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Implications of Individual Subsidies in the Affordable Care Act—What Stakeholders Need to Understand

By Greg Fann

// If you are one of the 30 million Americans who don't yet have health insurance, starting in 2014 this law will offer you an array of quality, affordable, private health insurance plans to choose from." This statement and others like it on the White House website suggest that an abundance of low-cost health plans with relatively generous benefits are now available nationwide in the commercial non-group (individual) market due to provisions in the Affordable Care Act (ACA) and that the number of uninsured Americans should rapidly decline. The success of the ACA in accomplishing the stated goal of ensuring that every American has access to affordable health care has been unremittingly questioned, and will continue to be debated long after the administrative implementation struggles are resolved, and likely long after the market stabilizes and all individual and small group enrollees have transitioned to ACA-compliant plans.

Embedded in all of these messages is the nebulous title of the law and the term "affordable," which lacks consensus of determination and remains largely undefined. "Affordable" is

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frequently cited without explanation and with little communicated understanding of the net financial consequences for different groups of consumers for 2014 and beyond, nor in terms of the change compared to 2013. This lack of understanding is highlighted in a March 2014 McKinsey study¹ that suggests that uninsured Americans have been slow to enroll and primarily cites “perceived affordability challenges” as the most common reason. While 80 percent of the McKinsey respondents were eligible for a federal premium subsidy, 66 percent were not aware of their subsidy eligibility or the applicable amount.

This article discusses the details of the ACA provisions of federal subsidies that affect consumers’ cost of coverage in the individual market, and breaks down how the net effect of these provisions will shape consumers’ decisions to buy a new level of coverage, retain current coverage, or elect to be uninsured (or underinsured according to the ACA definition) despite new tax penalties. Prior to diving into the consumer-directed affordability mechanisms crafted in the ACA, it is worthwhile to review other new market impacts that will also affect affordability.

Gross Premiums and Risk Mitigation Programs in the New Market

Numerous articles and studies have been published regarding the ACA’s overall effect on underlying claim costs and premiums in the individual market, including a major undertaking by the Society of Actuaries released in March 2013.² While the conclusions have varied across studies, there is unanimous agreement that actuaries faced great uncertainty in the development of premiums for 2014, and that they will continue to face similar uncertainty for several years to come. Contributing to this uncertainty is the health risk of those who will enroll in individual plans who are now currently uninsured. The composition of the expanded individual market is unknown; the individual market will grow significantly and may be older and less healthy than anticipated. The degree of change will

differ by market; each state is starting from a different point and has a different demographic profile. To manage the financial consequences of these risks, premium stabilization processes were put in place by the ACA that will smooth the transition to the new market environment and will partially protect issuers from losses (and partially limit gains). These temporary protections and the potential of an increased market size could enhance competition and might attract new issuers who see a limited-time opportunity to enter the market with lower risk implications.

Similar to the abundance of premium impact research, many of the technical aspects of the ACA that will find their way into actuaries’ daily routines have been thoroughly presented in numerous formats. This includes topics such as the risk corridor program, the risk adjustment program, the reinsurance subsidy, the cost-sharing reduction subsidy, and minimum loss ratio regulations.

In general, the gross premium implications (including related assumptions such as the effect of guarantee issue, pent-up demand and induced utilization) and the technical aspects of premium stabilization are mostly understood. That said, it is my observation that there is a wide gap in understanding what lies between these two areas. Specifically, the risk mitigation program calculations are dependent upon the enrollment in the individual market, which is predicated on the expected *net* costs to consumers after adjusting gross costs for federal subsidies.

While some advanced analytical models have presumably accounted for subsidies in projecting individual behavior, the technical nature of the mechanics has been overlooked in public forums, and the impact of these subsidies is frequently generalized and misrepresented. A methodological understanding of how the subsidies work is required to understand the transition from gross premium to net premium, which is needed in order to model consumer behavior and develop reasonable enrollment and financial projections. This understanding can



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Affordability does not take into account accumulated savings and assets, nor the notion that older people generally budget a higher percentage of spending for health care services. Income is the only affordability measure.

provide an opportunity for actuaries to correct common misconceptions and facilitate the construction of thoroughly vetted analytic models that will add clarity and confidence for stakeholders assessing the market impact.

ACA Impact on Individual Rates

The ACA includes several provisions that impact gross premium rates, rate relativities, and net costs paid by individuals. Moreover, access to insurance is guaranteed and health status can no longer be used as a rating variable. No longer can issuers exclude coverage for pre-existing conditions. Comprehensive coverage with guarantee issue, along with new industry taxes, obviously increases underlying costs and associated premiums. The ACA offsets some of this upward force on premiums by creating penalties for those not retaining adequate insurance, as well as through encouraging healthier people to enroll by providing generous premium and benefit subsidies to some based on income levels. A description of the major items affecting rates is included below.

RATE REVIEW

While rate review oversight remains at the state level, exchange-qualified plans also must be reviewed at the federal level. Some states received federal grants to increase the scope of reviews. As will be discussed later in this article, the net impact of rate review will have a different, and likely surprising, impact on individuals when viewed separately by age and income level.

MINIMUM LOSS RATIO

After allowing for quality improvement costs as well as taxes and assessments, an 80 percent minimum loss ratio must be met in the individual and small group markets (separately, unless the state has merged the two markets into one pool, as has Vermont). A result below 80 percent results in refunds to policyholders. This calculation will be performed on results that will include proceeds to or from the risk adjustment, transitional reinsurance, and risk corridor programs. It is important to note that the risk corridor program transfer payments occur prior to the calculation of minimum loss ratio rebates.

INDIVIDUAL MANDATE

The guarantee issue provision and the age rating compression (discussed below) increase the premium rates for younger individuals. To entice healthier uninsured individuals to enroll, and thus subsidize higher-cost individuals, a tax penalty will apply to individuals who do not enroll in “minimum essential coverage.” The penalty is the greater of \$95 or 1 percent of income in 2014. These amounts increase significantly in 2015 (\$325 and 2 percent) and 2016 (\$695 and 2.5 percent). There are several qualifying exemptions to the tax penalty, but generally it will ultimately be a significant financial consideration for consumers who are hesitant about purchasing coverage.

