Milliman

OVERVIEW
IMPACT ANALYSES IN SIX STATES OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

Center Forward engaged Milliman to study the potential impact of the Patient Protection and Affordable Care Act (ACA) on current premium rates for individual and group comprehensive medical insurance plans in Arizona, Florida, Illinois, New Jersey, Ohio, and Wisconsin.

Our analysis includes the potential impact of the following ACA provisions on premium rates and rate structures for the individual market in these six states:

- Minimum benefit coverage (i.e., essential health benefits).
- Maximum and specified levels of member cost sharing, or metallic tiers.
- Premium rating restrictions regarding gender, variation by age, health status, and other insured characteristics.
- Guaranteed issue requirements without preexisting condition limitations in the individual market
- Federal premium subsidies (prepaid tax credits) for low-income individuals purchasing coverage on individual exchanges.
- ACA-related taxes and fees.

Our analysis for the small group market was limited to the impact of the elimination of health status ranges and the introduction of the new ACA-related taxes and fees.

The primary purpose of each state report is to educate interested parties about the type of changes people may see to their health care premium rates, given the ACA provisions. The results provide an overview of the potential impact across varying age, gender, income, and health status levels. The study only looks at the impact of ACA provisions and does not include additional increases that would normally occur and are due to general medical cost inflation and attained age increases.

KEY OBSERVATIONS

Although the ACA grants states latitude to design and implement health care benefits, it mandates certain benefit requirements and cost-sharing provisions. As a result, the difference between existing rate structures and those emerging from the changes fostered by ACA can vary from state-to-state according to factors we discuss under “Methodology and Assumptions” in each report.

Individual Market Analysis

1) “Traditional” States - Arizona, Florida, Illinois, Ohio, and Wisconsin

   - Before ACA, these states allowed more “traditional” methods to price and design products for consumers and employers (e.g., medical underwriting, health status rating). With ACA requirements their individual market premiums could increase sharply, before accounting for the federal premium subsidies.

   - Participants in the individual market in these states tend to select much higher insured cost-sharing programs with leaner benefits which will no longer be allowed under ACA. These people will need to move to an ACA-qualified plan with lower deductibles and out-of-pocket maximums, which have anticipated increases between 5% and 25% depending on the plan and the state.

2) States with More Stringent Requirements – New Jersey

- Because of New Jersey's richer mandated plan benefits, guaranteed issue, and modified community rating requirements, its average individual premiums are already about 60% higher compared to nationwide. New Jersey individual premiums are also about the same as New Jersey small group premiums, whereas nationwide, small group premiums are about 55% higher than those of the individual market).

- Except for individual basic and essential (B&E) plans — which have benefit limits that will not be allowed after January 1, 2014 — New Jersey mandated standard benefit plan designs for individuals and small groups generally provide coverage for comprehensive benefits and member cost-sharing levels in excess of the minimum requirements under ACA.

- Thus, in many ways, New Jersey individual premiums already reflect the costs expected with the changes in 2014, before accounting for the federal premium subsidies. However, individuals that currently purchase the more limited B&E plans will have higher increases.

3) Federal Premium Tax Credits

- Individuals eligible for premium tax credits (i.e. premium subsidies) can receive a reduction in costs, varying by household income, if they purchase health insurance through the exchanges. The subsidy dollars received by a person are the same irrespective of the exchange plan that they choose. As such, more of the premium for a bronze plan will be subsidized than that of a silver or richer plan. For persons at the lowest eligible income levels, it may cover 50% - 100% of the premium cost before the tax credit.

- Younger persons with higher eligible income levels may not receive credits since the premium rates before the credits are often lower than the amount of premium they are required to pay before receiving the tax credit. Older persons at these income levels more likely will receive credits since their premium rates are higher.

- The inclusion of subsidies under ACA is intended to address the affordability issue for persons that will now be required to purchase coverage under the individual mandate. However, for people with higher subsidy-eligible incomes, as well as those that are not eligible for subsidies, 2014 premium costs are anticipated to be sufficiently high such that paying the individual penalties and not purchasing insurance may become a more viable financial option, particularly for persons that are healthier and less in need of coverage. The strength of the individual mandate and how subsidies impact this is discussed in the Milliman research report *"Measuring the Strength of the Individual Mandate"*, March 2012.

4) Summary of ACA Impacts from Study

Figure 1 Impacts of ACA Changes from 2013 to 2014 Individual (Non-Group) Market*				
State	Average Changes*	Value of Benefits and Cost Share (AV)	% of Silver Premium Subsidized for eligible individuals by FPL	
			140%	350%
Arizona	40% to 50%	10% to 20%	90% to 95%	15% to 65%
Florida	40% to 60%	10% to 25%	85% to 95%	0% to 55%
Illinois	20% to 60%	10% to 25%	85% to 95%	0% to 55%
New Jersey	-25% to 0%	-10% to 0%	80% to 95%	0% to 45%
Ohio	30% to 50%	5% to 25%	85% to 95%	0% to 49%
Wisconsin	15% to 50%	15% to 25%	90% to 95%	30% to 70%

** Average changes will be lower for persons currently in richer benefit plans (i.e., exceeding the minimum requirements that elect to downgrade their coverage. These values are based on the sample plans reviewed and modeled; the results could vary for other plans.*

