SOA Advanced Pricing Boot Camp

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SOCIETY OF ACTUARIES

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While participating in all SOA in person meetings, webinars, teleconferences or side discussions, you should avoid discussing competitively sensitive information with competitors and follow these guidelines:

- -**Do not** discuss prices for services or products or anything else that might affect prices
- -**Do not** discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
- -**Do not** speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
- -**Do** leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
- -**Do** alert SOA staff and/or legal counsel to any concerning discussions
- -**Do** consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone's responsibility; however, please seek legal counsel if you have any questions or concerns.

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Who?

- Mary van der Heijde
- Lindsy Kotecki
- Doug Norris

- Attendees - who are you, where do you work, what do you do, what you seek most from this bootcamp?

Housekeeping

- The boot camp concept
- Stop us to ask questions throughout
- Consider anti-trust and anti-collusion laws in your conversations with one another
- Cell phones = vibrate or off
- There will be breaks, but feel free to step out

Caveats and Limitations

- This presentation and question and answer session is not intended to be an actuarial opinion or advice, nor is it intended to be legal advice.
- Any statements made during the presentation and subsequent question and answer session shall not be a representation of Milliman or its views or opinions, but only those of the presenter.
- In preparing this presentation, we relied on data and information from publicly available sources, such as the Centers for Medicare and Medicaid Services (CMS). We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the information we present may likewise be inaccurate or incomplete.
- This presentation reflects our combined experience working in this space. Each organization's circumstances, beneficiaries, and infrastructure are unique.

Advanced Topics

Who Benefits? ...where are they?

Medicaid expansion interactions
Individual subsidies relation to enrollment
Anti-selection amongst individuals
Anti-selection amongst employers
Grandfathered rules and impacts
Transitional policies
Predictive modeling techniques for new enrollees
Geographic Factors

What is the Benefit?

New product requirements, coverages & design implications, EHBs
Mental Health Parity compliance
Pediatric Dental
Catastrophic plans
Grandfathered rules and impacts
Transitional policies
Actuarial Value / Minimum Value
Where? ...Tiered networks, smaller networks, ACOs

Who Pays For It?

Individual and small employer subsidies
Risk adjustment, reinsurance, and risk corridor

How Much Will It Cost Us?

Predicting the statewide risk pool
Induced demand
Pent up demand

What About Our Price?

Everything on this page (obviously, plus...)
Underwriting rules, minimums loss ratio rules
Administration, Taxes, Assessments,
Profit Margin, Contribution to Reserves
Competition

When?

Deadlines
When will Stability be reached in the market?

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What about me?
Keeping current with guidance and research
Code of conduct and ASOPs

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When?
Deadlines
When will Stability be reached in the market?

Individual Mandate

Guaranteed Issue

Individual Mandate

- Everyone is required to have insurance or pay a penalty
- Supreme court ruling:
  - Unconstitutional under commerce clause
  - However, Congress has power to tax; therefore, it's constitutional
- Penalty:
  - In 2014, either
    - $95 for each adult and $47.50 for each child, capped at $285 per family.
    - 1% of family income
  - In 2015, higher of:
    - $325 for each adult and $162.50 for each child, capped at $975 per family.
    - 2% of family income.
  - In 2016-2018, higher of:
    - $695 for each adult and $347.50 for each child, capped at $2,085 per family.
    - 2.5% of family income.
  - Flat dollar amount is indexed to inflation after 2017.
  - Imposed on individual tax returns

Guaranteed Issue

- Insurers must accept every individual and group that applies for coverage
- Enrollment periods
  - Group
    - Employer can purchase any time
    - Denial allowed based on employer contribution and group participation rules
  - Individual (on or off the Exchange)
    - 2016-2017 open enrollment: Nov 1 to Jan 31
    - 2018+ open enrollment: Nov 1 to Dec 15
  - Qualifying ERISA events still trigger a special enrollment period

Related Provisions and Rules

- Healthcare Benefit Exchanges
- Cost sharing subsidies
- Medicaid Expansion
- Standardized benefit designs (AV and EHBs)
- Rating restrictions and rules
- Risk sharing and limiting techniques

Premium Subsidies

Income Level	Premium as a % of Income (2014)
Up to 133 % FPL	2.00% of income
133 – 150 % FPL	3.00 – 4.00 % of income
150 – 200 % FPL	4.00 - 6.30 % of income
200 – 250 % FPL	6.30 - 8.05 % of income
250 – 300 % FPL	8.05 - 9.50 % of income
300 – 400 % FPL	9.50 % of income
https://www.irs.gov/irb/2014-50_IRB/ar11.html	

Premium Subsidies - Indexing

Income Level	Premium as a % of Income (2019)
Up to 133 % FPL	2.08% of income
133 – 150 % FPL	3.11 – 4.15 % of income
150 – 200 % FPL	4.15 - 6.54 % of income
200 – 250 % FPL	6.54 - 8.36 % of income
250 – 300 % FPL	8.36 - 9.86 % of income
300 – 400 % FPL	9.86 % of income
https://www.irs.gov/pub/irs-drop/rp-18-34.pdf	

- Maximum premium “indexed” annually to keep up with medical inflation

Premium Subsidies - Indexing

$$Adjustment\ (Year\ X) = \left[\frac{Premiums\ (X-1)}{Premiums\ 2013} / \frac{Personal\ Income\ (X-1)}{Personal\ Income\ 2013}\right]$$

- Premiums source: Projections of average per-enrollee employer sponsored insurance premiums from National Health Expenditure Accounts (NHEA) calculated by CMS
- Personal Income source: Personal income projections from NHEA data

$$Adjustment\ (2017) = \left[1.1325256291 / \frac{\$49{,}875}{\$44{,}925}\right] = 1.0201245892$$

$$2.00\%\ X\ 1.0201245892 = 2.04\%$$

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$$9.50\%\ X\ 1.0201245892 = 9.69\%$$

Premium Subsidies

- Compute the available subsidy and out of pocket premium payment in the following example:
  - 2 member household
  - $32,920 annual income
  - Cost of second lowest silver plan is $3,600 per year

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,320 for each additional person.	
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8	$42,380

https://aspe.hhs.gov/poverty-guidelines

Premium Subsidies

- Compute the available subsidy and out of pocket premium payment in the following example:
  - 200 % FPL
  - Maximum premium is 6.54 % X $32,920 = $2,153
  - Subsidy is $3,600 - $2,153 = $1,447
- Subsidy is flat, so anything below the cost of the second lowest Silver plan is free
- For higher AV (or higher cost) plans, the enrollee can pay the difference

Medicaid Expansion

Implications for the Medicaid Markets

- Most important result of ruling on Medicaid Expansion
  - Expansion of Medicaid up to 133% is not required, to retain federal funding
- Current Medicaid programs remain unchanged
  - Current programs usually only cover families, pregnant women, children, or disabled
  - Healthy men are usually not covered now

Medicaid Expansion:
Impact on commercial carriers

How does Medicaid expansion affect the commercial market?

1. Changes the mix of purchasers within the exchange

2. Changes the overall average health status of the market, which affects risk adjustment

The < 133% population

What do they look like?

- Many don't file taxes
- If required contribution is greater than 8% of gross household income, this is considered an "affordability exemption" and would result in exception to the penalty requirement.
- Other exceptions may be made for:
    - Certain religious beliefs
    - Incarcerated individuals
    - Undocumented aliens
    - Individuals in a hardship situation
    - Indian tribe members
    - Medicaid/Medicare members
    - Individuals lacking coverage for less than 3 months

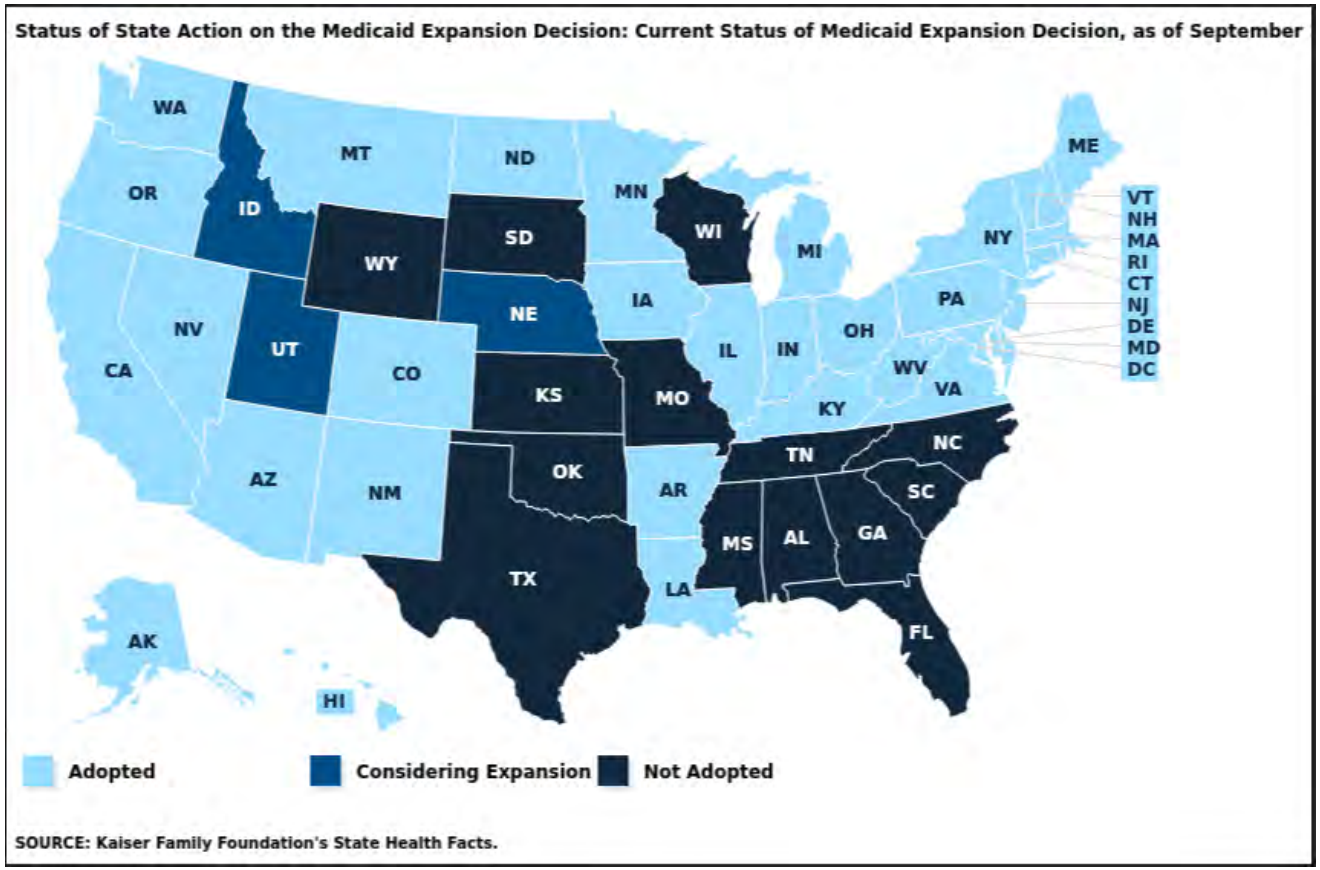
- Additionally, PPACA allows for a 90-day grace period (before coverage can be terminated for reason of no premium payments)

What happens to the portion of the population who would have been newly Medicaid eligible?

- As ACA is currently written, they are in a “no man’s land”
- ACA assumed those up to 133% of FPL would have Medicaid, so only discussed and provided subsidies for > 133% FPL in the Commercial market
- ACA includes a table of what the subsidies are by FPL which includes values for “up to 133%”. It would seem that covers this population.
- However, it does not because only “applicable taxpayers” may have a subsidy.

Medicaid Expansion:

Current Status – As of September 11, 2018



https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Non-ACA: Short-Term Major Medical plans

- Risk selection:
  - Underwriting / rate-ups / declination
  - Pre-existing condition exclusions
- Limited benefit coverage
  - Maternity
  - Prescription drugs
  - Essential Health Benefits (EBHs) not required to be covered
- No risk adjustment
- Priced competitively
- Impacts on risk pool:
  - Potential to attract younger and healthier members

Non-ACA: Association plans

- Health insurance coverage sponsored by industry, trade, professional group
  - Previous requirements limited number of AHPs
  - New Department of Labor language expands eligibility:
    - Ease classification as a “single employer group” plan.
    - Removal of “same industry or business” requirement
    - Removal of “sole purpose” requirement
- Impacts on risk pool:
  - Likely to attract younger and healthier members
  - Cannibalism considerations

Benefit Design Implications of the Affordable Care Act

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Benefit Design Implications

Maximum Out-of-Pocket tied to HSA limitations in 2014, but different thereafter

- $6,350 single, $12,700 family in 2014
- $6,600 single, $13,200 family in 2015
- $6,850 single, $13,700 family in 2016
- $7,150 single, $14,300 family in 2017
- $7,350 single, $14,700 family in 2018
- $7,900 single, $15,800 family in 2019
- Coincidentally very close to the Minimum Value 60% limit on the large group market, as well as the least rich “bronze” plans on the individual and small group markets
- Unexpected implications for all markets
  - Co-pays must accumulate towards the OOP Max, both medical co-pays and pharmacy co-pays – major affect on benefit set up that also affects pricing
  - One-year delay mainly for pharmacy carve-out situations

Benefit Design Implications

Annual Maximums on Essential Health Benefits Eliminated

Lifetime Maximums Eliminated

Retiree-only plans exemption from ACA

also stand-alone dental, LTC, Medigap

Benefit Design Implications

Grandfathered: exist on March 23, 2010 and applied for GF status

Applies to group (ASO and insured) and individual

Requirements to maintain GF status:

- Disclosure requirements to members
- Cannot significantly reduce or cut coverages
- Cannot raise coinsurances on members
- Cannot significantly raise co-pays.. no more than greater of $5 or medical inflation +/- 15%
- Cannot significantly raise deductibles and OOP Maximums (medical inflation +/- 15%)
- Cannot add or tighten annual limits
- Cannot reduce employer subsidization
- Cannot restructure such as in mergers, acquisitions to have people moved into a GF plan
- Cannot force employees into other less valuable, albeit GF plans

Benefit Design Implications

Grandfathered versus Non-grandfathered

- GF plans still must comply with certain ACA rules:
  - Dependents to age 26
  - Lifetime limit elimination
  - Annual limit elimination
  - Prohibition of pre-existing conditions
  - Prohibitions on rescissions of coverage

Benefit Design Implications

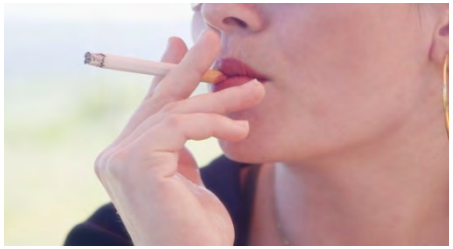
100% preventive coverage:

- Services rated A or B by the U.S. Preventive Services Task Force (USPSTF)
- Includes immunizations
- Pay close attention to mammograms and colonoscopies, which are high cost and prevalent, big portion of the preventive bucket
  - Possibility for differences among geographies or through time for coding as “preventive” and following timing guidelines allowed

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

How many Essential Health Benefit categories can you name?

What are Essential Health Benefits?



Which plans must offer EHB?

YES

NO

Benchmark Plan Options

What are Essential Health Benefits?

We propose to provide states with **additional flexibility** in how they select their essential health benefits (EHBs) benchmark plans for benefit years 2019 and beyond, and outline potential future directions for defining EHBs. Specifically, we propose to allow states to **select a new EHB-benchmark plan on an annual basis**, which would allow states to update their EHB-benchmark plan on a schedule that works for the state, rather than one set by HHS. We also propose to provide states with **substantially more options** in what they can select as an EHB-benchmark plan. Instead of being limited to 10 options, states would be allowed to: 1) choose from the 50 EHB-benchmark plans that other states used for the 2017 plan year; 2) replace one or more EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or 3) otherwise select a set of benefits to become its EHB-benchmark plan, provided that the new EHB-benchmark plan does not provide more benefits than a set of comparison plans and is equal to the scope of benefits provided under a typical employer plan, as required by the PPACA.

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Proposed-2019-HHS-Fact-Sheet.pdf

Gaps?

- Pediatric Dental
- Vision
- Habilitative Services

What is a habilitative benefit?

Rules for pediatric dental EHBs

- For those under the age of 19
- Can include “medically necessary” orthodontia
- May be provided in a QHP or in a stand-alone dental plan on the Exchange
  - “When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB”

Rules for pediatric dental EHBs

- For stand alone plans inside the Exchange, separate AV and cost-sharing limits apply:
  - AV must be at either
    - High – 85 %
    - Low – 70 %
    - Still allows de minimis variation of 2 %
    - No AV calculator available from HHS
    - Must be certified by a member of the American Academy of Actuaries
- Cost Sharing must be a “reasonable annual limitation as determined by the Exchange.”

Rules for Prescription Drug EHBs

- EHB plan must cover at least the greater of:
  - One drug in every category and class, or
  - The same number of drugs in each category and class as the EHB-benchmark plan
- Drugs listed must be chemically distinct

Other Benefit Design / Coverage Items

- Specified preventive visits must have no member cost sharing
- Out of network emergency coverage must be at in network levels (along with prior authorization or coverage limits)
- Existing state mandates (as of 12/31/2011) are retained
  - If additional mandates are added, then the state must fund them
- MHPAEA expansion to the individual and small group markets

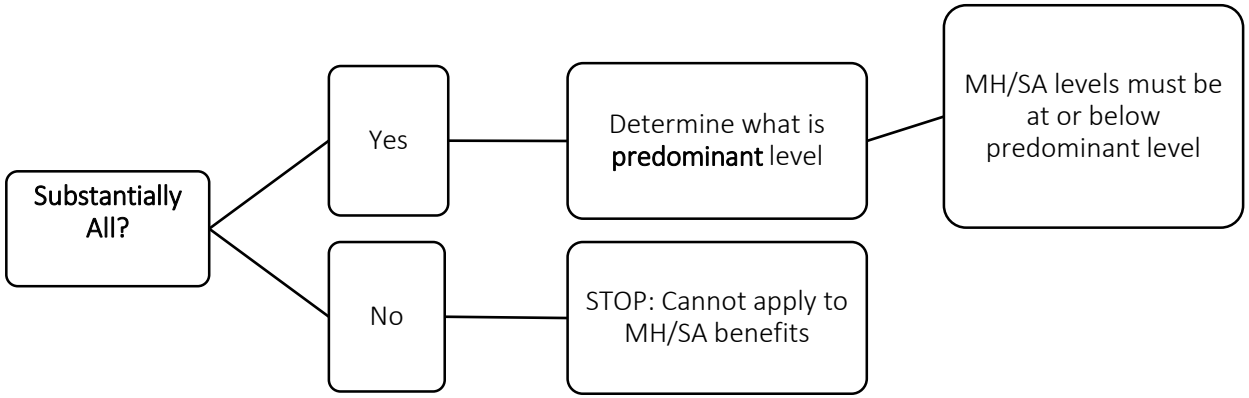
MHPAEA - Parity Must Exist

- Within all combinations of benefit plans
- Within all classifications of benefits
  - Inpatient (in and out-of-network)
  - Outpatient (in and out-of-network)
    - Office visits
    - Non-office visits
  - Emergency Care
  - Prescription Drugs
- Within each coverage unit
  - Employee, employee plus spouse, employee plus family

MHPAEA – What is Allowed?

