



State of Market Exchanges

2013 ACHS Annual Meeting
May 21, 2013

Presented by:
Daniel S. Pribe, FSA, MAAA

Agenda

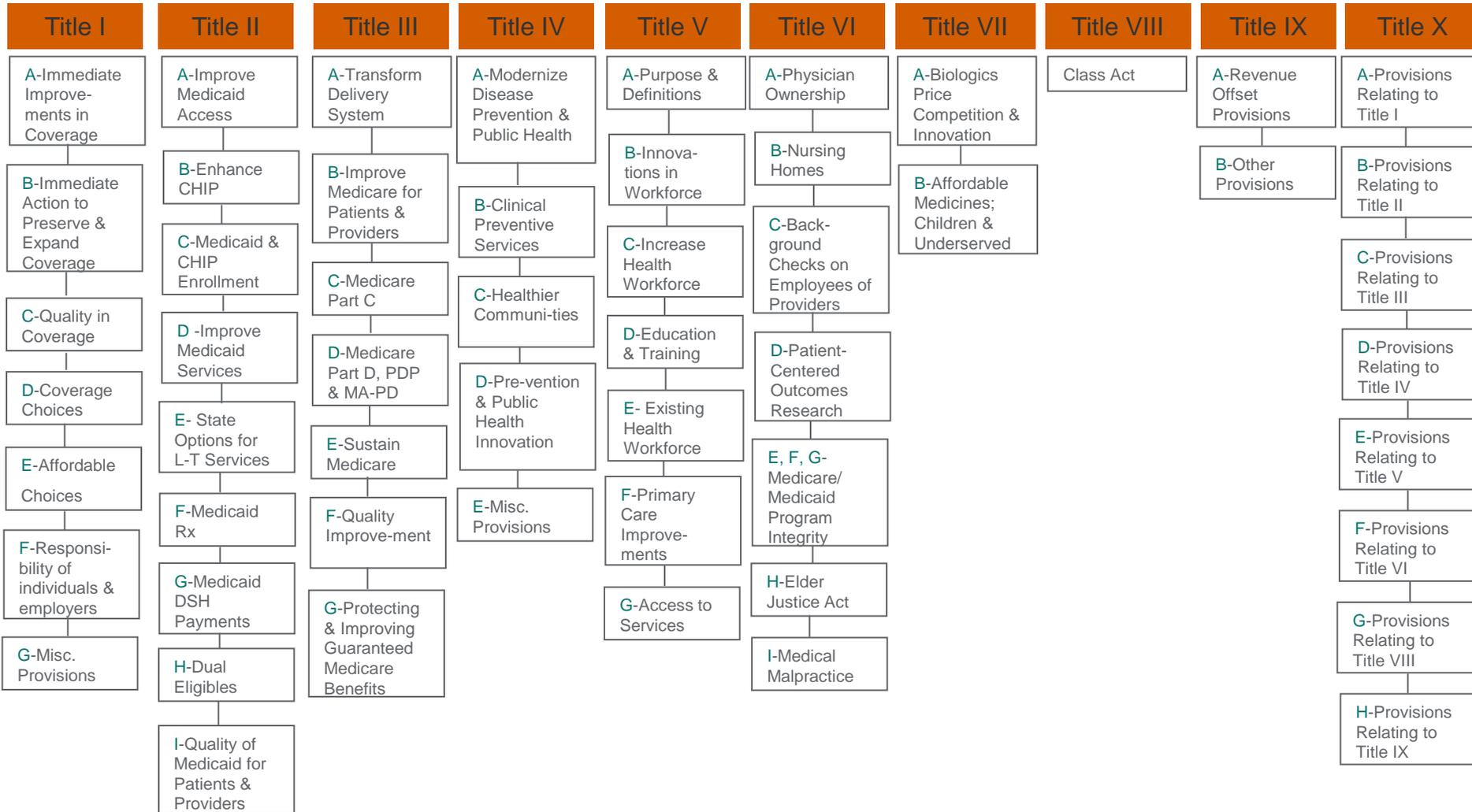
- Background
- Health Benefit Exchanges
- Pricing Challenges
- Closing Thoughts



Background

Patient Protection and Affordable Care Act (PPACA)

100,000 foot view



Quantifying Uncertainty

Movement Under ACA – One Scenario Example

Transitions in coverage under ACA for Total U.S. in 2014 (in 1,000s)

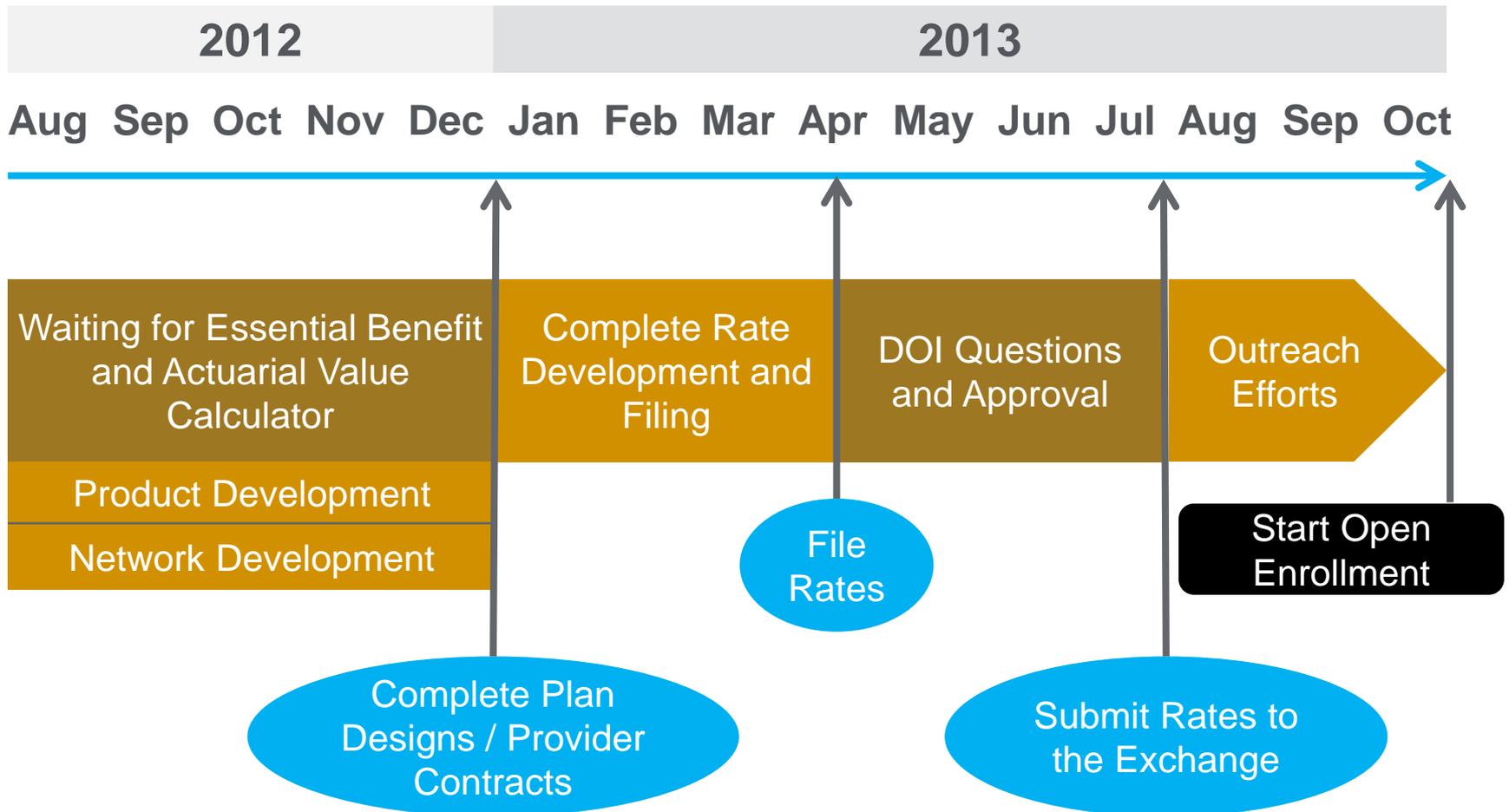
Baseline Coverage	Total	Coverage under ACA						
		Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/TRICARE	Medicaid/CHIP	Uninsured
Employer 2-50	35,455	9,452	1,918	22,671	40	0	1,137	237
Employer 51-100	5,665	472	250	4,850	1	-	72	20
Employer 101+	109,712	-	2,220	105,275	89	11	1,694	423
High Risk Pool	386	4	322	11	-	-	49	-
Other Non-Group	11,872	271	4,771	753	4,506	-	865	706
Retiree	3,465	-	-	2,966	-	-	498	-
TRICARE	5,637	-	-	-	-	5,637	-	-
Medicare	35,919	-	-	-	-	35,919	-	-
Dual Eligible	9,308	-	-	-	-	9,308	-	-
Medicaid/CHIP	45,993	432	473	814	3	-	44,270	-
Uninsured	52,392	2,180	10,455	5,390	352	-	14,012	20,002
Total	315,804	12,812	20,410	142,731	4,991	50,876	62,596	21,388