METAL TIERS

The ACA attempts to standardize health care coverage by requiring that plans sold in the individual and small group market meet an actuarial value (AV) criterion, which is the average value of the plan benefits relative to the total allowed costs. This allows consumers to compare benefit values across issuers and is intended to increase price transparency. Bronze plans have an AV of 60 percent. Silver plans have an AV of 70 percent. Gold plans have an AV of 80 percent. Platinum plans have an AV of 90 percent. A +/- 2 percent variation in AV is allowed to meet the metal level criterion. Issuers have flexibility in designing benefits packages to meet the AV criterion, but must meet some specific minimum requirements such as maximum out-of-pocket limits.

RISK ADJUSTMENT

A critical permanent balancing item in the new framework is risk adjustment. Risk adjustment is “a zero-sum game” across each market in each state, and is intended to have issuers compete on their ability to provide quality affordable care and an efficient administrative system, rather than their ability to attract a less risky membership. Risk adjustment fosters market stability and overall competition. While new to the commercial market, risk adjustment programs are prevalent in Medicare Advantage and various state Medicaid programs.

PREMIUM SUBSIDIES

Each of the above items is intended to decrease the level of gross premium rates. Similar regulatory ideas have been implemented in various states in the last 30 years and have generally not succeeded in reducing premiums, largely due to issuer withdrawal from the market and higher claim costs due to lower participation of young and healthy enrollees. The authors of the ACA were familiar with states' histories and believed that a successful regulatory system could be developed with the addition of the aforementioned mandate, a few balancing items, and a large financial commitment from the federal government, mainly in the form of benefit and premium subsidies. It is recognized that adequate participation from young and healthy individuals is required for success, so targeted promotional efforts and outreach are also necessary in addition to the framework of financial incentives.

The large financial commitment in the ACA, the crown jewel of the law, is the allocation of premium subsidies directly to some individuals, which is intended to lower the net cost of insurance for those specific purchasers. The subsidies are intended to lower the purchasers' costs to a more affordable rate. How is affordability determined? Who is eligible to receive subsidies? How are the subsidies calculated? How do the subsidies facilitate more affordable coverage? These are the right questions to ask, and they are listed in sequential order with each subsequent answer being more complex. To be eligible for a premium subsidy, an individual must have an income level between 100 and 400 percent of the Federal Poverty Level (FPL), purchase a plan in an individual exchange, and generally not be eligible for other coverage.

Affordability is determined based on a graded scale as a percentage of income; specifically, as income rises, individuals are deemed to be able to afford to spend a larger share of their income on health care services. Affordability does not take into account accumulated savings and assets, nor the notion that older people generally budget a higher percentage of spending for health care services. Income is the only affordability measure. Individuals who have incomes above 400 percent of FPL are not eligible for subsidies and thus are technically presumed

to be able to afford health coverage, regardless of the cost relative to income. This is particularly significant given the wide difference in premium levels throughout the country.

The affordability definition is applied to a benchmark plan in the individual's geographic region. The benchmark plan is the second-lowest-priced silver plan option available. If the gross premium for this plan is higher than the affordability measure, the individual only pays the "affordable" amount, and the federal government subsidizes the remainder of the premium cost. If the individual selects a more expensive or lower-cost plan, that plan can be purchased for a lower rate by carrying over the calculated subsidy to the selected plan.

The resulting impact of the premium subsidies on net premium rates is not intuitive, and generally not well understood. While a technical analysis is required to understand the different impacts to different people, the natural inclination is to generalize and believe that the premium subsidies will have uniform and directionally appropriate effects across the eligible population, as most government entitlement programs are intended to do. However, the following sections will illustrate that the subsidies will primarily benefit older people, as premium rates for younger people are more likely to be considered "affordable" before a subsidy adjustment. This reality is either unknown or overlooked when reliance on premium subsidies is the automatic explanation of why there is no reason to be concerned that young people may choose not to enroll in the individual exchanges.

The concern that young people will not enroll in enough levels to support the sustainability of the individual market is further strained by the widely known ACA provision requiring employers to allow children under the age of 26 to enroll or remain on their parents' plans, as well as age compression of the individual market premiums that will discourage younger members from enrolling compared to premiums they would pay if age rating were on an actuarially appropriate basis. A detailed illustration of the premium subsidy calculation and resulting

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net premiums by age and income level is provided below.

COST-SHARING SUBSIDIES

Cost-sharing subsidies are available only for individuals with incomes below 250 percent of the FPL who select a silver plan in the exchange. Individuals select a standard silver plan from the exchange and the benefits are adjusted to gross up the AV from 70 percent to 73 percent (200 to 250 percent FPL), 87 percent (150 to 200 percent FPL) or 94 percent (100 to 150 percent FPL). The premium rate for these eligible individuals remains at the 70 percent level, and the federal government subsidizes the difference between 70 percent and the grossed-up AV through reimbursing the issuers for the enriched plan design. Effectively, the enhancements change the expected cost-sharing percentage from 30 percent to 27 percent (200 to 250 percent FPL), 13 percent (150 to 200 percent FPL) or 6 percent (100 to 150 percent FPL). While there is benefit design flexibility in adjusting the benefits to achieve the right cost share level, a minimum requirement is adjusting the maximum out-of-pocket limit (MOOP) to \$2,250 for individuals at 100 to 200 percent FPL and to \$5,200 for individuals at 200 to 250 percent FPL. The 2014 maximum before the required reduction is \$6,350 for individuals and \$12,700 for families.

It should be noted that all cost sharing is zero for Native Americans below 300 percent FPL for all

metal level plans. For simplicity, applicable scenarios for qualifying Native Americans are not included in the illustrations below as the financial implications related to plan selection for these individuals are straightforward.

AGE RATING COMPRESSION AND GENDER NEUTRALITY

The allowable rating relationship of costs by age and gender varies across states, but the cost curve is generally thought to be in the 5:1 or 7:1 range.³ The ACA prescribes a 3:1 age rating limit, which is intended to lower the premium costs to older people. The ACA also prohibits rating differently based on gender starting in 2014. The ACA prescribes a common rate slope across issuers in each state, with the federal default slope adopted in most states. The rate impact will obviously vary by age and gender, and create a market that is less attractive to young people, all else being equal.

President Obama’s announcements that allow for further extension of pre-ACA benefits presumably preserve the pre-ACA age and gender rating structure for individuals and groups in states and with issuers that elect this extension option. Hence, it is likely that younger people currently rated on a steeper age curve will have a greater propensity to keep their current plan than older people.