- Member cost sharing can be applied to MH/SUD benefits only if a particular **type** (copay, coinsurance, etc..) of cost sharing is applied to '**substantially all**' (>= 2/3) of medical/surgical benefits
- If cost sharing is allowed the '**predominant**' level of cost sharing applied to medical/surgical benefits (>50%) needs to be determined
- The 'Substantially All' and 'Predominant' tests also apply to non-financial quantitative limits such as visit limits

MHPAEA – What is Allowed?



MHPAEA Cautions

- Effective in 2015, testing by tier is allowed.
  - Since multiple in-network benefit tiers will be tested separately, no longer must apply “best“ tier to all MHPAEA benefits.
- Careful with tobacco cessation coverage (if covered in one benefit category, it must be covered in all)
- Careful with non-quantitative parity
  - Pre-approval limits
  - Pre-authorization procedures
  - Step therapy
  - Behavior modification class enrollment requirements

Question #1

An HMO provides unlimited benefits (with no cost sharing) for treatment of anxiety, alcoholism, and major depression. For bipolar disorder, only inpatient care is covered. No other behavioral condition is covered at all.

What does the plan do to be in compliance?

Answer Choices

a. Nothing – this is compliant
b. Add coverage for all other behavioral conditions
c. Expand bipolar disorder coverage to include outpatient care, emergency care, and prescription drug coverage.
d. Remove coverage for bipolar disorder.

Question #2

A plan is designed such that:

- 30% of the in-network medical/surgical benefits in a class are subject to a $20 copay; in the same class
- 30% are subject a $30 copay,
- 30% are subject to 15% coinsurance, and
- 10% do not have any cost-sharing requirements.

Currently, behavioral services in the class are subject to the $30 copay. What could be done to comply with MHPAEA?

Answer Choices

a. Eliminate the $30 copay for behavioral services
b. Change the $30 copay for behavioral services to 15% coinsurance
c. Change the $30 copay for behavioral services to the $20 copay
d. Use actuarial equivalence to express coinsurance as a copay before testing for substantially all
e. Nothing, this is compliant

Question #3

A plan imposes copays for office visits (behavioral and medical/surgical) and coinsurance for all other outpatient services (behavioral or medical/surgical). Neither copays nor coinsurance would satisfy the Substantially All test in the in-network outpatient classification, since each is 50% of costs.

What should the plan do?

Answer Choices

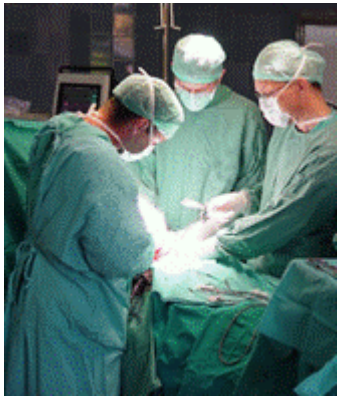
a. Nothing, this is compliant
b. It must remove all cost sharing for in-network outpatient behavioral services
c. It should classify all non-office outpatient services as inpatient, in order to satisfy the Substantially All test
d. It should divide the outpatient classification into two subclasses (office visits and other) and test each subclass separately

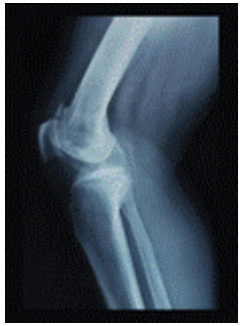
The Outpatient Safe Harbor

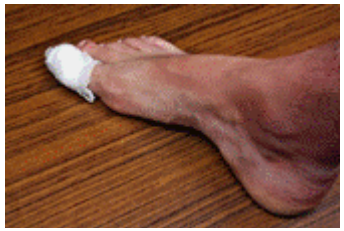
Service	Cost Sharing	Total Allowed Dollars
PCP office visits	$20 copay	$100,000
Specialist office visits	$30 copay	$75,000
Lab/X-Ray	20% coinsurance	$25,000
Outpatient surgery/Other	20% coinsurance	$100,000
MH/SA office visits	$20 copay	
MH/SA partial hospital	20% coinsurance	

The Outpatient Safe Harbor

- What are other outpatient behavioral services?







- Why does this matter?
- Are my SPDs specific enough?

FAQ (April 2016)

Measuring medical/surgical benefit costs

- Tests require having dollar weights
- Final rule: “Any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation”

FAQ (April 2016)
Measuring medical/surgical benefit costs

- Question: When performing "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under MHPAEA, may a plan or issuer base the analysis on an issuer's entire overall book of business for the year?

- DOL answer: No. This “is not a reasonable method.”

FAQ (April 2016)
Measuring medical/surgical benefit costs

- DOL says the following “should” be used:
  - Self-insured: Group-specific data
  - Fully insured large group: Group-specific data
  - Small group and individual: Plan-level data
- What does “any reasonable method” actually mean?

FAQ (April 2016)
Measuring medical/surgical benefit costs

- Likely consequences
  - Increase in cost and complexity of demonstrating compliance
  - A given plan design is compliant for some large or self-insured groups, but not for others
  - A given individual or small group plan design is compliant in some network configurations or areas, but not in others

FAQ (October 2016)
Measuring medical/surgical benefit costs

- Question: If a group health plan or issuer does not have sufficient claims data, what data can they use to conduct the analyses?
- DOL answer
  - If a group health plan has sufficient claims data, such data should be used for these analyses
  - Should not use claims data from an issuer's or TPA's entire book of business in an unreasonable manner.
  - Use appropriate and suffiecient data to comply with ASOPs
    - Self-Funded and LG – consider group health plan-level claims data
    - SG and Individual – consider "plan"-level (as opposed to product-level) data
  - Qualified actuary should determine what's appropriate from a credibility standpoint

Common areas of Non-compliance
Quantitative

- Day/Visit Limits
- Limits on smoking cessation drugs
- Emergency Care

Question #4

County Hospital provides health insurance to its employees, administered by ABC Insurance. County Hospital is an in-network facility for all ABC plans. The normal coinsurance rate for in-network inpatient services is 20%, but the coinsurance rate is only 10% if members choose County Hospital. (This applies to both medical/surgical and behavioral care.)

Most County Hospital employees use County Hospital when they require inpatient care.

What does the plan do to be in compliance?

Answer Choices

a. Nothing – this is compliant
b. Remove the coinsurance for all in-network behavioral care.
c. Reduce the in-network (non-County Hospital) coinsurance rate on behavioral care to 10%.
d. Increase the County Hospital coinsurance rate to 20% for all care (medical/surgical and behavioral).

Non-quantitative Compliance

- Usual, reasonable, customary
- Network admission requirements
- Unequal access to providers of care
- Care management procedures
- Utilization management practices
- Different penalties for failing to get preauthorization

Can Plans Still Manage MH/SUD Benefits?

- Common non-quantitative treatment limits such as utilization management, medical necessity criteria, step therapy, and pre-authorization must be

> "comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification"

Common areas of Non-compliance

Non-quantitative

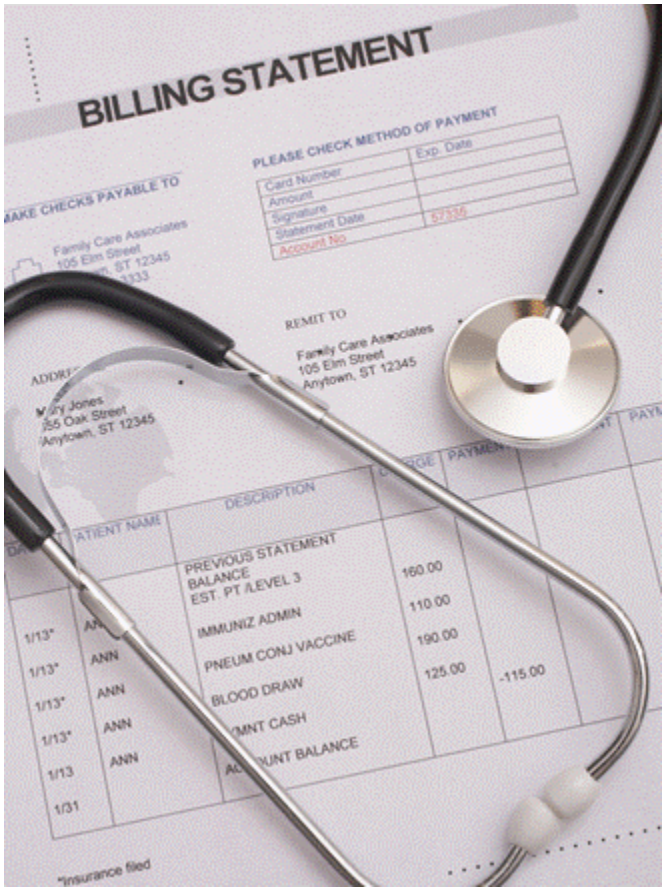
- Pre-approval limits
- Pre-authorization procedures
- Behavior modification class enrollment requirements
- Step therapy

The new “warning signs”
Possible NQTL red flags

- Prior authorization
- Fail-first
- Probability of improvement
- Treatment plans
- Other

Scope of Services

- Condition coverage
- How much coverage is enough?



Scope of Services Examples

- Plan covers inpatient and outpatient treatment for drug abuse but excludes residential treatment facilities.

- Is it OK to exclude coverage for residential treatment facilities?

Scope of Services – Final Rules

Clarifications regarding requirements for scope of services

The preamble also addresses comments seeking clarification around the scope of services that must be included within each of the six classifications of benefits. In particular, the Departments make it clear that MHPAEA is not intended to create a "benefit mandate," requiring greater MH/SUD benefits than medical/surgical benefits. However, the Departments also clarify that they did not intend that plans and issuers could exclude "intermediate levels of care," such as residential treatment, from parity requirements on the grounds that these services do not clearly fall within one of the six classification levels.

Plans and issuers must assign intermediate MH/SUD benefits to the six benefit classifications in the same way that they assign intermediate medical/surgical benefits. The preamble provides the example that if a plan classifies care in a skilled nursing facility as inpatient care, then it must treat covered care in a residential treatment facility for MH/SUDs as inpatient care. The Departments do not anticipate that this clarification will result in a significant increase in costs due to the small number of enrollees that reportedly utilize intermediate levels of care.

Source: Manatt Phelps & Phillips LLP, "Final mental health parity rules clarify requirements regarding treatment limitations and plan disclosure obligations," 11/13/2013, http://www.lexology.com/library/detail.aspx?g=6e6c1d2c-3eb9-4135-b243-e67383c6d1ef

The ACA Impact

Plans must cover these benefits:

- Alcohol misuse counseling
- Depression screening
- Tobacco use counseling and interventions

The ACA Impact

Does this mean alcoholism, depression, and tobacco addiction need to be covered in full?

Cautionary tales in non-compliance

- Can't create benefit classifications – often a concern for ambulance use
- What seems "fair" is not necessarily compliant
- Matching PCP cost sharing does not guarantee compliance
- Matching the state benchmark plan does not guarantee compliance
- Receiving DOI approval does not guarantee compliance

Market Segmentation

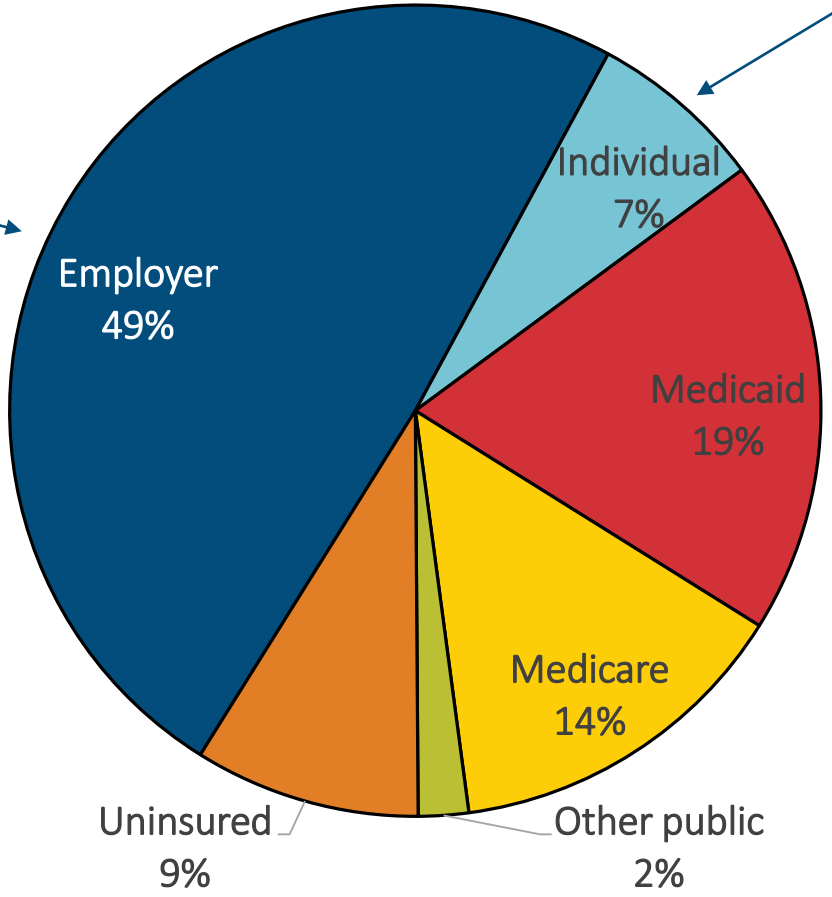
SOCIETY OF ACTUARIES

Birds eye view

Traditional ACA (MEC):
-Marketplace
-Off-exchange individual
-Grandfathered
-Transitional

Short term
AHPs (for sole proprietors)

Small group
Large group
Self-funded
AHPs

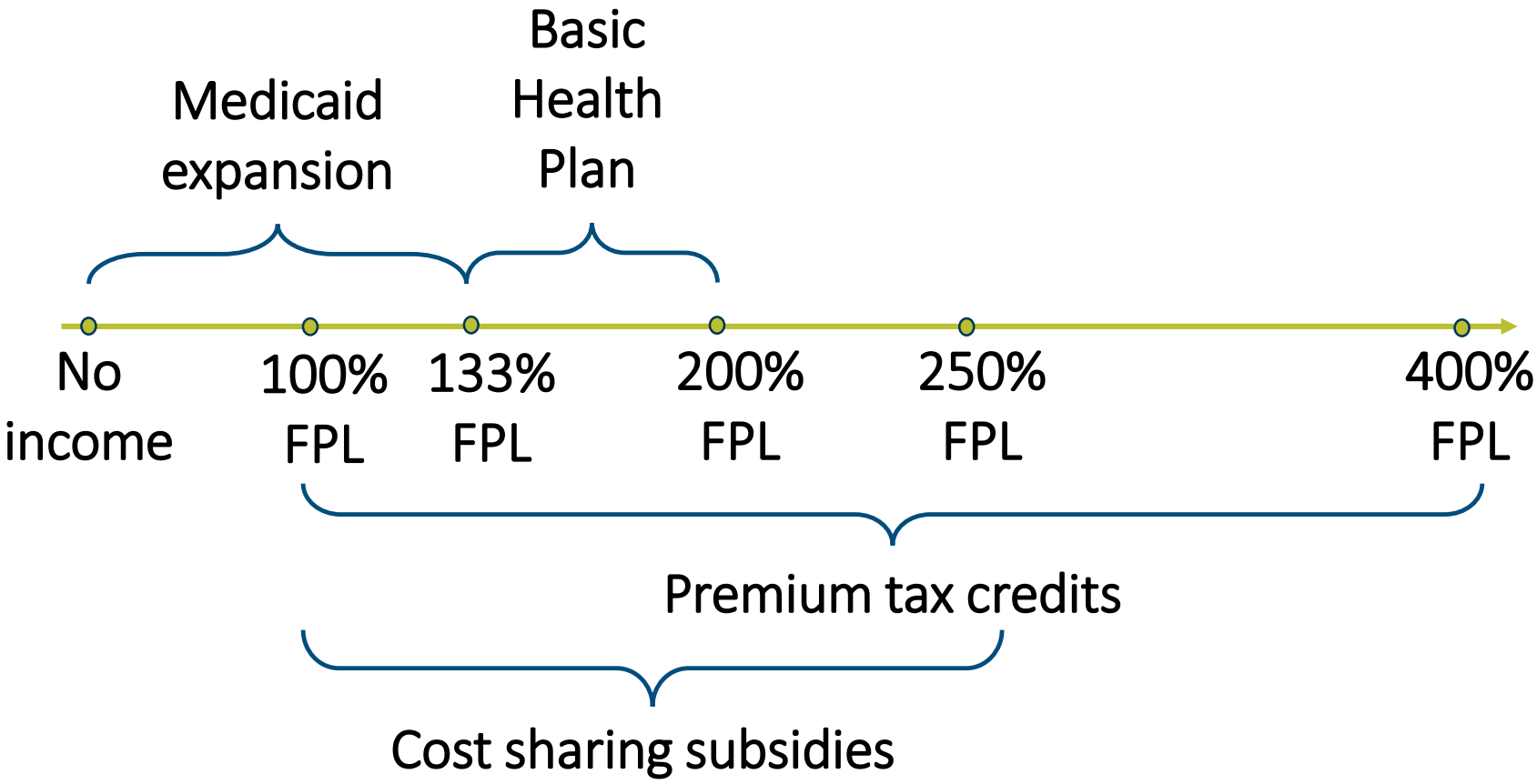


Kaiser Family Foundation. State Health Facts (2016). https://www.kff.org/other/state-indicator/total-population/

