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What Is Available in 2014 for 2015 Individual Health Insurance Rate Filings

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As 2013 comes to an end, it surely is a good time to prepare for the individual health insurance market that will exist in 2015. For federally funded exchanges, the deadline is April 30, 2014 for submitting the 2015 rates and, as was the case when rating for the 2014 market, you will have very little meaningful experience with which to understand the morbidity of your current population.

Much uncertainty was prevalent when individual carriers were pricing products for 2014. Uncertainty in pricing assumptions will be just as critical an issue when pricing for 2015. Following are four considerations in pricing for your appropriate 2015 rating level.

1. Regulatory Environment for 2015

Recent regulatory guidance during the summer of 2013 certainly altered scenarios that actuaries were anticipating, most notably being the delay of the employer penalty provision until a 2015 effective date. Impacts are expected to vary by state and service area depending upon type of exchange, Medicaid expansion and employer profile.[1]

After we complete our 2015 rate filings, you could expect a similar pattern of subsequent regulations occurring during the 2014 calendar year. This regulatory uncertainty should be carefully considered by each insurer as they undertake their pricing for 2015. Barring regulatory delays, there are several scheduled developments for 2015 described in the Affordable Care Act:

- **Increase in the individual mandate penalty**. The law says that the maximum 2014 penalty that individuals who do not purchase a plan with Essential Health benefits must pay is 1 percent of their annual income (or a flat amount of $95, whichever is larger). In 2015, it's mandated to increase to 2 percent (or a flat amount of $325, whichever is larger).[2] (It's important to note that this applies to individuals who have not been granted an exemption from the exchange.)

- **Decreased significance of the reinsurance program.** The reinsurance program is only certain to be in place for 2014 through 2016, with the program decreasing in scope each year. In 2014, the reinsurance payments are based on expected reinsurance collections of $10 billion. In 2015, the reinsurance collections will be reduced to $6 billion. Resulting reinsurance payments to nongrandfathered individual health insurance plans will be reduced accordingly.[3]

- **Introduction of the Basic Health Plan**. Slated to go into effect in 2014, its implementation has been delayed until 2015. The Basic Health Plan allows interested states to offer coverage for enrollees from 139 to 200 percent of federal poverty level (FPL). The federal government will make payments to the participating states for 95 percent of the federal subsidy payments these enrollees would have received from the federal government. In return, states will have the "flexibility to define benefits, cost-sharing, delivery systems and procurement strategies to provide a potential bridge between those on Medicaid and those with subsidized QHP coverage."[4]

These provisions are effective according to federal purview. However, it will be critical to understand the corresponding state regulatory framework. For 2014, states were largely reacting to the deadlines required for implementation of the law. In contrast, for 2015, it can be expected that states will have more opportunity to follow up with their own state-specific policies. Emerging regulations for each state can largely be anticipated by understanding what states did during their 2013 sessions. For example, what kind of decisions did states yield due to time and/or operational constraints? In other states, those that chose minimal involvement in the Affordable Care Act, what are their options available for continuing this path in future years?

State decisions for 2015 can be very significant. Examples include:

1) Will your state become a state-based exchange in 2015?
2) Will your exchange move to an active purchaser model?
3) Will your state opt for changes in qualified health plan (QHP) certification such as allowable rat-

ing factors, state-administered risk adjustment or network adequacy requirements?

Two recommended websites for keeping track of state-specific legislation would be from the National Conference of State Legislatures (*http://www.ncsl.org/issues-research/health/health-reform-database-2011-2013-state-legislation.aspx*)[5] and the State Refor(u)m (*https://www.statereforum.org/*).[6]

2. Employer Impact

It will be helpful to understand how the small and large employers react, by type of industry, to the Affordable Care Act as 2014 begins. As you price for 2015, you will be able to see the emerging dynamics for varied segments of the employer marketplace. There are many ways to analyze the marketplace. Some possible ways would be to look at: (1) whether it's a small employer or large employer, (2) type of industry, and (3) those currently offering coverage (or not).

