ACA impact illustrations
Individual and group medical
New Jersey

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EXECUTIVE SUMMARY

As part of the Patient Protection and Affordable Care Act (ACA), a series of provisions applicable to individual and group comprehensive medical insurance plans, effective January 1, 2014, will potentially have a significant impact on current premium rates. Major changes include:

- Minimum benefit coverage (i.e., essential health benefits).
- Minimum and specified levels of member cost sharing, or metallic tiers.
- Premium rating restrictions regarding gender, variation by age, and health status.
- 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.

Center Forward engaged Milliman to conduct a study regarding the estimated impact of these provisions on people in select states. This report provides the results of our analysis for the state of New Jersey.

The New Jersey regulatory environment and current plan and premium rate requirements are much more stringent compared to most other states and more comparable to the ACA provisions:

- Individual and small group insurance plans are guaranteed issue
- Insurance companies are not allowed to rate for health status and, for some plans, gender
- Standard benefit plan designs for individual and small group that generally provide coverage for comprehensive benefits and member cost-sharing levels in excess of the minimum requirements under ACA, except for individual basic and essential (B&E) plans, which have benefit limits that will not be allowed

ACA provisions include minimum benefit coverage and specified levels of member cost sharing, or metallic tiers. Our analysis includes gold and silver plans, which equate to an insurance plan covering about 80% and 70% of medical costs, respectively. These metallic tiers were selected as being comparable to the standard benefit plans available that are commonly selected by individuals in New Jersey.

The primary purpose of this analysis is to educate interested parties about the type of changes people may see to their healthcare premium rates, given the ACA provisions. The results provide an overview of the potential impact across varying age, gender, income, and health status levels, to help the reader have a better understanding of the scope of these variations.

These values do not include additional increases that would normally occur because of general medical cost inflation and attained age increases. These changes are typically 5% to 9% per year and would be additional to those identified in this report.

Key observations from our study in New Jersey include:

Individual Market

- With the similarities to ACA provisions such as New Jersey's richer mandated plan benefits, guaranteed issue, and modified community rating requirements, current New Jersey premiums are reflective in many ways of expected costs with the changes in 2014.
    - Average individual premiums are about 60% higher in New Jersey compared to nationwide.[1]
    - Average individual and small group premiums are about the same in New Jersey, whereas nationwide small group premiums are about 55% higher than those of the individual market.
- The uninsured population is generally healthier than those with coverage. With the individual mandate and federal premium subsidies, the inclusion of the previously uninsured into the risk pool is anticipated to improve the overall health status about 1% to 5%.
- Individual market pre-subsidy premiums in and out of the exchanges are anticipated to be reasonably comparable to current plans, on average. However, this will vary between B&E and standard plan designs:
    - B&E plans provide limited benefit coverage, which appears to attract a healthier group of people compared to the standard plans.
    - Given the single risk pool rating requirement under ACA, the average health status of the combined B&E and standard market will result in increases for B&E plans and decreases for standard plans.
    - The impact for combining the current B&E and standard risk pools is estimated to be an increase of 7% to 12% for B&E plans and a decrease of 15% to 25% for standard plans.
    - People who switch to plans that have less choice in participating network providers, more managed care features, or do not cover out-of-network services (except for emergency care) may also be able to lower their premium increases.
- The change in the allowable rating structure, in conjunction with overall drivers of cost change, results in a substantial amount of variation in premium rate changes for people with varying demographics. For example, moving from a B&E plan to a Silver plan, a 27 year old male will face increases of 20% while a 27 year old female will have a decrease of 18%. In comparison, a 57 year old male will face an increase of 10% and a 57 year old female will see an increase of 35% (see Figure 3).
- The impact of federal premium subsidies (prepaid tax credits) is anticipated to be quite significant, with subsidies of 50% to 100% available for many eligible individuals if they purchase coverage on the exchange.
    - About 49% of persons either currently uninsured or covered in the individual market will be eligible for these subsidies.

[1] Based upon an analysis of 2011 statutory supplemental healthcare exhibits available through SNL Financial.

- These subsidies will mitigate premium increases for many individuals, though results vary by age and gender. For example, a 37-year old male at 350% of poverty level changing from a B&E plan to a Silver plan will see a 2% rate increase over his current rate while a 37 year old female sees a 20% reduction in her current rate. Comparatively, 57-year old males and females would see a 37% and 22% reduction over their current rates, respectively.

Small Group Market

- Small groups are not currently rated for health status in New Jersey, which is the same as the requirement under ACA. As such, there is anticipated to be little change in the current mix of business and overall health status in the small group market in 2014.

- Small group standard benefit plans are generally fairly comprehensive and meet ACA benefit and cost-sharing requirements. There may be some marginal benefits required to be added for essential health benefits (EHB), but the impact is expected to be minimal.

- Average small group premiums are anticipated to increase about 4% to 5% for plans offered either in or out of the exchange due to ACA-related taxes and fees.