Medicaid and Individual

SOCIETY OF ACTUARIES

Population Segments



Population Segments

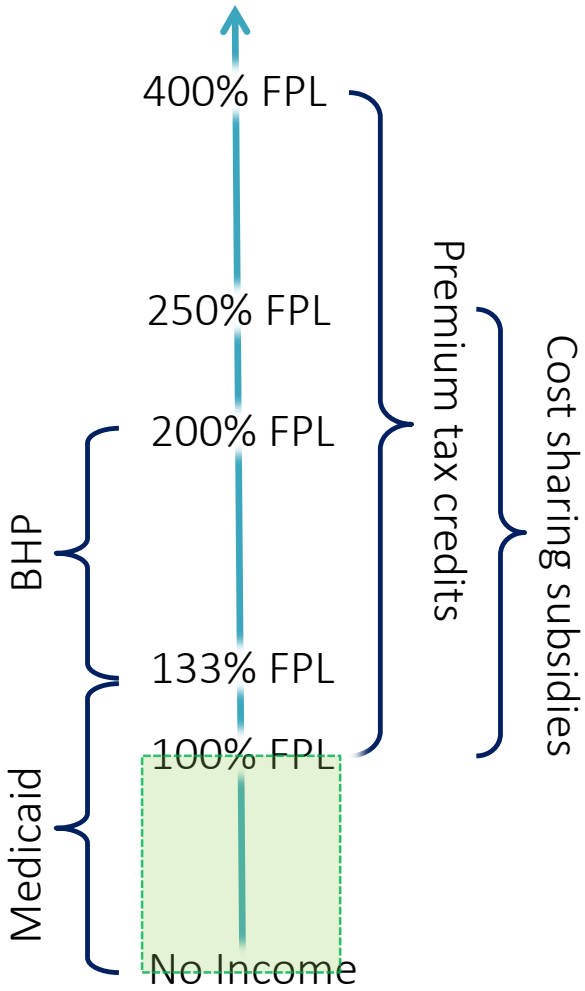
- Different segments of the population are eligible for different benefits
- Eligibility depends on what plans and subsidies they are eligible for
  - Use premium subsidy levels as a guide

Income Level	Premium as a % of Income (2018)	Premium as a % of Income (2019)
Up to 133 % FPL	2.01% of income	2.08% of income
133 – 150 % FPL	3.02 – 4.03 % of income	3.11 – 4.15 % of income
150 – 200 % FPL	4.03 - 6.34 % of income	4.15 - 6.54 % of income
200 – 250 % FPL	6.34 - 8.10 % of income	6.54 - 8.36 % of income
250 – 300 % FPL	8.10 - 9.56 % of income	8.36 - 9.86 % of income
300 % – 400 % FPL	9.56 % of income	9.86 % of income

https://www.irs.gov/pub/irs-drop/rp-17-36.pdf
https://www.irs.gov/pub/irs-drop/rp-18-34.pdf

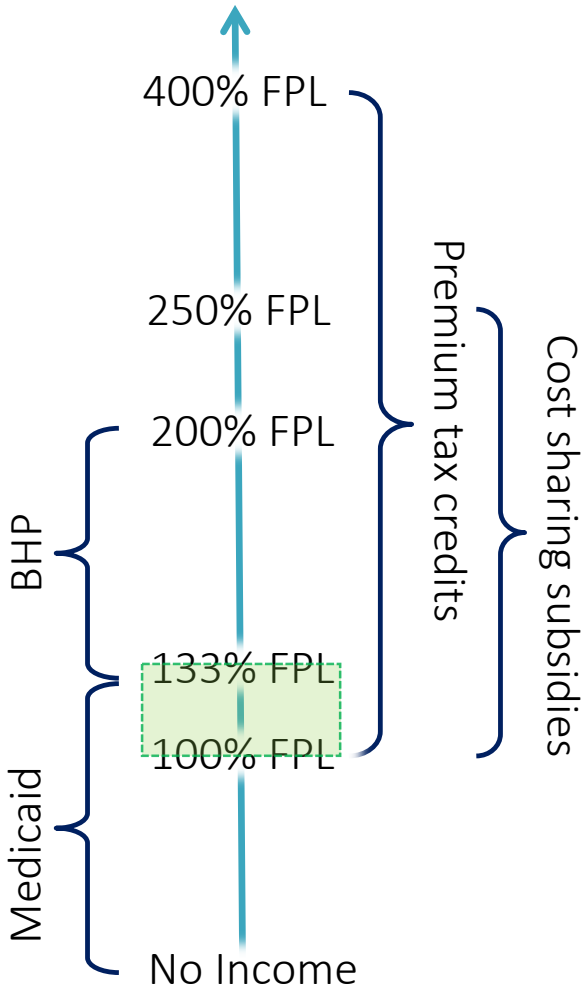
Population Segments
<100% FPL

- If state expands Medicaid:
  - Individual is eligible for Medicaid
  - Individual may not seek commercial coverage on Exchange
- If state does not expand Medicaid:
  - Regulation lists that only "applicable taxpayers" may be eligible for subsidies
  - Below 100% FPL is not an "applicable taxpayer"
  - In "no man's land" regarding subsidies
  - Likely still eligible for 94% CSR Plan



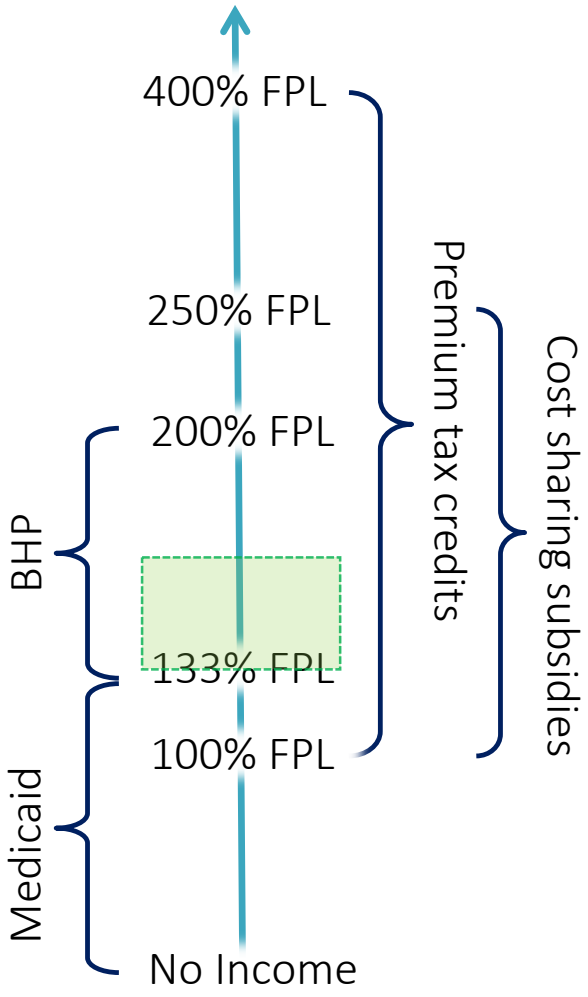
Population Segments
100%-133% FPL

- If state expands Medicaid:
  - Individual is eligible for Medicaid
  - Individual may not seek commercial coverage on Exchange
- If state does not expand Medicaid:
  - Member eligible for premium subsidies covering almost all premiums
  - Eligible for 94% CSR Silver plan
  - Individual would benefit from selecting CSR Silver plan



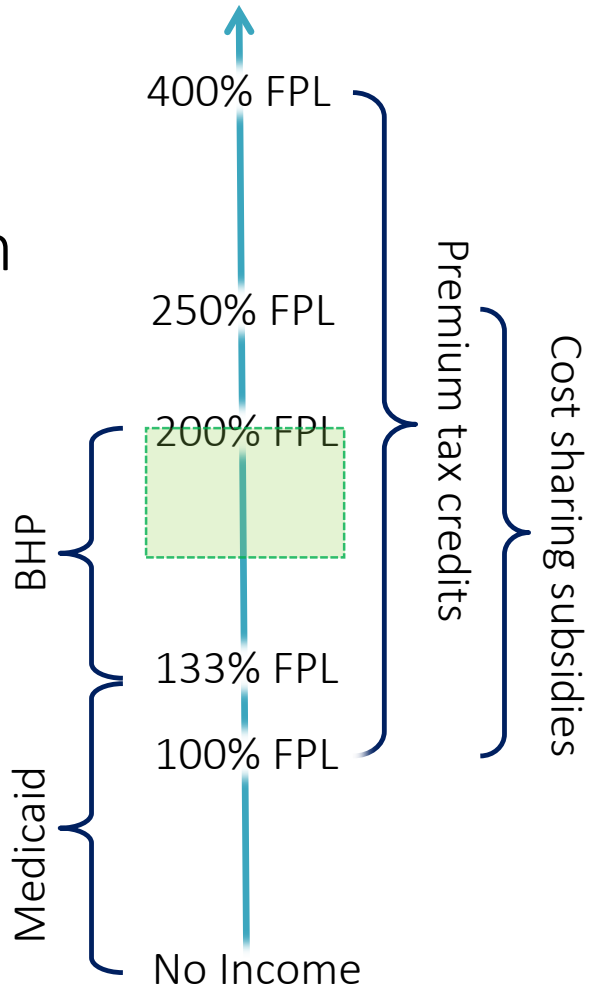
Population Segments
133%-150% FPL

- Member eligible for premium subsidies covering almost all premiums
- Eligible for 94% CSR Silver plan
- Individual would benefit from selecting CSR Silver plan



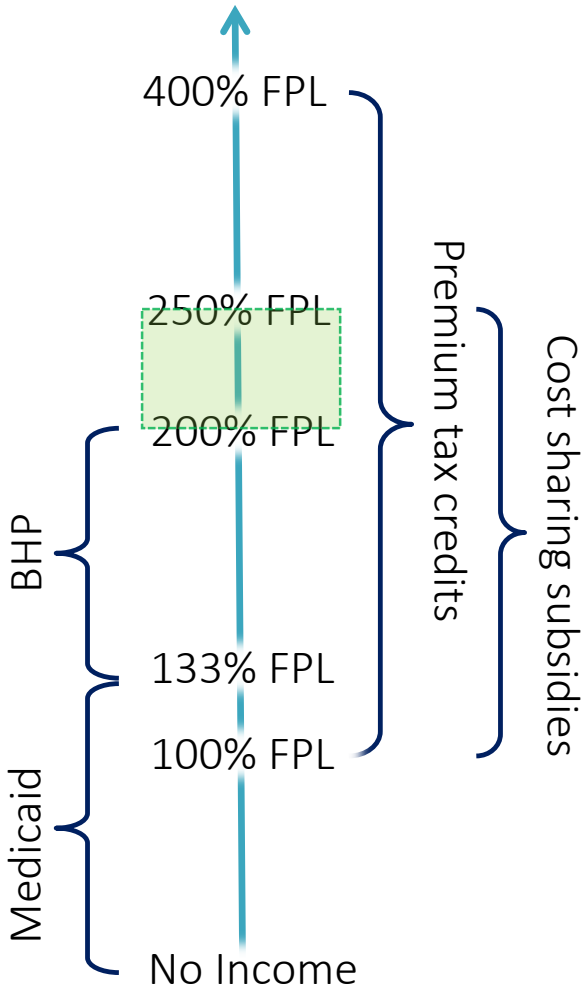
Population Segments
150%-200% FPL

- Member eligible for premium subsidies covering significant portion of premiums
- Eligible for 87% CSR Silver plan
- Individual would benefit from selecting CSR Silver plan



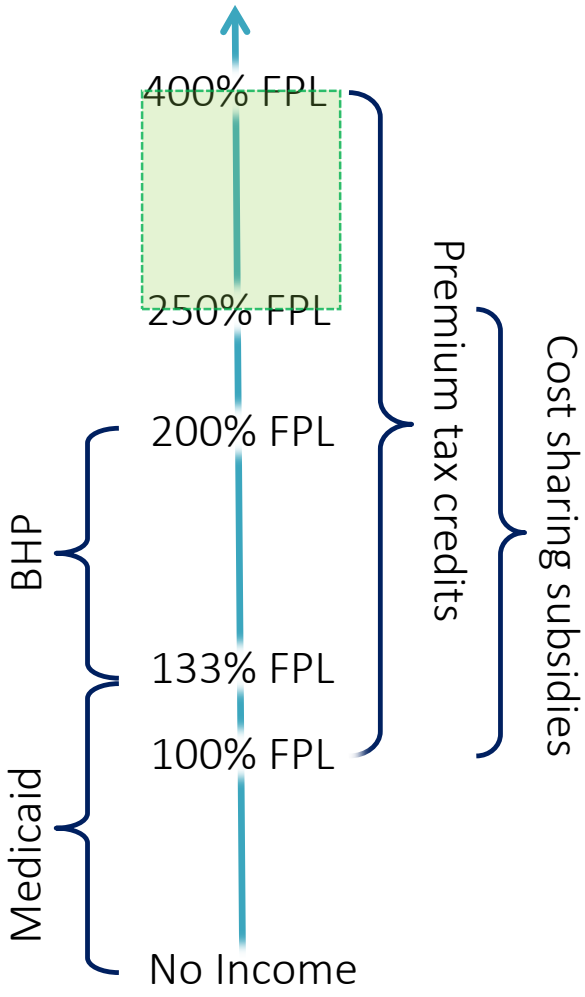
Population Segments
200%-250% FPL

- Member eligible for premium subsidies covering significant portion of premiums
- Eligible for 73% CSR Silver plan
- Since CSR plan is not much richer than standard silver and subsidies tied to second-lowest cost silver, benefit of selecting CSR not as strong



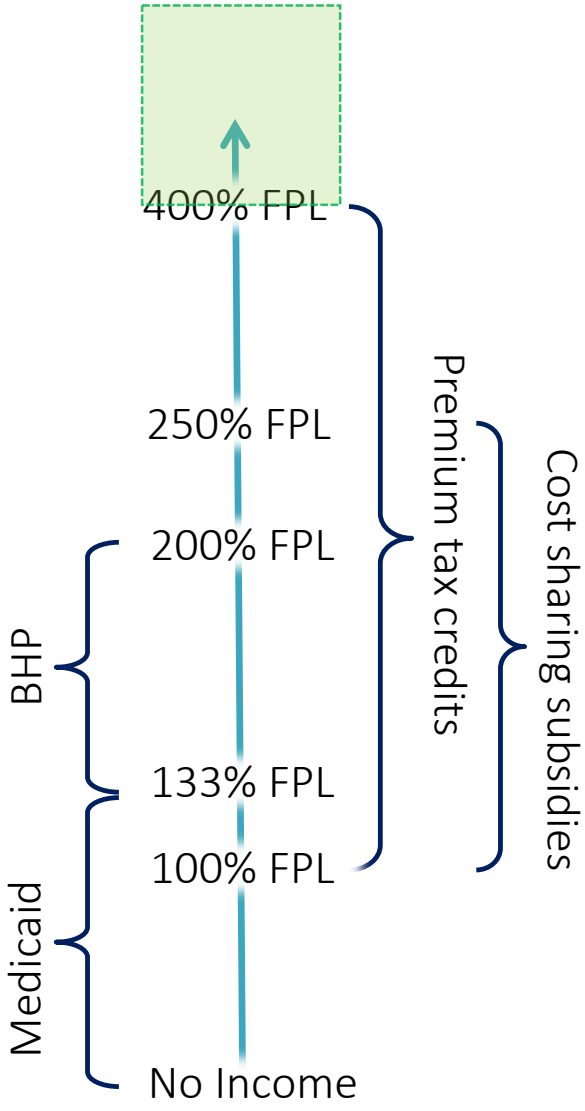
Population Segments
250%-400% FPL

- Member eligible for premium subsidies covering portion of premiums
- Not eligible for any CSR plans



Population Segments
>400% FPL

- Not eligible for premium subsidies or CSR plans
- Not a financial incentive to purchase on the exchange (since they do not receive subsidies)



Population Segments

Likely Options

Income Level	Medicaid Expansion?	Premium Subsidies	CSR Plan Eligibility	Likely Selection
Up to 100 %	Yes	Maybe none	94%	Medicaid or 94% CSR Silver
100 – 133 %	Yes	Most of cost	94%	Medicaid or 94% CSR Silver
133 – 150 %	No	Most of cost	94%	94% CSR Silver
150 – 200 %	No	Significant	87%	87% CSR Silver
200 – 250 %	No	Significant	73%	73% CSR Silver or Bronze
250 – 400 %	No	Some	None	Silver or Bronze, but all metallics are good options
400%+	No	None	None	All metallics are good options (May leave market)

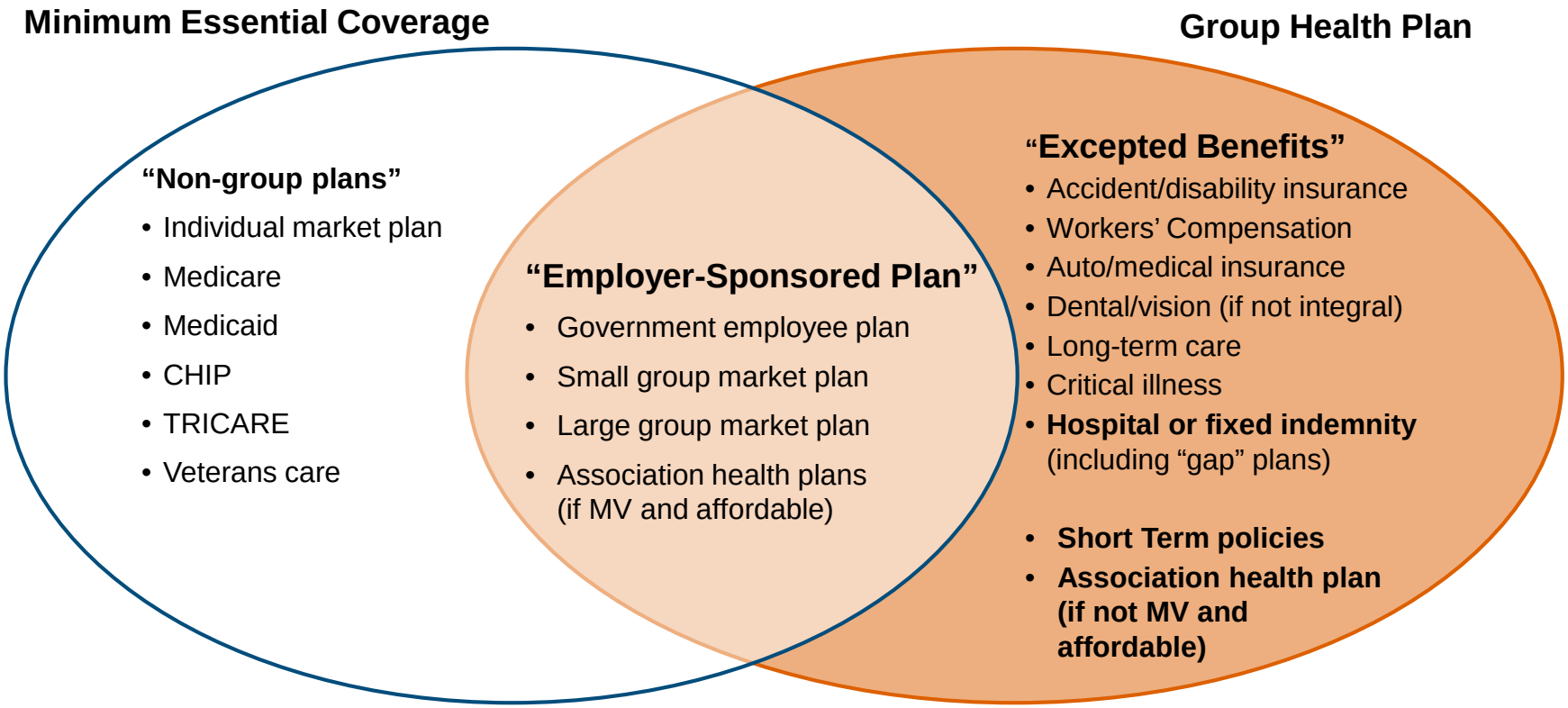
Other Population Segments

- Native Americans
  - Eligible for Native American CSR plans
    - Zero cost sharing for those <300% FPL
    - For others, free coverage at Indian Health Services facilities
  - Most will select these CSR plans
- Young and healthy
  - If under 30, and if available and priced favorably, can select catastrophic coverage
  - Group most likely to forego coverage and pay penalty
  - If under 26, can still be on parents' plan
- Grandfathered Plan Members
  - Those benefitting from old rating rules tended to stay, older and less healthy will move to new ACA compliant plans
- Transitional Plan Members

Group coverage

SOCIETY OF ACTUARIES

Minimum Essential Coverage (MEC)



Not MEC, not group:

- Individual Short term policy

Group Mandates (employers with 50+ FTEs)

	Employer-Sponsored Plans –60% MV or greater	Employer-Sponsored Plans –Less than 60% MV	Excepted Benefits
Employer Mandate	If employer offers and it is affordable, satisfies mandate	By itself, does NOT help employer satisfy mandate	Does NOT help employer satisfy mandate
Individual Mandate	If employee is enrolled in an employer-sponsored plan that provides MEC, then the employee satisfies the mandate. (Penalty is zero in 2019.)		Does NOT help employee satisfy individual mandate
Applicable Rules	All rules for small group and/or large group markets, including: • OOPM ceiling • Prohibition on lifetime/annual dollar limits • First dollar preventive coverage		Do NOT need to follow health reform plan design rules.

