Credit

- This provision, along with cost-sharing reduction, will significantly increase size of the individual market
- Premium subsidies available to beneficiaries under 400% of Federal Poverty Level
  - Only available on Individual Exchange
  - Available for all metal tiers
- Exchange estimates (Silver Plan) are developed from the Kaiser Premium Subsidy Calculator ([http://healthreform.kff.org/SubsidyCalculator.aspx](http://healthreform.kff.org/SubsidyCalculator.aspx))
- Maximum Premium Contribution is used to calculate Federal Subsidy for 2nd lowest Silver Premium in Exchange; which is then fixed for other plans
Individual Premium Subsidies

“Low income” eligible is relative

- Subsidy population is a very broad population base

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100% FPL</th>
<th>400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,490</td>
<td>$45,960</td>
</tr>
<tr>
<td>2</td>
<td>$15,510</td>
<td>$62,040</td>
</tr>
<tr>
<td>3</td>
<td>$19,530</td>
<td>$78,120</td>
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<td>4</td>
<td>$23,550</td>
<td>$94,200</td>
</tr>
<tr>
<td>5</td>
<td>$27,570</td>
<td>$110,280</td>
</tr>
<tr>
<td>6</td>
<td>$31,590</td>
<td>$126,360</td>
</tr>
<tr>
<td>7</td>
<td>$35,610</td>
<td>$142,440</td>
</tr>
<tr>
<td>8</td>
<td>$39,630</td>
<td>$158,520</td>
</tr>
</tbody>
</table>

Individual Premium Subsidies
- will attract current SG members

- Select common occupations and median salary

<table>
<thead>
<tr>
<th>Occupation</th>
<th>National Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiters and Waitresses</td>
<td>$18,570</td>
</tr>
<tr>
<td>Maids and Housekeeping Cleaners</td>
<td>$19,390</td>
</tr>
<tr>
<td>Retail Salesperson</td>
<td>$21,010</td>
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<tr>
<td>Hairdresser</td>
<td>$22,570</td>
</tr>
<tr>
<td>Veterinary Assistant</td>
<td>$22,830</td>
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<tr>
<td>Nursing Aides, Ordinaries, and Attendants</td>
<td>$24,190</td>
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<tr>
<td>Preschool Teachers</td>
<td>$26,620</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td>$28,940</td>
</tr>
<tr>
<td>Secretaries/Administrative Assistants</td>
<td>$31,870</td>
</tr>
<tr>
<td>Bookkeeping, Accounting, and Auditing Clerks</td>
<td>$34,740</td>
</tr>
<tr>
<td>Paralegal and Legal Assistants</td>
<td>$46,730</td>
</tr>
<tr>
<td>Insurance Sales Agents</td>
<td>$47,450</td>
</tr>
<tr>
<td>Radiology Technician</td>
<td>$55,120</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>$65,950</td>
</tr>
<tr>
<td>Mechanical Engineers</td>
<td>$79,230</td>
</tr>
</tbody>
</table>

Individual Premium Subsidies

- Maximum Premium Contribution is a % of income which varies by % of FPL (~$11,500 in 2014, Single Taxpayer)

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>150%</td>
<td>4.00%</td>
<td>$58</td>
<td>$690</td>
<td>$17,250</td>
</tr>
<tr>
<td>200%</td>
<td>6.30%</td>
<td>$121</td>
<td>$1,449</td>
<td>$23,000</td>
</tr>
<tr>
<td>250%</td>
<td>8.05%</td>
<td>$193</td>
<td>$2,315</td>
<td>$28,750</td>
</tr>
<tr>
<td>300%</td>
<td>9.50%</td>
<td>$273</td>
<td>$3,278</td>
<td>$34,500</td>
</tr>
<tr>
<td>350%</td>
<td>9.50%</td>
<td>$319</td>
<td>$3,824</td>
<td>$40,250</td>
</tr>
<tr>
<td>400%</td>
<td>9.50%</td>
<td>$364</td>
<td>$4,370</td>
<td>$46,000</td>
</tr>
</tbody>
</table>

[1] Per final IRS regulation on premium credits

- Again, Maximum Premium Contribution used to calculate Federal Subsidy for 2nd lowest Silver Premium in Exchange
- Maximum Annual Premium Contribution is prior to Tobacco Use Factor