Source: Lewin/Optum Health Benefit Simulation Model (HBSM)

Observations:

- **Uninsured** – Decreases by over 30 million
- **Individual Market** – Increases by about 13 million
- **Group Market** – Increases by about 5 million

Timeline

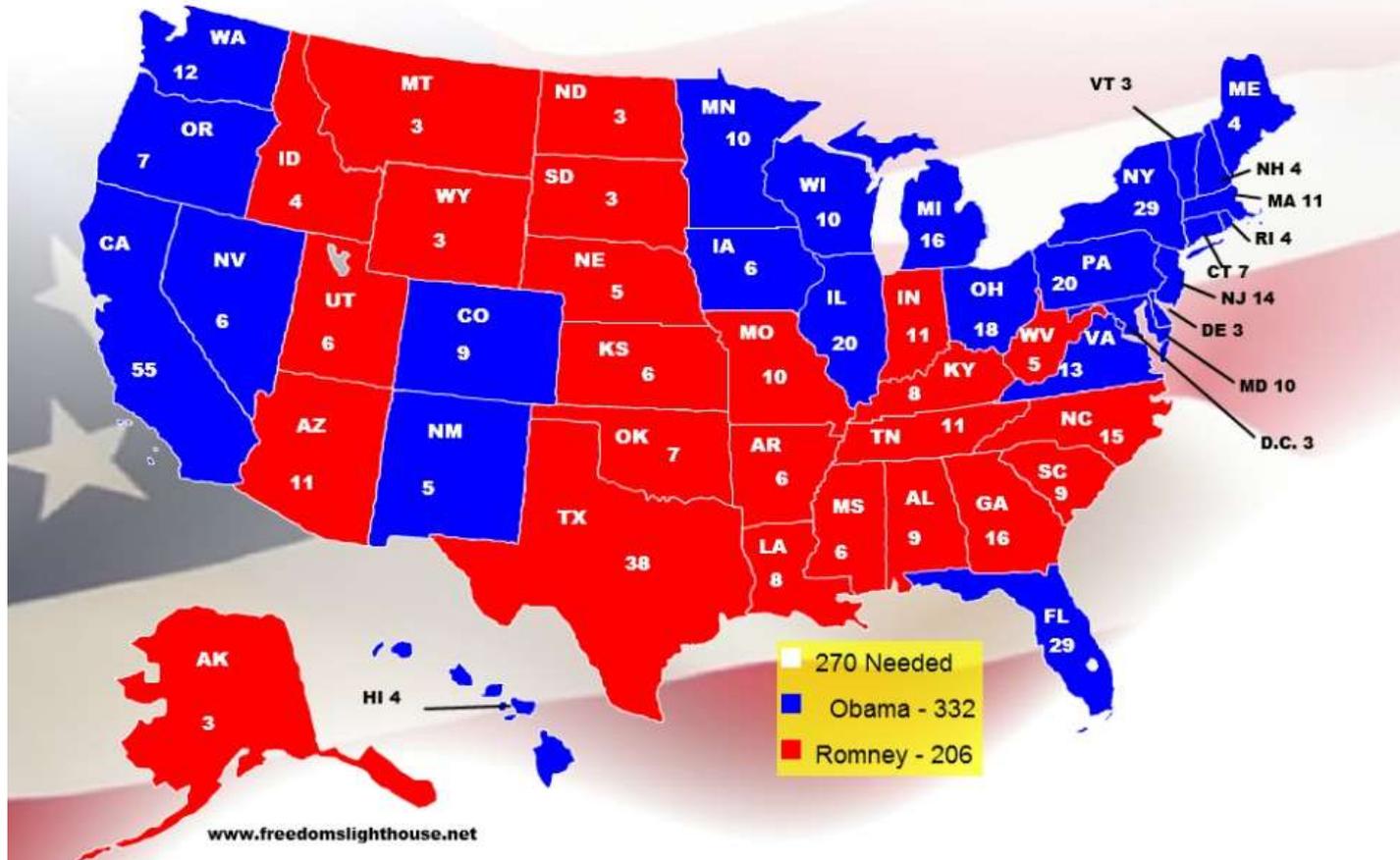


Key Components

2010	<ul style="list-style-type: none">• PPACA and HCERA signed into law• Early Retiree Reinsurance Program (ERRP) in place• Accounting recognition of change in taxability of RDS payments• \$250 rebate for seniors who hit Medicare Part D coverage gap
2011	<ul style="list-style-type: none">• W-2 reporting of aggregate value of employees' health coverage• Insurance Market Reforms<ul style="list-style-type: none">• Extended dependent coverage to age 26,• No lifetime dollar limits,• Restricted annual dollar limits,• No preexisting condition exclusions for those under age 19• HSA withdrawal penalty increased• No reimbursement of over-the-counter (OTC) medicines from account-based health plans
2012	<ul style="list-style-type: none">• Supreme Court Ruling• Presidential Election
2013	<ul style="list-style-type: none">• Medicare payroll tax increased for high-wage employees and new tax on unearned income• Cap on salary-reduction contributions to health FSAs• Change employer tax treatment for Medicare Part D retiree drug subsidy (RDS)
2014	<ul style="list-style-type: none">• Individual health coverage mandate• Employer mandates: play-or-pay, automatic enrollment,• Health Benefit Exchanges operational (?)• Premium and cost-sharing subsidies for low- and middle-income individuals• Additional consumer protection standards (e.g., excessive waiting periods)
2016	<ul style="list-style-type: none">• Health insurance sales across state borders permitted
2018	<ul style="list-style-type: none">• 40% nondeductible excise tax on high-cost group health plans

Presidential Election Results by State

2012 Presidential Election Electoral Vote Results





Health Benefit Exchanges

Federal Requirements for Health Benefit Exchanges (HBEs)

- **Core Functions**

- **Certification**, recertification and decertification of plans
- Operation of a **toll-free hotline**
- Maintenance of a **website** for providing information on plans to current and prospective enrollees
- Assignment of a **price and quality** rating to plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an **electronic calculator** to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Provision of information on certain individuals identified in Section 1311 (d)(4)(I) to the Treasury Department and to employers
- **Establishment of a Navigator program** that provides grants to entities assisting consumers as described in Section 1311(i)

- **Additional Functions**

- Presentation of **enrollee satisfaction survey** results under Section 1311(c)(4)
- Provision for **open enrollment periods** under Section 1311(c)(6)
- Consultation with stakeholders, including tribes, under Section 1311(d)(6)
- Publication of data on the Exchange's **administrative costs** under Section 1311(d)(7)

Source: <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html>

Federal Requirements for Health Benefit Exchanges (HBEs) (cont.)