Employer Obligations – Play or Pay

Employer mandate to applies to all employers

- Mandate applies to **employers with 50+ FTEs** (for calendar years 2016+; 100+FTEs for pre 2016) (based on avg. count full/part-time in prior calendar year)
- Uses **IRS aggregation rules** to determine if subsidiaries and jointly owned companies treated as one
- Applies to **both fully insured and self-funded** groups and to **grandfathered** groups
- Must offer coverage to dependents up to 26, but NOT to spouses or foster or step children.

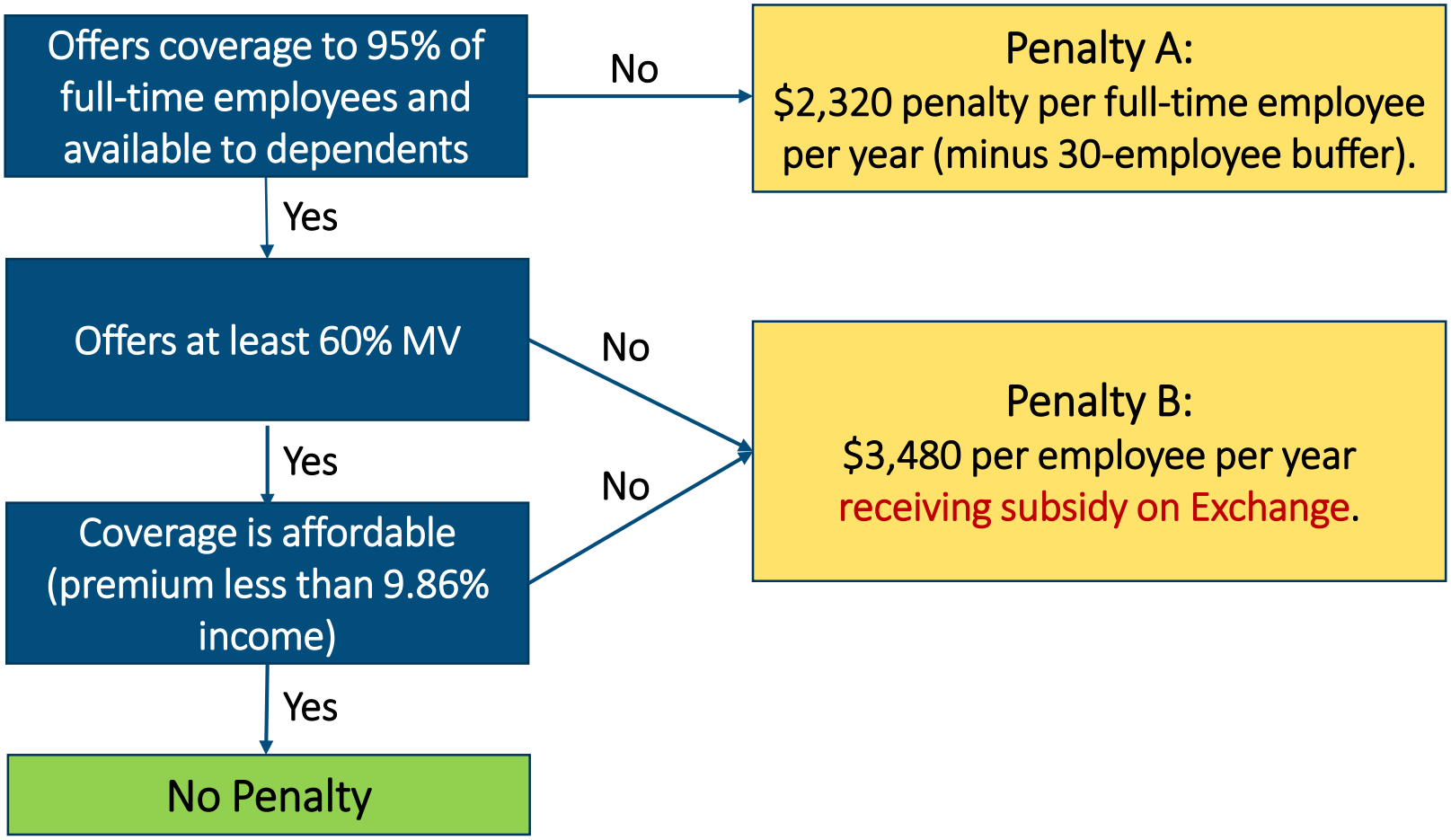
Minimum Essential Coverage

- Must **provide "minimum essential coverage"**
  - NOT a limited benefit or mini-med plan, disability, accident, critical illness, indemnity plan
- **Offer must include 95% of full-time employees, and be available to dependents**

Minimum Value & Affordable

- Must be **affordable**
  - Single employee contribution for lowest cost plan must not exceed 9.86% of household income in 2019.
  - 3 safe harbors to use as proxies for household income:
    - W2 income, Box 1
    - 130 times hourly wage monthly
    - Poverty level
- Must provide **minimum value**
  - Plan pays 60% or more of medical costs across a typical population

Employer Obligations – Penalties



Small Group

SOCIETY OF ACTUARIES

Small Group Segments

- Fewer than 25 FTEs, less than $53,000 average salary (2017)
  - SHOP Exchange = tax credits
  - Credits up to a maximum of 50% of employer-paid premiums
- Other small groups
  - SHOP Exchange = employee choice
  - Massachusetts Exchange: low small group exchange take-up
  - Organizations with more paternal environment will want to choose plan, will seek coverage off Exchange
- Small didn't have coverage mandate in 2014; many didn't offer coverage. Mandate for 2016+ applies to groups with 50+ FTEs (states may expand to 100+ FTEs).

Small Group: Product overview
Description of funding sponsor costs

Funding mechanism	Description of funding and costs to sponsor
Fully-Insured	Premium paid to insurer, who covers claims
Minimum Premium/Level-Funded	Level monthly amount paid to insurer to fund: - expected claims; - additional charges for administrative costs; - premium for “stop-loss” coverage for unfavorable claims. Plus annual settlement for favorable/unfavorable claims.
Self-Funded (ASO)	Plan sponsor purchases administrative services from insurer, and funds claims as they are adjudicated.

Small Group: Product overview

Risks and overall costs

Funding mechanism	Risk to Plan Sponsor	Overall Cost to Plan Sponsor
Fully-Insured	Least: Plan sponsor does not retain any risk of unfavorable claims.	Highest: Plan sponsor is required to pay premium taxes on full amount of coverage. Risk margins highest on fully-insured coverage where insurer takes full risk.
Minimum Premium/Level Funded	Some: Plan sponsor may retain some risk of unfavorable claims (but will hedge catastrophic risk with stop-loss insurance).	Some: Premium taxes are often required on the unfavorable claims insurance only. Lower risk margins since insurer is taking less risk.
Self-Funded	Most: Plan sponsor retains full risk of unfavorable claims.	Least: In many states, the portion of the monthly outflow used to fund claims and administrative expenses is not considered premium, so the plan sponsor does not owe premium taxes on that portion of the funding.

Small Group:
Self-Funded and Level Premium Comparison

Consideration	Level Premium	Self-Funded
Costs to plan sponsor	Level payment for expected claims, administrative services, stop-loss insurance End of year settlement	Administrative services Fund claims as adjudicated
Risk to plan sponsor	Some	High
Overall cost to plan sponsor	Some	Low
Month-to-month variance	None, until the end	High
Administrative complexity	Low	High
Characteristics of groups choosing this option	Smaller groups (250 employees or fewer) Some risk appetite Perceive themselves to be lower cost	Larger groups (500 employees or more) More risk appetite Can handle extra administrative burden
Insurance against catastrophic claims	Aggregate	Specific (per claimant)

Large Group

SOCIETY OF ACTUARIES

Large Employer Requirements

EHB and Benchmark Plans

The EHB benchmark plan defines the essential health benefits that must be covered by plans in the state

All large group

- Not required to cover EHB
- If they do, may not apply annual or lifetime dollar limits
- Non-dollar (duration) limits are still allowed
- Employers may remove benefit if they do not want to waive dollar limits

Fully Insured

- Plans will follow the benchmark for their situs state
- Many carriers removed dollar limits from all EHBs starting in the first plan year on or after Jan. 1, 2014

Self-funded

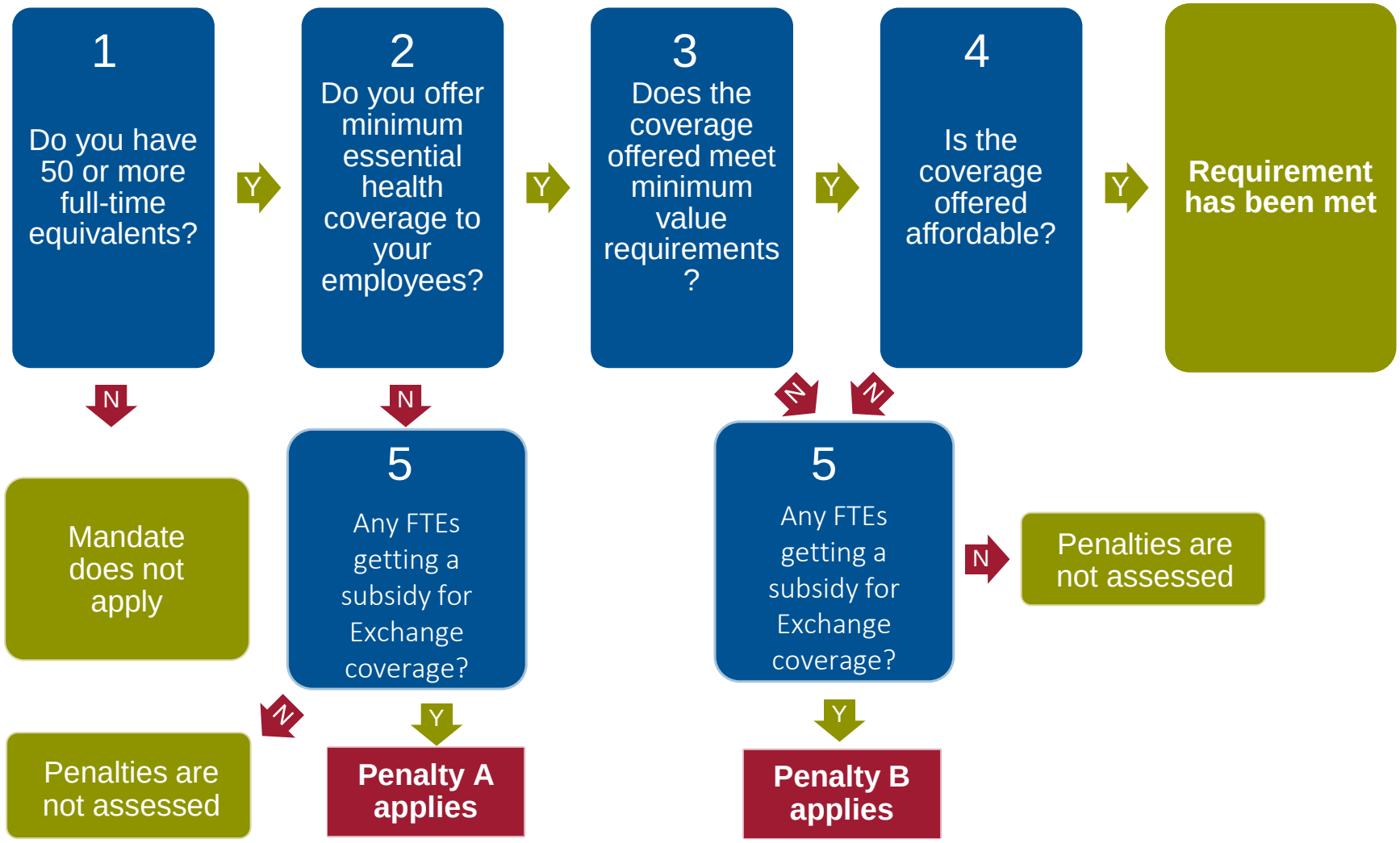
- Self-funded employers must choose a benchmark option to determine which of the benefits they cover are considered EHB
- Can choose any state or federal plan as their benchmark plan

EHB Final Rule, 2/20/13

HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS **(including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories)** [and intends] to work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.

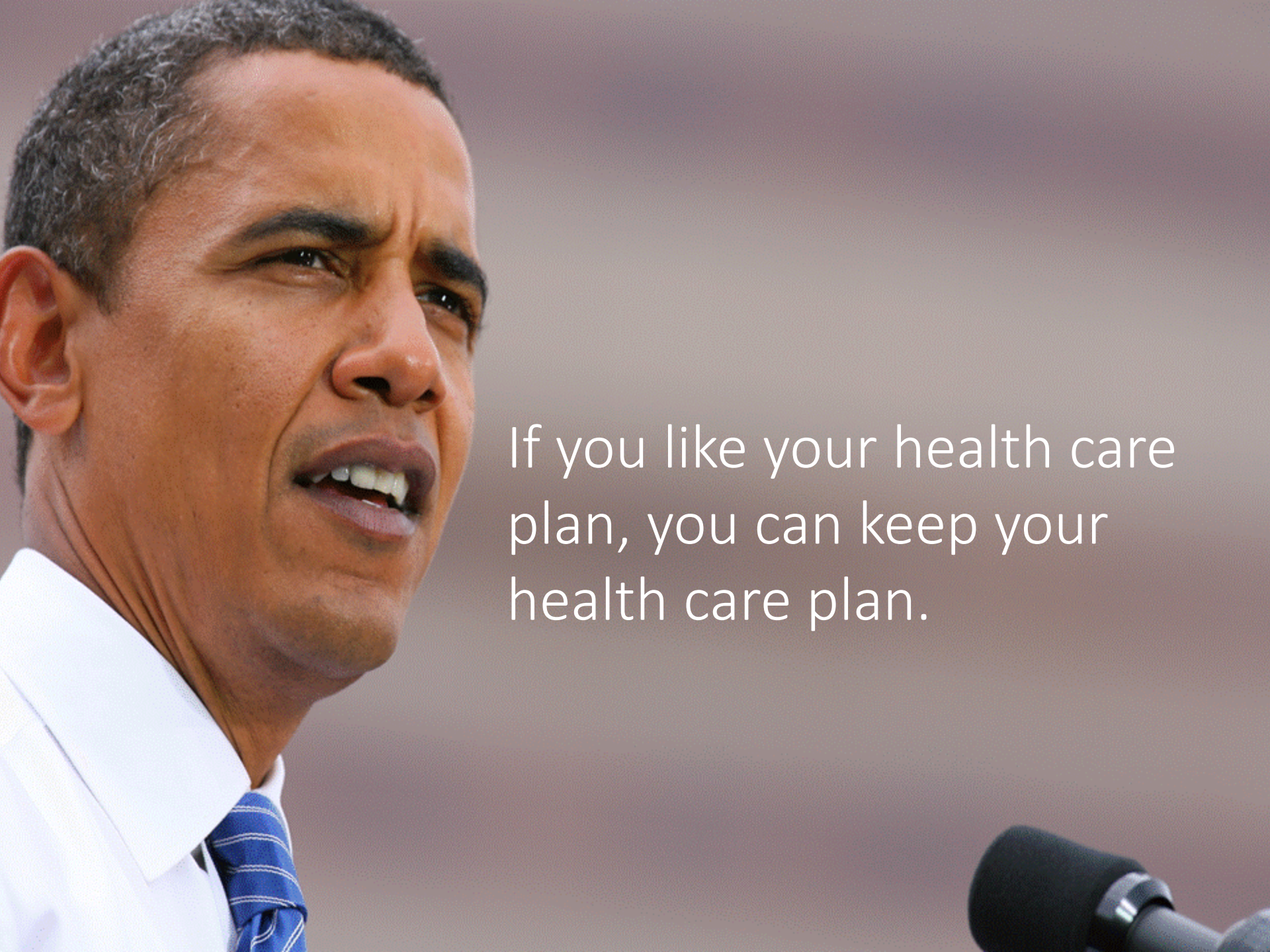
Elimination of any benefit coverage including EHB will result in plan losing grandfathered status

Five Key Employer Questions



Individual / Small Group Pricing Considerations

SOCIETY OF ACTUARIES


If you like your health care plan, you can keep your health care plan.