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Individual Premium Subsidies

Annual Premium for Single 250% FPL (2nd Lowest Carrier)

<table>
<thead>
<tr>
<th>Age</th>
<th>Area</th>
<th>Low Cost</th>
<th>High Cost</th>
<th>Low Cost</th>
<th>High Cost</th>
<th>Low Cost</th>
<th>High Cost</th>
<th>Low Cost</th>
<th>High Cost</th>
<th>Low Cost</th>
<th>High Cost</th>
<th>Low Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bronze Premium (before subsidy)</td>
<td>Silver Premium (before subsidy)</td>
<td>Silver Premium Contribution*</td>
<td>Federal Subsidy</td>
<td>Bronze Premium Contribution</td>
<td>Bronze Premium Contribution Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td>Low</td>
<td>2,325</td>
<td>2,712</td>
<td>2,315</td>
<td>397</td>
<td>1,928</td>
<td>83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>3,487</td>
<td>4,068</td>
<td>2,315</td>
<td>1,753</td>
<td>1,734</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Low</td>
<td>6,975</td>
<td>8,137</td>
<td>2,315</td>
<td>5,822</td>
<td>1,153</td>
<td>17%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>10,462</td>
<td>12,206</td>
<td>2,315</td>
<td>9,891</td>
<td>571</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*8.05% * $11,500 * 250%
### Annual Contribution / Subsidy Range

#### (2nd Lowest Carrier)

**Low Cost Area - High Cost Area**

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>250% of FPL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>1928-1734</td>
<td>2315-2315</td>
<td>2702-2315</td>
</tr>
<tr>
<td>30</td>
<td>1922-1735</td>
<td>2315-2315</td>
<td>2708-2305</td>
</tr>
<tr>
<td>40</td>
<td>1801-1544</td>
<td>2315-2315</td>
<td>2829-3086</td>
</tr>
<tr>
<td>50</td>
<td>1518-1119</td>
<td>2315-2315</td>
<td>3112-3511</td>
</tr>
<tr>
<td>60</td>
<td>1155-571</td>
<td>2315-2315</td>
<td>3477-4059</td>
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<tr>
<td><strong>275% of FPL</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20</td>
<td>2325-2195</td>
<td>2712-2776</td>
<td>3099-3357</td>
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<tr>
<td>30</td>
<td>2359-2186</td>
<td>2712-2776</td>
<td>3145-3466</td>
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<tr>
<td>40</td>
<td>2262-2005</td>
<td>2776-2776</td>
<td>3290-3547</td>
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<tr>
<td>50</td>
<td>1979-1580</td>
<td>2776-2776</td>
<td>3573-3972</td>
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<tr>
<td>60</td>
<td>1634-1052</td>
<td>2776-2776</td>
<td>3938-4320</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
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<tbody>
<tr>
<td><strong>Annual Premium Range</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>397-1753</td>
<td>397-1753</td>
<td>397-1753</td>
</tr>
<tr>
<td>30</td>
<td>437-1813</td>
<td>437-1813</td>
<td>437-1813</td>
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<tr>
<td>40</td>
<td>1285-3085</td>
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<tr>
<td>50</td>
<td>3267-6059</td>
<td>3267-6059</td>
<td>3267-6059</td>
</tr>
<tr>
<td>60</td>
<td>5822-9891</td>
<td>5822-9891</td>
<td>5822-9891</td>
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<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
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</thead>
<tbody>
<tr>
<td><strong>Total Premium Range</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>20</td>
<td>2325-3487</td>
<td>2712-4068</td>
<td>3099-4649</td>
</tr>
<tr>
<td>30</td>
<td>2359-3538</td>
<td>2752-4128</td>
<td>3145-4718</td>
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<tr>
<td>40</td>
<td>3086-4629</td>
<td>3600-5400</td>
<td>4114-6171</td>
</tr>
<tr>
<td>50</td>
<td>4785-7178</td>
<td>5582-8374</td>
<td>6379-9570</td>
</tr>
<tr>
<td>60</td>
<td>6975-10462</td>
<td>8137-12206</td>
<td>9299-13950</td>
</tr>
</tbody>
</table>