- Our study did not include an analysis of the impact on small group plans that the ACA limitations on setting premium rates based a group's demographic makeup will have. New Jersey has a state-specific age curve approved for small group that is comparable to the variation allowable by age for current plans. As such, we anticipate the impact will minimal, but groups could see increases or decreases depending on their specific demographics.

REPORT QUALIFICATIONS

There are several points of context that are important when considering the results presented in the report.

- Our analysis focused on items that explicitly impact premiums because of the 2014 ACA provisions. It does not include premium increases in 2014 that would be additional to those illustrated, such as general medical cost inflation and attained age increases.

- Our analysis is a snapshot of the current individual and small group markets based upon data and information representing a significant market share in New Jersey. We have illustrated only two plan designs from which to measure the impact of ACA. However, there are a variety of health plans sold by different insurers, which will differ from those we used. The impact of ACA may be more or less pronounced on people currently covered by these other plans than is illustrated in this report.

- Similarly, the plans modeled to be available in 2014 are illustrative. It is unknown at this time if there will be standardized metallic tier plans in New Jersey, similar to the standard benefit plans required today. Any standard metallic tier plans should be designed to have actuarial values that meet the ACA metallic levels, as determined by the Centers for Medicare and Medicaid Services (CMS) actuarial value calculator, though some plan features and provisions may vary. In particular, plans will likely be allowed to differ in terms of the makeup of their healthcare provider networks and the prescription drug formularies that they use. They could result in greater or lesser premium levels than those illustrated.

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

- Our illustrations are focused on the impact to an individual and not to a family. We included one example of the impact to a sample family in our analysis, but the results could vary. In general, this is because families are to be rated in 2014 and later on a per member basis and not as a family unit, as they currently are. Other variations could occur that would be due to the mix of persons in the family unit (i.e., age, gender, single- vs. two-parent household).

- Underlying our analysis is an assumption as to the level of migration of uninsured people and employees of employer groups into the individual market during 2014, which insurers must make in setting their 2014 premium rates. If an insurer assumes greater or lesser migration than we assumed, its premium rates may differ.

- Our analysis does not include the Medicare-eligible population, nor any anticipated impact of the health insurer fee to insurers providing Medicare Advantage coverage. Any reference to the “older” population throughout the report refers to non-Medicare-eligible persons only.

- Our analysis assumes the healthcare delivery system in place today. The U.S. healthcare system is constantly evolving and responding to changes that are due to economic influences, regulatory changes (such as ACA), political actions, technological and pharmaceutical innovations, and business considerations. While we do not anticipate dramatic changes in the healthcare delivery system over the next year, the impact to local markets could vary from these results because of such changes (e.g., consolidation of hospital systems or vertical integration of providers).

- The premium rate changes illustrated throughout the report are based upon movement from a 2013 plan to a 2014 plan with an identical participating provider network, prescription drug formulary, managed care provisions, and out-of-network coverage. We recognize that, in order to provide more affordable premium rates, many insurers will introduce new plans with less choice of participating providers, reduced out-of-network coverage, and tighter managed care requirements.

- We have assumed that New Jersey will accept and implement the expansion of Medicaid offered through ACA to each state. However, our analysis does not consider the impact of other funding changes that the federal or state governments might make to other healthcare financing programs such as Medicare or ACA.

- This analysis requires assumptions as to future unknown events. As such, another person conducting a similar analysis could have different results, which would be due to the assumptions he or she might choose. However, we believe that, directionally, results will be similar for most knowledgeable actuaries conducting such studies.

- It is important to note that the actual premiums charged in 2014 will not depend on the estimates in this report, or even on actual 2014 costs. Instead, 2014 premiums will be based on the premium rates each insurer submits to and gets approved (where required) by its regulator. As a result, 2014 individual premiums will depend significantly on how insurers expect costs to change under ACA. Also, 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.

- The views, comments, and analyses presented in this report are those of the authors and do not represent the opinions or conclusions of Milliman, Inc.

INTRODUCTION

As part of the Patient Protection and Affordable Care Act (ACA), there are a series of provisions applicable to individual and group comprehensive medical insurance plans to be implemented effective January 1, 2014, including changes to:

- Minimum benefit and cost-sharing requirements
- Allowable premium rating and underwriting characteristics
- New taxes and fees

Some of the new provisions are anticipated to impact the market as a whole, and therefore rate levels on average. Other provisions will result in a variety of impacts across rating cells (i.e., age, gender, health status, income level, current health plan coverage); in some cases, the differences are likely to be significant. The primary purpose of this analysis is to educate interested parties about the type of changes people may see to their premium rates, given the ACA provisions.

Center Forward engaged Milliman to assist it with estimating the premium impact related to the 2014 ACA rating provisions on individual and small group market premium rates in selected geographic areas. This report provides the results of our analysis in the state of New Jersey. The table in Figure 1 summarizes major changes in ACA provisions reviewed as part of this analysis.