- **Oversight Responsibilities** – Secretary to develop regulatory standards in five areas that insurers must meet in order to be certified as qualified health plans by an
 - **Marketing**
 - **Network adequacy**
 - **Accreditation for performance measures**
 - **Quality improvement and reporting**
 - **Uniform enrollment procedures**
- **Additional Oversight Responsibilities** - Additional areas where Exchanges must ensure plan compliance with regulatory standards established by the Secretary include:
 - Information on the **availability of in-network and out-of-network providers** as identified in Section 1311(c)(1)(B) and (C), including provider directories and availability of essential community providers
 - Consideration of **plan patterns and practices** with respect to past premium increases and submission of plan justifications for current premium increases under Section 1311(e)(2)
 - **Public disclosure** of plan data identified in Section 1311(e)(3)(A), including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by the Secretary
 - Timely information for consumers requesting their amount of cost sharing for specific services from specified providers as described in Section 1311(e)(3)(C)
 - Information for participants in group health plans as described in Section 1311(e)(3)(D)
 - Information on **plan quality improvement activities** as specified in Section 1311(g)

Source: <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html>



Pricing Challenges

Rating Challenges

- Filing HBE products for predominately lower income population largely uninsured today
- Adjustments for guarantee issue, pent-up utilization, resulting morbidity mix
- Regulatory pressure on rates and lack of precedent and expectation

Major Contributors for Pricing

Relativity to current market experience

Margin and expense load

Uninsured uptake and morbidity

Actuarial estimates for plan design factors

New network strategies? Cost Impact?

Estimating the actual impacts of the 3-Rs

Distribution Systems

Morbidity Change due to market churn



- Market churn will create change in morbidity
- SOA / OptumInsight study shows an increase for California of about 60%
- A Milliman study shows the increase to be about 25%
- Conclusions:
 - No one knows “right” answer
 - Large variation by state

ALABAMA	60.3%	HAWAII	21.8%	MASSACHUSETTS	-12.8%	NEW MEXICO	34.9%	SOUTH DAKOTA	29.0%
ALASKA	19.2%	IDAHO	62.2%	MICHIGAN	25.8%	NEW YORK	-13.9%	TENNESSEE	46.4%
ARIZONA	22.2%	ILLINOIS	50.8%	MINNESOTA	18.9%	NORTH CAROLINA	13.5%	TEXAS	33.8%
ARKANSAS	40.9%	INDIANA	67.6%	MISSISSIPPI	43.2%	NORTH DAKOTA	8.4%	UTAH	28.4%
CALIFORNIA	61.6%	IOWA	9.7%	MISSOURI	58.8%	OHIO	80.9%	VERMONT	-12.5%
COLORADO	39.1%	KANSAS	18.9%	MONTANA	20.1%	OKLAHOMA	29.3%	VIRGINIA	28.4%
CONNECTICUT	28.8%	KENTUCKY	34.1%	NEBRASKA	30.8%	OREGON	14.3%	WASHINGTON	13.7%
DELAWARE	29.3%	LOUISIANA	28.6%	NEVADA	29.2%	PENNSYLVANIA	28.0%	WEST VIRGINIA	35.3%
D.C.	51.9%	MAINE	4.1%	NEW HAMPSHIRE	36.8%	RHODE ISLAND	-6.6%	WISCONSIN	80.0%
FLORIDA	26.5%	MARYLAND	66.6%	NEW JERSEY	-1.4%	SOUTH CAROLINA	36.8%	WYOMING	31.6%
GEORGIA	27.6%								

Source: SOA and OptumInsight Study

Sample Rating Algorithm

<u>Description</u>	<u>PMPM</u>
(1) 2012 Allowed Amount	\$ 300.00
(2) Adjustments	
IBNR Adjustment	1.010 x
Morbidity Adj.	1.200 x
Induced Demand	0.995 x
Trend @6%	1.124 x
(3) Adjusted Allowed	\$ 406.50
(4) Benefit/Network Adjustments	
EHB - Habilitative	1.001 x
EHB - Pediatric Vision	1.000 x
EHB - Pediatric Dental	1.001 x
Rx Formulary Change	0.980 x
Provider Reimbursement	0.970 x
Network Change	1.000 x
(5) Index Rate	\$ 387.19

- Adjustments must be made for:
 - Traditional factors (e.g., IBNR, Trend)
 - Change in Morbidity
 - Induced utilization from underlying experience to index rate
 - EHB

Sample Rating Algorithm (cont.)

<u>Description</u>		<u>PMPM</u>
(5)	Index Rate	\$ 387.19
	Paid to Allowed	0.742 x
(6)	Paid Index Rate	\$ 287.30
(7)	"R" Adjustments	
	Reinsurance Premium	\$ 5.25 +
	Reinsurance -10.0%	(28.73) +
	Risk Adjustment 0.0%	- +
(8)	Adjusted Paid Index	\$ 263.82
(9)	Other Fees	
	Exchange Fees	\$ 12.23 +
	Health Insurance Tax	3.49 +
	Premium Tax	8.74 +
	Admin/Margin	61.15 +
(10)	Premium Rate for index plan	\$ 349.42

- Index Rate is adjusted for:
 - Metallic Plan
 - The "R's"
 - Exchange Fees
 - Premium Tax
 - Admin and
 - Margin

Whatever method is used needs to fit into the Unified Rate Review Template (URRT)

Unified Rate Review Template (URRT)

Data Collection Template

Add Product Validate Finalize

Company Legal Name: State:
 HIOS Issuer ID: Market:
 Effective Date:

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: to 12/30/1900
Period Aggregate

	Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	<input type="text"/>	#DIV/0!	#DIV/0!
Incurred Claims in Experience Period	<input type="text"/>	#DIV/0!	#DIV/0!
Allowed Claims:	<input type="text"/>	#DIV/0!	#DIV/0!
Index Rate of Experience Period	<input type="text"/>	<input type="text"/>	
Experience Period Member Months	<input type="text"/>		

Section II: Allowed Claims, PMPM basis

Benefit Category	Experience Period				Projection Period: 1/0/1900 to 12/30/1900				Mid-point to Mid-point, Experience to Projection: -6					
	on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment		Credibility Manual			
	Utilization Description	Utilization per 1,000	Average Cost/Service	PMPM	Pop'l risk Morbidity	Other	Cost	Util	Utilization per 1,000	Average Cost/Service	PMPM	Utilization per 1,000	Average Cost/Service	PMPM
Inpatient Hospital	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	\$0.00
Outpatient Hospital	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	0.00
Professional	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	0.00
Other Medical	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	0.00
Capitation	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	0.00
Prescription Drug	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	0.00
Total	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	#DIV/0!	#DIV/0!	#DIV/0!	<input type="text"/>	<input type="text"/>	\$0.00

Actuarial Certification

- **Capture appropriate certification for:**
 - Methodology used to calculate the **AV Metal Value** for each plan
 - Appropriateness of the essential health benefit portion of premium upon which **advanced payment of premium tax credits** (APTCs) are based,
 - **Index rate** is developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates
- **Must include:**
 - General information
 - Company ID and contact information
 - Proposed rate increase
 - Reasons for rate increase:
 - Single risk pool experience which is more adverse than that assumed in the current rates
 - Medical inflation
 - Increased utilization
 - Prospective changes to benefits covered by the product or successor products
 - New taxes and fees imposed on the issuer
 - Anticipated changes in the average morbidity of the covered population that is market wide, as opposed to issuer specific morbidity that is reflected in risk adjustment
 - Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program
 - Experience period premium and claims
 - Benefit categories
 - Projection factors
 - Manual rate development
 - Credibility of experience
 - Risk Adjustment and Reinsurance
 - Non benefit expenses, and profit and risk

Actuarial Certification (cont.)