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### Cost-sharing Subsidies

- Individual market only
- Must enroll in a silver plan in the Exchange
- Maximum out of pocket (MOOP) will be reduced from HSA ceiling by two-thirds for 100-200% FPL and by half for 200-250% FPL
- Resulting AV based on income
  - 200-250% FPL: 73%
  - 150-200% FPL: 87%
  - 100-150% FPL: 94%
- If further adjustments are needed to achieve the required AV, deductibles and other cost sharing can be adjusted
- QHPs must submit Silver plan “variations” and charge lower cost sharing for <250% FPL
- QHPs receive monthly advance payments to cover cost sharing difference, reconciled like LICS for Medicare Part D
SHOP Subsidies: less generous than individual market

- Who qualifies?
  - Fewer than 25 employees
  - Average annual wages less than $50,000
  - Business must pay at least half of the premium for covering a single person (not family)

- What is the subsidy? (2010-2013)
  - Up to 35% of the premiums paid
  - Up to 25% of the premiums paid for tax exempt organizations

SHOP Subsidies: less generous than individual market

- What is the subsidy? (2014)
  - Up to 50% of premiums paid
  - Up to 35% of premiums paid for tax exempt organizations

- Small businesses with fewer than 10 employees and average wages less than $25,000 get the full tax credit.
  - Credit is graduated up to 25 employees and average wages up to $50,000

- Only available through 2015.
Enrollment Estimate Example - FL

Figure 1: Changes in Sources of Coverage under the ACA in Florida in 2014

<table>
<thead>
<tr>
<th>Baseline Coverage</th>
<th>Total</th>
<th>Employer Exchange</th>
<th>Individual Exchange</th>
<th>Private Employer</th>
<th>Private Non-Group</th>
<th>Medicare/ TRICARE</th>
<th>Medicaid/ CHIP</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer 2-50</td>
<td>2,090,820</td>
<td>825,296</td>
<td>1,129,588</td>
<td>1,272,933</td>
<td>5,657</td>
<td>48</td>
<td>63,059</td>
<td>19,259</td>
</tr>
<tr>
<td>Employer 51-100</td>
<td>5,791,579</td>
<td>-</td>
<td>119,223</td>
<td>5,055,426</td>
<td>5,754</td>
<td>907</td>
<td>88,717</td>
<td>21,552</td>
</tr>
<tr>
<td>High Risk Pool</td>
<td>18,417</td>
<td>156</td>
<td>14,408</td>
<td>874</td>
<td>-</td>
<td>-</td>
<td>2,981</td>
<td>-</td>
</tr>
<tr>
<td>Other Non-Group</td>
<td>843,935</td>
<td>22,873</td>
<td>320,154</td>
<td>32,935</td>
<td>311,522</td>
<td>-</td>
<td>77,481</td>
<td>84,251</td>
</tr>
<tr>
<td>Retiree</td>
<td>207,840</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>28,467</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TRICARE</td>
<td>446,562</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>446,562</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medicare</td>
<td>2,950,970</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,950,970</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dual-Eligible</td>
<td>733,025</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>733,025</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medicaid/CHIP</td>
<td>2,508,365</td>
<td>22,120</td>
<td>96</td>
<td>54,080</td>
<td>-</td>
<td>-</td>
<td>2,432,566</td>
<td>-</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3,888,529</td>
<td>188,734</td>
<td>755,447</td>
<td>437,708</td>
<td>26,766</td>
<td>-</td>
<td>943,747</td>
<td>1,036,139</td>
</tr>
<tr>
<td>% of Currently Uninsured</td>
<td>4.9%</td>
<td>18.4%</td>
<td>11.3%</td>
<td>0.7%</td>
<td>0.0%</td>
<td>24.3%</td>
<td>39.5%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Total</td>
<td>19,804,231</td>
<td>921,370</td>
<td>1,336,976</td>
<td>7,796,295</td>
<td>347,751</td>
<td>4,131,491</td>
<td>3,633,196</td>
<td>1,637,152</td>
</tr>
</tbody>
</table>

- Individual market grows by 98% (844K to 1.68M)
- Small Group market grows by 5% (2.09M to 2.20M)

Source: Society Of Actuaries Study, Cost of the Future Newly Insured under the Affordable Care Act (ACA) MARCH 2013

