

Chicago Actuarial Association

Session A3 – Health Care Reform Explicit Costs

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Introductions / Agenda

- Current Status
- Pricing Considerations
- New Fees and Taxes

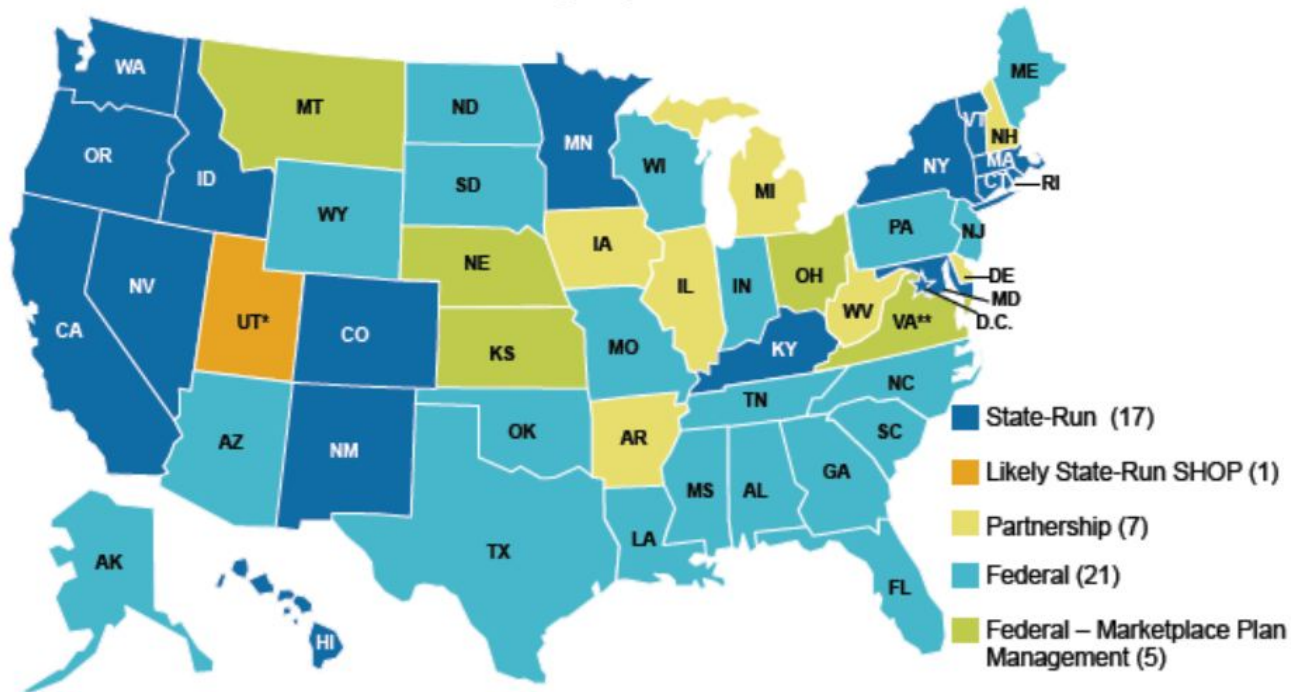
Current Status

- Exchange readiness
- Federally-facilitated exchange

Exchange Readiness – Current Tally

16 States and DC Will Run Exchanges in 2014, 7 States Conditionally Approved for Partnership

Insurance Exchange Operational Model



Source: Avalere State Reform Insights, March 12, 2013.

*UT will not pursue a state-run individual exchange but continues to request HHS certify its existing small group exchange, Avenue H.

**VA has indicated they will perform plan management functions and QHP certifications but has not received HHS approval like the other Marketplace Plan Management states (KS, MT, NE, and OH).



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Regulatory Puzzle Coming Together...

Numerous regulations have been provided

- SHOP considerations
- Premium subsidy
- Essential health benefits
- Reinsurance, risk adjustment and risk corridor (3Rs)

On-going guidelines on Federally-facilitated exchange structure

State exchanges begin to collect plans and rates

...And Several Rating Pieces Determined

Rating specifics

- Geographic parameters
- Age slope
- Tobacco load
- Network factors

Benefit specifics

- Confirmation of essential health benefits
- No standardized benefits but application of meaningful difference requirements
- Actuarial value calculation

FFE Role in Plan Management

All qualified issuers / plans accepted at least for 2014

- Model application released and due by April 30, 2013
- Issuer applications due with rate and benefit submissions