Figure 1
Comparison of Current and 2014 Rating Characteristics
New Jersey

Characteristic	Current Benefits/Rating		2014 Rating Change
	Individual	Small Group	
Covered Benefits	Basic and essential (B&E) or standard (STD) benefit plans. B&E plans are comprehensive, but have limits on some benefits.	Standard benefit plans	Essential health benefits (EHB), including some supplemental benefits (e.g., pediatric, dental, and vision)*
Member Cost Sharing	Defined by plan. Generally meet ACA minimum requirements.	Defined by plan. Generally meet ACA minimum requirements.	Minimum actuarial value of 60% (i.e., health plan must pay at least 60% of charges for covered EHB services; the member pays no more the 40%).* Maximum OOP based on HSA/HDHP allowable limits ($6,250 in 2013).
Attained Age	5-year age bands	5-year age bands, 2-to-1 differential by age	Maximum 3-to-1 differential by age (adults). Single age band for children and for ages 64+. Single-year age bands for ages 21-63.
Gender	STD: Unisex rates B&E: Allowed	Allowed	Unisex rates
Health Status Rating	Not allowed, guaranteed issue.	Not allowed, guaranteed issue	Not allowed, guaranteed issue.
Household Income (% of federal poverty level)	No federal subsidies	No federal subsidies, except a 35% limited tax deduction for some small groups	Persons meeting income level and other requirements will be eligible for premium subsidies through the individual market exchange.
ACA Taxes and Fees	N/A	N/A	Exchange fees, insurer fee, Research Trust Fund. Applicable to both markets.
Transitional Reinsurance Program	N/A	N/A	Individual and group plans pay an estimated fee of $5.25 PMPM. Only individual market plans are eligible for benefits.

** We are not aware at this time if New Jersey will develop a series of standard metallic tier plans, based off of the selected EHB plan. For small group and individual, there are maximum deductible requirements of $2,000 and $2,500, respectively.*

For the individual market analysis, we looked at current individual health plan enrollment data for the fourth quarter of 2012 from the New Jersey Department of Banking and Insurance (DBI) website, and selected two plans with varying benefits that we believed to be representative of commonly sold plans in the state of New Jersey. We then compared for each of these plans the premium impact of moving to a sample 2014 gold and silver plan (i.e., comparable benefit richness to what is in New Jersey benefit plans today). The 2014 sample plans illustrated were designed based on the New Jersey benchmark plan for essential health benefits (EHB). 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.

Though similar rating provisions are applicable in 2014 for the small group market, there is anticipated to be less impact on the variability of increases compared to that anticipated for the individual market. Primary drivers mitigating the potential rate changes include:

- Small group standard plans are generally fairly comprehensive and include most of the EHB requirements without limitations.
- Premium rates by group reflect a mix of age and gender, so their total premium would have less variation due to requirements of unisex rates and age band restrictions, although these regulatory changes may have more impact on smaller groups.
- Small groups are subject to comparable underwriting and rating requirements as individual (i.e., guaranteed issue and rating for health status is not allowed)

Given these factors, the focus of our small group analysis was limited to the impact of anticipated ACA taxes and fees. Premium subsidies are not included because they are only available in the individual market. While ACA offers federal income tax incentives, they are only available for a two-year period to a limited number of groups based upon number of employees and average salaries. We have not considered their impact.

Additional commentary regarding the impact of ACA taxes and fees on large group business, including those applicable to self-funded groups, is included as part of this report.

This report also includes a summary of the results, methodology, and assumptions used in the analysis.

SUMMARY OF RESULTS: INDIVIDUAL MARKET

ACA provisions going into effect in January 2014 are anticipated to have a significant impact in most states on premium rates in the individual comprehensive medical insurance market for many persons. However, in the state of New Jersey, many of these provisions are already required, including guaranteed issue, no allowance for health status rating, and limited allowance for gender rating.

ACA provisions and their anticipated impact to influence New Jersey premium rates in aggregate include:

- New Jersey has a series of allowable benefit plan designs in the individual market:
  - The standard plan designs are fairly comprehensive in the scope of benefits they cover
  - The basic and essential (B&E) plan has significant dollar limitations on the amount of benefits covered, which will not be allowed under ACA provisions
  - The member cost sharing for the benefits that are covered under plans generally exceeds ACA minimum requirements

- The inclusion of previously uninsured individuals into the marketplace, which is due to the individual mandate and the availability of federal subsidies

- The impact of anticipated reimbursement through the ACA transitional reinsurance program

- The introduction of various taxes and fees to cover ACA provisions

For our analysis we looked at two popular benefit plans sold in the state of New Jersey and estimated the premium rate impact of moving to 2014 plans in the gold and silver metallic plan tiers. Anticipated changes were reviewed in aggregate by plan and for sample pricing cells. The sample plans selected are as follows:

- Plan 1 is a popular B&E exclusive provider organization (EPO) plan. B&E plans have fairly low member cost sharing for services that are covered, but a number of limitations on the amount for services covered (e.g., $500 per year for diagnostic testing). The combination of the member cost sharing and service limitations for the selected plan are about 73% coverage, but some B&E plans are even more limited. About 70% of persons covered in the New Jersey individual market have B&E plans.