SHOP: Group Size Considerations

- SHOP (up to 100 Employees beginning 2016)
- 2014,2015 are Transition Years for State Operated SHOPs
  - State operated SHOPs can define size
  - State can use its own counting method
- Full time Employee – 30+ hours/week
- “part-time employees must be taken into account in some reasonable way to be consistent with the ACA standards for determining employer size.”
  - Hire 1 person at 60 hours/week?
  - Hire 2 people at 30 hours/week?
Small Group Decisions

- Do I have to pay a penalty under the Employer Mandate? (more than 50 employees)
- Do I qualify for tax credits?
- Are my employees eligible for Individual subsidies or government programs?
- Can I offer “defined contribution” to my employees to get insurance on the exchange?
- Should I renew my small groups early (before 2014)?

Group Penalties

- **No Offer Penalty**: If employer does not offer minimum essential coverage:
  - $2,000 (annual, but calculated on monthly basis) tax per full-time employee, if at least one full-time employee obtains federally-subsidized Exchange coverage
  - Calculated after first 30 employees; 5% de minimis

- **Unaffordable Coverage Penalty**: If employer does offer minimum essential coverage but at least one full-time employee obtains federally-subsidized Exchange coverage:
  - Tax is lesser of $3,000 per subsidized full-time employee, or $2,000 per all full-time employees (annual, but calculated on monthly basis)
Strategic Considerations - Product

- What benefits to offer in the exchange vs. out of the exchange?
- Should plans offer platinum products?
  - Potential for anti-selection based subsidy leveraging
  - Potential for duplication of risk adjustment and reinsurance
- Should plans offer bronze products?
  - Lower reinsurance recoveries
  - Potential for significantly lower risk scores
- Should plans offer catastrophic products?
- How many plans should be offered? Multiple plans on same metal tier with different networks?
- Plan design options?
  - Deductible levels, coinsurance, copays, maximum out-of-pocket amounts

Strategic Considerations - Pricing

- Cost estimates of the uninsured and changes in the marketplace
- Actuarial value
  - Where to be in the range (silver = 68% - 72%)?
  - Limitations of federal calculator
- Provider Contracting strategies
  - Multi-tier networks, narrow networks
- Implications of 2\textsuperscript{nd} lowest silver plan and relative positioning
  - Leveraging of premium subsidies
  - Potential for large membership swings based on positioning
- Coding
  - Will risk scores accurately reflect the population?
  - Provider education similar to Medicare Advantage plans
- Adverse selection – Individual vs. small group, on vs. off exchange
- Pent-up demand
Strategic Considerations - Timing

- Move effective or renewal dates to 12/1/13 or 1/1/14
  - Group of young men above 400% FPL will want 12/1 date
  - Low income older individual will want 1/1 date
  - If population renewing in 2014 is older, are carriers made whole?
    - Does risk adjustment fully account for age rating compression?

Timeline for 2014 Plan Year

- 2013
  - April 1 – April 30: 2014 QHP Applications submitted
  - May 1 – June 16: CMS Reviews QHP Applications
  - June 17: CMS Releases QHP Applications Results to Issuers
  - June 17 – June 21: Issuers Revise QHP Applications Based on any Identified Deficiencies
  - June 21 – mid-August: CMS Reviews Revised QHP Data
  - August 22 – August 26: Issuers Review Data During Plan Preview Period and Submit Data Corrections
  - September 4: CMS Notifies all Issuers of QHP Certification Decisions for the FFEs
  - September 5 – September 9: Issuers Sign Agreements with CMS
  - October 1: Open Enrollment Begins
Timeline for 2014 Plan Year

• 2014
  ◦ Quarterly throughout 2014: HHS provides reinsurance recovery estimates
  ◦ Late 2014: Issuers submit $5.25 PMPM reinsurance assessment to HHS

• 2015
  ◦ April 30: Risk adjustment data submission due to HHS
  ◦ June 30: Issuers receive notification of risk adjustment payments and charges (including user fees due), and reinsurance recovery amounts
  ◦ July 31: Risk corridor and MLR reporting deadline
  ◦ Sep 30: MLR rebate disbursement deadline
Foundations of ACA: Part 1
QHPs, EHBs, AV, and Individual & Employer Mandates

Presentation for SOA 2013 Health Conference
June 10, 2013

Laurel Prokopow, ASA, MAAA
1199SEIU Benefit & Pension Funds

A, B, C’s of 2014
Healthcare Reform

How does the ACA make care more “Affordable”?