FFE will certify and manage QHPs

- All state laws will still apply
- Will use completed state work to support certification (e.g., licensure)
- Indicates FFE review of plans to be completed by July 30, 2013
- Rates can be submitted before approval by state DOI as indicated on the application, may need to resubmit rates if state DOI requests changes (not totally clear how this will work)

Issuers Will Interact With FFE By

- Confirming plan and rate information displayed and used in comparisons on website
- Providing a web portal for FFE to direct potential applicants to, receive data already entered by applicant
- Enrolling exchange members selecting their plan and collecting premiums
- Support ongoing FFE operations through user fees

Small Group Exchange (FF-SHOP)

Size of employers

- Based on FTEs as defined in Public Health Service Act
- Will adopt state definition in 2014 / 2015

Support

- Website tools to model plan and contribution choices
- Collect and aggregate premium payments from employers to QHPs

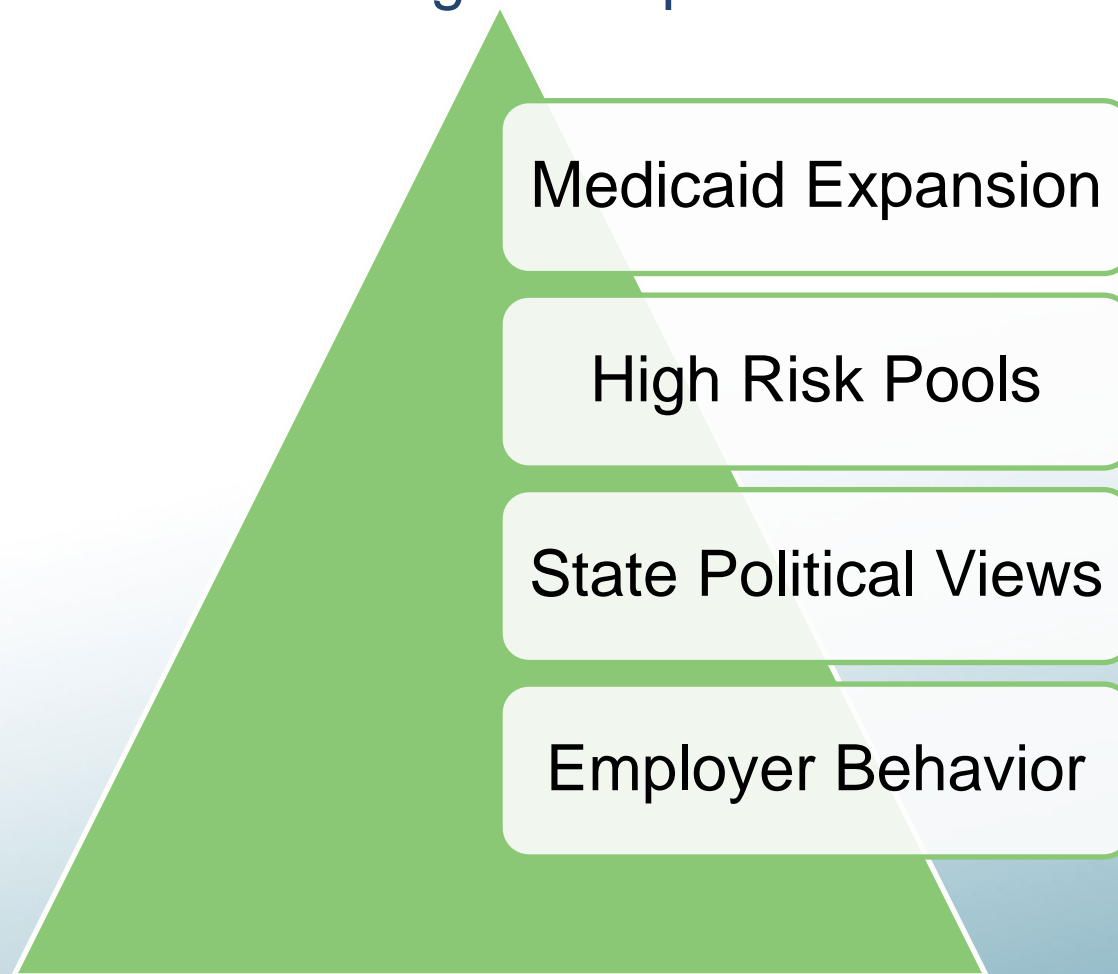
Assumes agents / brokers used to access coverage

Pricing Considerations

- Macro-Factors affecting the Individual Market
- Impact of Risk Mitigation on Individual Market (3Rs)

State Exchanges – Individual Market

Macro-Variables Influencing Participation and Selection



State Exchanges – Individual Market

Medicaid Expansion – Impact of SCOTUS

Pre-SCOTUS

- Mandatory state Medicaid expansion to 138% FPL.
- Population between 100% and 138% FPL not eligible for premium subsidies.