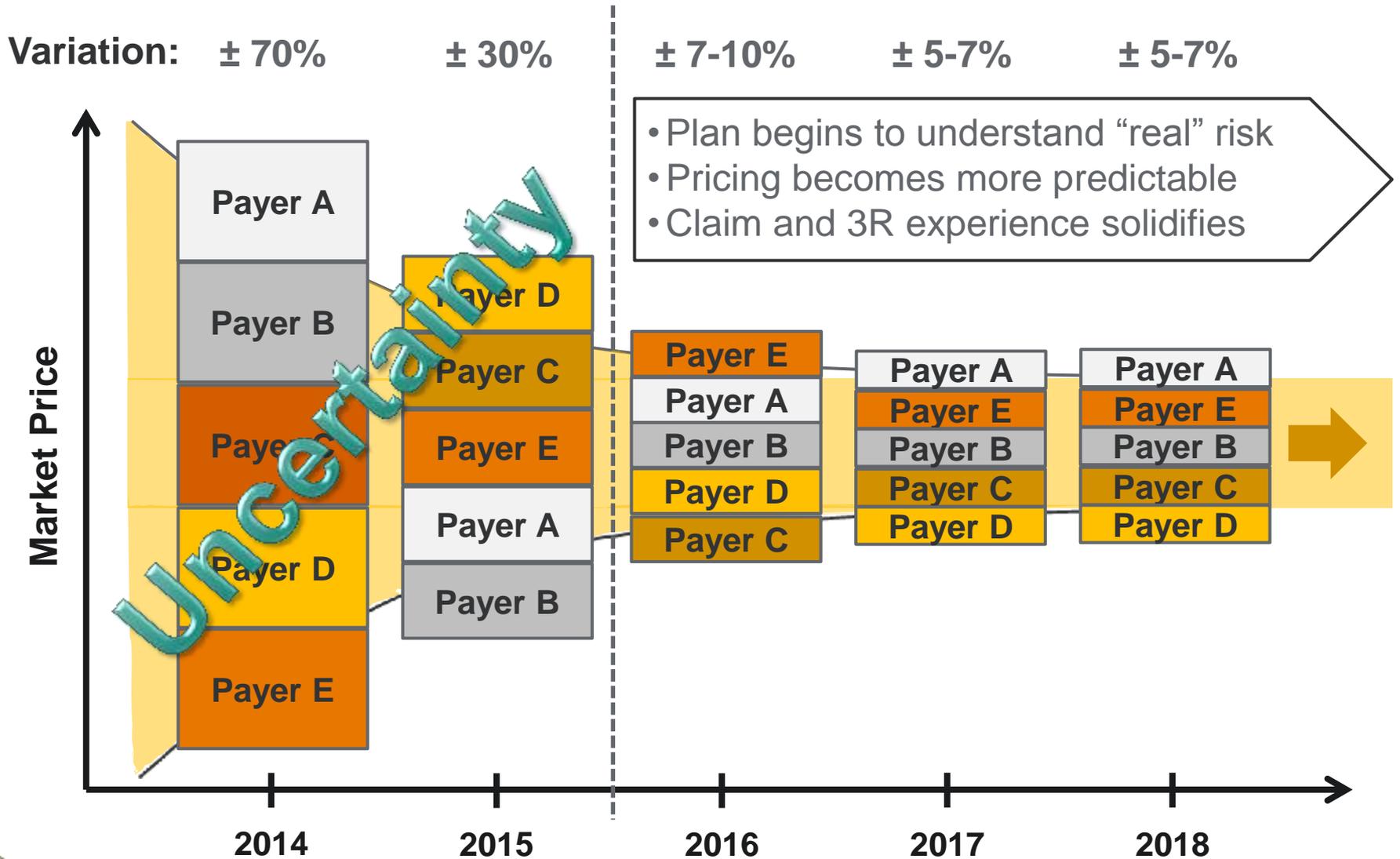
- **Must include (cont.):**
 - Projected loss ratio
 - Index Rate
 - AV pricing values
 - **Membership projections**
 - Terminated products
 - Plan type
 - Warning alerts
 - Actuarial certification

Dealing with Uncertainty

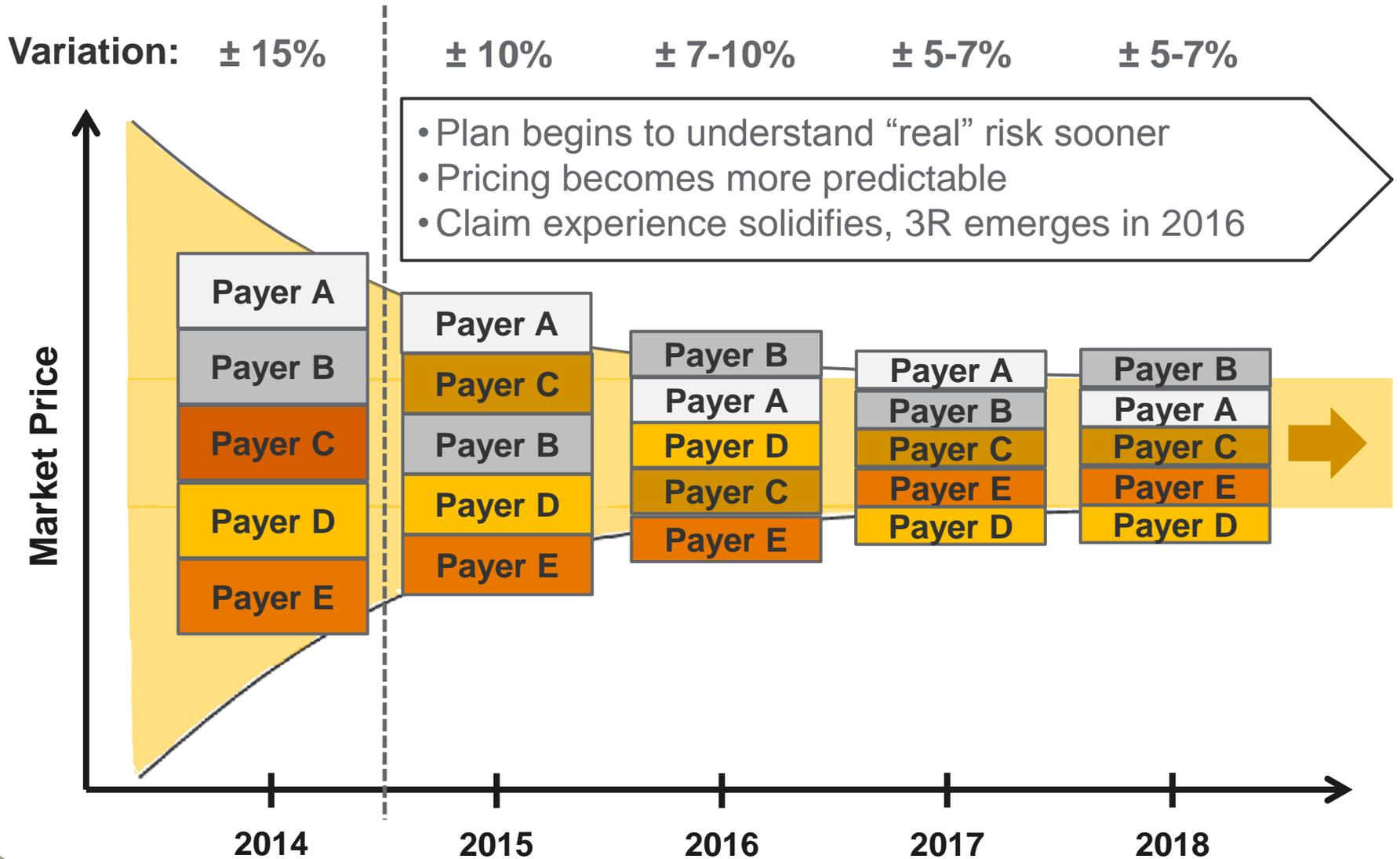
- Federal subsidies reduce out-of-pocket expenses for lower incomes
- Cost Sharing subsidy only applies to Silver Plan.
- Lowest income individuals receive benefits better than Platinum
 - no reason to buy up or down.
- 150%-200% receive benefits better than Gold
 - very costly to buy up to Platinum for only 3% additional benefits.
- 200%-250% may decide to buy benefits up or down
 - Depends on cost differentials and individual healthcare needs.