- Plan 2 is a popular standard PPO Plan C with an actuarial value of about 65%. Standard benefit plans are designed to provide comprehensive benefits for individuals with few limitations.

The 2014 metallic tier plans were designed to meet EHB requirements in New Jersey. Additional details on the 2013 and 2014 benefit plans are provided later in this report.

Our analysis focused on items that explicitly impact premiums because of the 2014 ACA provisions, and assumed that the state of New Jersey continues with its stated plan of expanding Medicaid per ACA. Our analysis does not include premium increases in 2014 that would be additional to those illustrated, such as general medical cost inflation and attained age increases. We have assumed rating based on the average New Jersey market and with no adjustments for tobacco use.

Aggregate premium impacts

The first step of our analysis was to estimate the impact of ACA provisions that affect premiums in aggregate (i.e., at the plan level). The table in Figure 2 summarizes the estimated impact of various ACA provisions, in aggregate, for each 2013 benefit plan moving to sample silver and gold plans. The cumulative total of these items reflects the increase to average rate levels across all persons insured under the given plan, prior to the impact of federal premium subsidies for lower-income individuals.

Figure 2
Individual Medical
Summary of Aggregate Rate Changes From 2013 to 2014*

	2013 Plan 1 (Basic and Essential)		2013 Plan 2 (Standard Plan C)	
ACA Provision	**to Gold**	**to Silver**	**to Gold**	**to Silver**
Benefit Changes (EHB)	22%	22%	0%	0%
Member Cost Sharing (AV)	-13%	-23%	12%	-1%
Risk Pool Composition/Adverse Selection	10%	10%	-20%	-20%
Pent-up Demand from Previously Uninsured	1%	1%	1%	1%
Net Impact of Federal Reinsurance and Fees	-8%	-10%	-9%	-10%
ACA Taxes and Fees	5%	5%	5%	5%
Aggregate Impact of ACA Changes	13%	-2%	-14%	-25%

** Rate impact reflects best estimate results from our analysis.*

Given the similarity of current requirements to ACA provisions, it is anticipated that current premium rates are reflective in many ways of anticipated costs for 2014. With average individual premium rates in New Jersey about 60% higher than those nationwide, this points to the potential rate impact that may be seen in states with less restrictive current rating practices relative to those permitted under ACA.

Our analysis finds that the overall impact of ACA provisions appears fairly minimal, as expected (less than 10% on average, excluding the impact of trend). However, given different allowable plan designs, the anticipated differences by plan type are substantial:

- The upgrade in benefits to EHB levels for the B&E plan (i.e., removal of dollar limitations) is a substantial increase in rates, about 22%. However, the average level of member cost sharing would still be very low in that case (about 89%). By switching to a gold or silver plan, the overall rate impact is mitigated significantly; however, some services will require additional cost sharing.
- The limited benefit B&E plans tend to attract a healthier pool of people compared to the standard plan, but under ACA this segmentation of risk pools will not be allowed. As such, these individuals will ultimately be subsidizing those less healthy individuals that generally currently select the standard plans.

For purposes of our analysis, we assumed that the B&E benefit limitations would be removed in 2014 for EHB compliance, but we make no assumptions regarding a change in the impact of the narrow network for the selected B&E plan.

Additional items that may impact rates because of insurer's plan specifics include:

- Shift in overall anticipated claim costs that is due to a shift in the age/gender distribution of business (increase or decrease)
- Current vs. proposed provider network arrangements, including the use of narrower and tiered network arrangements
- An insurer's competitive positioning strategies

Premium changes by pricing cells

While overall individual rate levels are estimated to have an average rate impact as shown in Figure 2 above, the introduction of limitations on allowable rating characteristics, and the amounts by which they may differ, will result in varying impacts for individuals in a given rate "cell" (i.e., age, gender, health status, etc.). To some extent there will be less variation than seen in other states because New Jersey does not allow for health status rating. However, the age and gender rating requirements do result in a fair amount of variation to what they are paying today.

To illustrate this variation, the table in Figure 3 provides the estimated impact for sample pricing cells reflecting variations in age, gender, and health status. Note that the illustrated changes are before the impact of federal premium subsidies for lower-income individuals.