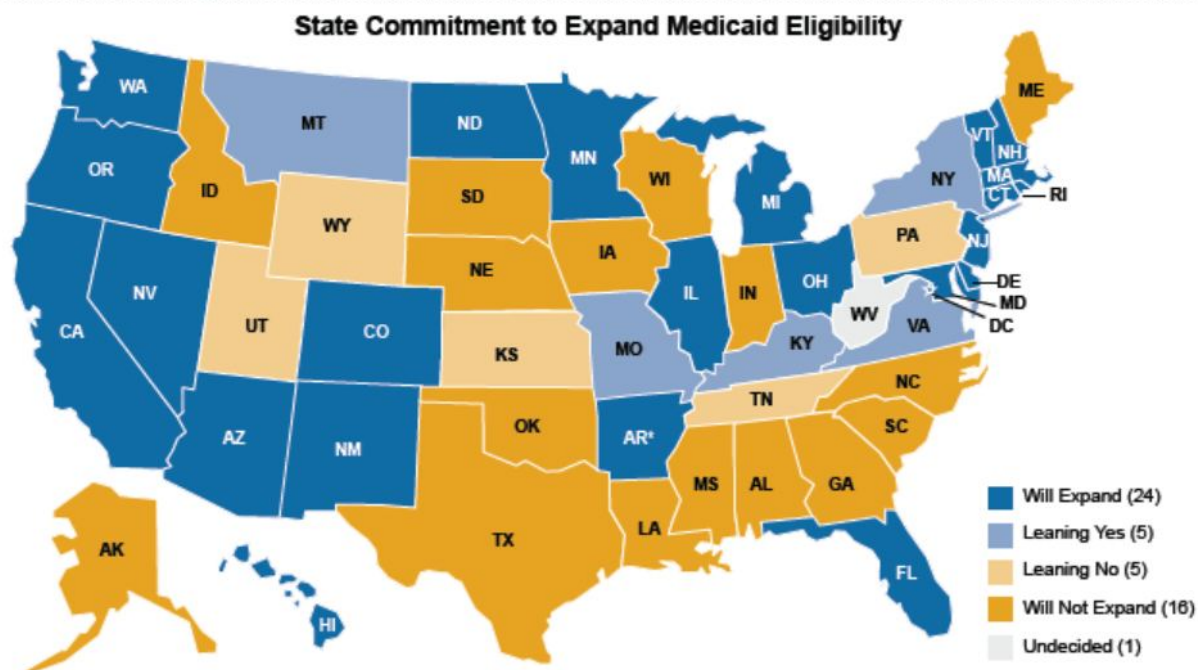
Post-SCOTUS

- Optional state Medicaid expansion.
- Population between 100% and 138% FPL eligible for premium subsidies.

State Exchanges – Individual Market

Medicaid Expansion – Current State Thinking

To Date, 23 States & DC Plan to Expand Medicaid Eligibility, 16 Will Not Expand, and the Remainder Are Undecided



Source: Avalere *State Reform Insights*, Updated March 1, 2013
*AR plans to use Medicaid funds to pay for exchange coverage for newly-eligible beneficiaries



State Exchanges – Individual Market

Medicaid Expansion – The 100% - 138% FPL Population

- Uninsured population potentially eligible for premium subsidies increases 25% to 30% without Medicaid Expansion.
- Potential exemption from the individual mandate.
- Eligible for significant cost sharing subsidies (94% actuarial value).
- Reinsurance impact.
- Higher morbidity level than population above 138% FPL..

Non-Elderly Uninsured	
FPL Cohort	Population
Under 100%	18,100,000
100-138%	6,400,000
139-250%	12,000,000
251-399%	6,500,000
400%+	4,900,000

Source: Statehealthfacts.org

State Exchanges – Individual Market

Existing State High Risk Pools

“CBOs analysis did not account for states folding their high risk pools into the exchanges..” – Dr. Jonathan Gruber

(<http://theincidentaleconomist.com/wordpress/what-will-consumers-make-of-health-insurance-exchanges/>)

Sample Enrollee Costs

State	Average Per Member Cost
New Mexico	\$16,300
Wisconsin	\$8,900
Indiana	\$18,300