Income Level	Actuarial Value (After CS subsidy)	Actuarial Value (No subsidy)
100-150% FPL	94%	90% - Platinum Plan
151-200% FPL	87%	80% - Gold Plan
201-250% FPL	73%	70% - Silver Plan

Probable Individual Market Dynamics

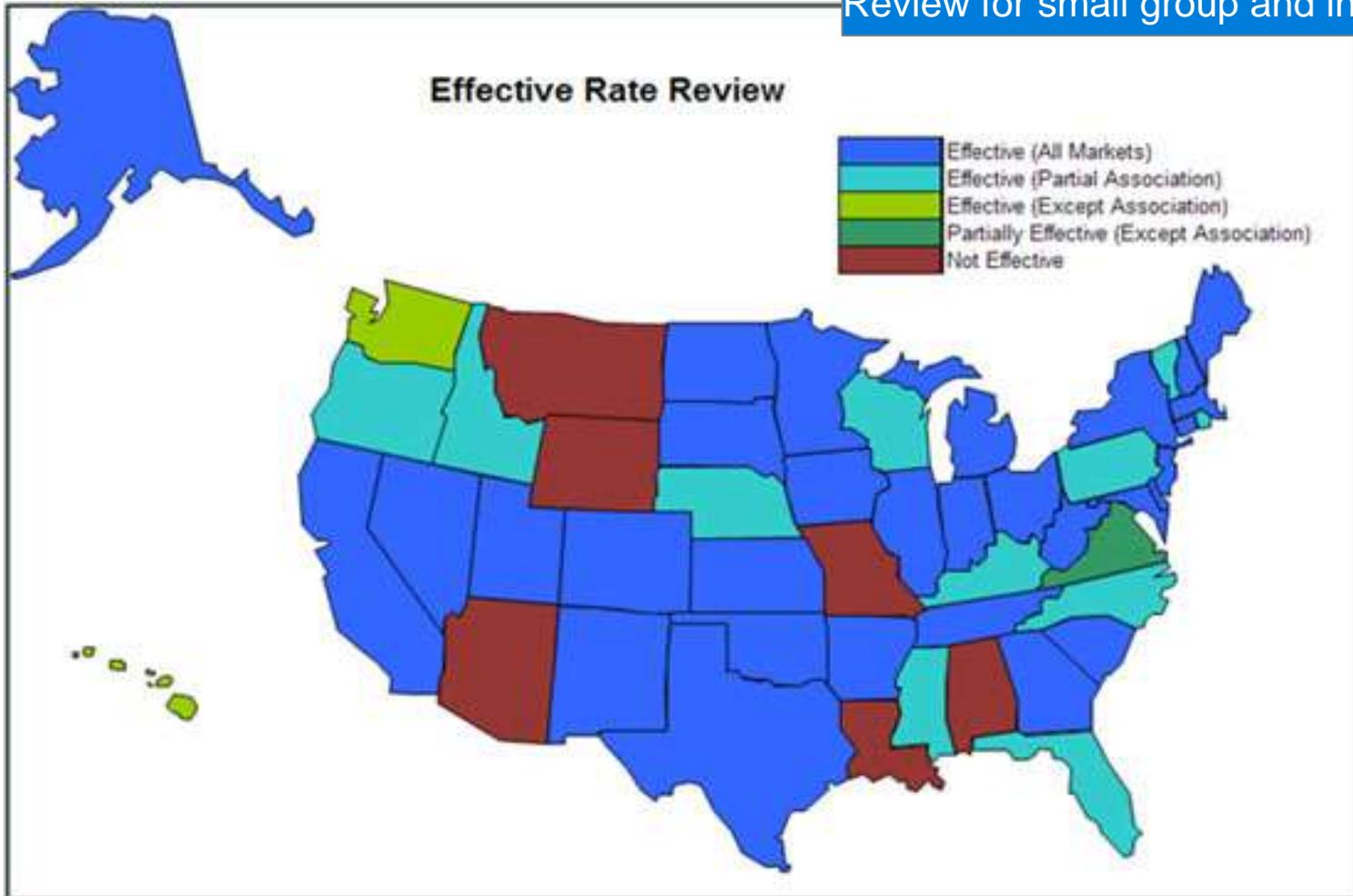


Probable Small Group Market Dynamics



States with “Effective” Rate Review

Majority of states currently administer Rate Review for small group and individual market





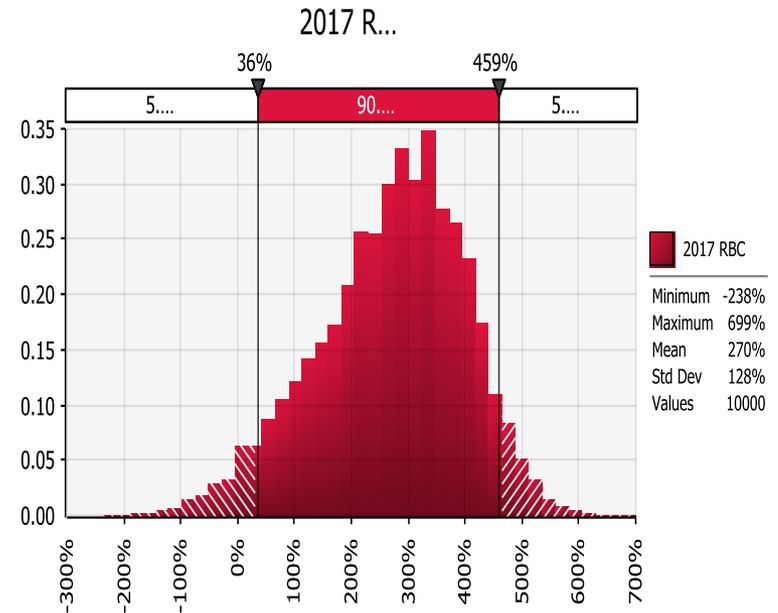
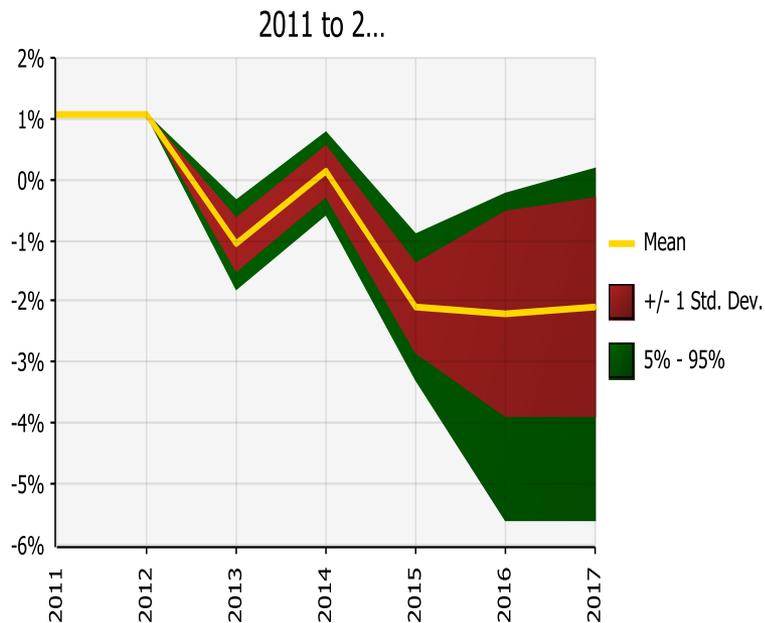
Closing Thoughts