EMPLOYER SIZE

Employer surveys clearly indicate that the larger the employer, the more likely it is to offer insurance. Indeed, in the 2012 Kaiser Employer Survey, the results showed that 47 percent of employees in companies with fewer than 200 employees were covered, while 62 percent of employees were covered if working for a company with more than 200 employees.[7] In addition to these survey results, employers with fewer than 50 employees do not face a penalty for not offering insurance. As a result, these market and regulatory forces would create a significant likelihood that an employee of a small employer would be more likely to be without employer-sponsored insurance, and so more likely to be subject to the individual mandate.

TYPE OF INDUSTRY

Employers competing against one another in their respective industries are likely to have similar business models. This likely would include similarities in what kind of insurance, if any, they provide for their employees. For example, "firms with more

high-wage workers are more likely to offer coverage to their employees than those with more low-wage employees."[8] Lining up industries with similar wage structures can provide a basis for anticipating whether an employer will provide employer-sponsored coverage or not.

CURRENTLY OFFERING COVERAGE OR NOT

Another type of employer to look at is those that currently offer health insurance as part of their compensation to their employees. Dropping insurance would mean disrupting their employees' current access to the health care system. On the other hand, you would have to consider what would induce an employer to now begin offering employer-sponsored coverage. Will the introduction of the Small Business Health Options Program (SHOP) be able to do so?

You can observe employer health care strategies by similar characteristics such as these, in order to project how employer reactions will follow for 2015. Questions to ask could be: Are there leaders in certain significant segments that have demonstrated significant success or problems with their health insurance strategy? If so, will others in their indus-

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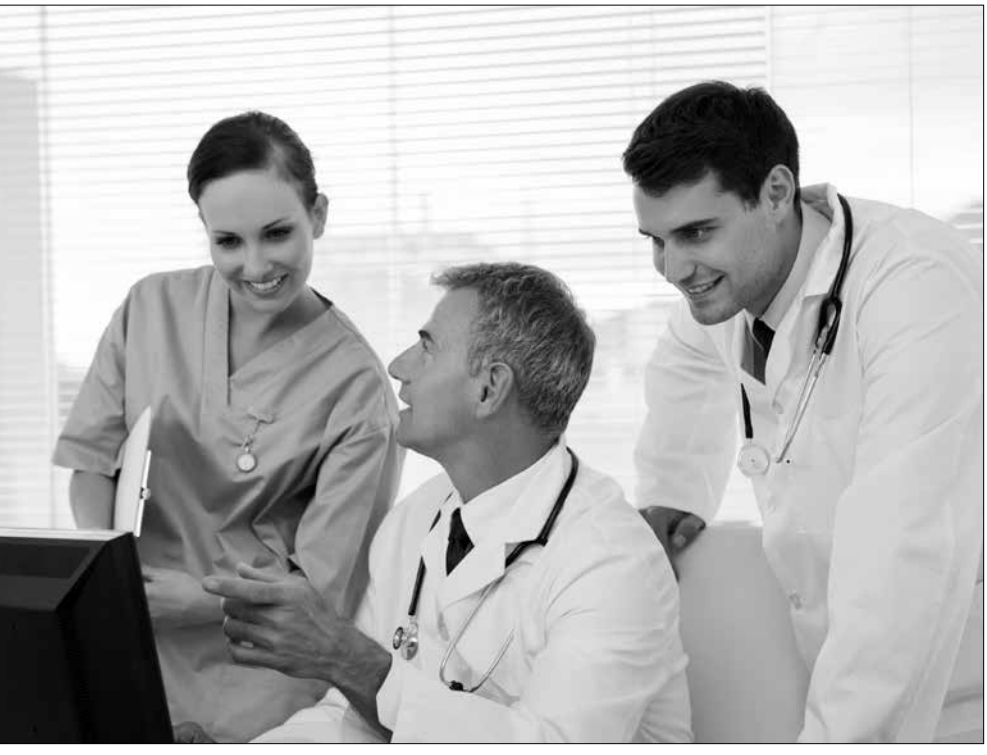
try follow those employers that have demonstrated success?