State	Size of High Risk Pool Relative to Individual Market
New Mexico	13.8%
Maryland	11.1%
Minnesota	10.8%
Wisconsin	10.6%
Oregon	7.8%
Montana	5.7%
Mississippi	4.6%
New Hampshire	4.5%
Colorado	4.4%
Indiana	4.1%
Illinois	4.0%



State Exchanges – Individual Market

High Risk Pools

- Many states are indicating they will not continue to operate their high risk pools beyond January 1, 2014
- Typically most states cannot prevent high risk pool recipients from enrolling in the regular individual market risk pool after January 1, 2014

State Exchanges – Individual Market

State Political Views

Anti-ACA

- May have little outreach
- Rely on federal government for promotion
- Little public support

Pragmatic

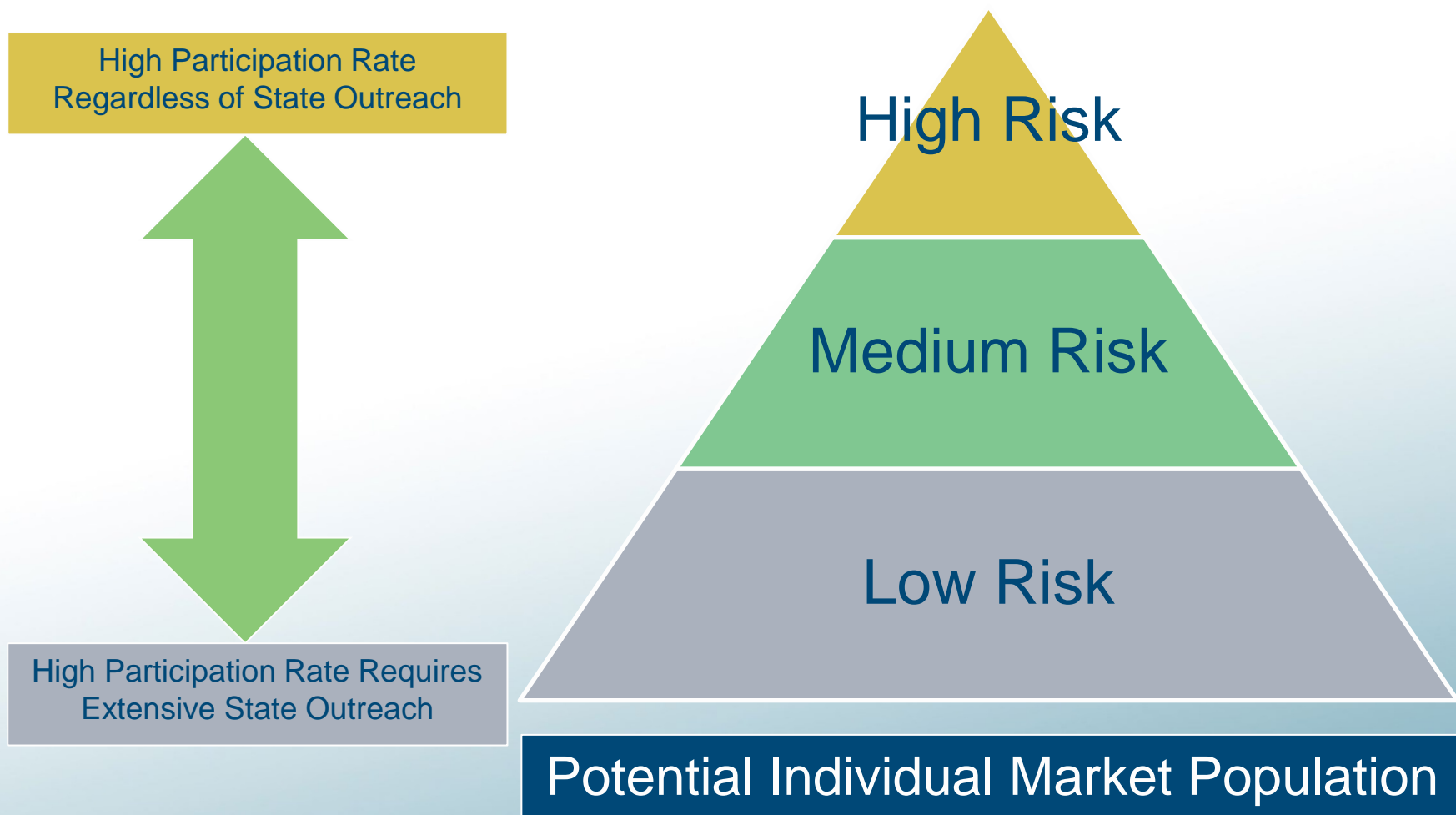
- Goal of minimizing insurance market disruption
- May have minimal resources

Pro-ACA

- Extensive outreach
- Marketing plan and budget
- Willing partners
- Public support

State Exchanges – Individual Market

State Political Views – Participation Impact



State Exchanges – Individual Market

Large Employer Behavior

Informed?