PREMIUM SUBSIDY ILLUSTRATIONS

A simplified and transparent numerical example is

Figure 1: Per Member per Month Claim Cost of 2nd Lowest Plan

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	150.00	75.00	90.00	105.00	120.00	135.00
44	375.00	187.50	225.00	262.50	300.00	337.50
64	900.00	450.00	540.00	630.00	720.00	810.00

Figure 2: Per Member per Month Claim Cost of Lowest Plan

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	135.00	67.50	81.00	94.50	108.00	121.50
44	337.50	168.75	202.50	236.25	270.00	303.75
64	810.00	405.00	486.00	567.00	648.00	729.00

Figure 3: Monthly Premium of 2nd Lowest Plan

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	150.00	93.75	198.03	231.03	264.04	297.04
44	375.00	234.38	276.64	322.75	368.86	414.96
64	900.00	562.50	594.08	693.09	792.11	891.12

Figure 4: Monthly Premium of Lowest Plan

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	135.00	84.38	178.22	207.93	237.63	267.34
44	337.50	210.94	248.98	290.48	331.97	373.47
64	810.00	506.25	534.67	623.78	712.90	802.01

constructed that will be used throughout the remainder of this article. Three individuals of different ages are assumed to represent a sampling of the population for respective issuers. Varying income levels for each individual are modeled to allow comparisons by age, benefit plan and income level.

Allowed cost for a representative issuer with the second-lowest silver plan is assumed for the three individuals in Figure 1 on page 8. Also shown in Figure 1 are the expected issuer-paid share of the allowed cost paid by the individuals' current plan and four ACA-compliant metal plan options available to the individuals.⁴ Allowed cost represents claims cost, prior to attribution between the member (through deductibles, copays and coinsurance), the issuer, and the federal government through cost-sharing subsidies. A very simplistic scenario is assumed, including single coverage (that is, no family coverage), with no induced utilization reflected in cost (in reality, richer plan designs tend to drive up the allowed cost expected for the individual), and the underlying claim cost relationship is assumed to be gender-neutral, with a 6:1 age relativity.⁵ A hypothetical lowest-cost plan was arbitrarily set at 10 percent below the second-lowest plan premium and is displayed in Figure 2. For both plans, a current non-ACA compliant plan design with 50 percent actuarial value is assumed to be in place for these three individuals.

Figures 3 and 4 above illustrate the gross premium structure before premium subsidy reductions for both plans assuming an 80 percent pricing loss ratio. The current plan is priced to an 80 percent pricing

loss ratio specific to age (the product is assumed to be offered in a state that prior to the ACA allowed actuarially justified age ratios), while the metallic plans are priced to 80 percent in aggregate for the three individuals and compliant with the federal age curve. While the illustration reflects different rates for the current plan due to benefits and age slope, it does not reflect that rates may also be relatively lower due to preferred underwriting status at the time the policy was issued prior to 2014.

Figure 5 below displays the first input to the premium subsidy calculation. Depending on income relative to the FPL, an individual's contribution (that is, net premium) is capped based on the benchmark plan (the second-lowest silver plan) offered in the individual's geographic region. As mentioned earlier, premium subsidies are not available to individuals with incomes below 100 percent of FPL or above 400 percent of FPL; applicable percentages are linearly interpolated in between the data points in Figure 5.

Figure 5: Maximum Premium Contribution

FPL Level	Maximum % of Income
100-133%	2.00%
133%	3.00%
150%	4.00%
200%	6.30%
250%	8.05%
300-400%	9.50%

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Some savvy young individuals may be disillusioned to learn that the mandated coverage that they are strongly being encouraged to purchase is not only more expensive due to age rating compression, but that the premium subsidies are allocated in such a way that the net premium costs for older people is actually lower than the net premiums for younger people for the lowest-cost plan options.

Figure 6: Premium Subsidy Calculation

Age	FPL Amount*	FPL Level	Maximum % of Income	Benchmark Plan	Maximum Contribution	Calculated Subsidy
24	11,490	275%	8.78%	231.03	231.06	0.00
44	11,490	275%	8.78%	322.75	231.06	91.69
64	11,490	275%	8.78%	693.09	231.06	462.04

*2013 Amount

Figure 7: 2nd Lowest Plan Net Premium Calculations (275% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	150.00	93.75	198.03	231.03	264.04	297.04
44	375.00	234.38	184.95	231.06	277.16	323.27
64	900.00	562.50	132.04	231.06	330.07	429.08

Figure 8: Lowest Plan Net Premium Calculations (275% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	135.00	84.38	178.22	207.93	237.63	267.34
44	337.50	210.94	157.29	198.78	240.28	281.77
64	810.00	506.25	72.64	161.75	250.86	339.97

Figure 6 illustrates the premium subsidy calculation for each individual age. For an income level of 275 percent FPL, the monthly contribution is capped at \$231.06 ($\$11,490 \times 275\% \times 8.78\% / 12$). As the benchmark plan (second-lowest silver plan) rate is lower than the maximum contribution, the 24-year-old is not eligible for a premium subsidy. The older individuals can purchase the second-lowest silver plan for the maximum contribution or transfer the calculated subsidy to another lower or higher cost plan in the exchange. While this is only one example, and not an exhaustive study, this example demonstrates that the calculation results in subsidy dollars that are heavily distributed toward older people.

Figures 7 and 8 illustrate the net premiums available to an individual at the 275 percent FPL level after accounting for the premium subsidy calculation. A few things should be noted from the resulting net premiums. First, the rates for the current plans have not changed from Figures 3 and 4, as these plans are not ACA-compliant and therefore not eligible for federal subsidies. Second, the rates

for the 24-year-old also did not change as no subsidy was calculated in Figure 6, since the gross premium is below the affordability measure. Third, the net premium for the second-lowest silver plan is the same for the older individuals since the affordability threshold depends only on income and not on age.