Grandfathered Plans

- Allows carriers to retain previously existing healthcare plans that are not subject to some of the ACA requirements.
  - Exempt from EHBs
  - Exempt from 100% coverage of preventive benefits
  - Exempt from AV level requirement
- Still must comply with the following:
  - Removal of annual and lifetime limits
  - Pre-existing condition provisions
  - Dependents to age 26
- Does **not require** carriers to maintain these plans

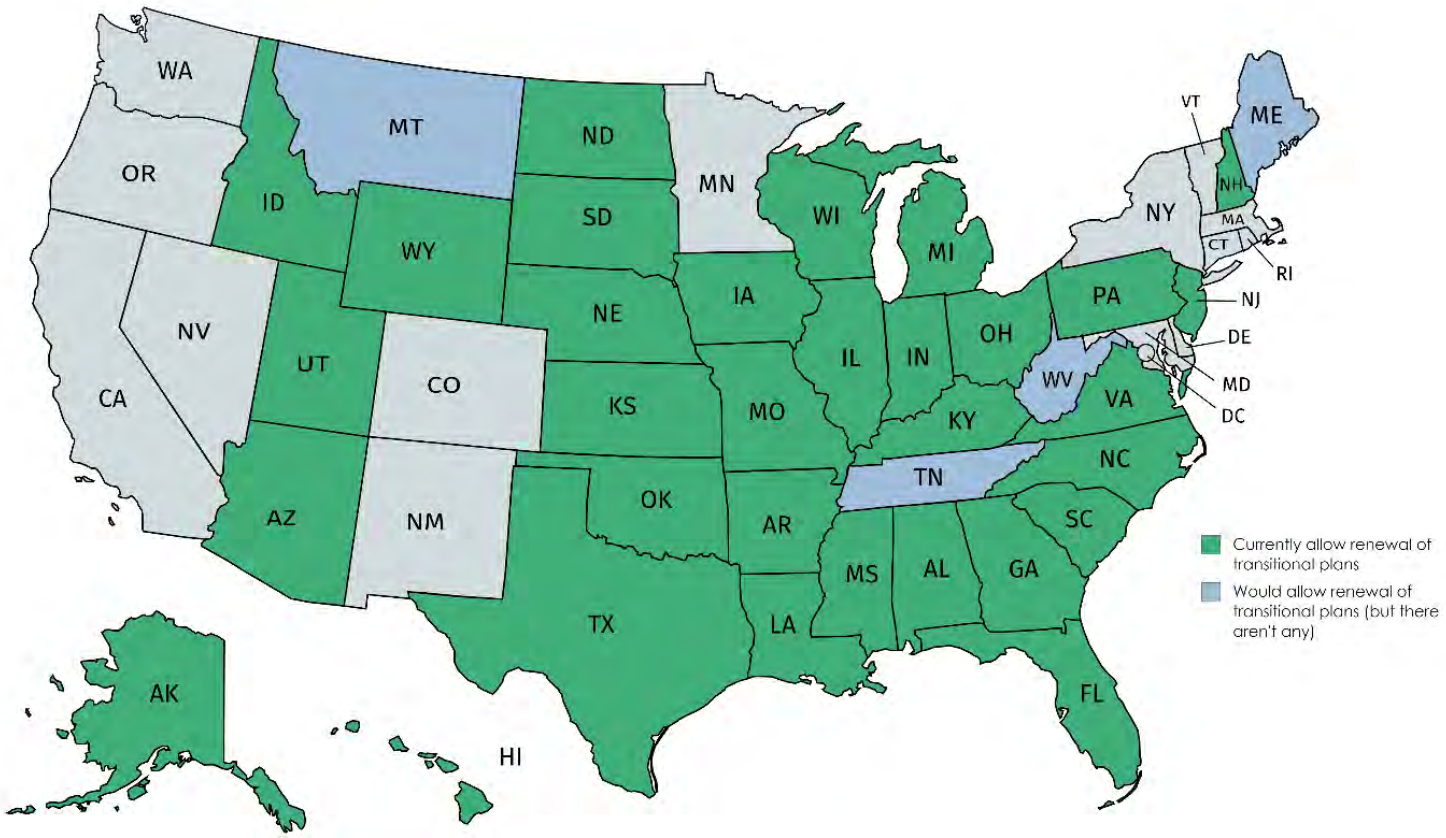
Grandfathered Plans - Membership

- Who stayed in grandfathered plans?
  - People who benefit from pre-ACA rules
  - Decision based on premiums and plan designs
- Premiums
  - Those benefitting from old rating rules tended to stay in GF plans
    - Healthy members
    - Younger members
  - Unhealthy or older members tended to move to take advantage of age rating restrictions and no health rating
- Plan designs: Those who prefer their plans without the necessary changes to become ACA compliant remain in these plans

Transitional Policy Coverage

- “Grandmothered” plans
- Must include preventive care with no cost sharing, eliminate annual benefit limits for EHBs.
- April 2018 – at state discretion, extended transitional policy to renew as late as October 1, 2019 (with coverage ending no later than December 31, 2019).

Transitional Policy Coverage



Current as of September 30, 2018. Source: https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/#renew

Individual and Small Group Pricing

- Single Risk Pools
- Rating Categories
- Trends
- Induced Utilization
- Required Fees
- Individual Market Considerations
- Small Group Market Considerations

Individual and Small Group Pricing
Single Risk Pools

- February 2012 – HHS issued final rule effective on plan years beginning Jan. 1, 2014 or later.
- Prevents insurers from segmenting enrollees into separate rating pools in order to increase premiums at a faster rate for higher-risk individuals.
- Index Rates
- Product-specific rates determined through:
  - Actuarial value and cost sharing design
  - Provider network, delivery system and utilization management
  - Benefits in addition to the EHBs
  - Expected impacts of eligibility categories for catastrophic plans

Allowable Rating Factors

Individual and Small Group Pricing
Area Factors

- Different rating factors for individual and small group markets
  - Based on expected differences in costs between areas
- Must apply uniformly within each market
- Cannot vary by product
- Areas based on divisions by county
- Number of areas equals the number of MSAs plus one non-MSA area, unless there was formal request at the state level, and approval from CMS
- Factors can be set based on unit cost and provider practice pattern differences, but not based on morbidity by region

Individual and Small Group Pricing

Age Rating

- ACA allows for variation of up to 3:1 for similar individuals over 21
  - For instance, 64-year-old's premium cannot exceed 3 times a 21-year-old's, for the same product and area
- Age defined as that at time of effective/renewal date of policy
- Age curve may vary by state, but is uniform within each state (most states use standard curve determined by CMS)

CMS Standard Age Curve (2018+)

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-14	0.765	31	1.159	48	1.635
15	0.833	32	1.183	49	1.706
16	0.859	33	1.198	50	1.786
17	0.885	34	1.214	51	1.865
18	0.913	35	1.222	52	1.952
19	0.941	36	1.230	53	2.040
20	0.970	37	1.238	54	2.135
21	1.000	38	1.246	55	2.230
22	1.000	39	1.262	56	2.333
23	1.000	40	1.278	57	2.437
24	1.000	41	1.302	58	2.548
25	1.004	42	1.325	59	2.603
26	1.024	43	1.357	60	2.714
27	1.048	44	1.397	61	2.810
28	1.087	45	1.444	62	2.873
29	1.119	46	1.500	63	2.952
30	1.135	47	1.563	64+	3.000

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf

Individual and Small Group Pricing

Age Rating

Figure 1: Disease Prevalence by Age, Commercially Insured Adults

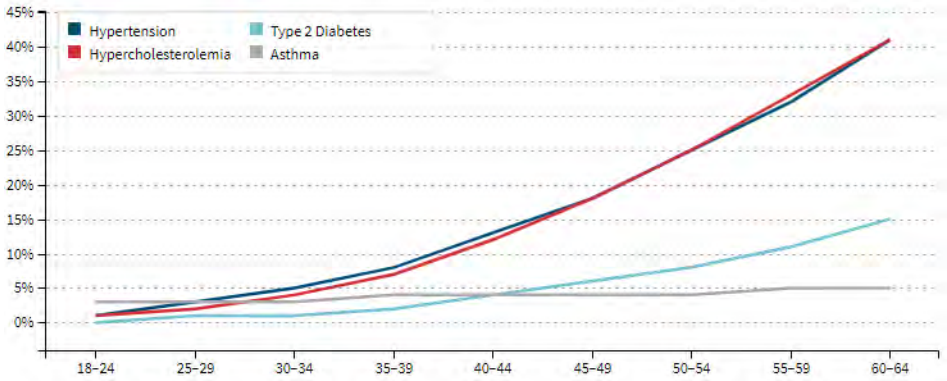
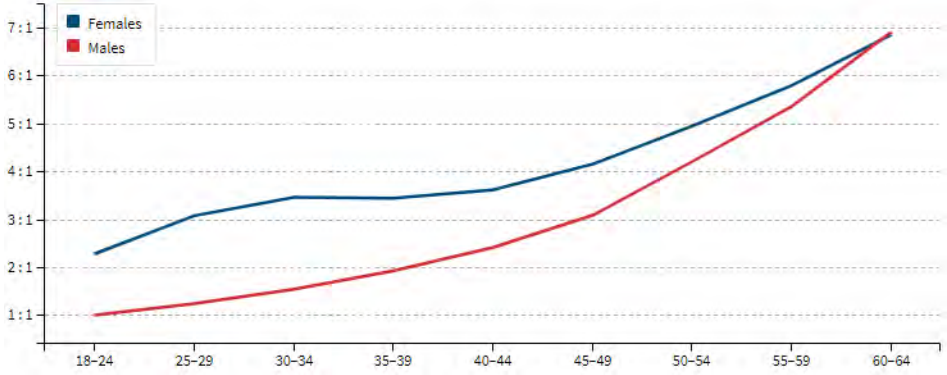


Figure 2: Allowed Claim Cost Relativities by Age/Gender, Commercially Insured Adults



Individual and Small Group Pricing
Tobacco Rating

- ACA allows for up to 50% smoker load
  - Smoker load can differ by age
    - e.g., A 64 year old smoker can be charged a total of 4.5 times a 21 year old smoker (3x for age and 1.5x for smoking)
  - Some states have stricter limitations on smoker load

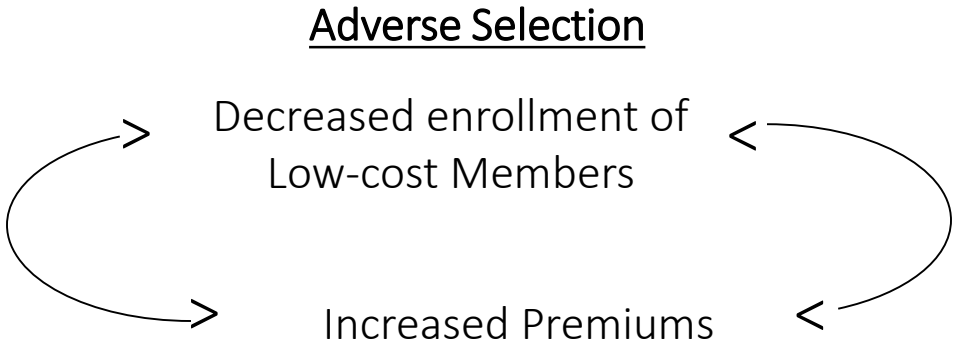
Individual and Small Group Pricing

Family Rating and Child Loads

- Rate based on individual or family enrollment
  - i.e., Individual + Spouse, Individual + Dependents, etc..
- Three child cap
- How to prepare for unexpected costs?
  - Child load
  - Spread expected cost of additional children over population

Individual and Small Group Pricing
Pricing for Selection

- Prohibited pricing based on expected plan selection of enrollees
  - Can rate by age category
- Mitigates ongoing adverse selection



Individual and Small Group Pricing

- Must include EHBs
- Must consider plan AV
  - Actual plan AV, not AV calculator values
  - AV calculator values should not be used for pricing

Individual Pricing: Market Changes

- Increased costs due to individual mandate and plan design requirements
  - Morbidity in the newly insured
  - Pent-up demand
  - Induced utilization
- Pricing must be at your carrier's cost structure, but price at the market average risk. Must not price for carrier average risk.
  - Critical pricing consideration for both individual and small group:

Individual Pricing: Market Changes

- How to price at market-level risk?
  - This was very difficult for the 2014 pricing season.
  - Unfortunately, this is still very difficult (but easier).
  - Official CMS reports are a good basis
    - Adjusted for information promulgated from DOI, KFF, others
    - Trended
    - Coding efforts versus health of market
    - Consistency with SAO work?

Individual Pricing: Market Changes

- Must also consider change in impact between years, especially as the market population changes over time.
  - Penalties increase over time
- Market alternatives?
  - What's allowed in your markets?
  - Also changing over time
- Will cover the "Three Rs" in more detail tomorrow morning, quick overview here first.
  - Mostly risk adjustment now

Individual Pricing: Transitional Reinsurance

- Only insurers in individual market receive payments; all contribute (including small group, large group, self-insured group plans)
  - Existed from 2014 to 2016 – no longer exists for 2017+
- Value depends on the expected members with high claims
  - Attachment point:
    - 2014: $45,000
    - 2015: $70,000 originally; lowered to $45,000
    - 2016: $90,000
  - Cap:
    - $250,000 (each year)
  - Coinsurance rate:
    - 2014: 80% (paid out at 100%)
    - 2015 and 2016: 50% (paid at 55.1% for 2015, 52.9% for 2016?)
- Removal in 2017 contributed to rate increases

Individual Pricing: Risk Adjustment

- How does the carrier's risk score in the market compare to the statewide market as a whole?
  - New insurers
  - Existing carriers
  - Actual risk versus measured risk
- What is the carrier's market share?
  - Small issuers have greater variation in risk scores
  - As an issuer gains market share, their risk profile approaches the same level as the market, so risk adjustment receipts and payments trend toward $0.
- A risk score of 1.00 does not mean no payment.
  - Risk scores are compared to the market wide (state, and individual or small group) risk score, which are usually something other than 1.00.

Individual Pricing: Risk Corridors

- How were risk corridors considered?
  - The Risk Corridors program incorporate the results of Transitional Reinsurance and Risk Adjustment programs, so projecting Risk Corridor receipts was at least as difficult as projecting those programs
  - What are your allowable administrative costs?
  - If there is a non-zero amount built into pricing, it can imply that expected costs are different than what you priced for and the pool is 'priced incorrectly'
- CMS announced on October 1st, 2015 that 12.6% of payments requested in 2014 will be paid in 2015, with charges for the 2015 and 2016 plan year filling in the rest
  - November 2016 announcement – about another 1% for 2014.
  - November 2017 announcement - ???

Individual Pricing: STLDI

Short-Term Limited Duration Insurance (STLDI)

- 2004: STLDI must be less than 12 months duration
- 2016: Term reduced to be less than 3 months duration
- October 1, 2018: New STLDI rule takes effect
  - Initial duration maximum of less than 12 months
  - Total duration maximum of less than 36 months

Federal Authority vs. State Authority

Individual Pricing: STLDI

STLDI Considerations

- Medical Underwriting
- Benefit Exclusions
- Target Population

Small Group Pricing: Early Renewals

- Existing small group carriers have an established membership pool
- Some groups were better off under current plan design and rating rules
- Many insurers decided to offer early renewal on 12/1/2013 for these groups to keep their current coverage longer
  - The insurer gets to keep the group for an extra 11 months prior to extra competition on Exchanges
  - The small group got to keep their current plan priced under the current rating rules for an extra 11 months

Small Group Pricing: Early Renewals

- Who was a candidate for early renewal?
  - Healthy groups: to avoid rating rules that don't allow health status as a risk factor
  - Less expensive industries: to avoid the removal of industry as a rating factor
  - Groups that enjoy their current plan not compliant with ACA
  - Will be more prevalent in states with less strict current rating rules
- What is the implication?
  - Fewer healthy groups entering the Exchange
  - For insurers newly entering the market, fewer potential groups

Small Group Pricing: 3Rs

- Transitional Reinsurance receipts do not (and never did) apply to the small group market
- Risk Adjustment receipts should be smaller (closer to zero) than for individual market
  - Less market shifting than in the individual market
  - Fewer newly insured members in the small group market
  - Small insurers still need to worry about large swings
  - Exact amount will still be difficult to project because you still have to compare your risk score to the statewide market
- Since there is less market shifting, risk corridors were relatively easier to project in the small group market than in the individual market

Small Group Pricing: Open Enrollment

- Open enrollment for small groups is year-round, with one exception
- Issuers may impose a minimum contribution or minimum participation requirement
  - Groups not meeting this requirement must be allowed to purchase during a specified open enrollment period
  - Outside of this open enrollment period, groups may be denied
  - The open enrollment period from Nov. 15 to Dec. 15
- Small groups purchasing coverage on the SHOP Exchange must contribute at least 50% of a single employee's monthly premium to qualify for tax credits

Small Groups: ACA Alternatives

- Self funding
- Level funding
- Association options

Statewide Pool Information

- Publicly posted rate filings can assist in developing rates
- Publicly available information varies by state
- New ACA filing requirements can provide useful information
- Sources include:
  - Actuarial Memorandum
  - Unified Rate Review Template (URRT)
  - Shadow Pricing

Actuarial Memorandum

- A new requirement with the ACA, the Part III Memorandum is publicly available
  - Intended to accompany URRT
- Useful information includes:
  - Trend rates
  - Projected loss ratios
  - Process for projection of 3Rs (now just risk adjustment)
  - Load for increased morbidity in individual market
- A state required actuarial memorandum may also be available, and could include additional information

Unified Rate Review Template (URRT)