From the Street – Observations on Exchange Strategies

Attribute	Theme	Observation
Price	Market Share	General acceptance that the Exchange is a price play. Plans are making an honest assessment of whether they have the infrastructure to achieve low price targets.
Financial Modeling	Risk	Plans focused on what should they do and how big is their share. Topics include market share scenarios, 3Rs, market expansion or selection. Surplus modeling imperative.
Operational Readiness	Investment	Larger plans focused on scaling operational functions and focusing on efficient transactional process to make things simple for the consumer. Regional plans slower to react.
Retail Readiness	Investment	Significant investment by national carriers. Regional carriers may still developing strategies. General acceptance that plans need to better understand the Exchange population.
Product Design	Tactics	Ongoing sense of urgency, final decisions must be made now for filings, uncertainty remains. Plans investing in consumer understanding such as focus groups.
Providers and ACOs	Cost	High interest in narrow network strategy and network optimization (including payment integrity). However plans struggle with how to produce significant cost reductions. Plans contemplating how to best leverage Medicaid.

Future Impact to Payers

- Measurement of Trend
 - Changes in enrollment
 - Changes in morbidity
- Significant changes in enrollment and impact to net income and surplus
 - Lowest two priced plans could gain significant portion of market share
 - Significant increase in enrollment could impact surplus
 - Sample analysis:



Future Impact to Provider Organizations

The immergence of the ACO business model has providers exploring new strategic paths.

Topic	The Conversation
Readiness and Appetite for Risk	Are they prepared to manage risk transferred from a payer or plan sponsor? (i.e. data, people, organization, technology, partnerships, capital)
Physician Affiliation	How do I select the right Primary Care Providers for my network and find the “best” specialists for referrals?
Cost & Utilization Control	How do I manage the risk of the attributed population? How do we perform on our high-cost episodes versus the competition?
Value	Do I have a value proposition with payers and plan sponsors? How do I negotiate bundled payments and total cost of care contracts.
Measure and Report	What is data and reporting is required to monitor a cost of care contract. What kind of human capital and technology is required?