3. Individual Economic Impact

Following is a brief overview of the coverage decisions that each and every person must answer for themselves and their family:

- Do you have employer- or government-sponsored coverage that fulfills your requirement for minimum essential coverage?
- If not, then decide if you will have insurance coverage or not.
  - -If you will not have coverage, then these are two options:
    - Can you get an exemption from the exchange, or
    - Will you pay the individual mandate penalty?
  - -If you will have coverage, then:
    - Determine if you are eligible for premium and/or cost-sharing subsidies, and
    - Make your preferred purchasing decision.

There are not "typical" answers to these questions; rather there are a myriad of possible answers pertaining to each individual's circumstances. The answers will be different based on many unique factors (such as state of residence, household earnings and family size).



Of course, someone's preferred purchasing decision will be largely based on how the Affordable Care Act impacts them in their unique circumstances. There are many different ways to understand what will be common economic drivers for people's purchasing decisions.

If someone does not have affordable employer-sponsored or government-sponsored insurance, they have a couple of options to address their health insurance coverage for 2014: (1) Go without health insurance coverage; (2) Medicaid or CHIP coverage; or (3) commercial individual health insurance.

For those who choose to go without health insurance, two ways to go about this would be to get an exemption from coverage, or else to pay the individual mandate. Exemptions from coverage are obtained from the exchange in one's state and are available for several circumstances such as hardship or religious beliefs. A hardship exemption is based on such considerations as demonstrating an inability to access affordable health insurance (based on lowest cost bronze plan available) or unexpected events such as homelessness or death of a close family member.[9]

Otherwise, if you wish to pay the individual mandate penalty, you can forgo health insurance as well. The 2014 penalty would be based on a formula that considers household income as well as family size. For a family of four, one recent Congressional Research Service article estimated a 2014 penalty of $285 if household income is between about $20,000 and about $50,000. The penalty rises for household incomes beyond this $50,000 threshold to be based on 1 percent of "applicable income." In this case, the penalty could be expected to be around $1,000 for a family of four that is at approximately $120,000 of household income.[2]

For Medicaid and CHIP programs, eligibility varies by state. In all states, it will depend on household income, but income thresholds for each program will vary by state. Additionally, states may be able

to apply Medicaid eligibility of an individual toward premium and cost-sharing assistance to make coverage available in the commercial insurance market.[10]

Another aspect of the purchasing decision is whether an individual could choose to purchase commercial health insurance, either on or off the exchange. If the coverage is purchased on the exchange, one can qualify for premium tax credits or cost-sharing reduction subsidies. The amount of subsidy available depends on household income and the premium they would have paid for the second lowest cost silver plan available to them. Household income is determined according to the FPL, which is a function of family size.

4. Overview of Data in 2014 to Help with 2015

Individual health insurance will introduce several new means of sharing revenue and expenses between issuers and the applicable government entity, some at the benefit plan level and some at the issuer level. It will be critical to have an understanding of each of these programs in order to correctly interpret emerging experience. For examples at the benefit plan level, there are Medicaid wrap plans and cost-sharing reduction plans that have issuer plan liability as a subset of the total plan liability.

Medicaid "wrap" plans are coordinated coverage provided to Medicaid-eligible members, in part by a QHP and in part by the state Medicaid agency, allowable if the applicable state receives a section 1115 demonstration waiver. A state may pay the premium of an individual's QHP coverage if they believe it to be an effective way to meet Medicaid cost-sharing and premium assistance responsibilities, and then provide the balance of its Medicaid cost-sharing responsibilities.[10]

Similarly, cost-sharing reduction plans are coordinated coverage provided to members with household incomes up to 250 percent FPL. An eligible member may purchase a "variation" of a silver plan provided in the exchange by a QHP. This variation has reduced cost sharing for the member from the applicable silver plan.