- Understand value of ESI?
- Making decision solely on penalty vs. premium.

Affordability Test

- Based on single only contribution
- May change ESI migration significantly.

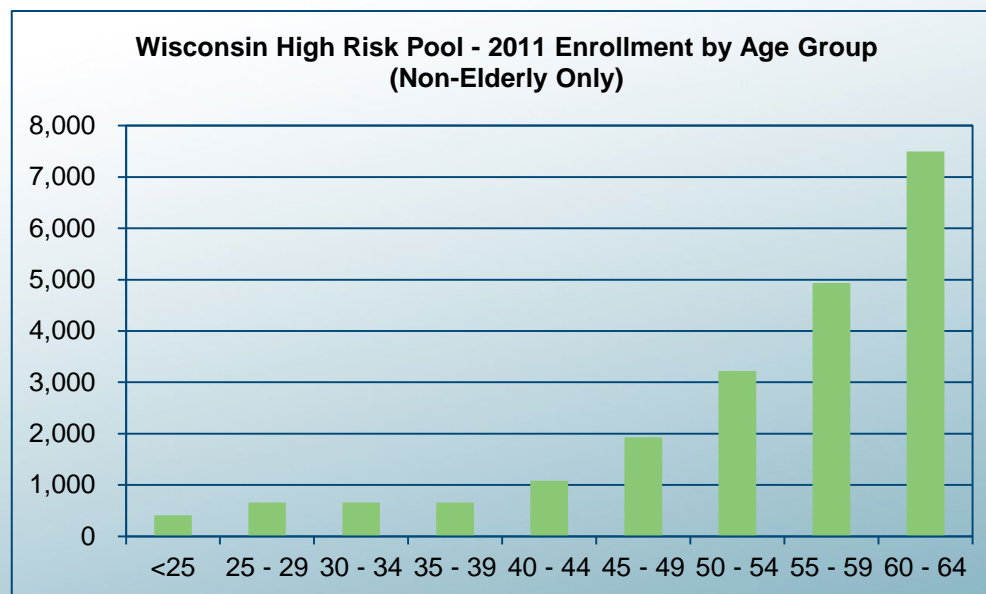
Segmentation

- Part-time employees.
- Early retirees.
- Population under 200% FPL.

State Exchanges – Individual Market

Employer Behavior – Early Retirees

- 3:1 age rating.
- Cost is no longer sustainable for some groups.
- Premium subsidies.
- Continue to offer coverage with a defined contribution approach.