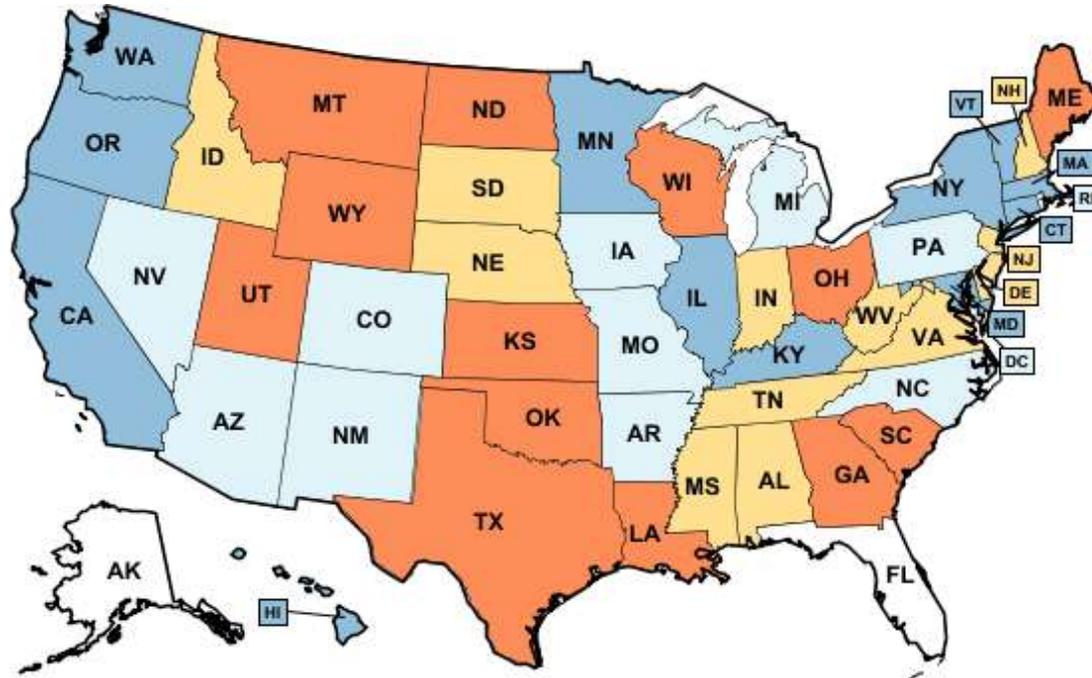
Thank you

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Appendix

HBE Grants by State



Total Health Insurance Exchange Grants, 2013: Total Exchange Grant Amount

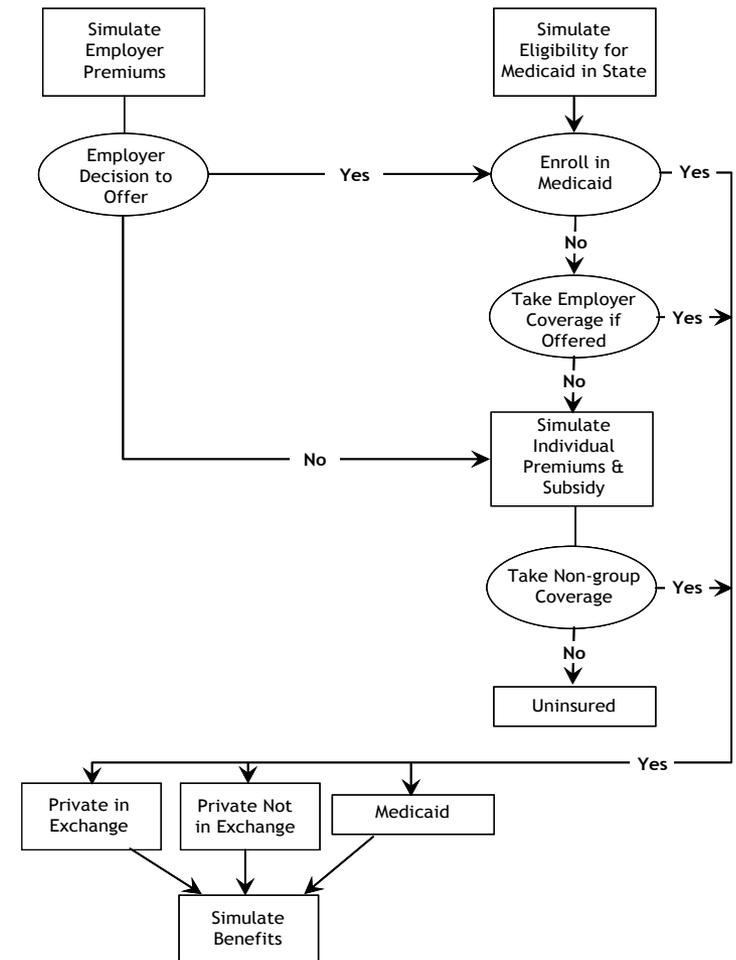


statehealthfacts.org
Your source for state health data

Dealing with Uncertainty

Member Movement Modeling: HBSM Scenario

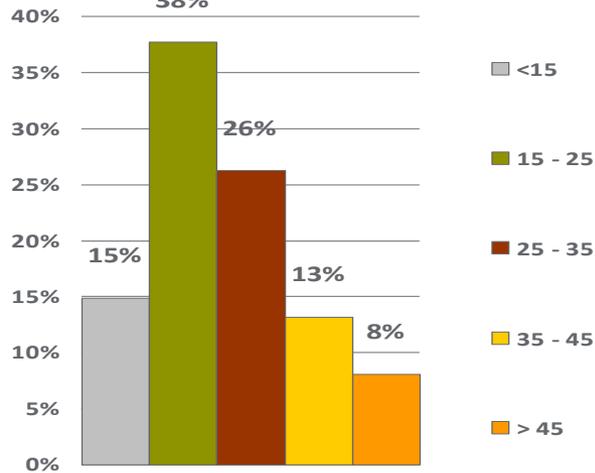
- **Micro-Simulation Model of the U.S. Health Care System**
 - NHI, MEPS Household Survey, KFF-HRET Employer
 - Medical, Pharmacy, Behavioral Health Cost & Use
 - Demographic data
 - Consumer data
- **Simulates Medicaid Using Eligibility Rules in Each State**
- **Firm Impacts and Coverage Decisions**
 - Estimates Current Premiums under State Rules
 - Change in Premiums due to Rating Reforms, Subsidies and Penalties
 - Model Employer Decision to Take/Drop Coverage
 - Firm Response to Mandate and Available Non-Group Subsidies
- **Individual Impacts and Coverage decisions**
 - Estimates Current Premiums under State Rules
 - Change in Premiums due to Rating Reforms, Subsidies and Penalties
 - Individual Decision to Take/Drop Coverage



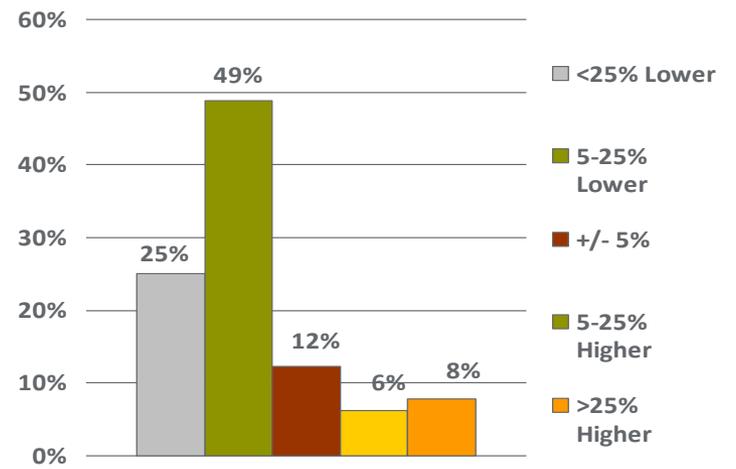
Uncertainty in Pricing Outcomes

Presentation: Over 300 Actuaries

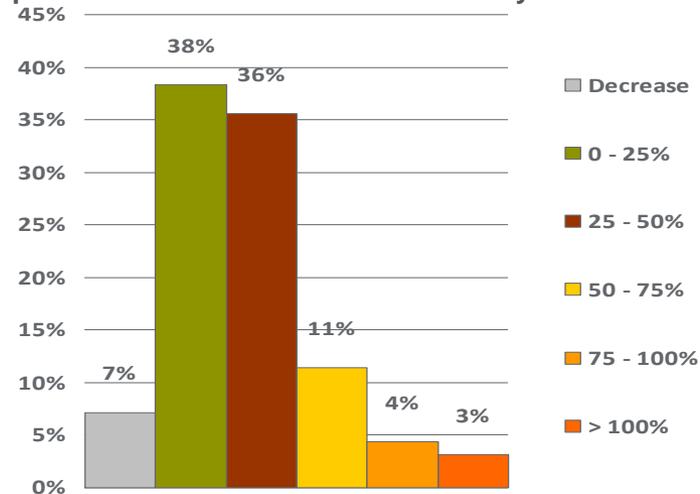
How Many of the 52 Million Uninsured Will Remain Uninsured



How Does Morbidity of the Uninsured Compare to Currently Insured



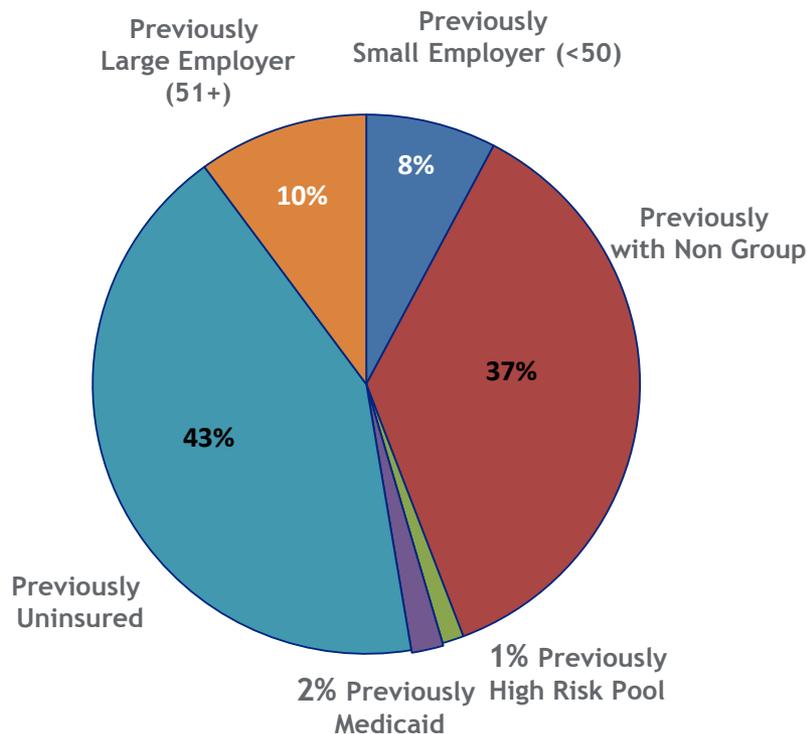
Expected Increase in Individual Morbidity Due to ACA



Quantifying Uncertainty

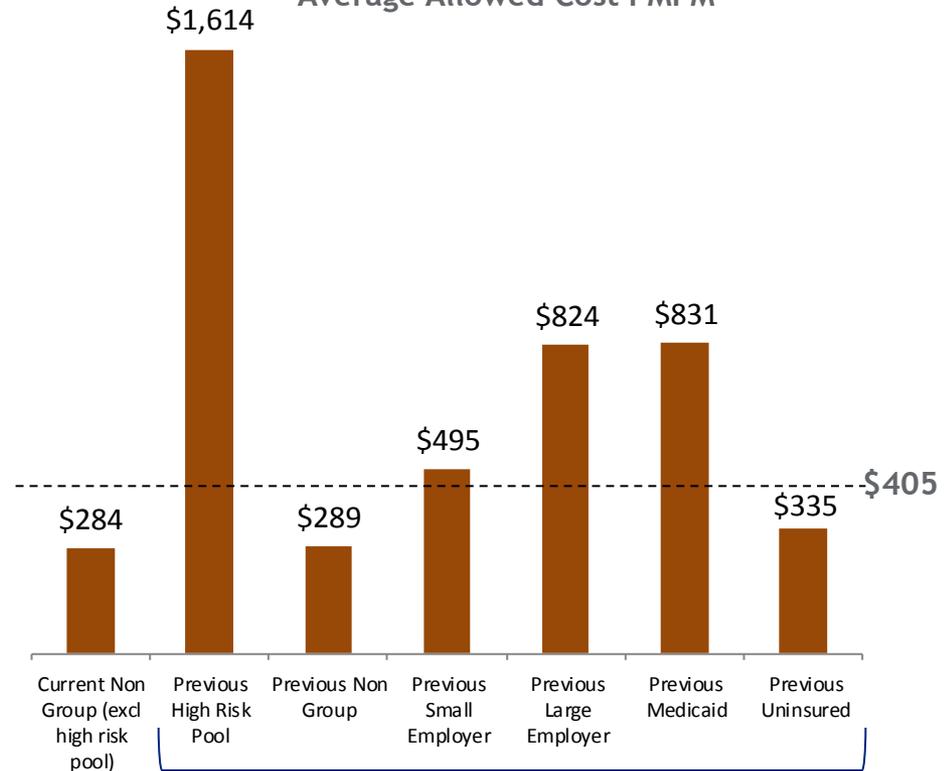
Impact of ACA on the Individual Market - National