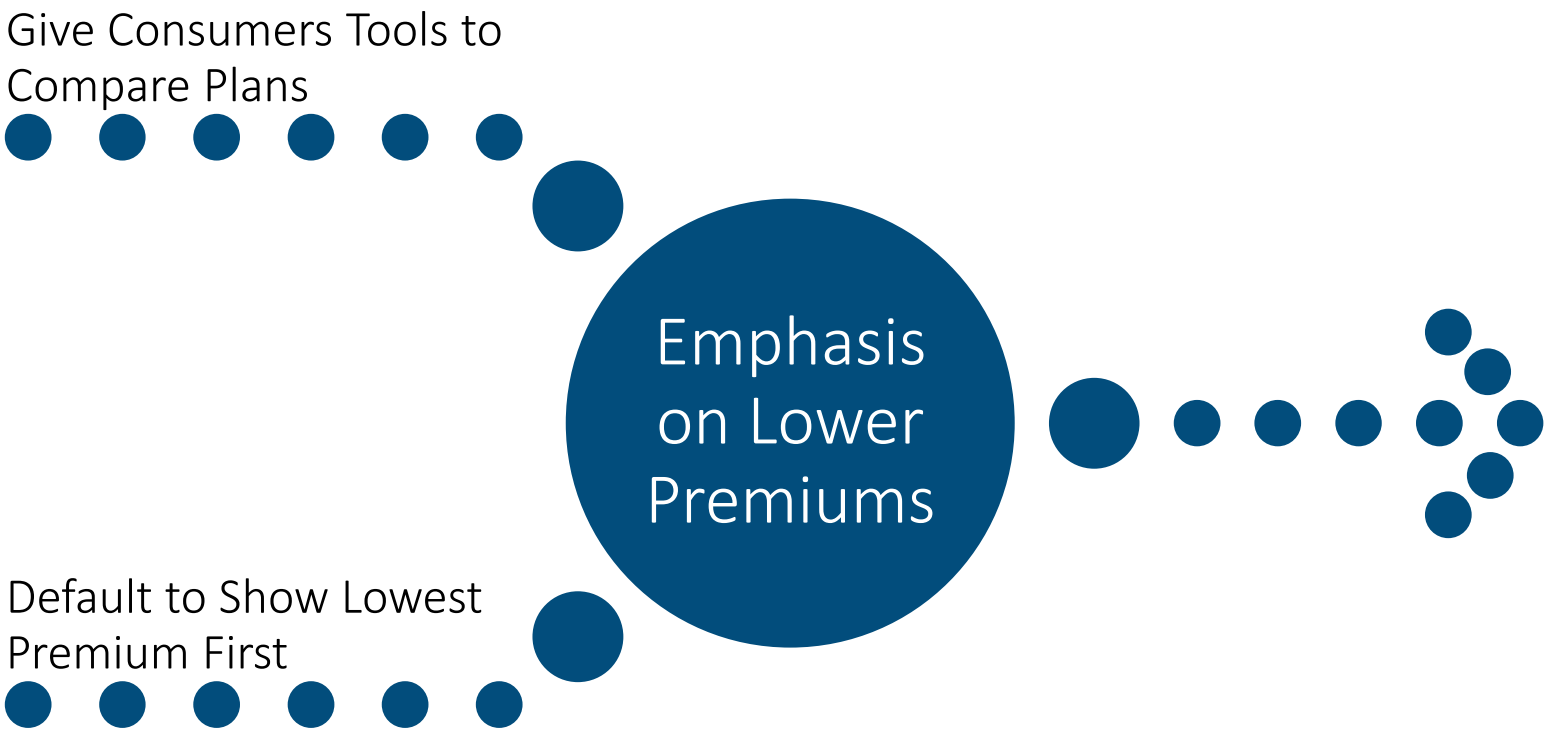
- A new ACA requirement, URRTs are made public
- Wealth of useful information, including:
  - Projected benefit richness
  - Projected transitional reinsurance
  - Projected risk adjustment
  - Enrollment take-up assumptions
  - Enrollment distribution by product and metal level
  - Retention components (profit, taxes and fees, and other)
  - Projected CSR receipts

“Shadow” Pricing Review

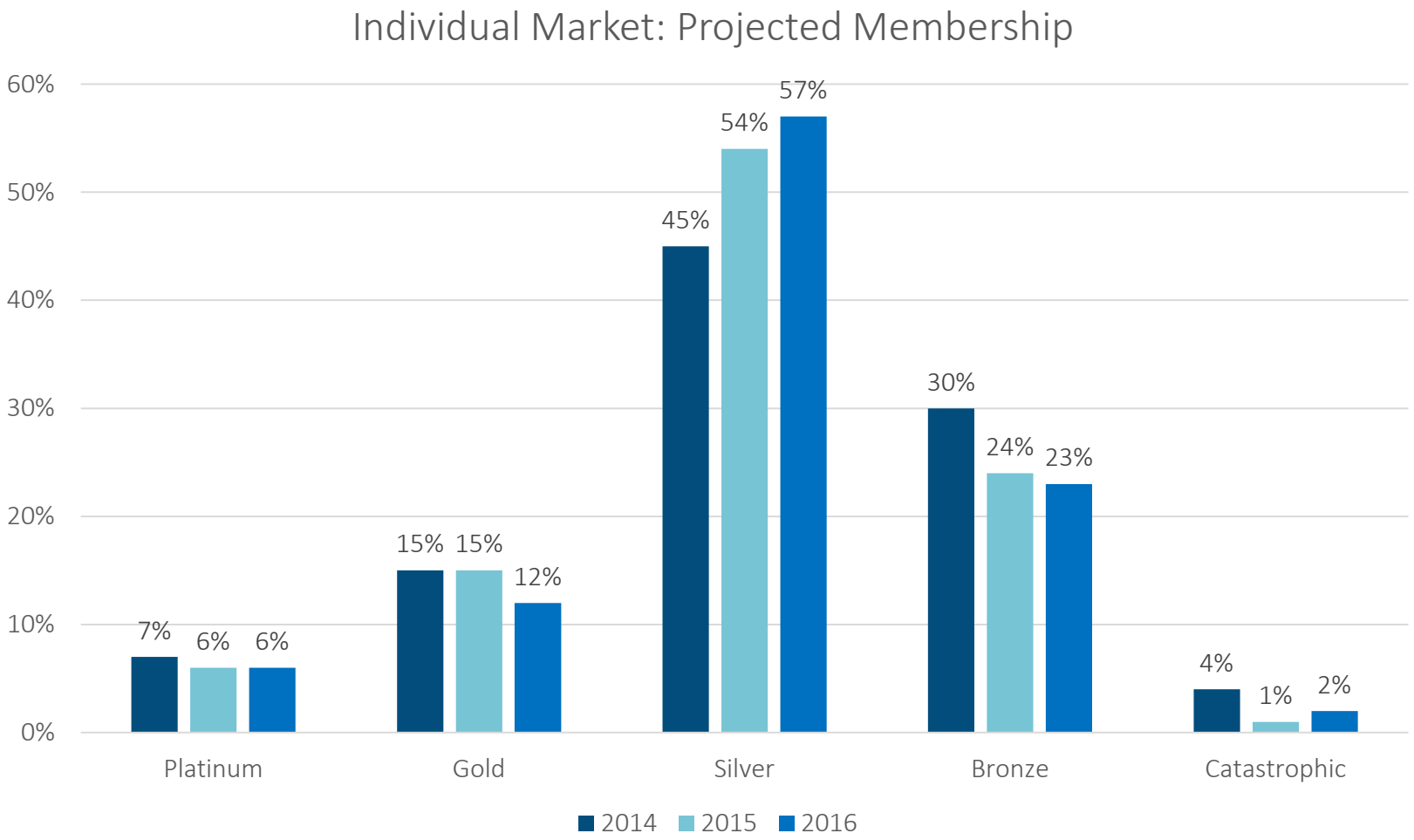
- In some instances, states make filed rates immediately available
  - Issuers filing later can use filed rates and factors as competitive information
  - There is no bonus for filing early!
- In some instances, rates and filings were released by DOIs and issuers were allowed to resubmit rates
  - Competition among rates
  - Ability to review competitor assumptions to revise your own assumptions

Plan Design Strategies In the ACA Marketplace

Exchange Hypothesis



Plan Design Strategies In the ACA Marketplace



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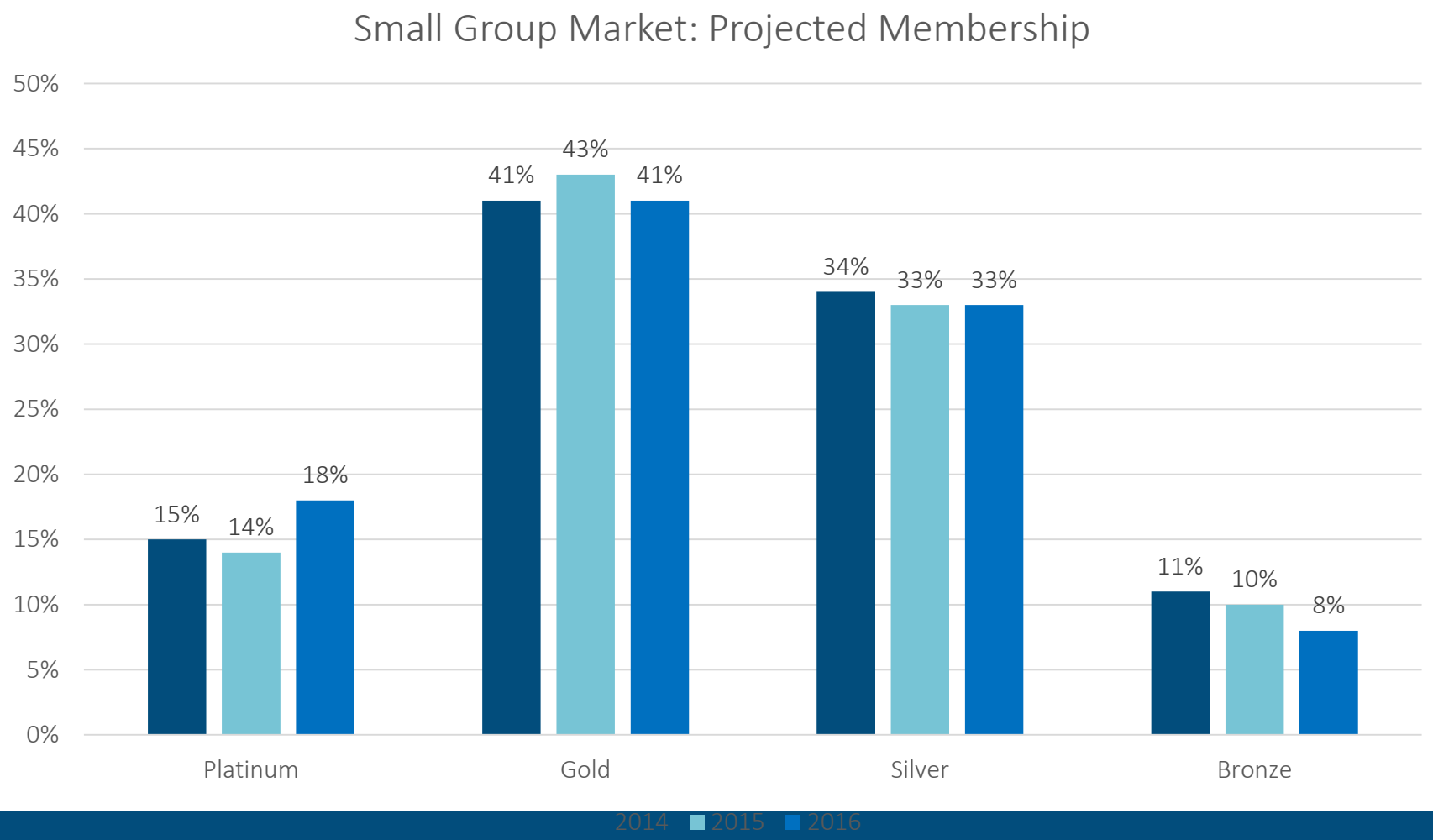

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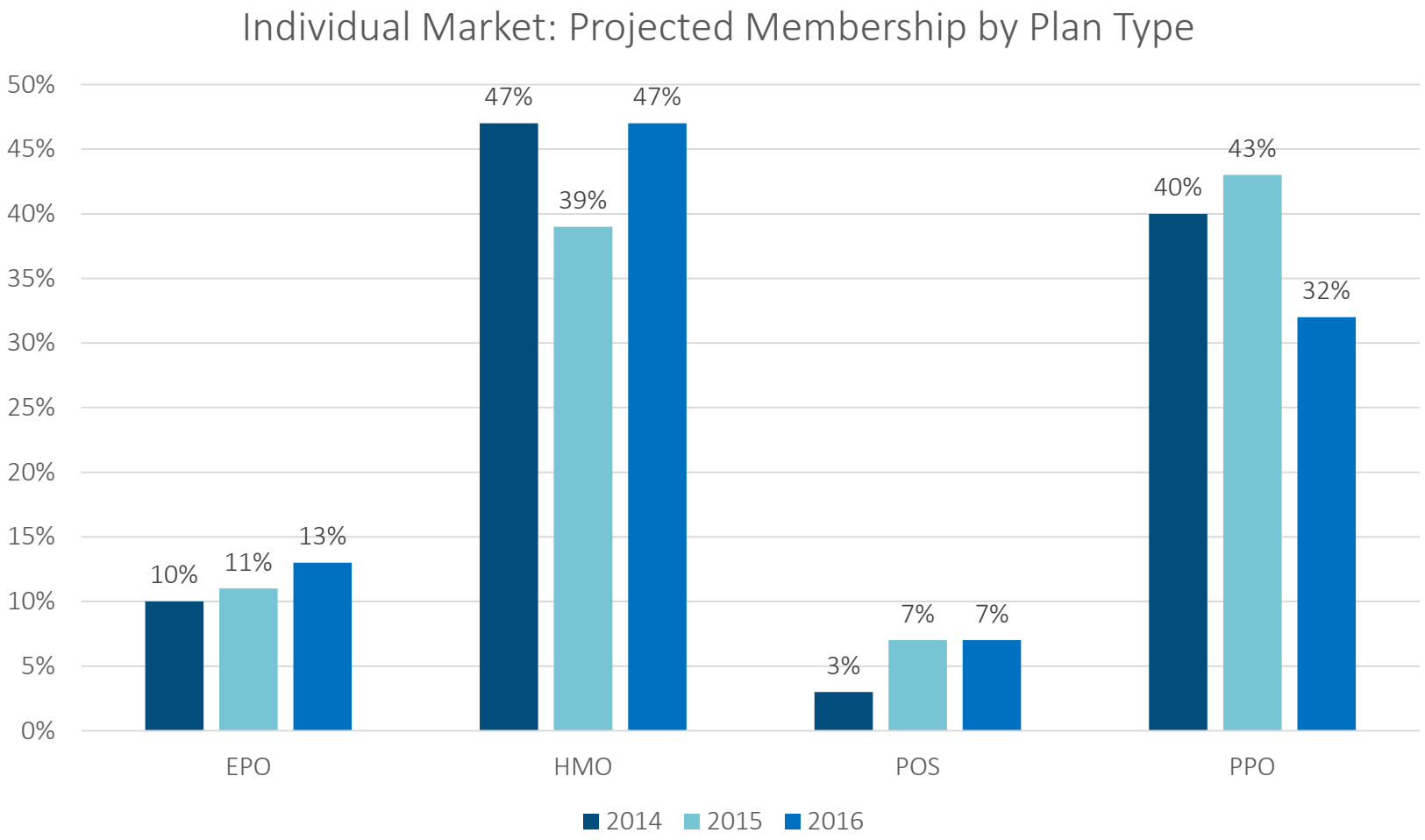

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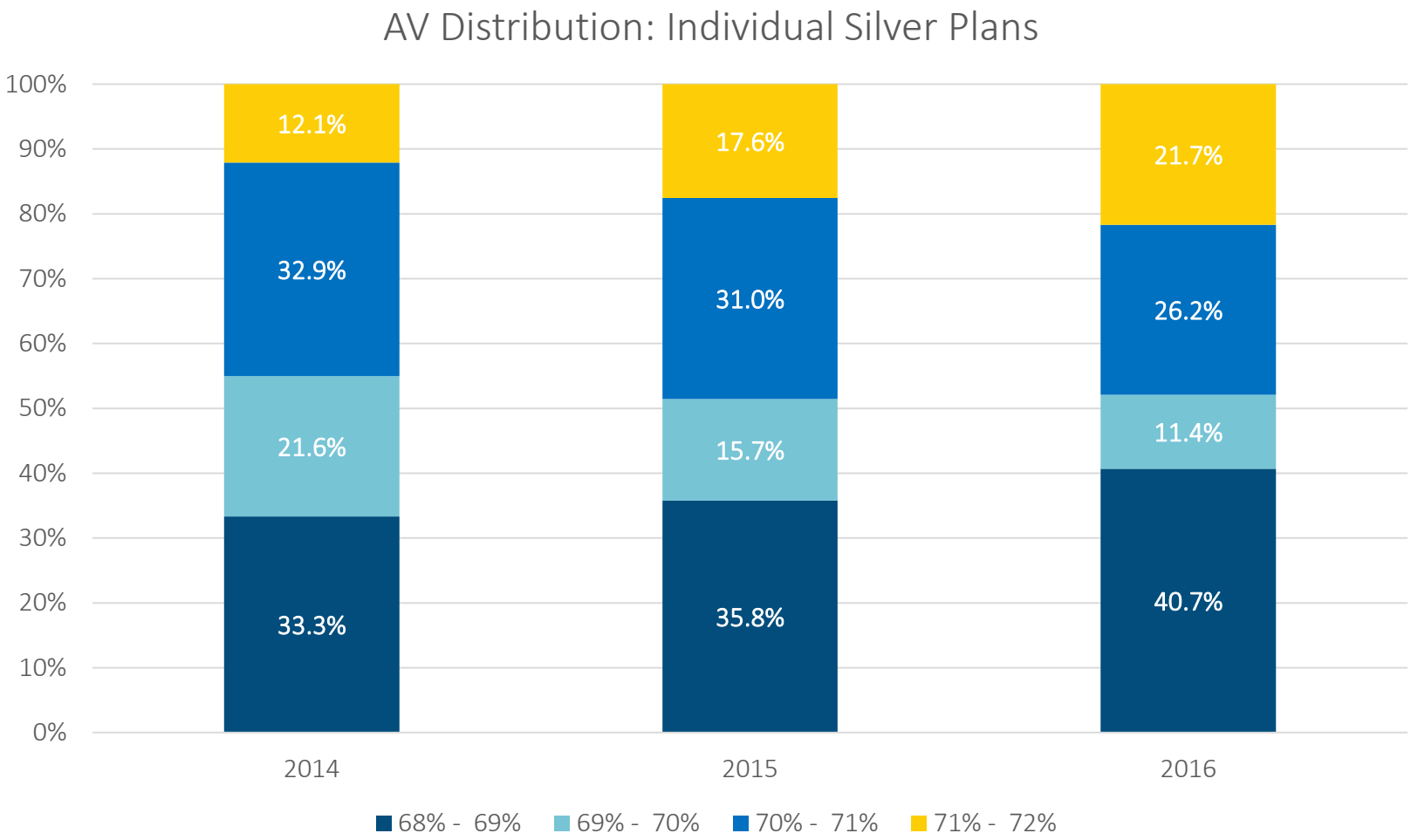