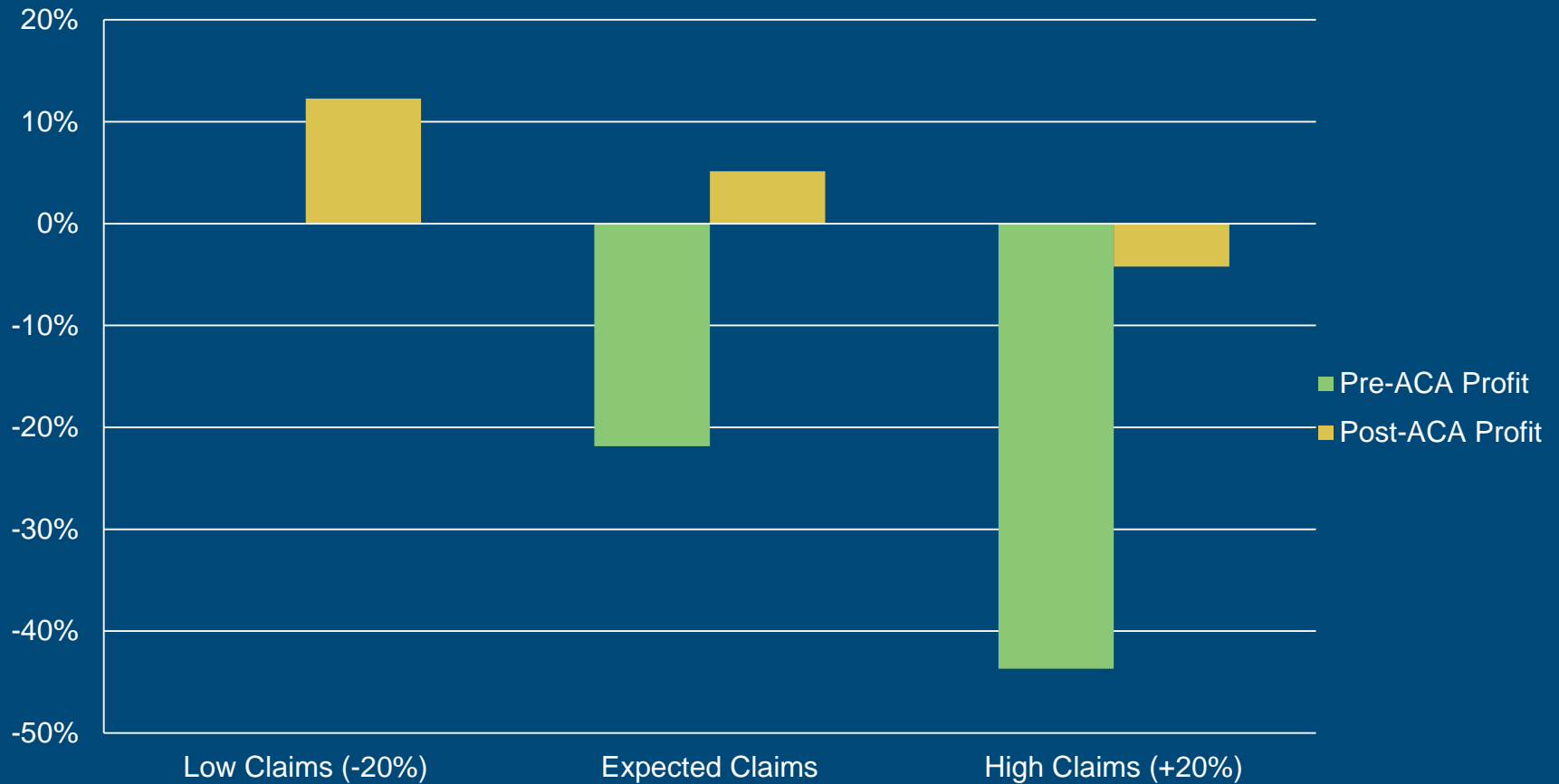




Will the 3Rs Save the Day?