Finally, perhaps most enlightening and not at all intuitive, is the finding that at a given income level, plans with lower costs than the second-lowest silver plan (second-lowest bronze, lowest bronze, lowest silver) have net premium relationships that are inverted due to the leveraging of the premium subsidies (that is, the age-64 individual will pay *less* than the age-44 individual who will pay *less* than the age-24 individual). A direct comparison of the current and bronze plans illustrates why it is expected that more young people will remain on current plans while older people will more quickly move to the subsidized exchange plans. Some savvy young individuals may be disillusioned to learn that the mandated coverage that they are strongly being encouraged to purchase is not only more expensive due to age rating compression, but that the premium

Figure 9: Lowest Plan Net Premium Calculations (175% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	135.00	84.38	33.49	63.19	92.90	122.60
44	337.50	210.94	12.52	54.02	95.52	137.01
64	810.00	506.25	-	16.99	106.10	195.21

Figure 10: Lowest Plan Cost Sharing (275% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	135.00	67.50	54.00	40.50	27.00	13.50
44	337.50	168.75	135.00	101.25	67.50	33.75
64	810.00	405.00	324.00	243.00	162.00	81.00

Figure 11: Lowest Plan Cost Sharing (175% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	135.00	67.50	54.00	17.55	27.00	13.50
44	337.50	168.75	135.00	43.88	67.50	33.75
64	810.00	405.00	187.50	105.30	162.00	81.00

subsidies are allocated in such a way that the net premium costs for older people is actually lower than the net premiums for younger people for the lowest-cost plan options.

Expected Total Cost (ETC) Illustrations

The premiums represented in the figures above do not present the total consumer cost, as individuals will still have a cost-sharing responsibility in the form of deductibles, copays and coinsurance. An individual’s ETC for health care can be thought of as the net premium, calculated in the figures above, plus the expected net cost sharing, plus the applicable tax penalty if qualifying minimum essential coverage⁶ is not obtained. For purposes of simplicity, it is assumed that costs at each age are homogeneous, and individuals have a good understanding of their expected cost sharing and make price-sensitive decisions.

In order to illustrate the cost-sharing subsidy impact and the ETC for different income levels, Figure 8 is replicated in Figure 9 above with a lower income level (175 percent FPL) eligible for a cost-sharing subsidy; and Figures 10 and 11, respectively, display the expected cost sharing for individuals at 275 percent of FPL and 175 percent of FPL. Two observations should be noted with regard to Figure 9 relative to Figure 8: Net premiums are significantly lower due to the more generous premium subsidies and the age-64 individual has a subsidy large enough to fund the entire cost of the bronze plan. Two differences should be noted moving from Figure 10 to Figure 11. The silver plan cost sharing is lower for each age as the applicable cost sharing is 13 percent in the 175 percent FPL scenario rather than 30 percent, and the bronze plan cost sharing for the age-64 enrollee is capped by the reduced MOOP amount allocated on a monthly basis (\$2,250 / 12) as discussed above.

To calculate the ETC in Figures 12 and 13, the net premiums are added to the expected cost sharing. For completeness, a no-coverage-cost option is included, which is the sum of the allowed cost plus the tax penalty. This is a simplistic assumption, since the same individual lacking coverage would not have prearranged network discount savings and may tend not to seek similar levels of services.

Continuing with this example, expected cost sharing is added to the net premium for each age at various income levels. As one might expect, the value of the cost-sharing subsidy (17 percent of allowed costs) makes the silver plan attractive for the 175 percent FPL individual. For the 275 percent FPL individual, the current plan is clearly the most attractive option for the 24-year-old.

Without consideration of the cost-sharing subsidies and the MOOP impact, the ETC of the metal plans is relatively close in value for older individuals. Risk-averse and higher-cost individuals may prefer richer plans. Figure 14 shows the percentage change in ETC for increasing through each metal level (i.e., “Silver” column is the ETC percentage increase from bronze to silver) for an average costing individual at the 275 percent FPL. For older individuals, the higher administrative costs built into the premium for richer plans are partially offset, due to the age-compressed rate range. Stated another way, older individuals may elect to “buy as much benefit as possible” through opting for the platinum plan, and will have roughly 90 percent of their increased financial outlay partially subsidized because of the 3:1 age compression. This should be understood as you review the conclusions offered in the next section.

ETC Analysis

Using the same method discussed above, an ETC is developed for each age, income level and plan type. Figures 15, 16 and 17, respectively, illustrate the ETC for age 24, 44 and 64 utilizing the example’s lowest issuer premiums for various income levels and plans.

While it should be noted that some of the results in Figures 15 through 17 are relatively close across plan design, the optimal plan decision based on

ETC methodology varies by age and income level. These optimal plan choices are displayed in Figure 18 on page 14 to highlight some generalities by age and income. Figure 18 is replicated in Figures 19 and 20 to model the impact of the significantly increasing tax penalty and how that might impact coverage decisions by age and income in 2015 and 2016. The tax penalty relative to the lowest bronze premium is also displayed in Figures 18 through 20 to highlight the proportional penalty of not having coverage relative to purchasing a low-cost plan. In some cases, the net bronze premium is zero (indicated by “n/a”) or less than the tax penalty. It is assumed here that the current plan is no longer an option after 2015 as that is the most recent guidance from the administration. The elimination of the current plan as a viable option is reflected in Figure 20.

While issuers’ experience and models will differ, several general comments can be made about likely decisions based on age and income:

- Individuals with low incomes (below 200 percent FPL) will overwhelmingly select silver plans to take advantage of the cost-sharing subsidy. The 3 percent cost-sharing subsidy in the 200 to 250 percent FPL range does not have much impact compared to the 17 percent and 24 percent subsidies for incomes below 200 percent FPL.
- To avoid the rate change due to age compression, many high income young people will elect to stay on their current plan for as long as possible. A similar outcome is expected for grandfathered plans.
- Middle to high income young people are the most likely to go without coverage, particularly in 2014 and 2015. As the penalty is a percentage of income, at high income levels, the penalty will exceed the gross premiums (which do not vary based on income) and high income individuals will likely purchase at least the minimum required coverage.
- For higher income levels, the tax penalty as a percentage of the lowest bronze premium is significantly higher for younger people. This might provide greater incentive for young uninsured individuals to obtain coverage; this incentive will increase in 2015 and again in 2016.
- The tax penalty for the low income older individuals relative to the lowest bronze premium

Figure 12: Expected Total Cost (275% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	161.33	151.88	232.22	248.43	264.63	280.84
44	363.83	379.69	292.29	300.03	307.78	315.52
64	836.33	911.25	396.64	404.75	412.86	420.97

Figure 13: Expected Total Cost (175% FPL)