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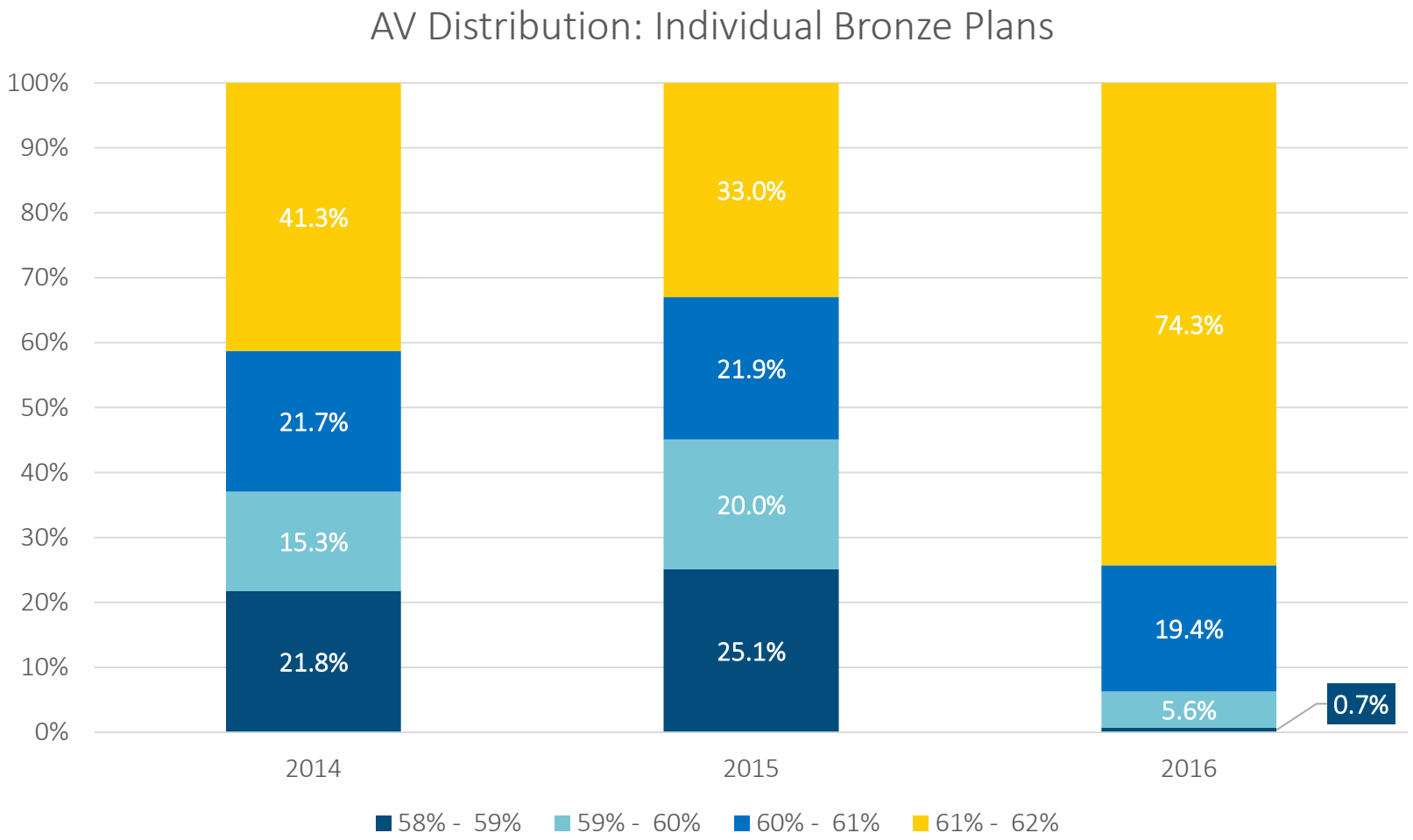

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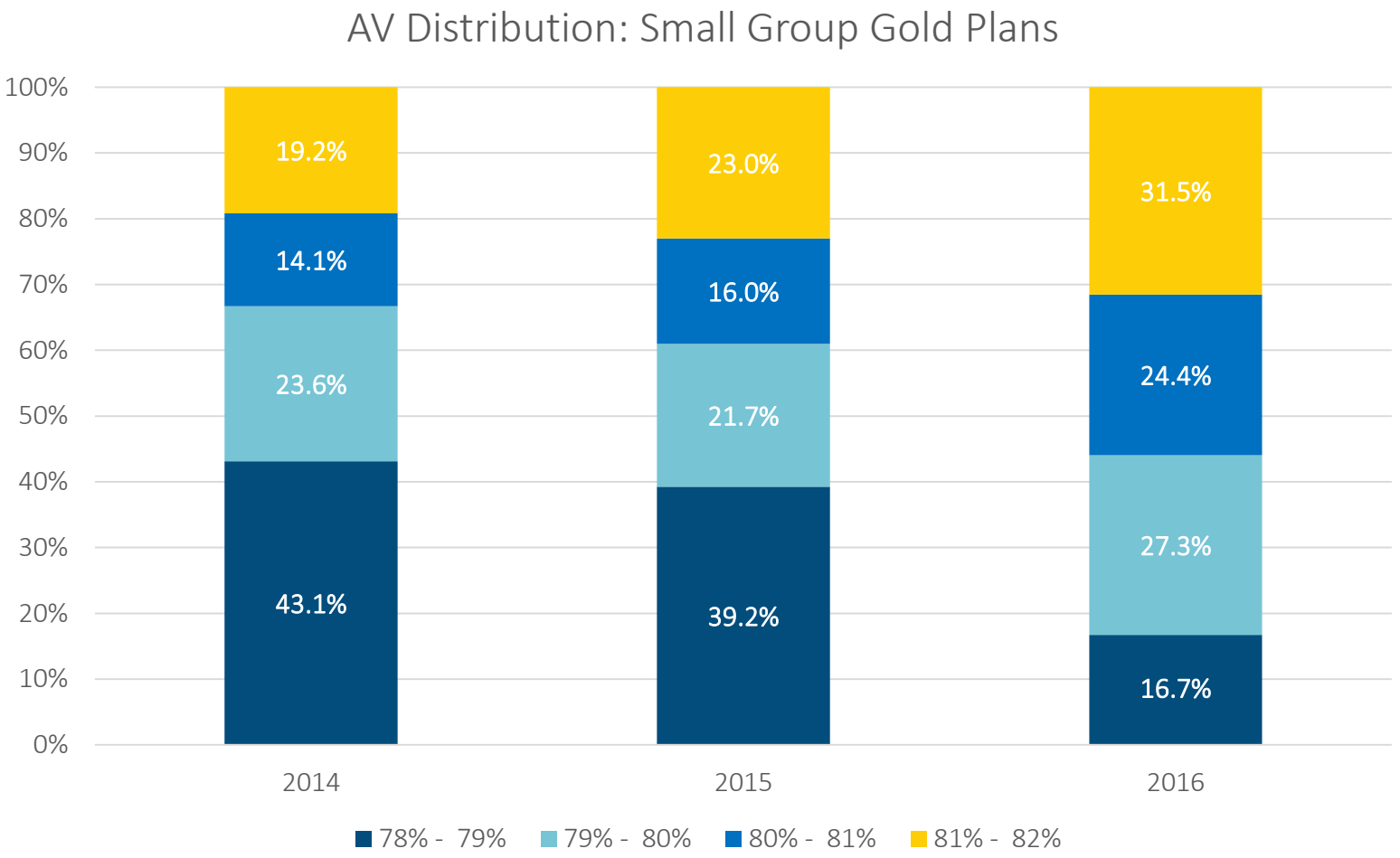

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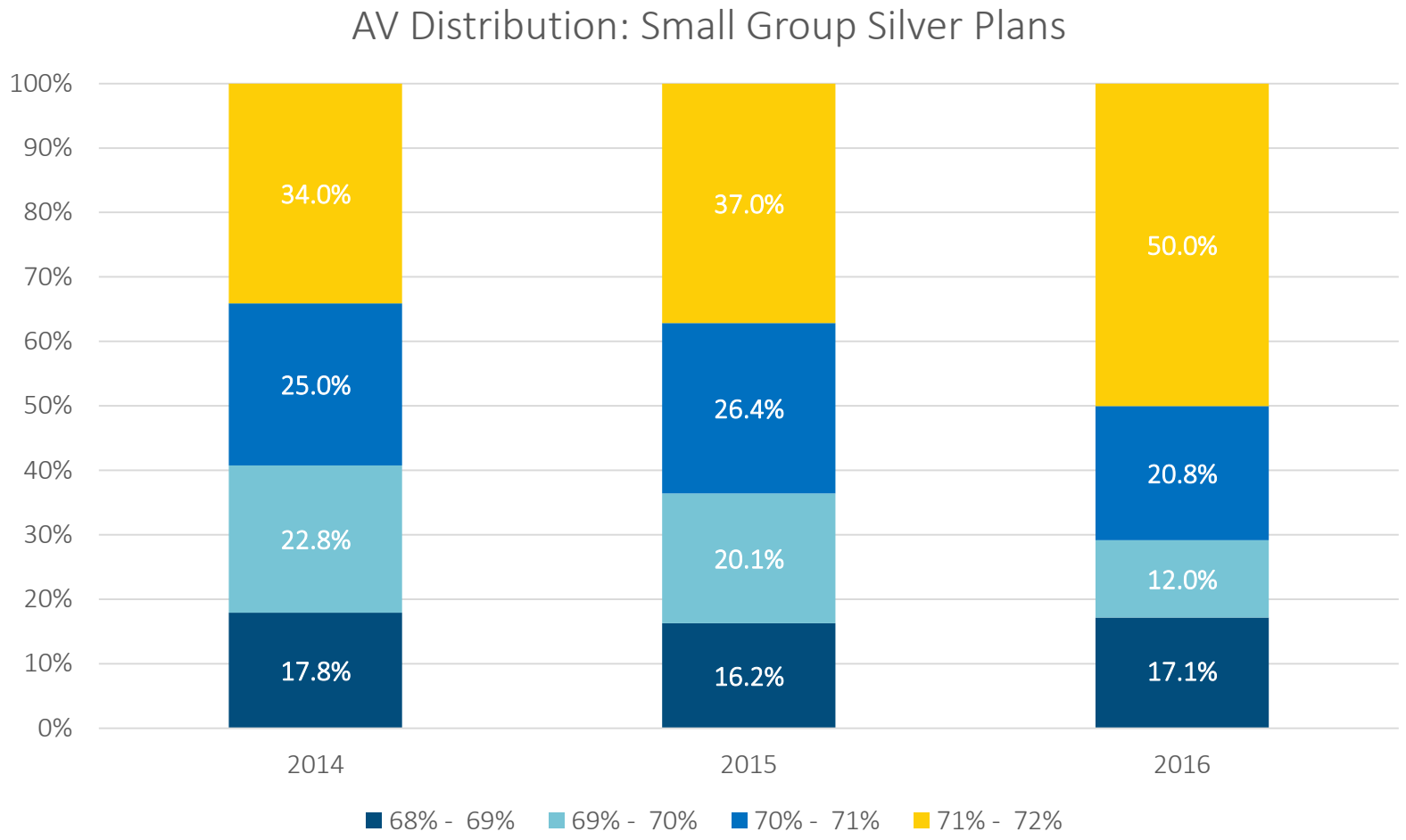


Plan Design Strategies In the ACA Marketplace

- Market membership projections exhibited a preference for
  - Individual market:
    - Lower-cost plans
    - Health maintenance organization (HMO) plans
    - Plans at the lower-end of the allowable actuarial value range
  - Small Group market:
    - Higher AV ranges within metallic levels

Modeling utilization

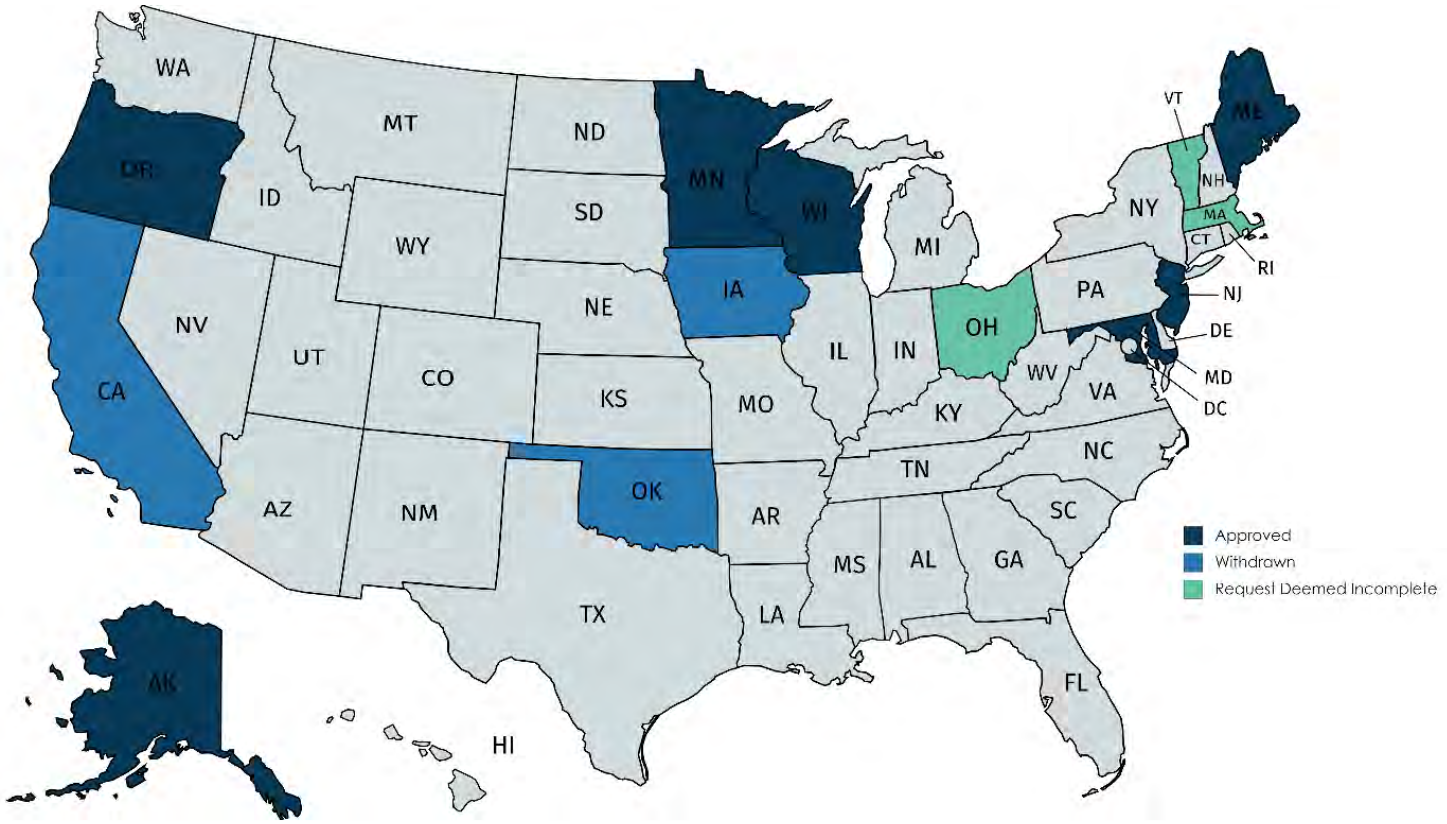
- Do people use more services, and/or do the services that they use cost more?
- Sources:
  - Your carrier's ACA data
  - Adjusted non-ACA data
  - Outside data

Section 1332 Waivers

- State flexibility.
- Available beginning with 2017 plan year.
- Bigger, faster, stronger!
- Some options:
  - Attachment point reinsurance pools
  - Condition based reinsurance pools
  - Modifications to ACA rating and exchange rules
    - Age curve, single risk pool, metallic levels
  - Modifications to subsidies
    - CSR payments, APTC adjustments

Section 1332 Waivers – State Activity

(Current as of August 23, 2018)



Source: Kaiser Family Foundation, https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

Section 1332 Waivers – But Wait!

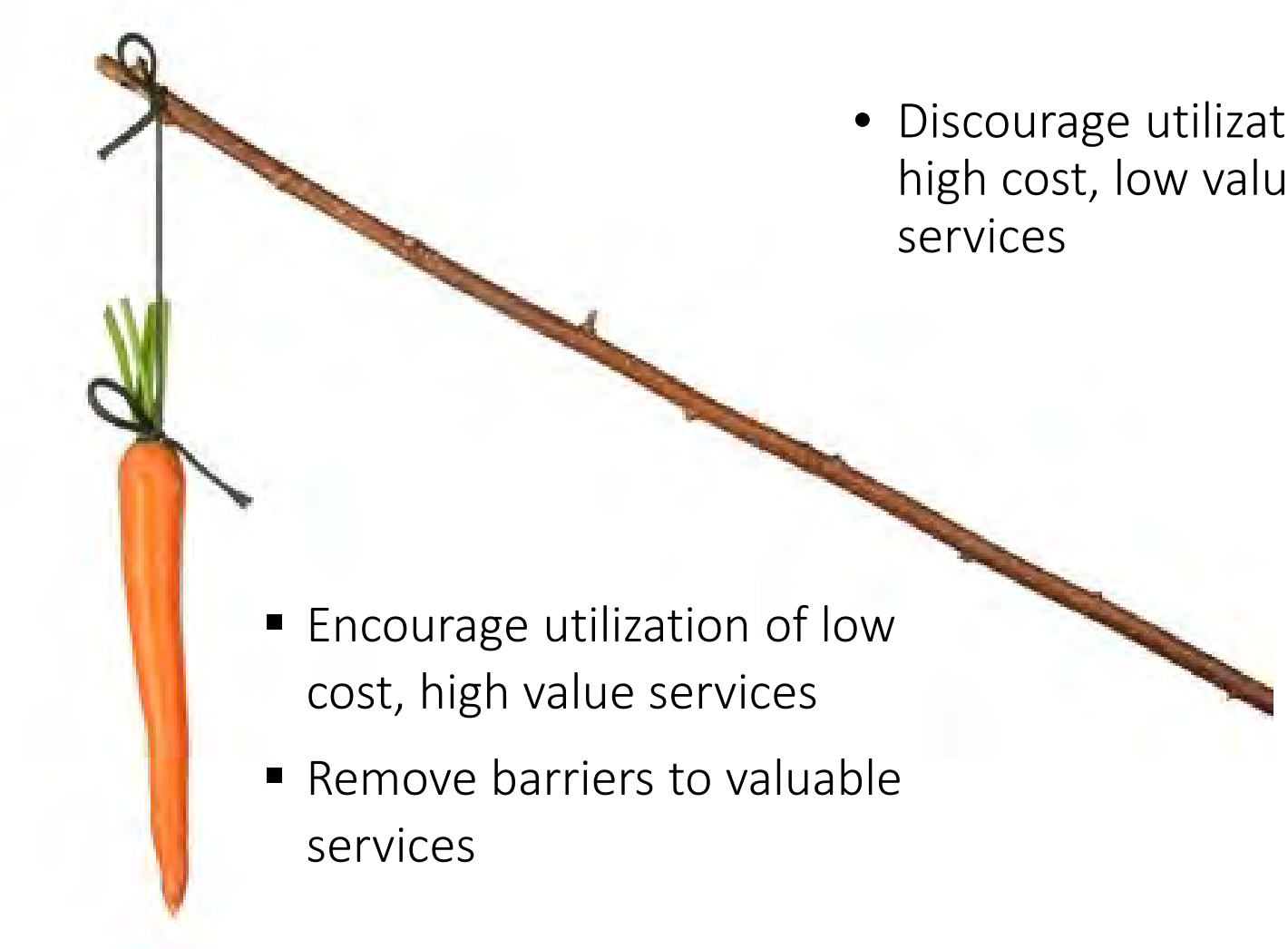
- On October 22, 2018, HHS released updated guidance on 1332 waivers.
  - May loosen guidance on 1332 requirements related to ACA guardrails
  - Relaxes earlier standard about comprehensiveness and/or affordability of coverage
  - Relaxes interpretation of requirement that states "enact a law" to implement a 1332 waiver
  - May be vulnerable to legal challenge