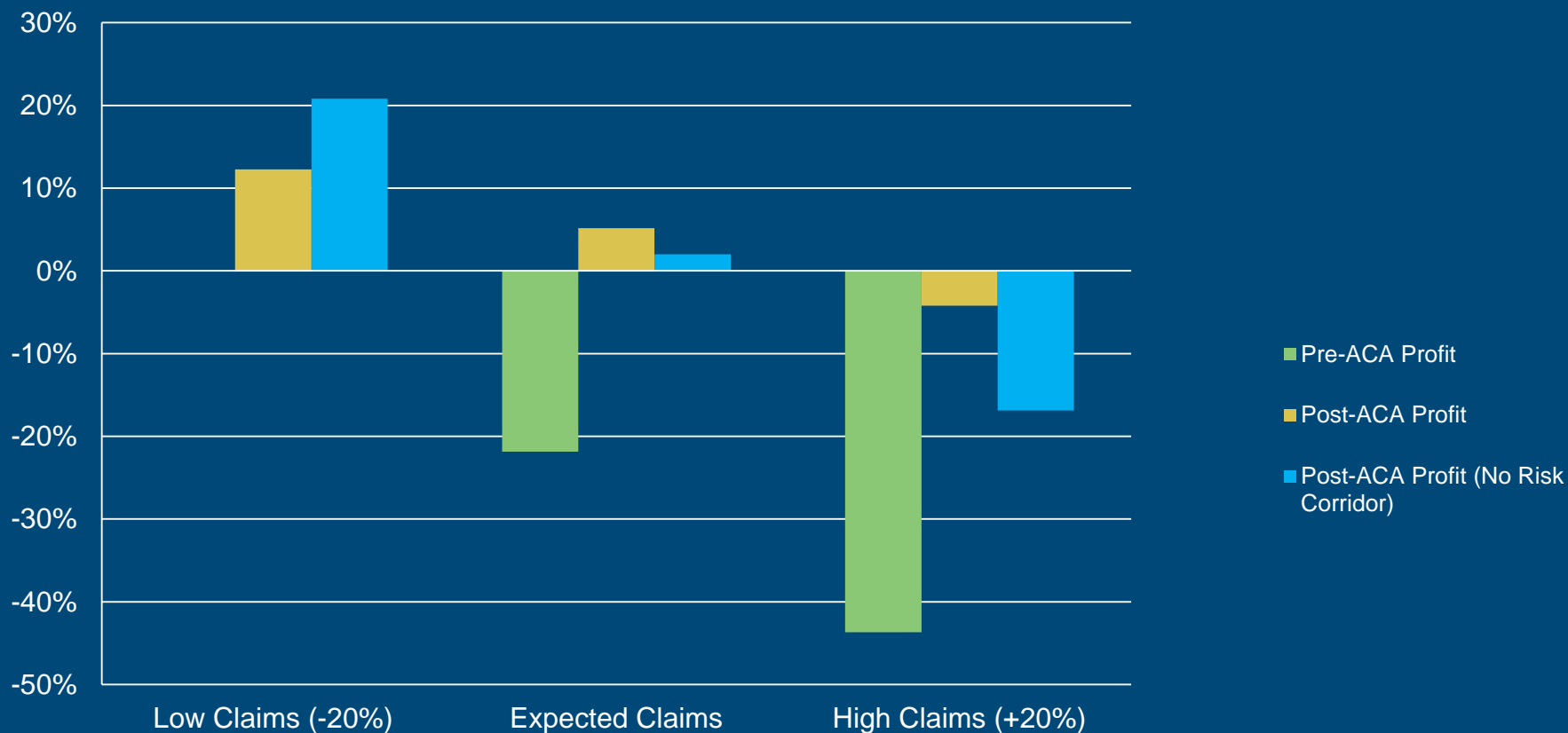
The 3 Rs Risk / Reward

Pre-tax Profit Margins
Pre-ACA vs. Post-ACA
Assuming Neutral Pricing Strategy



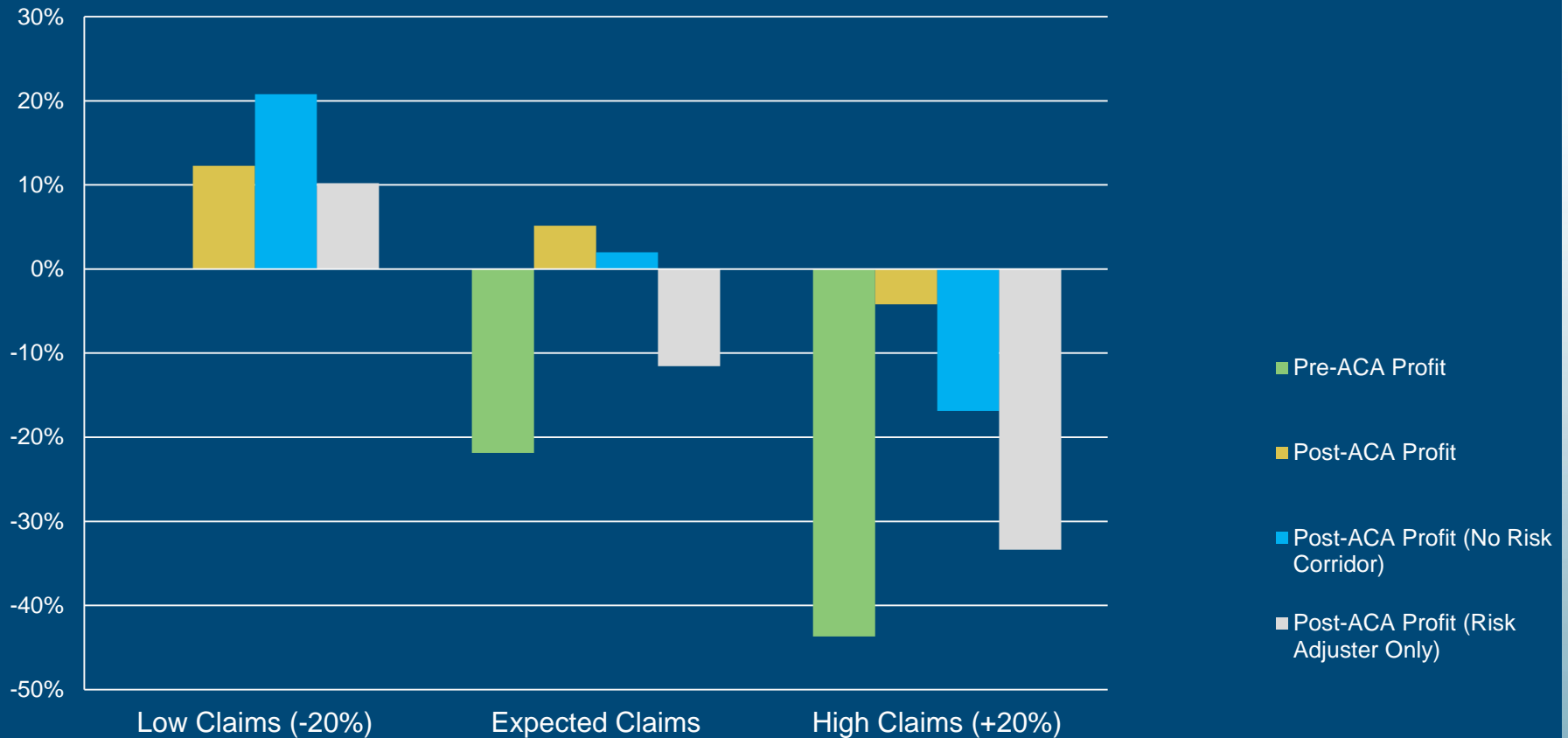
“Fiscal Cliff” Scenario – Remove Risk Corridor