Figure 3
Individual Medical
Sample Rate Impact by Pricing Cell

	2013 Plan 1 (Basic and Essential)		2013 Plan 2 (Standard Plan C)	
ACA Provisions	**to Gold**	**to Silver**	**to Gold**	**to Silver**
Age 27, Healthy Male	39%	20%	-16%	-28%
Age 27, Healthy Female	-5%	-18%	-16%	-28%
Age 27, Unhealthy Male	39%	20%	-16%	-28%
Age 27, Unhealthy Female	-5%	-18%	-16%	-28%
Age 57, Healthy Male	28%	10%	12%	-3%
Age 57, Healthy Female	57%	35%	12%	-3%
Age 57, Unhealthy Male	28%	10%	12%	-3%
Age 57, Unhealthy Female	57%	35%	12%	-3%
Average Rate Change	13%	-2%	-14%	-25%
Minimum Rate Change	-8%	-21%	-31%	-40%
Maximum Rate Change	61%	40%	12%	-3%

As illustrated, there is a fair amount of variation by pricing cell in the impact of moving to 2014 premium rates. These variations illustrate the differentials between the age and gender relationships currently used in New Jersey and the ACA-required curves. Current age curves are generally flatter than the values allowed by the U.S. Department of Health and Human Services (HHS), so older individuals may experience higher increases than younger individuals. We are not aware at this time if New Jersey is submitting a state-specific age curve to HHS for approval that would be more comparable to the current rates. In this case, these projected variations could look very different.

Attachment A provides expanded results to those shown above, with illustrated changes by age (27, 37, 47, 57, and 62), gender, and health status (100%, 125%, and 150% of the base level).

Impact of premium subsidies

For eligible low-income people, exchanges offer subsidies through the federal government to reduce both monthly premiums and member cost sharing. Premium subsidies are available to eligible people with incomes less than 400% of the federal poverty level (FPL) who do not qualify for Medicare, Medicaid, or have access to qualified affordable employer-sponsored insurance. Out-of-pocket cost-sharing reduction (CSR) subsidies are available to eligible people with incomes up to 250% of FPL who purchase a silver plan on the exchange. These subsidies are anticipated to significantly improve the affordability of insurance for those who qualify, particularly as we observe a sizeable increase in overall rate levels. For purposes of our analysis, we focused on the impact of the premium subsidy only, compared to what eligible people would be paying in 2014 without subsidies. The table in Figure 4 illustrates the average rate change from the 2013 Plan 1 to a silver plan under various income levels for sample rate cells.

Figure 4
Individual Medical
Sample Impact of Premium Subsidy
2013 Plan 1 (Basic and Essential) to Silver

	Healthy Male, 27		Unhealthy Female, 57	
FPL levels	Rate Change From 2013	% of 2014 Rate Subsidized	Rate Change From 2013	% of 2014 Rate Subsidized
140%	-77%	81%	-89%	92%
175%	-56%	64%	-79%	84%
225%	-22%	35%	-62%	72%
275%	17%	3%	-44%	58%
350%	20%	0%	-22%	43%
500%	20%	0%	35%	0%

Attachment A includes an expansion of the sample pricing cells shown above, with illustrated values for varying income levels by age, gender, and health status.

We note that the amount of premium subsidy that individuals receive is to be calculated based on the second-lowest-cost silver plan. For purposes of this analysis, we assumed that the sample silver plan in each case was reflective of this benchmark. In actuality, the rate changes would vary, depending on where the given plan is priced relative to other silver plans. That being said, insurers with silver plan rates closer to the second-lowest silver plan are likely to get a greater proportion of individuals eligible for premium subsidy, because those individuals will be able to minimize their out-of-pocket premium cost.

The second-lowest-cost silver plan may be a newly introduced plan with narrower provider networks, increased managed care requirements, stricter prescription drug formularies, and/or reduced or eliminated out-of-network benefits (none of which affects a plan's AV). These plans are likely to be priced lower than the silver plan we have modeled, but with a trade-off to individuals of the freedom of choice that is typically available in today's individual market health plans. An unfortunate result of this market competition from the perspective of a consumer who wishes to purchase a plan with a broad provider network will be higher out-of-pocket premiums if one of these narrow network, lower-priced plans is the second-lowest-priced silver plan. For such a consumer, the subsidies will be lower as a percentage of premium than those indicated in Figure 4 and Attachment A.

Case studies

The table in Figure 5 provides a breakdown of the impact of various ACA provisions on sample pricing cells for a change from a 2013 B&E plan to a silver plan, with and without federal premium subsidies.

Figure 5
Individual Medical
Buildup of Rate Changes for Sample Pricing Cells

	2013 Basic and Essential EPO to Silver			
	Age 27 Healthy Male		Age 57 Unhealthy Female	
Component	Annual Premium	Change	Annual Premium	Change
Current Premium	$2,426		$5,010	
No Rating for Health Status	$2,426	0%	$5,010	0%
Age/Gender	$2,975	23%	$7,008	40%
Benefit Changes (EHB)	$3,623	22%	$8,534	22%
Member Cost Sharing (AV)	$2,777	-23%	$6,542	-23%
Risk Pool Composition/Adv. Selection	$3,055	10%	$7,196	10%
Pent-up Demand	$3,093	1%	$7,286	1%
Exchange Fee	$3,158	2%	$7,439	2%
Insurers Fee (ACA §9010)	$3,237	2%	$7,625	2%
Reinsurance Claims Impact	$2,854	-12%	$6,722	-12%
Reinsurance Pay-In	$2,917	2%	$6,785	1%
Research Fee	$2,919	0%	$6,787	0%
Total Rate Change		20%		35%
Premium After Subsidy				
140% FPL	$560	-77%	$560	-89%
175% FPL	$1,056	-56%	$1,056	-79%
225% FPL	$1,892	-22%	$1,892	-62%
275% FPL	$2,828	17%	$2,828	-44%
350% FPL	$2,919	20%	$3,897	-22%
500% FPL	$2,919	20%	$6,787	35%