• Spreads risk pool
• Increases consumer’s ability to compare plans and make an informed choice
• Offers premium and cost sharing subsidies to low-income families
• New payment innovations (such as ACOs)
• Comparative Effectiveness Research
A, B, C’s of 2014 Healthcare Reform

- Law will require all to have health insurance, or pay a tax penalty

- Healthcare reform establishes Exchanges as a marketplace for individuals and families to purchase health insurance

- Exchange subsidies will be available to low-income citizens and legal permanent residents with household income below 400% of the Federal Poverty Level
## Key ACA Plan Requirements

**for non-grandfathered, non-Medicaid/Medicare plans**

<table>
<thead>
<tr>
<th>ACA Plan Provision</th>
<th>Applies to...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective 1/1/2011:</strong></td>
<td></td>
</tr>
<tr>
<td>No annual or lifetime limits (permissible phase-out by 1/1/14)</td>
<td>Yes</td>
</tr>
<tr>
<td>Coverage of dependents to age 26</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Effective 2013:</strong></td>
<td></td>
</tr>
<tr>
<td>Plans issue Summary of Benefits &amp; Coverage (SBC)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Effective 1/1/2014:</strong></td>
<td></td>
</tr>
<tr>
<td>Annual limitation on out-of-pocket maximum</td>
<td>Yes</td>
</tr>
<tr>
<td>A.V. must be over 60%**</td>
<td>Yes</td>
</tr>
<tr>
<td>Must offer EHB package</td>
<td>Yes NO</td>
</tr>
<tr>
<td>Participate in Three-R's subsidies</td>
<td>No NO</td>
</tr>
<tr>
<td>Subscribers eligible for Premium Tax Credits &amp; Cost Sharing Subsidies</td>
<td>Yes NO</td>
</tr>
</tbody>
</table>

* *Employer-Sponsored Insurance (ESI) is not required to have A.V. over 60%, but it would need to be in order to avoid any employer shared responsibility penalties.*

**Exception for catastrophic plans offered to individuals under age 30**

## Qualified Health Plans (QHPs)

- QHPs are offered on the Exchange by accredited issuers in each State
- QHPs must:
  - Provide Essential Health Benefits Package
  - Adhere to cost-sharing limitations
  - Meet Actuarial Value “metal” levels
  - Have no pre-existing condition exclusions
  - At most 3:1 age rating, can’t rate based on health factors
  - Meet Minimum Loss Ratio standards
- QHPs are eligible for:
  - Risk-Adjustment, Risk-Corridor, and Reinsurance Payments
  - Premium tax credits and cost sharing subsidies for low-income subscribers
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services (incl behavioral health treatment)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, incl oral and vision care

Listed in ACA Section 1302.

- States select “base-benchmark” plan among 4 options of existing large plans in the State as defined by HHS
- State then modifies the base-benchmark plan to cover all EHBs, if it doesn’t already, to define the “EHB-benchmark” plan
- States can require benefits beyond the EHBs, but they must defray the costs of such benefits
- Benchmark plans will vary by State.

1) ACA Section 1311(d)(3)(B)
Actuarial Value (AV) = percentage paid by health plan of the total allowed costs of benefits

Based on the benefits in the “Essential Health Benefits” package only

Calculated with a standard actuarial health cost pricing model issued by HHS

All calculations based on a standardized population and standardized claims (utilization and price) data

Similar actuarial pricing model to calculate employer plan “Minimum Value”, standardized data set based on claims from self-insured group health plans

1) 45 CFR S.156.20  2) 45 CFR S.156.145

### Metal Tiers allow for +/- 2% variation around the baseline Actuarial Values shown above.

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Actuarial Value</th>
<th>Deductible</th>
<th>Out-of-Pocket Maximum</th>
<th>Insurer's Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>$175</td>
<td>$1,500</td>
<td>85%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>$300</td>
<td>$3,700</td>
<td>70%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>$1,000</td>
<td>$5,000</td>
<td>60%</td>
</tr>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>$3,150</td>
<td>$6,500</td>
<td>50%</td>
</tr>
</tbody>
</table>

Assumes integrated medical/rx deductible and out-of-pocket maximums, applying to all services in model. Tier 1 only. Out-of-pocket maximums include the deductible. These are illustrative designs only, and are not required by the ACA.