In both cases, the health plan issuer is responsible only for the benefits of the QHP, while the state or federal government is responsible for the balance of the benefits of the plan. It will be imperative to understand which portion of the total coverage provided is the responsibility of which entity.

Also, at the issuer level, there are the 3Rs (risk adjustment, reinsurance and risk corridor) to consider, which were created to stabilize member premiums, particularly in the early years. It's not clear what data would be available to help for 2015 pricing by early 2014. Some states may have state average risk scores, which would be helpful in understanding the impact that risk adjustment will have on your financial results. Other sources of information that may be available and useful in early 2014 could be early indications of risk score diagnosis categories or unexpected high claim results that may result in a greater impact of the reinsurance program than expected. Understanding emerging administrative costs in early 2013 can be helpful for understanding what risk corridor results will be for 2014. The March 1, 2013 release of the HHS Notice of Benefit and Payment Parameters for 2014 provides the background of the mechanics of the 3Rs.

As with any new process, it will be critical to evaluate data quality to understand what should or should not be used in order to project to the future. Due to the complexity and scope of new individual health insurance program requirements, you will want to establish methods to verify the internal consistency and reasonableness of any internally generated data results with external data (for example, the exchange-related 820 Payment report). You will want to determine which reported results are most reliable for use in preparing 2015 pricing.

Perhaps the most reliable source of information available at the outset of 2014 will be enrollment information. Open enrollment begins in October 2013 and ends March 2014. With the enrollment information that you do have, you can get an early estimate for which subpopulations are choosing to purchase coverage and which are not. You may not have any credible claims experience, but at least you will be able to get a fairly clear idea of the effective-

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ness of your marketing efforts, and be able to react with product decisions for 2015.

With the lack of any credible experience available for understanding the reasonableness of your 2014 plan pricing assumptions, perhaps evidence of pent-up demand may be available. First, it is helpful to understand what, if any, delays in access to care that newly insured members may be facing in early 2014. Delays can happen for various reasons such as in implementing new member enrollment into exchange or off-exchange plans, or due to a lack of access to primary care. Of course, if you are aware of primary care shortage in the early stages of 2014, this would be an indication that there could be pent-up demand. Even with adequate primary care, it is still valuable to compare utilization patterns in early 2014 with utilization patterns from past Januarys and Februarys.

Conclusions

In summary, there are several things actuaries can do to prepare for pricing in 2015. Anticipate regulatory action to come at the federal and state level by paying attention to what regulators are doing in early 2014. Evaluate the emerging employer health insurance strategies that will impact your individual health insurance market. Try to gain an early understanding of the purchasing decisions of the emerging individual health insurance market. The population of the individual health insurance market will be very different in 2015 than it is now, but at least you will be able to observe in early 2014 the beginning trends compelled by the Affordable Care Act.

END NOTES

[1] "Update: Reporting Information about Employer Coverage for Purposes of Shared Responsibility and Premium Assistance: Transitional Relief for 2014." (Lopez, Rosenbaum July 23, 2013, *http://www.healthreformgps.org/resources/update-reporting-information-about-employer-coverage-for-purposes-of-shared-responsibility-and-premium-assistance-transitional-relief-for-2014/*).

[2] "Individual Mandate and Related Information Requirements under ACA." Mulvey, Chaikind of Congressional Research Service, July 2, 2012.

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[4] "The Role of the Basic Health Program in the Coverage Continuum." Bachrach, Dutton et al. Kaiser Family Foundation Focus on Health Reform, March 2012.

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[7] "Kaiser Employer Health Benefits, 2012 Annual Survey." Claxton, Rae, et al.

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[10] "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes and Premiums and Cost Sharing." Federal Register, July 15, 2013.