The table in Figure 6 provides a breakdown of the impact of various ACA provisions on sample pricing cells for a change from a 2013 Standard Plan C to the silver plan, with and without federal premium subsidies.

Figure 6
Individual Medical
Buildup of Rate Changes for Sample Pricing Cells

	2013 Standard Plan C to Silver			
	Age 27 Healthy Male		Age 57 Unhealthy Female	
Component	Annual Premium	Change	Annual Premium	Change
Current Premium	$5,222		$9,113	
No Rating for Health Status	$5,222	0%	$9,113	0%
Age/Gender	$5,066	-3%	$11,897	31%
Benefit Changes (EHB)	$5,002	-1%	$11,748	-1%
Member Cost Sharing (AV)	$6,168	22%	$14,487	22%
Risk Pool Composition/Adv. Selection	$5,002	-19%	$11,748	-19%
Pent-up Demand	$4,031	1%	$9,467	1%
Exchange Fee	$4,116	2%	$9,665	2%
Insurers Fee (ACA §9010)	$4,218	2%	$9,907	2%
Reinsurance Claims Impact	$3,719	-12%	$8,734	-12%
Reinsurance Pay-In	$3,782	2%	$8,797	1%
Research Fee	$3,784	0%	$8,799	0%
Total Rate Change		-28%		-3%
Premium After Subsidy				
140% FPL	$560	-89%	$560	-94%
175% FPL	$1,056	-80%	$1,056	-88%
225% FPL	$1,892	-64%	$1,892	-79%
275% FPL	$2,828	-46%	$2,828	-69%
350% FPL	$3,784	-28%	$3,897	-57%
500% FPL	$3,784	-28%	$8,799	-3%

The illustration of the two sample plans indicates the anticipated changes resulting in the requirement to group all individuals into a single risk pool for pricing. Differences between the metallic tier rates in each scenario reflect some continued variation due to the use of narrower network arrangements.

Summary of sample plan benefits

The table in Figure 7 provides a high-level summary of the primary cost-sharing provisions for each of the sample 2013 and 2014 plans used in our analysis. Information on the 2013 benefit plans was based on information provided by participating insurers. Sample 2014 plans were developed based on New Jersey's benchmark EHB plans.

Figure 7
Individual Medical
Summary of Modeled Benefit Plans

	Sample 2013 Plans		Sample 2014 Plans	
Plan Benefits	**Plan Option 1 (B&E)**	**Plan Option 2 (Standard C)**	**Silver**	**Gold**
Actuarial Value*	73%	65%	71%	79%
Individual Deductible	$0	$2,500	$2,500	$1,000
Family Deductible	$0	2x Individual	2x Individual	2x Individual
Plan Coinsurance	70%	80%	80%	80%
Out-of-Pocket Max (after deductible)	Unlimited	$2,500	$3,000	$1,500
Inpatient Hospital	$500 per Admit, 90 day limit	Ded+Coins	Ded+Coins	Ded+Coins
Office Visit Copay: PCP/SCP	$30/$30	$30/$50	$30/$50	$30/$50
Diagnostic Services	100%, up to $500 per year	Ded+Coins	$50 copay	$50 copay
Emergency Room/ Urgent Care	$100/$30	$100 + Ded+Coins/ Ded+Coins	Coins/$30	Coins/$30
Preventive	100% Covered	100% Covered	100% Covered	100% Covered
Maternity	Included	Included	Included	Included
MH/SA	Included	Included	Included	Included
Prescription Drugs	$15/50%/50% $500 max/year**	50% Coins	50% Coins	50% Coins

** 2014 values are determined based on the CMS actuarial value calculator. Current plans were not modeled using this calculator, given that the CMS calculator does not recognize benefit limitations. AV estimates for current plans are based on the in-network cost-sharing value determined using the Milliman Health Cost Guidelines™ modeled claim costs.*

*** Maximum per year applicable to brand drugs only.*

SUMMARY OF RESULTS: SMALL GROUP

ACA provisions going into effect in January 2014 are generally anticipated to have a less significant impact on the average premium level in the small group insurance market compared to the individual, which is primarily due to the fact that there are already underwriting and rating restrictions in place through small group rating regulations that are comparable to some of the ACA provisions. In New Jersey the impact is anticipated to make less of a difference, given that both individual and small group are subject to the same underwriting and rating restrictions. ACA provisions and New Jersey small group regulations compare as follows:

- Some additional benefits will be added through the EHB requirement, though the current New Jersey small group standard plans are generally comprehensive already.