### Individual Mandate

**Individual Mandate: Penalties for no Coverage**

<table>
<thead>
<tr>
<th>Year</th>
<th>Individual Penalty Amounts</th>
<th>Greater of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$95</td>
<td>1% of income above the tax-filing threshold</td>
</tr>
<tr>
<td>2015</td>
<td>$325</td>
<td>2% of income above the tax-filing threshold</td>
</tr>
<tr>
<td>2016</td>
<td>$695</td>
<td>2.5% of income above the tax-filing threshold</td>
</tr>
</tbody>
</table>

Penalty for individuals under age 18 will be one half of the applicable amount shown above. Total household penalty is capped at 3 times the applicable penalty amount, regardless of family size. Penalties only apply if household is above the federal income tax filing threshold.

This means that a family of 3, with household income of $35,000 in 2016, will pay an approximately $1,700* penalty in 2016 if they do not have coverage.

* = $695 x 2 + $695/2

### Employer Shared Responsibility

To avoid any penalties, employers with at least 50 full-time workers must offer “minimum essential coverage”:

- Meets “Minimum Value” (ie: > 60% actuarial value)
- Does not need to cover the entire Essential Health Benefits package
- Must be “Affordable” (ie: Employee contribution for self-only coverage <9.5% household income)
- Must offer coverage to children of full-time workers; child contribution does not need to be ‘affordable’
- Does not need to offer spouse coverage
- Offer to at least 95% of full-time employees
**Employer Shared Responsibility**

- **S. 4980H(a):** If employer has at least 50 full-time workers and no employer coverage is offered, employer pays $2,000 per year per full-time worker, minus the first 30 workers, if at least one worker receives subsidized Exchange coverage.
  - In order for employee to come out whole if ESI is dropped, may cost the employer more in increased wages.

- **S.4980H(b):** If coverage is offered but it doesn’t meet Minimum Value or Affordability test, penalty is lesser of $3,000 for each worker who receives subsidized Exchange coverage, or $2,000 for all full-time workers.

---

**Employer Shared Responsibility**

Employers will need to analyze if it’s more efficient to provide Minimum Essential Coverage, or pay the penalty

*General model set-up; Example of one scenario at 225% FPL (results will vary by plan):*

<table>
<thead>
<tr>
<th></th>
<th>ESI</th>
<th>Gold Exchange Plan</th>
<th>Difference (Exchange - ESI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Annual Premium</td>
<td>$1,200</td>
<td>$3,900</td>
<td></td>
</tr>
<tr>
<td>Average Employee Out-of-Pocket Cost Sharing</td>
<td>$1,300</td>
<td>$1,300</td>
<td></td>
</tr>
<tr>
<td>LESS: Increased Wages, net of income taxes</td>
<td>n/a</td>
<td>($2,700)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Employee Net Costs (after increased wages)</strong></td>
<td>$2,500</td>
<td>$2,500</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ESI</th>
<th>Gold Exchange Plan</th>
<th>Difference (Exchange - ESI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Plan Cost</td>
<td>$4,500</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Employer ACA Penalty*</td>
<td>n/a</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Increased Wages &amp; payroll taxes</td>
<td>n/a</td>
<td>$4,300</td>
<td></td>
</tr>
<tr>
<td><strong>Total Employer Costs</strong></td>
<td>$4,500</td>
<td>$6,300</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

| 2014 Total Employee + Employer Costs/Penalties | $7,000 | $8,800 | $1,800 |

*For small employers, no $2,000 penalty.*
Generalized ACA provisions shown may not apply to all plans. For example, transitional relief rules, exceptions for multiemployer plans, Indian tribes and religious organizations are not considered. Furthermore, results may vary based on State-specific regulations and plans.

This presentation is based on final and interim regulations for the Affordable Care Act as of May 20, 2013. Future regulations could significantly change the analysis presented herein.

The Exchange premium estimates in this report rely on assumptions for 2014 Exchange premiums. The actual premiums could vary significantly from the estimates presented herein.

This presentation has been prepared by Laurel Prokopow, ASA, MAAA of the 1199SEIU Benefit & Pension Funds for the 2013 Society of Actuaries Health Conference.