5) Summary of ACA Impacts from Study for Sample Benefit Plans

Figure 2 Aggregate Impact of ACA Changes from 2013 to 2014 Values for Sample Plans– Before Premium Tax Credits Individual (Non-Group) Market*				
State	2013 Plan 1 (AV > 60%)**		2013 Plan 2 (AV < 60%)**	
	to Bronze	*to* Silver	*to* Bronze	*to* Silver
Arizona	1%	43%	47%	108%
Florida	10%	43%	58%	106%
Illinois	21%	50%	56%	94%
New Jersey¤	-25%	-14%	-2%	13%
Ohio	-2%	28%	55%	101%
Wisconsin	14%	56%	50%	104%

** Rate impact reflects best estimate results of our analysis of the effect of benefit changes, risk pool composition and adverse selection, pent-up demand from previously uninsured, net impact of federal reinsurance, and ACA taxes and fees.*

*** The AV of each 2013 plan varies from state to state. Note that downgrading from these Plan 1coverages to a Bronze plan will result in lower increases.*

¤Note: We used New Jersey's "Basic and Essential" and "Standard Plan C" as our 2013 plan baselines and Silver and Gold as their 2014 metallic equivalents.

Small Group Market Analysis

1) "Traditional" States - Arizona, Florida, Illinois, Ohio, and Wisconsin

- Before ACA, these states allowed more "traditional" methods to price and design products for consumers and employers (e.g., medical underwriting, health status rating). However, small groups are not allowed to be denied for coverage and tend to have richer benefit plans, which is comparable to ACA provisions.

- ACA provisions impacting small groups may motivate healthier groups to seek alternatives for coverage (e.g., self-funding, subsidizing their employees to purchase insurance in the individual market, paying the penalty and foregoing coverage). We estimate that 10% to 35% of people with small group insurance may be in these groups that move to alternative coverage.

- Average potential small group premium increases range from 6% to 12%.

- In most states, 20% to 30% of people with small group insurance may receive an increase of 20% of more. In Florida, groups will see less variation due to current regulations that are more restrictive.

2) States with More Stringent Requirements – New Jersey

- In states that are more stringent with small group requirements (i.e., they do not allow health status rating), we anticipate minimal variability in the rate impact by group.

- Average small group premium increases of 4% to 5% due to ACA-related taxes and fees.

GENERAL METHODOLOGY, ASSUMPTIONS AND QUALIFICATIONS

Individual Market Analysis

For the individual market analysis, Center Forward selected the six states used for the studies based upon the information and data available from the major insurers from whom it solicited data, as well as getting a mix of states that currently vary in regulatory environment. The participating insurers provided data regarding current benefits and premium rates for popular individual plans sold in each state, as determined by each insurer based on its recent sales.

We selected two current plans from the participating insurers, one with an estimated actuarial value (AV) that exceeds 2014 benefit minimums (i.e., AV greater than 60%), and one that does not. The plan designs and AVs differ from state to state. Due to limited information from carriers in New Jersey, we selected plans based on current membership information available on the New Jersey Department of Banking and Insurance website.

For each of the current plans selected, we then compared the premium impact of moving to a sample 2014 silver and bronze plan. Sample 2014 plans were designed based on the given state's benchmark plan for essential health benefits. We reviewed the premium impact of the changes to the 2014 benefit plans in aggregate, as well as for various pricing cells segmented by age, gender, health status, and income level pricing cells.

Small Group Market Analysis

The small group market has several provisions that are comparable to those required under ACA. As such, our analysis focused on the impact of prohibiting rating using the health status or claims experience of a group, as well as anticipated ACA taxes and fees. For this analysis, Center Forward solicited major insurers for data regarding information on the health status distribution of their book of business, as a proxy for measuring the impact to the statewide market.

Assumptions and Qualifications

As you review each report, keep in mind:

- We have selected two popular plans currently sold in each state from which to measure the impact of ACA. The popularity of plans was determined based on recent sales and publicly available membership data. However, there are a variety of health plans sold by different insurers, which will differ somewhat from those we selected. The impact of ACA may be more or less pronounced on people currently covered by these other plans than is illustrated in these reports.

- Because ACA provisions include minimum benefit coverage and specified levels of member cost-sharing, or "metallic tiers," we focus on two metallic plan designs in each study — Gold and Silver in the case of New Jersey and Bronze and Silver in the five other states — to provide a snapshot of the impact of the ACA.

- The plans modeled for 2014 are simply illustrative. In reality, people will probably be able to choose from many plans which conform to ACA requirements and offer a different mix of benefits, provider networks, and other provisions. These different features could result in greater or lesser premium levels than those we illustrate.

- Our analyses focus primarily on the individual, not the family; beginning in 2014, families will be rated on a per member basis rather than as a family unit.

- These reports require assumptions as to future unknown events. Although different people conducting a similar analysis might come to different conclusions (depending on their underlying assumptions), we believe that most results will trend in a direction similar to ours.

- Actual 2014 premiums will depend significantly on each insurer's experience as well as its expectations of how costs will change under ACA. Some insurers may strategically price to gain market share, while others may add margin to account for uncertainty or for their belief that the ACA risk mitigation programs will not satisfactorily address the risks inherent in the new rules. Some may also introduce plans with more restrictive provider networks and increased management of care in order to offer lower premiums than they otherwise could.

- Assumptions different from those we make about the migration of uninsured individuals and employees from employer groups into the individual market in 2014 may result in greater or lesser premium levels than those illustrated.

- These studies look only at the impact of ACA on premium rates. The new law also provides cost-sharing reductions to people meeting specific qualifications, which may reduce the out-of-pocket costs an individual must pay in addition to the premium.