Age	Allowed Cost	Current	Bronze	Silver	Gold	Platinum
24	151.76	151.88	87.49	80.74	119.90	136.10
44	354.26	379.69	147.52	97.89	163.02	170.76
64	826.76	911.25	187.50	122.29	268.10	276.21

Figure 14: Expected Total Cost Metal Level Buy-Up (275% FPL)

Age	Silver	Gold	Platinum
24	7.0%	6.5%	6.1%
44	2.7%	2.6%	2.5%
64	2.0%	2.0%	2.0%

Figure 15: Age 24 Expected Total Cost

FPL	No Coverage	Current	Bronze	Silver	Gold	Platinum
116.5%	146.15	151.88	54.00	8.10	55.91	72.11
141.5%	148.55	151.88	54.00	32.42	81.02	97.23
175.0%	151.76	151.88	87.49	80.74	119.90	136.10
225.0%	156.54	151.88	155.77	167.92	188.18	204.38
275.0%	161.33	151.88	232.22	248.43	264.63	280.84
325.0%	166.12	151.88	232.22	248.43	264.63	280.84
375.0%	170.91	151.88	232.22	248.43	264.63	280.84
425.0%	175.69	151.88	232.22	248.43	264.63	280.84

Figure 16: Age 44 Expected Total Cost

FPL	No Coverage	Current	Bronze	Silver	Gold	Platinum
116.5%	348.65	379.69	135.00	20.25	99.03	106.78
141.5%	351.05	379.69	135.00	35.40	124.14	131.89
175.0%	354.26	379.69	147.52	97.89	163.02	170.76
225.0%	359.04	379.69	215.80	213.43	231.30	239.04
275.0%	363.83	379.69	292.29	300.03	307.78	315.52
325.0%	368.62	379.69	356.86	364.60	372.35	380.10
375.0%	373.41	379.69	383.98	391.73	399.47	407.22
425.0%	378.19	379.69	383.98	391.73	399.47	407.22

Figure 17: Age 64 Expected Total Cost

FPL	No Coverage	Current	Bronze	Silver	Gold	Platinum
116.5%	821.15	911.25	187.50	48.60	204.11	212.22
141.5%	823.55	911.25	187.50	48.60	229.22	237.33
175.0%	826.76	911.25	187.50	122.29	268.10	276.21
225.0%	831.54	911.25	264.58	303.97	336.38	344.49
275.0%	836.33	911.25	396.64	404.75	412.86	420.97
325.0%	841.12	911.25	461.21	469.32	477.43	485.54
375.0%	845.91	911.25	506.69	514.80	522.91	531.02
425.0%	850.69	911.25	858.67	866.78	874.90	883.01

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Figure 18: Optimal Plan Selection for 2014

FPL	Expected Lowest Cost Option			Penalty as % of Bronze Premium		
	24	44	64	24	44	64
116.5%	Silver	Silver	Silver	n/a	n/a	n/a
141.5%	Silver	Silver	Silver	n/a	n/a	n/a
175.0%	Silver	Silver	Silver	50.0%	133.8%	n/a
225.0%	Current Plan	Silver	Silver	21.2%	26.7%	n/a
275.0%	Current Plan	Bronze	Bronze	14.8%	16.7%	36.3%
325.0%	Current Plan	Bronze	Bronze	17.5%	14.0%	22.7%
375.0%	Current Plan	No Coverage	Bronze	20.1%	14.4%	19.7%
425.0%	Current Plan	No Coverage	No Coverage	22.8%	12.1%	5.0%

Figure 19: Optimal Plan Selection for 2015

FPL	Expected Lowest Cost Option			Penalty as % of Bronze Premium		
	24	44	64	24	44	64
116.5%	Silver	Silver	Silver	n/a	n/a	n/a
141.5%	Silver	Silver	Silver	n/a	n/a	n/a
175.0%	Silver	Silver	Silver	100.1%	267.6%	n/a
225.0%	Current Plan	Silver	Silver	42.3%	53.3%	n/a
275.0%	Current Plan	Bronze	Bronze	29.5%	33.5%	72.5%
325.0%	Current Plan	Bronze	Bronze	34.9%	28.1%	45.4%
375.0%	Current Plan	Current Plan	Bronze	40.3%	28.8%	39.3%
425.0%	Current Plan	Current Plan	Bronze	45.7%	24.1%	10.0%

Figure 20: Optimal Plan Selection for 2016

FPL	Expected Lowest Cost Option			Penalty as % of Bronze Premium		
	24	44	64	24	44	64
116.5%	Silver	Silver	Silver	n/a	n/a	n/a
141.5%	Silver	Silver	Silver	n/a	n/a	n/a
175.0%	Silver	Silver	Silver	125.1%	334.5%	n/a
225.0%	Bronze	Silver	Silver	52.9%	66.7%	n/a
275.0%	No Coverage	Bronze	Bronze	36.9%	41.9%	90.6%
325.0%	No Coverage	Bronze	Bronze	43.7%	35.1%	56.7%
375.0%	No Coverage	Bronze	Bronze	50.4%	36.1%	49.1%
425.0%	Bronze	Bronze	Bronze	57.1%	30.1%	12.6%

also illustrates why these individuals are the most likely to enroll in subsidized exchange coverage.

Limitations of Example Calculation and Advanced Modeling

This example analysis is intended to be simplistic for purposes of illustrating the subsidy mechanics and does not consider many non-financial variables. For example, market competitiveness and pressure from state regulators for lower rates led to some state exchanges having more narrow networks than the off-exchange market. Many individuals will likely pay more to keep their current plan, or buy an off-exchange plan if their exchange subsidy is small, particularly if their doctor is not in the exchange plan's network. Also, as contentious as the rollout of the ACA has been, some consumers will undoubtedly view exchange enrollment as a statement of support of the ACA and may make a political decision to either enroll or not enroll in an exchange product. President Obama himself noted his perceived foolishness of this rationale on March 6, 2014 stating, "The main point that I have for everybody watching right now is, you don't punish me by not signing up for health care. You're punishing yourself or your family if in fact there's affordable health care to be had." Similarly, some consumers will not labor through all the math and network options and will ultimately view exchanges as "government products" and may make purchasing decisions based on their respective trust level of government versus private insurance companies.