Source: Kaiser Family Foundation, https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

Benefit Design Considerations

SOCIETY OF ACTUARIES

VBID Benefit Design Features



- Discourage utilization of high cost, low value services

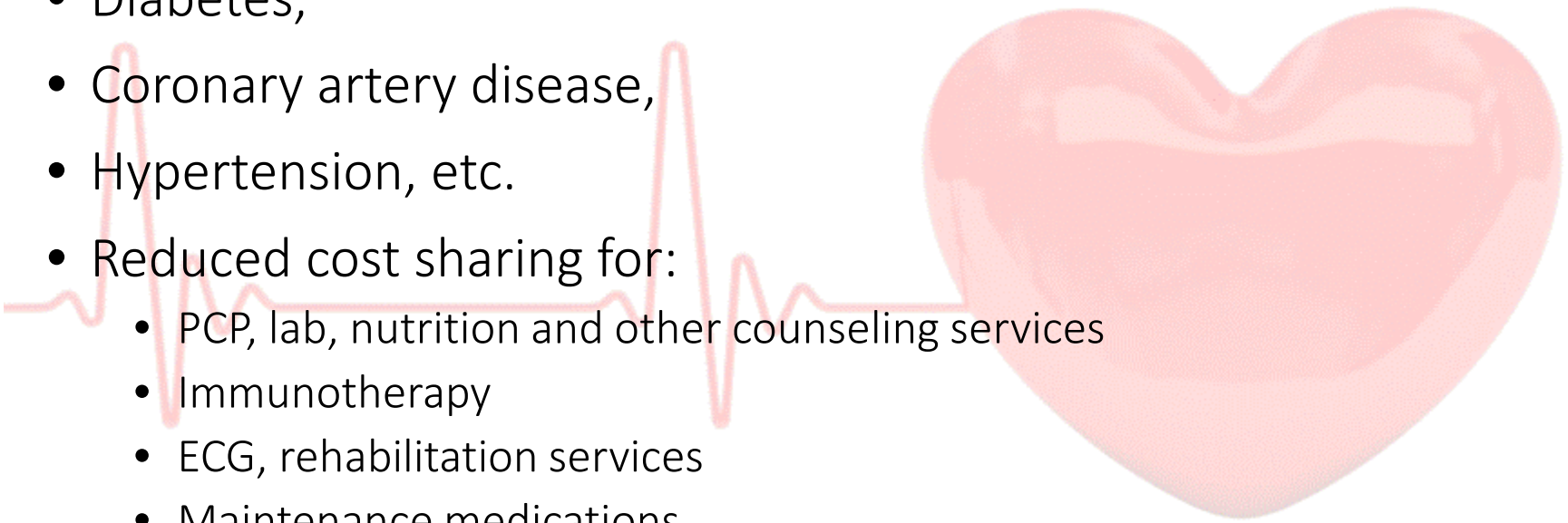
- Encourage utilization of low cost, high value services
- Remove barriers to valuable services

VBID Benefit Design Features: Carrots

- Impact on utilization from member cost sharing
- Reduced or waived cost sharing for specific medications
  - Maintenance medications for chronic conditions
  - Generic vs. brand drugs
  - 7-tier drug formulary
  - Increase adherence through mail order
- Waiving cost sharing for preventive services, routine supplies, maintenance specialist visits
- Telehealth
- Steering to center of excellence:
  - Differential cost sharing between tiers of providers
- Encouraging urgent care utilization vs. ER

Focus on Chronic Conditions

- Asthma and COPD,
- Diabetes,
- Coronary artery disease,
- Hypertension, etc.
- Reduced cost sharing for:
  - PCP, lab, nutrition and other counseling services
  - Immunotherapy
  - ECG, rehabilitation services
  - Maintenance medications
  - Wellness visits



VBID Benefit Design Features: Sticks

- Evidence based
  - Higher cost sharing for high cost/low value services
  - Additional costs for overused procedures such as an MRI or knee surgery
  - Prior authorization
  - Step therapy for drugs
  - Coinsurance for high-cost services like specialty Rx and MRI/CT/PET
  - Prioritize treatment options (e.g., X-ray before MRI)

Wellness Programs

- Reward health engagement
- 24/7 access to health advice
- Web-based support

- Encourage healthy lifestyle
  - Free weight-management, smoking cessation programs
  - Nutrition coaching

Predictive Analytics

- Can you find enrollees who are at risk for becoming sick in the future (and impact their cost of care)?
- Population health / chronic disease management
- Appointment no-shows
- Patient engagement and satisfaction
- Predicting patient utilization patterns
- Readmission risk

Be careful not to over-promise (even to yourself!)

Population Health Resources

The Actuary Magazine, Public Health (Sara Teppema):

https://theactuarymagazine.org/category/web-exclusives/public-health/

The Actuary Magazine, The Opioid Epidemic (Rebecca Owen):

https://theactuarymagazine.org/the-opioid-epidemic/

Centers for Disease Control and Prevention, Social Determinants of Health:

https://www.cdc.gov/socialdeterminants/

MedInsight Health Waste Calculator

- Milliman and VBID Health collaborative tool to identify and reduce wasteful healthcare spending
- Algorithms process data to identify wasteful services, such as:

Service Category	Example
Common treatments	Antibiotics for pink eye
Disease approach	Neuroimaging for simple febrile seizure in child
Diagnostic testing	Emergency room CT scans for dizziness
Monitoring	Annual stress testing after coronary artery revascularization
Screening tests	Pap smears on women under 21

- Provides Milliman benchmark reports
- Defines services with a degree of appropriateness for care

Value Based Designs: Tiered Networks of Providers

- Contracts with select high performing hospitals and provider groups:
  - Centers of excellence
  - Narrow network products
  - Offered in a limited geographic area
  - Brand name recognition (could be tied to provider)
- Consider plan license type (HMO, PPO)
- Closed network: specialists and PCPs, possibly with gain sharing
- Price differential is needed to drive enrollment
- Caution! Link between quality and cost

Other Considerations

- Quality improvement but no savings? (Health Affairs, July 2013)
- AV rules still apply – have to comply with AV calculator
- Reflect VBID in product pricing
- How to incorporate VBID into policy forms?
- Claim adjudication
- Cost sharing administration in real time

Basic Health Plans

SOCIETY OF ACTUARIES

Basic Health Plans

- States may offer one or more standard health plans to eligible individuals in lieu of coverage through an Exchange
- Only MN and NY have done so
- Requirements:
  - Monthly premium cannot exceed amount required by enrollees in second-lowest cost Silver plan on the individual exchange
  - Cost sharing follows the rules for Silver CSR plans on the Exchange
  - Benefits must cover at least EHBs

Basic Health Plans

- Who is eligible?
  - Income 133 – 200 % FPL
  - Not eligible for Medicaid
  - Not eligible for minimum essential coverage
  - Eligible for ESI that is not providing affordable coverage
  - Under 65 years of age at beginning of plan year

Catastrophic Plans

SOCIETY OF ACTUARIES

Catastrophic Plans

- Intended to give young, healthy potential members an attractive and affordable option
  - Very low take-up
- Also provides an option for lower-income, older members
- What is covered?
  - Deductible equal to maximum allowed OOP Max ($7,350 in 2018, $7,900 In 2019)
  - No coverage before deductible except for:
    - Three primary care visits per year
    - Preventive services covered at 100%
  - 100% coverage after deductible
  - Must meet all other requirements for QHPs

Catastrophic Plans

- Who is eligible?
  - Under 30 years of age

    OR
  - Qualify for hardship exemption
- Types of hardship exemptions
  - Affordability Exemption: Lowest bronze plan > 8% of household income (net of subsidies)
  - Examples of Other Hardship Exemptions: Homeless, eviction, victim of domestic violence, death of close family member, bankruptcy, etc..

Group Level Pricing

SOCIETY OF ACTUARIES

Rating and Market Rule Changes

RULES APPLYING TO LARGE SELF-FUNDED EMPLOYERS

Removal of pre-existing conditions

- Applies to individuals of all ages
- Applies to all sized employers, all funding types
- Applies to grandfathered plans

Summary by Employer Size and Funding Type: New Benefit and Coverage Rules

	Employer Impacts	Description	Small Group Fully Insured	Large Group Fully Insured	Self-Funded
1	Essential Health Benefits (EHB)	• Health plans must provide Essential Health Benefits for individual and small group only • If large group fully insured or self –funded provides an essential health benefit all annual and lifetime dollar limits must be removed • Large fully insured plans use situs state as benchmark plan • Self-funded employers may choose a benchmark plan	Yes*	No Lifetime and dollar limits removed for any EHB offered	No Lifetime and dollar limits removed for any EHB offered
2	Out-of-Pocket Maximum (OOPM)	• OOP limits must comply with OOP limits for HSA plans • All cost sharing (including copayments) for EHB services must count toward OOPM	Yes*	Yes*	Yes*
3	Clinical Trials*	• Cover certain routine patients costs incurred in approved clinical trials	Yes*	Yes*	Yes*

* Not required for grandfathered plans

Summary by Employer Size and Funding Type: Benefit and Coverage Rules

Employer Impacts	Description	Small Group Fully Insured	Large Group Fully Insured	Self-Funded
Max 90-day waiting period	• Waiting period before coverage is in place cannot exceed 90 days	Yes	Yes	Yes
FSA Limits	• Employee contributions to health FSAs limited to $2,500 per year (beginning in 2013), with indexed increases allowed in future years to adjust for inflation	Yes	Yes	Yes
Expanded Women's Preventive Services	• Beginning August 2012, women's preventive benefits expanded to include additional screening, prenatal office visits, breast-feeding support and some contraceptives. • Impact Range ~.32% or $1 pmpm	Yes*	Yes*	Yes*

* Not required for grandfathered plans

Summary by Employer Size and Funding Type: Employer Mandate, MEC and Market Changes

Employer Impacts	Description	Small Group Fully Insured	Large Group Fully Insured	Self-Funded
Employer Mandate And Minimum Essential Coverage	• Penalty delayed until 2015 • Employers 50+ (average # of employees definition) must provide full-time employees (and dependents) with minimum essential coverage to avoid paying a shared responsibility payment (i.e., tax penalty) • Individual states by substitute with 100+ • Minimum essential coverage must: — Be affordable (employee contribution must not exceed 9.69% household income — Provide minimum value (employer pays more than 60% of covered plan expenses)	50+ only in 2015; 100+ 2016 (pending political challenges and state)	Yes	Yes
Pre-existing Condition Exclusion (All Ages)	• Beginning in 2014, pre-existing condition exclusions must be removed for all members, not just those under age 19	Yes	Yes	Yes
Guaranteed issue	• Insurers must offer coverage to and accept every employer or individual who applies for coverage - certain exceptions • May restrict enrollment in coverage to special enrollment period 11/5 to 12/15 and to individuals in network area	Yes	Yes	No
Guaranteed renewability	• Insurers must renew at the option of the plan sponsor or the individual - limited exceptions • Exceptions include failure to meet minimum participation or contribution standards	Yes	Yes	No

Taxes and Fees Overview

	Description	Effective Date	Timing / Duration	Payment Cycle	Segment Impact	Basis of Assessment
PCORI Research Fee	• Help fund Patient-Centered Outcomes Research Institute • Will assist patients, clinicians, purchasers and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings	10/1/12	Begins 2012 Phases out 2019	July 31 (calendar year following end of plan year)	FI and ASO (ASO paid and remitted by customer) Groups and Individuals	$2.08 pmpy in 2015 $2.17 pmpy in 2016 $2.26 pmpy in 2017 $2.39 pmpy in 2018
Insurer Fee	• Annual fee on health insurance sector, allocated by market share, to fund health insurance exchange subsidies • Fees assessed on net written health insurance premiums, with certain exclusions.	1/1/14	Permanent	No later than September 30 of calendar year	FI Only Groups and Individuals	Industry wide targets $8B – 2014 $11.3B – 2015 $11.3B – 2016 $13.9B – 2017 $14.3B – 2018 ~ 2.5% of premium.
Transitional Reinsurance Fee	• Transitional fees to stabilize individual market; assessed on a per capita basis for both fully insured and ASO members • Fee funds reinsurance for high claimants in non-grandfathered individual market plans, on and off Exchange	1/1/14	3 Years (2014-2016)	Annual basis for state and federal ASO paid & remitted by customer	FI and ASO Groups and Individuals	Industry-wide federal targets, to which states may add: $12B – 2014 ($5.25 PMPM) $8B – 2015 ($3.67 PMPM) $5B – 2016 ($2.25 PMPM)

Taxes and Fees Overview

	Description	Effective Date	Timing / Duration	Payment Cycle	Segment Impact	Basis of Assessment
Risk Adjustment Fee	• Administrative expenses for the risk adjustment program will be supported by a user fee, estimated to be no more than $1.00 per enrollee per year • This user fee will be collected from issuers of risk adjusted plans in June of the year following the benefit year	1/1/14	Permanent	June (calendar year following end of plan year)	Individual and small group plans in and out of Exchange	Zero sum redistribution of premiums from plans with healthier populations to plans with unhealthier populations Administrative costs is ~$1 pmpy in year 1
Excise Tax on High Cost Coverage (Cadillac Tax)	• Imposes an excise tax on insurers and employers who offer rich benefit coverage. • Some guidance released on types of coverage counted	1/1/20	Permanent	TBD	All small groups and large groups, both fully insured and self-insured	40% of value of employer-sponsored coverage exceeding $10,200 individual/$27,500 family; indexed by cost of living

Cadillac Tax Overview

- Tax on high cost coverage through employers beginning in 2022 (delayed from 2020)
- Proposed structure: 40% tax on costs above $10,200 for single coverage and $27,500 for non-single coverage
  - Indexed to CPI + 1% in subsequent years
  - Higher thresholds for “high risk” occupations (law enforcement, paramedics, etc.)
- Plan cost includes HSA, FSA, etc.

Cadillac Tax Considerations

- Uses cost as proxy for richness
  - Doesn't differentiate whether high cost is due to rich benefits or high underlying costs (except high risk professions)
  - Industry groups have proposed changes on these grounds
- Could limit or alter frequency of HSA contributions
- If medical trend exceeds CPI, minimum value and Cadillac tax levels eventually converge

Minimum Values
Actuarial Values

SOCIETY OF ACTUARIES

MV / AV
Objective: Designing Plans

- **Minimum Value Calculator**: greater than 60% in large group and ASO market
  - Safe harbor provided
- **Actuarial Value Calculator**: Small group and individual Non-grandfathered products must meet actuarial value corridors of the four metal levels (the targets are 90%, 80%, 70% and 60% but +2 /- 4% wiggle room):
  - Platinum (86-92%)
  - Gold (76-82%)
  - Silver (66-72%)
  - Bronze (56-65%)
  - Cost sharing reductions products in individual market must meet +/-1% corridor around target
  - AV calculator corridor constraints do not apply to catastrophic designs, but...

MV / AV
Objective: Designing Plans

What the tool can account for (debatably)

- Induced demand differences between metal levels (tools' focus is plan share)
- HRA and HSA contributions from employer
- Tiered networks
- Up to four tier pharmacy designs
- "X-visits-for-free" designs
- Primary care versus specialist co-pay
- Out-of-network design features (by not handling for materiality reasons, or through tiering ability of material)

MV / AV
Key Warnings

- Not a pricing tool: Doesn't account for carrier-specific utilization or unit cost metrics
- Always use most recent tool, past tools had numerous bugs
- Calculator can only do one plan at a time
- Plans that meet requirements one year might not the next, due to updated data and fixed cost sharing leveraging

Let's Use The Calculators...

unless you are already comfortable enough as a group

MV / AV Practice Note

Final Practice Note on Minimum Value and Actuarial Value Determinations Under the Affordable Care Act:
http://www.actuary.org/files/MVPN_042314.pdf

(Academy of Actuaries)

- Provides Certification Language to include
- Provides discussion on Qualifications requirements
- Provides Two Illustrative Examples
- Material Effect Clause...
- Data Hierarchy
- What to Include in Report

Determining Minimum Value and Actuarial Value under the Affordable Care Act:
http://www.actuarialstandardsboard.org/wp-content/uploads/2015/10/asop050_181.pdf

(Actuarial Standards Board)

- Provides definitions of key terms (Actuarial Value, Essential Health Benefits, etc.)
- Analysis of issues and recommended practices
- Guidance on communications and disclosures

MV / AV
Embedded versus Non-embedded

- Benefit designs on exchange that seem equivalent when viewed as single coverage may be materially different when compared from the perspective of family coverage
- Embedded structure: there is a lower deductible for one individual within the family to meet, with no requirement for that one person to absorb the entire family deductible
- For AV/MV, wide berth on creating the family plan design's multiplier.
    - The family multiplier is something that is material enough to be included in insurer's pricing tools but HHS did not have the data it needed to value the family multiplier design element
- A solution may have been family multiplier standardization
- May create a competitive scenario for a given plan that changes when viewing single versus family contracts
        - Design attractiveness
        - Pricing
        - Risk adjustment

MV / AV
Embedded versus Non-embedded

- Alternative guidance for valuing “non-embedded” structures
  - Very common in plans compatible with HSAs
- Under guidance from HHS, actuaries are not allowed to simply rely on the single metal level valuation with non-embedded structure
  - Special actuarial adjustments are needed
- Wide range of legitimate data sources, methods, assumptions
  - Resulting in wide range of family designs at each metal level

MV / AV
Embedded versus Non-embedded

- Because *embedded* structures could use any family multiplier, only need "non-embedded versus embedded" adjustment?
  - Work to value family multiplier skipped
  - Visible through higher deductibles than competition

MV / AV
Embedded vs. Non-embedded

- In valuing the family multiplier for non-embedded plans, did the actuary build a family continuance table based upon HHS' AV and MV tools' source data?
  - Members, or hypothetical adults/children?
  - Distribution of family sizes and compositions? Or, expected "member-to-contract ratio"
  - Was experiential data or existing pricing tool adjustments used? If so , was calibration performed?

MV / AV
Embedded vs. Non-embedded

- Express family level and non-embedded as one aggregate adjustment factor?
  - If not, consistency between data sources, methods, and assumptions?
- Monte Carlo simulation to more easily model the difference between embedded versus non-embedded structures
  - Consistent with HHS' average member costs?
  - Distributions of family sizes and compositions?
  - Members, or adults and children?
- Reviewing previous designs' outcomes
  - Difficult since a myriad of embedded and non-embedded design parameter combinations exist.

MV / AV
Embedded vs. Non-embedded

- Should single and family each meet the de minimis corridor, or in aggregate?
- Weighting between single versus family
  - Past experience in the specific product
  - Past experience of the entire risk pool
  - Predicted compositions
  - Hypothetical estimate of HHS' data source