Pre-tax Profit Margins
Pre-ACA vs. Post-ACA
Assuming Neutral Pricing Strategy



2017 Steady State – Risk Selection Still Matters

Pre-tax Profit Margins
Pre-ACA vs. Post-ACA
Assuming Neutral Pricing Strategy





Other HCR Regulated Costs

Health Insurance Providers fee 2014 (2013)

**Comparative Effectiveness research fee 2013-2020
(Oct 2011- Sept 2018)**

Exchange fee 2015

Cadillac Plan tax 2018



Health Insurance Providers Fee

What you need to know

- Premium-based
- On previous year
- *On net premium => reinsurers pay too*
- \$8 Billion and growing
- Eternal



Health Insurance Providers Fee

What you want to know

- Section 9010 of PPACA
- “Market Share Tax”
- Initially an assessment, eventually a tax
- \$37.5MM reduction in basis for each “entity” (that files a consolidated federal income tax return) each year
- Funds Exchanges



Assessments

- The ultimate risk-transfer mechanism
 - * Retroactively determine cost to funders
- Increasingly common for states
 - * In addition to premium taxes of mostly 2% (.4% to 4.265%)
 - * Oklahoma 1% of claims 8/26/2010 to 1/1/2015
 - * Michigan 1% of claims 1/1/2012
- Support specific purpose, such as CHIP
- Only some lines of business
 - * Often exclude stop-loss or disability



Assessment Bases

- % of premiums written
- % of premiums earned
- Per person insured
- Per contract or certificate



So What's Different About This Assessment?

- 1st federal assessment on Medical insurance
- \$8B (sheer magnitude)
 - * TX, 2010: \$98MM
- Rising to \$14.3B in 2018
- Supports PPACA, but basis is larger
 - * Excludes self-funded, government
 - * **Includes** Dental, Vision
- Not tax deductible

Market Share Tax

Expected Basis for 2013, 2014

	<u>2014</u>	<u>2015</u>
Total Fee \$B	8.0	11.3
<i>current self-insurance</i>		
Industry Premium \$B	552	599
Average rate	1.45%	1.89%
Tax-Effectuated rate	2.23%	2.90%
<i>higher self-insurance</i>		
Industry Premium \$B	527	555
Tax-Effectuated rate	2.34%	3.13%



Market Share Tax

Other thoughts

- Becomes fixed % of earned premium
 - * Increases by premiums, not medical inflation
- Is deductible from rebate calc
 - * Enters rebate calc during year paid
 - Basis is the year before paid
 - * When can you collect it?
 - * First year is insurer's cost??
- Specific prohibition against collecting it in 2013



Comparative Effectiveness Research Fee

- Collected 2013-2020
 - * Policies issued Oct 2011 and later
- Buck a year becomes \$2 starting Oct 2012
 - * Future years increase by medical inflation
- Payable July after end of policy year
 - * Policy effective Dec 2011 is payable July 2013
- Funds Patient-Centered Outcomes Research Institute



Other Fees

- Exchange Fees (2015)
 - * Covers Exchange operating costs
 - * Each Exchange will set own
 - Basis not yet known (participants or industry)

- Cadillac Plan tax (2018)
 - * Excise tax on “too rich” plans
 - \$10,200 single, \$27,500 family

Questions?



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