For simplicity, these illustrations ignore conditions that would exempt individuals from the tax penalty for not enrolling in compliant plans. Examples include individuals who do not meet an affordability threshold (cannot purchase coverage for less than 8 percent of income) or who join a health care sharing ministry and are exempted from the penalty. These individuals could make similar decisions, but with the exclusion of the penalty from the equation. Also, catastrophic plans are excluded from this analysis but represent another option for some individuals, particularly young high income individuals weighing the premium costs versus the tax penalty.

An undertaking of a robust model should incorporate as many material variables as possible.

The illustrative examples provided above attempt to model individuals making optimal financial decisions. They do not take into account family or employment situations that will further complicate the decision options. Also, everyone is perceived in the illustrations as having similar morbidity characteristics for each age. In reality, health care costs are skewed at every age and consumers have a sense of their medical care usage and this will influence their decisions. Despite these simplifications, the examples illustrate that the relationship of age and income is critical and interrelated. Further, the examples uncover common misconceptions regarding the role that federal subsidies will have in recruiting the young and healthy to enroll in exchanges and brings to light the importance of modeling.

Advanced analytical models can readily be constructed to project enrollment based on the ETC concept illustrated in this article. While Figures 18 through 20 represent an optimal decision for an assumed homogeneous population with simplistic assumptions, advanced models should extend this analysis to include probabilities for different plan selections based on relative optimal values and simulate the results. A simulation model should consider the magnitude of the cost differences when assigning probabilities. Various provider reimbursement rates, utility research, network breadth, and heterogeneous populations should also be considered. The simplistic demographic assumptions applied in the example should become much more complex based on the data available to the model developer and after a comprehensive analysis of the market. To the extent that historical or current data is available, models should be tested against actual experience and refined as necessary.

Stakeholder Concerns

Numerous stakeholders will have an interest in the subsidy impacts. While their goals and interests will vary, they should each understand the underlying mechanics and start with a framework of modeling individual purchasing decisions. A sampling of

The availability of exchange subsidies has changed the equation of comparing costs between individual plans and group plan options for employees and their dependents.

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With the 2014 exchange rates, some states took a more aggressive approach to rate review and approved rates at considerably lower levels than what was originally requested by issuers.

stakeholders and some of their interests are listed below.

Issuers. Commercial health insurer issuers are joining their government program counterparts in a less comfortable place of developing rates far in advance without the opportunity for mid-year corrections. The 2014 rate development is now history, and 2015 preparations have begun at the time this article was written. There is still not very much traditional actuarial data to rely on for 2015 pricing, as the ACA plan experience will take several years to develop. A few items that issuers should consider reviewing are 2014 enrollment statistics (own company and industry, as detailed as possible), emerging pharmacy claims experience, and the market landscape of premium rates. Issuers can replicate the calculations shown in the example using actual market rates in each state. These results can be used to develop simulation models that can be tested and revised based on actual enrollment data.

As the individual market subsidies will attract an older and lower income demographic, issuers with government program contracts will have opportunities to offer gap coverage when Medicaid eligibility ceases and provide a bridge product to Medicare Advantage enrollees before they become eligible for Medicare.

Employers. The availability of exchange subsidies has changed the equation of comparing costs between individual plans and group plan options for employees and their dependents. Some employers may drop employee coverage and still more will drop dependent coverage. An understanding of how employees will make purchasing decisions will help employers with their health care cost budgeting and facilitate the estimation of potential penalties that may be incurred by employees joining the individual exchanges.

Many employers, including the cities of Chicago and Detroit, are now seeking to transition retirees under the age of 65 from group coverage to individual exchanges. To avoid disruption in coverage, these employers are being proactive and planning a soft landing for their retirees by explaining options and the additional potential value of enrolling in an exchange. Subsidies are what will make this decision attractive to employers and their retirees. An understanding of the subsidy mechanics can help employers understand the resulting net costs and develop tools that can be used to explain financial options to retirees.

Labor unions. Unions are appropriately concerned that they may be left out of the health benefits procurement process for some older, low income workers if more attractive options are available directly on the exchanges. Some employers who participate in multiemployer plans, particularly those with fewer than 50 employees, are finding the option of allowing employees to join exchanges attractive. Unions have argued that their benefits are generally richer than exchange plans, but many have not engaged in an analytical ETC analysis to project individual behavior. An understanding of the net premium by age and income of the workforce can help unions model their members' benefits and financial decisions. An ETC model can be developed that could be used to test the attractiveness of benefit packages against available exchange offerings.



Figure 21: Baltimore, Maryland Exchange Rates

Carrier	Bronze Plan: Age 25		Silver Plan: Age 25		Bronze Plan: Age 50		Silver Plan: Age 50	
	Requested	Approved	Requested	Approved	Requested	Approved	Requested	Approved
Aetna	\$286	\$203	\$331	\$234	\$509	\$361	\$588	\$417
All Savers	\$350	\$237	\$391	\$264	\$623	\$422	\$696	\$470
BlueChoice	\$136	\$124	\$184	\$168	\$242	\$221	\$328	\$298
CFMI	\$149	\$144	\$196	\$188	\$265	\$256	\$348	\$335
Coventry L&H	\$192	\$152	\$222	\$186	\$342	\$270	\$395	\$331
Coventry DE	\$180	\$131	\$205	\$150	\$320	\$233	\$364	\$267
Evergreen	\$218	\$191	\$260	\$228	\$388	\$340	\$462	\$405
GHMSI	\$149	\$144	\$196	\$188	\$265	\$256	\$348	\$335
Kaiser	\$179	\$177	\$216	\$214	\$318	\$315	\$385	\$381

States. State insurance departments have historically balanced their responsibility to guard against insurer solvency with rate review processes focused on consumer protection assuring that premium rates are not excessive or changing too much from one year to the next. With the federal government subsidies affecting net premiums, states should understand the new complexities of the subsidy mechanics and the impact of the rate review process across the population. Ironically, some of the states that were first in line to announce that they would accept federal funds for Medicaid expansion have also reduced the federal liability for exchange subsidies through the rate review process, which likely increased the net cost for some low income exchange enrollees in the process. An example that illustrates this surprising conclusion is provided below.

what was originally requested by issuers. This led to some issuers withdrawing from exchange participation and an expansion of narrow networks, with lower provider reimbursements facilitating lower rates relative to off-exchange plans with more expansive provider networks in the same area.