- Current small group rates are set in five-year age bands with a limitation of 2-to-1 differentials between age and gender. New Jersey has a state-specific age curve that has been approved for small group that continues use of this rate differential, though with specific factors that vary for each age instead of age bands. Given that groups generally reflect a mix of age and gender, the group's premium in total is anticipated to be reasonably comparable. However, this may be less so for mini-groups (groups with fewer than 10 employees).

- Small group plans in New Jersey are currently guaranteed issue and insurance plans are not allowed to rate for health status, which is comparable to the requirements under ACA.

Given the similarities of current New Jersey regulations to ACA requirements, there is not anticipated to be much rate impact of the ACA provisions compared to other states. Items that will impact small group rates include:

- The introduction of various taxes and fees to cover ACA provisions, which are anticipated to have a 4% to 5% impact to current rates.

- To the extent that small groups do not currently provide benefit options with the minimum pediatric dental and vision requirement, they will need to upgrade coverage to include this benefit. This may increase premium rates an additional 1% to 3% from the values indicated in Figure 7.

The premium impact related to the changes in moving to the New Jersey age curve is very specific to the demographics of each group and is expected to be quite varied, making it impractical to reasonably illustrate in a report like this.

Our analysis does not include the impact of items such as medical cost trend (e.g., 5% to 9%), which would be applicable with or without ACA changes.

ACA PROVISIONS IMPACTING LARGE GROUP

While ACA does not impose specified rating restrictions on large group business, as is required for the individual and small group markets, there are certain taxes and fees that will be assessed to large group insurers and self-funded groups that are anticipated to impact premium rates in 2014:

- The ACA §9010 insurer fee is assessed on all insurers with comprehensive medical business as well as Medicare Advantage and Medicaid managed care organization (MCO) plans. The fee is assessed based on the total premium volume in these lines of business. For large insurers we anticipate the premium impact to be 2% to 3% of premium. For smaller plans, there will less of an impact based on the deduction of premium amounts under $50 million. Certain nonprofit insurers will also pay less. The fee is expected to pass through to the employers through a premium adjustment. This fee is not applicable to self-funded plans, other than as reflected in their stop-loss medical premiums.

- The individual market transitional reinsurance program is to be funded through payments by all members with comprehensive medical coverage. The estimated fee is $5.25 per member per month (PMPM), based on calendar-year 2014 covered members, and is anticipated to be worth about 1% of premium. This fee is applicable to self-funded groups through their third-party administrators, though retirees covered under the group plans who are Medicare-eligible are not included in the assessment.

- Section 6301 of ACA imposes a fee in 2013 of $2 per member per year on insurers on behalf of the Patient-Centered Outcomes Research Trust Fund. This fee became effective in 2012, but was only $1 for that year. The fee is applicable to all large group business, including self-funded plans. The overall impact to premium is anticipated to be marginal.

The aggregate impact of these ACA fees is anticipated to be about 3% to 4% of premium for fully insured large group business, depending on the size of the insurer (which is due to the application of the ACA insurer fee). For self-funded plans, the estimated impact is approximately 1% of premium.

Large groups predominately provide comprehensive health benefit coverage that would meet ACA minimum benefit and cost-sharing requirements. As such, we did not include it as an additional component of our impact analysis. However, to the extent that an upgrade to coverage is needed, additional increases would apply.

METHODOLOGY AND ASSUMPTIONS

Individual analysis

The following summarizes key components of the methodology and assumptions used in preparing our analysis of the impact of ACA provisions in the individual insurance market.

- New Jersey has a series of standard plan designs from which companies can offer plans. We determined the sample 2013 plans used for our analysis based on individual health plan enrollment data for the fourth quarter of 2012 from the New Jersey Department of Banking Insurance website. We selected two plans with varying actuarial values that we believed to be representative of commonly sold plans in the state of New Jersey. Given the sizeable portion of membership in the Basic and Essential (B&E) plan, we selected one of these as representative.

- Illustrated 2013 premiums are reflective of the average premium for each of the given plans in the state of New Jersey. Average state rates were calculated as a weighted average of each plan's January 2013 rates by geographic area, weighted using area distributions from the Milliman Health Cost Guidelines™, 2012 edition (HCGs), as opposed to the specific insurer's distribution. This distribution is likely more representative of the population distribution for each of the markets.

- Given that New Jersey has a standard set of plan designs, it may be developing a set of EHB-compliant metallic tier plans for 2014. However, as of the time of this report we were unable to obtain further information on this development. As such, we designed sample 2014 benefit plans based on the benchmark essential health benefit (EHB) plan for the state of New Jersey, which is an HMO small group standard plan. We assumed the same provider network, prescription drug formulary, and managed care provisions as those used for the sample 2013 plans.