Some states, notably Maryland, received attention for an aggressive rate review process when a large issuer withdrew its exchange application and cited rate levels as a primary reason. Fortunately, requested rates and approved rates were published so actual ramifications of the consequences of lower exchange rates can be illustrated. Figure 21 shows the requested and approved non-smoker rates in Baltimore. The bronze age-25 rate and the silver age-50 rate were provided; the other rates were calculated using the federal age curve.

With the 2014 exchange rates, some states took a more aggressive approach to rate review and approved rates at considerably lower levels than

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Figure 22: Baltimore, Maryland Subsidy with Requested Rates

Age	Benchmark	FPL Amount	FPL Level	Maximum %	Annual	Monthly	Subsidy
25	\$196	11,490	150%	4.00%	689.40	57.45	138.18
25	\$196	11,490	200%	6.30%	1447.74	120.65	74.98
25	\$196	11,490	250%	8.05%	2312.36	192.70	2.93
25	\$196	11,490	300%	9.50%	3274.65	272.89	0.00
25	\$196	11,490	350%	9.50%	3820.43	318.37	0.00
25	\$196	11,490	400%	9.50%	4366.20	363.85	0.00
50	\$348	11,490	150%	4.00%	689.40	57.45	290.55
50	\$348	11,490	200%	6.30%	1447.74	120.65	227.36
50	\$348	11,490	250%	8.05%	2312.36	192.70	155.30
50	\$348	11,490	300%	9.50%	3274.65	272.89	75.11
50	\$348	11,490	350%	9.50%	3820.43	318.37	29.63
50	\$348	11,490	400%	9.50%	4366.20	363.85	0.00

Figure 23: Baltimore, Maryland Subsidy with Approved Rates

Age	Benchmark	FPL Amount	FPL Level	Maximum %	Annual	Monthly	Subsidy
25	\$168	11,490	150%	4.00%	689.40	57.45	110.07
25	\$168	11,490	200%	6.30%	1447.74	120.65	46.88
25	\$168	11,490	250%	8.05%	2312.36	192.70	0.00
25	\$168	11,490	300%	9.50%	3274.65	272.89	0.00
25	\$168	11,490	350%	9.50%	3820.43	318.37	0.00
25	\$168	11,490	400%	9.50%	4366.20	363.85	0.00
50	\$298	11,490	150%	4.00%	689.40	57.45	240.55
50	\$298	11,490	200%	6.30%	1447.74	120.65	177.36
50	\$298	11,490	250%	8.05%	2312.36	192.70	105.30
50	\$298	11,490	300%	9.50%	3274.65	272.89	25.11
50	\$298	11,490	350%	9.50%	3820.43	318.37	0.00
50	\$298	11,490	400%	9.50%	4366.20	363.85	0.00

The results show that the rate review process benefits higher income individuals but actually increases net rates on low income individuals. This anomaly might alarm regulators who view the rate review process primarily as a consumer protection function with a focus on representing low income residents.

Figures 22 and 23 respectively illustrate the premium subsidy calculations with the requested and approved rates. The approved lower rates result in lower revenue for issuers and lower outlays for the federal government. The impact of lower rates to issuers and the federal government may be partially offset by the rate change impact to risk corridor settlements, which will eventually compensate issuers if they significantly underpriced products. While the rate review impact consistently reduces premiums for issuers and lightens the taxpayer burden, the impact on subsidy-eligible consumers' net premium is mixed as both the subsidy and the gross premium are reduced. The net premium rates are extremely relevant, as the majority of exchange enrollees will be eligible for premium subsidies. Emerging results

indicate that 83 percent of individuals who have selected an exchange plan are subsidy-eligible.⁷

Figure 24 explores the impact on net rates of the lowest bronze plan in the market. As the lowest plan, it has a higher degree of premium inversion, due to the subsidy leverage. Having said that, the individual market is very price sensitive; the lowest-priced plan is likely to be very popular, particularly amongst people seeking the minimum coverage needed to avoid the tax penalty. The results show that the rate review process benefits higher income individuals but actually increases net rates on low income individuals. This anomaly might alarm regulators who view the rate review process primarily as a consumer protection function with a focus on

Figure 24: Baltimore, Maryland Bronze Premium Net Rates

		Requested Rates			Approved Rates			Review Impact	
Age	FPL Level	Gross Premium	Subsidy	Net Premium	Gross Premium	Subsidy	Net Premium	\$ Impact	% Impact
25	150%	\$136	138.18	-	\$124	110.07	13.93	13.93	Infinite
25	200%	\$136	74.98	61.02	\$124	46.88	77.12	16.11	26%
25	250%	\$136	2.93	133.07	\$124	0.00	124.00	-9.07	-7%
25	300%	\$136	-	136.00	\$124	0.00	124.00	-12.00	-9%
25	350%	\$136	-	136.00	\$124	0.00	124.00	-12.00	-9%
25	400%	\$136	-	136.00	\$124	0.00	124.00	-12.00	-9%
50	150%	\$242	290.55	-	\$221	240.55	-	0.00	Infinite
50	200%	\$242	227.36	14.57	\$221	177.36	43.23	28.65	197%
50	250%	\$242	155.30	86.63	\$221	105.30	115.28	28.65	33%
50	300%	\$242	75.11	166.82	\$221	25.11	195.47	28.65	17%
50	350%	\$242	29.63	212.30	\$221	0.00	220.58	8.28	4%
50	400%	\$242	-	241.93	\$221	0.00	220.58	-21.35	-9%

Figure 25: Baltimore, Maryland Silver Premium Net Rates

		Requested Rates			Approved Rates			Review Impact	
Age	FPL Level	Gross Premium	Subsidy	Net Premium	Gross Premium	Subsidy	Net Premium	\$ Impact	% Impact
25	150%	\$184	138.18	46.21	\$150	110.07	40.02	-6.18	-13%
25	200%	\$184	74.98	109.40	\$150	46.88	103.22	-6.18	-6%
25	250%	\$184	2.93	181.45	\$150	0.00	150.09	-31.36	-17%
25	300%	\$184	-	184.39	\$150	0.00	150.09	-34.29	-19%
25	350%	\$184	-	184.39	\$150	0.00	150.09	-34.29	-19%
25	400%	\$184	-	184.39	\$150	0.00	150.09	-34.29	-19%
50	150%	\$328	290.55	37.45	\$267	240.55	26.45	-11.00	-29%
50	200%	\$328	227.36	100.65	\$267	177.36	89.65	-11.00	-11%
50	250%	\$328	155.30	172.70	\$267	105.30	161.70	-11.00	-6%
50	300%	\$328	75.11	252.89	\$267	25.11	241.89	-11.00	-4%
50	350%	\$328	29.63	298.37	\$267	0.00	267.00	-31.37	-11%
50	400%	\$328	-	328.00	\$267	0.00	267.00	-61.00	-19%

representing low income residents. Early results for premium-subsidy-eligible individuals in states with federally run exchanges indicate that 74 percent will select a silver plan and 13 percent will select a bronze plan.⁸ Preliminary results for cost-sharing-subsidy individuals have not been published as of the time of this article, but it is likely that the high silver plan concentration is partially due to the availability of the cost-sharing subsidy benefit.

sharing subsidies if a silver plan is selected. Figure 25 is similar to Figure 24, but illustrates the impact of rate review on the lowest silver plan in the market. The rate review impact lowers the net premium for each income category, but has a larger impact on higher income individuals where the subsidy is less material. In summary, states should understand how rate review will impact insurer revenues, federal subsidies flowing into the exchanges, the impact of net

As discussed earlier, individuals with incomes below 250 percent FPL are also eligible for cost-

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rates on the exchanges, and how this may differ by age, income level, family status and plan selection.

States that are considering a basic health plan (BHP) for low income enrollees (below 200 percent FPL) should also understand and model the impact of the benchmark plan's approved rates on federal funding and BHP premiums. For each BHP enrollee, the state receives premium and cost-sharing subsidies that may be predicated on the prior year or current year exchange rates. The enrollee can be charged a premium up to the *net* premium that would have been charged on the exchange. States should consider the consequences of the income-biased enrollment shift that will occur in the exchange when a BHP option is available. BHP planning should consider a multi-year scenario analysis that models the expected potential impacts of both the BHP and exchange market.

Federal government. The subsidies available in the individual exchanges represent the largest and perhaps most volatile expense of the ACA. The resulting amount is obviously dependent on how many subsidy-eligible individuals enroll, who enrolls as the subsidies vary considerably by income level, the gross premiums offered in the marketplace, ACA

awareness, unemployment rates, and overall economic conditions. Obviously, the level of issuers' gross premiums was not known when the original federal outlay estimates were developed. Now that initial premium level and distribution information is available, the overall premium and cost-sharing liability estimate to the federal government can be better estimated. Simulation models can take the vast amount of data available to the federal government and replicate a model that mirrors 2014 experience. Federal outlays for 2015 can then be modeled by taking into account projected material enrollment and premium changes, incorporating important factors such as the likely distribution of rate changes in the market (which should reflect the role that previously unavailable competitive 2014 information will have for carriers in 2015), an increased tax penalty, and the cancellation of existing policies.

Conclusion

It is common knowledge throughout the health insurance industry and among lawmakers and other policy experts that the ACA commits the federal government to a significant financial contribution intended to reduce the uninsured rate by providing partial or full premium and cost-sharing assistance to low income Americans. These large

financial outlays primarily expand two markets: 1) Medicaid in states that elect to expand coverage through expanding eligibility, as well as indirectly in all states through increased awareness driving up enrollment significantly under prior Medicaid eligibility policy; and 2) the exchange segment of the non-group (individual) commercial market. The federal Medicaid contribution is well understood; it is a direct contribution and is like the current program, except with a larger population and a larger federal contribution percentage for the newly eligible enrollees benefiting from the expansion. The exchange subsidy calculations, on the other hand, are quite complicated and not well understood. The repeated mantra that “young people will enroll in exchanges due to generous subsidies” illustrates this misunderstanding and presents an opportunity for actuaries to bring clarification to various stakeholders. An understanding of the subsidy mechanics presented in this article will equip actuaries to explain the disproportionate distribution of subsidy dollars to older Americans.

The financial examples in this article are illustrative and only scratch the surface of inputs that should be considered in predicting consumer behavior. The examples used throughout this article are intended to provide an understanding of the subsidy mechanics and illustrate relationships and implications that will be true across various issuers and state markets, although magnitudes will vary. Understanding these mechanics is step one. Step two is modeling the impact for a given population. With an understanding of the mechanics, the right data and well-thought-out assumptions, straightforward simulation processes can be developed, tested and revised. From both a micro and a macro perspective, it is important for stakeholders to understand the subsidy mechanics and how the details might impact enrollment by age, plan design and income level. A proper understanding with sufficient modeling will provide stakeholders with clarity of the projected enrollment and help facilitate more accurate pricing and projection of other dependent mechanisms in the ACA. ■

END NOTES

- ¹ Source: McKinsey Center for U.S. Health System Reform, Individual Market Enrollment: Updated View p. 2 (March 2014).
- ² Source: Society of Actuaries, Cost of the Future Newly Insured under the ACA Research Report (March 2013).
- ³ Source: Yamamoto, Dale, Health Care Costs—From Birth to Death, Part of the Health Care Cost Institute’s Independent Report Series—Report 2013-1 (June 2013).
- ⁴ For simplicity, catastrophic plans, which represent only 1 percent of exchange plan selections through January 2014, are ignored. Source: ASPE Issue Brief, HEALTH INSURANCE MARKETPLACE: FEBRUARY ENROLLMENT REPORT for the period: Oct. 1, 2013 to Feb. 1, 2014, p. 4. (Feb. 12, 2014).
- ⁵ Some states had age compression rating limits prior to the ACA. The “current plan” illustration assumes an age compression limit of less than 6:1 is not applicable.
- ⁶ Grandfathered plans and “transitional” plans fulfill the coverage requirements to be exempted from the tax penalty.
- ⁷ Source: ASPE Issue Brief, HEALTH INSURANCE MARKETPLACE: MARCH ENROLLMENT REPORT for the period: Oct. 1, 2013 to Mar. 1, 2014, p. 6. (Mar. 11, 2014).
- ⁸ Source: ASPE Issue Brief, HEALTH INSURANCE MARKETPLACE: MARCH ENROLLMENT REPORT for the period: Oct. 1, 2013 to Mar. 1, 2014, p. 12. (Mar. 11, 2014).