- We developed 2014 plans based on the actuarial value requirements for the gold and silver metallic tiers (i.e., AVs of 80% and 70%, respectively). These tiers were selected given that the allowable cost sharing in the most commonly selected current standard plan designs is generally reflective of these levels.

- Actuarial values were determined based on the CMS calculator. These values are 79% for the modeled gold plan and 71% for the silver plan.

- Claim costs for each of the sample 2013 and 2014 plans were modeled using the managed care rating model from the HCGs. The value of the benefit changes to each of the selected 2013 plans was determined based on the benefit relativities of the 2014 plan to that plan. Claim costs are reflective of:
    - Typical utilization and average billed charges for these services provided in the state of New Jersey
    - Average provider discounts in the state of New Jersey for in-network services
    - Mix of in- and out-of-network services consistent with that generally seen in the individual market
    - Mix of business by age/gender and geographic area based on the standard labor population presented in the HCGs

- Additional aggregate adjustments were applied to the benefit-adjusted rates to reflect consideration for the following:
  - The morbidity impact of the uninsured entering the market, which is due to the individual mandate and availability of federal premium and cost-sharing subsidies. Uninsured persons in the New Jersey market are generally healthier than those with coverage, given the guaranteed issue requirements. Estimates were developed based on population and self-reported health census data, as well as other information based on working with individual market insurers.
  - Increased claim activity that is due to pent-up demand from the currently uninsured population.
  - The impact of reimbursements from the ACA reinsurance program, as applicable. Expected reimbursements for the federal reinsurance program were estimated based on claim probability distributions from the HCGs.
  - We have assumed that the impact on premium of any reimbursements from or payments to the risk corridor and risk adjustment programs will net to zero.

- Additional premium was added to account for applicable ACA taxes and fees:
  - The impact of the ACA §9010 insurer fee was developed based on anticipated premium volumes for larger insurers. For smaller plans, there will be less of an impact based on the deduction of premium amounts under $50 million.
  - The impact of the exchange fee was developed assuming 60% exchange participation. This assumption was based on our experience working with insurers in the individual market and various industry resources, as well as our simulation modeling.

- Based on the methodology used, the resulting 2014 metallic tier premiums are reflective of premium rates that would be developed for the given insurer, as opposed to an average plan across all insurers. In this respect, insurer-specific items, such as average risk pool, benefit mix, network discounts, etc., are implicit in the developed 2014 rate.

- It is assumed that current 2013 plans reflect pricing for a target loss ratio designed to meet federal medical loss ratio (MLR) requirements, and that no adjustments are needed to the projected 2014 premiums to account for this provision.

Small group analysis

The following summarizes key components of the methodology and assumptions used in preparing our analysis of the impact of ACA provisions in the small group insurance market.

- Our analysis did not include any consideration for the potential impact of healthier groups opting for alternative arrangements, such as self-funding or subsidization for employees to purchase coverage in the individual market. We anticipate this movement would be marginal given the current regulatory environment.

- Additional premium adjustments to account for applicable ACA taxes and fees:
  - The impact of the ACA §9010 insurer fee was developed based on anticipated premium volumes for larger insurers. For smaller plans, there will be less of an impact based on the deduction of premium amounts under $50 million.
  - The impact of the exchange fee was developed assuming 10% exchange participation. This assumption is much lower for the small group market compared to the individual, reflecting lower anticipated participation by small groups in the Small Business Health Insurance Options Program (SHOP). This assumption was based on our experience working with insurers in the small group market and various industry resources.

RELIANCE AND LIMITATIONS

This analysis was prepared for Center Forward to provide illustrations regarding the potential impact of certain provisions of the Patient Protection and Affordable Care Act (ACA) on current premium rates in the state of New Jersey. The analysis is not intended for other purposes.

In performing this analysis, we relied on benefit and rate information from the websites of the New Jersey Department of Banking and Insurance (DBI), commercial carriers selling individual and small group products in New Jersey, and additional information available to us. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is highly likely that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Values were not normalized to account for the impact of influences that may be insurer-specific, including items such as provider network arrangements, distribution of business, risk pools, and market strategies. Assumptions used were intended to be reflective of the average market in the state of New Jersey.

This report was prepared by Milliman exclusively for the use or benefit of Center Forward for a specific and limited purpose. Center Forward may distribute this report to interested parties. Any third-party recipient of this report who desires professional guidance should not rely upon Milliman's report, but should engage qualified professionals for advice appropriate to its own specific needs. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. We, Margaret Chance and Jim O'Connor, are consulting actuaries for Milliman, Inc. We are members of the American Academy of Actuaries, and we meet the qualification standards of the American Academy of Actuaries to render the actuarial analysis contained herein.

This report is subject to the conditions agreed to in the engagement letter and consulting services agreement between Milliman and Center Forward, both dated December 19, 2012.

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