Prior Source of Coverage



Non Group under ACA = 25.4 Million Exchange & Non-Group

Average Allowed Cost PMPM

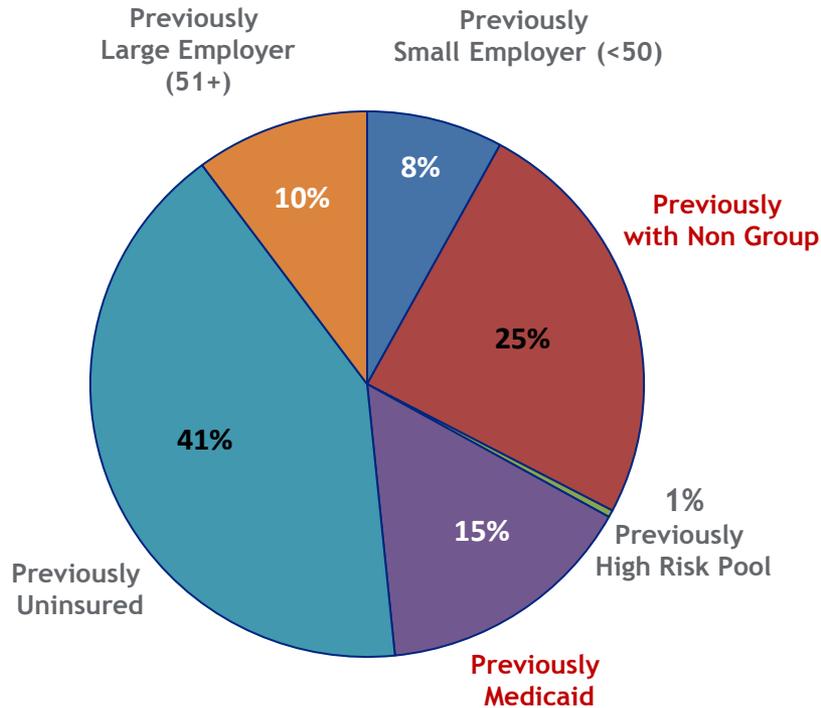


Non-Group under ACA

Quantifying Uncertainty

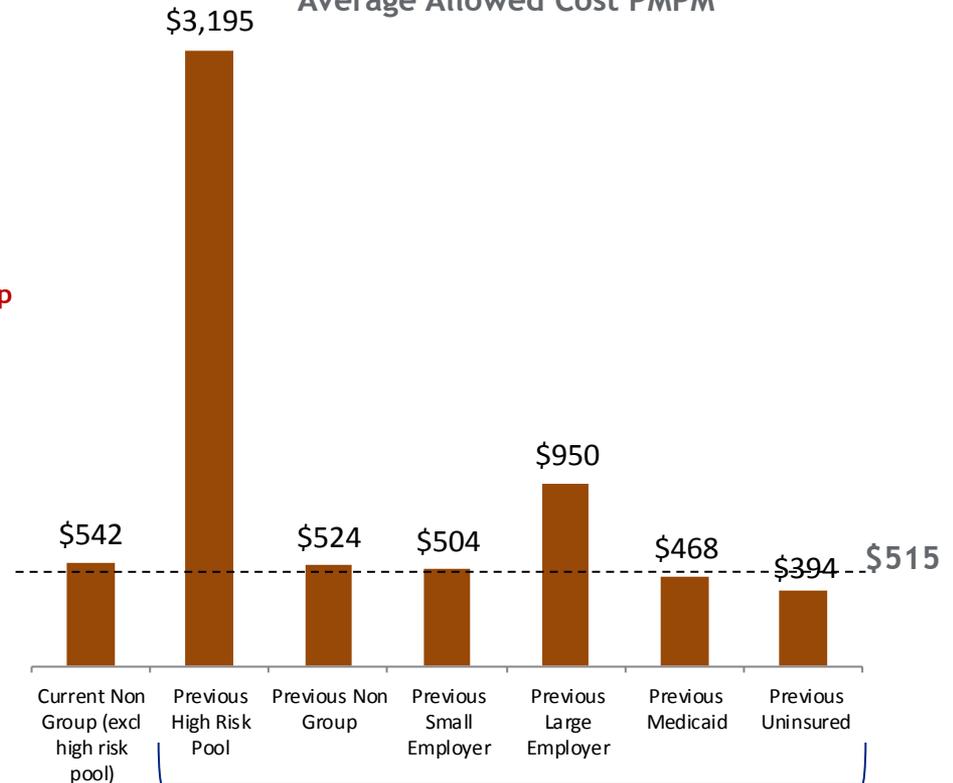
Impact of ACA on the Individual Market in New York

Prior Source of Coverage



Total in Non Group under ACA
1.610 Million

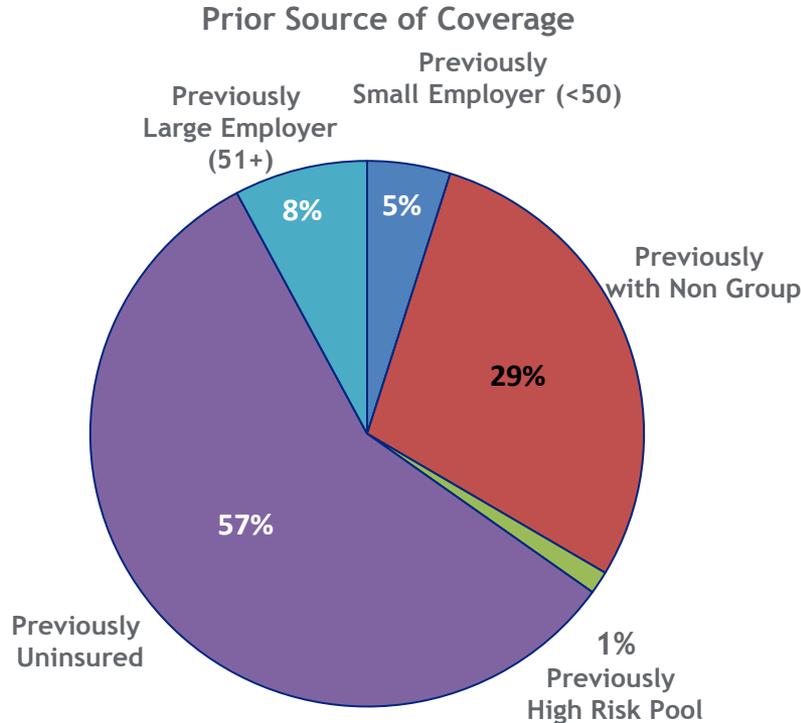
Average Allowed Cost PMPM



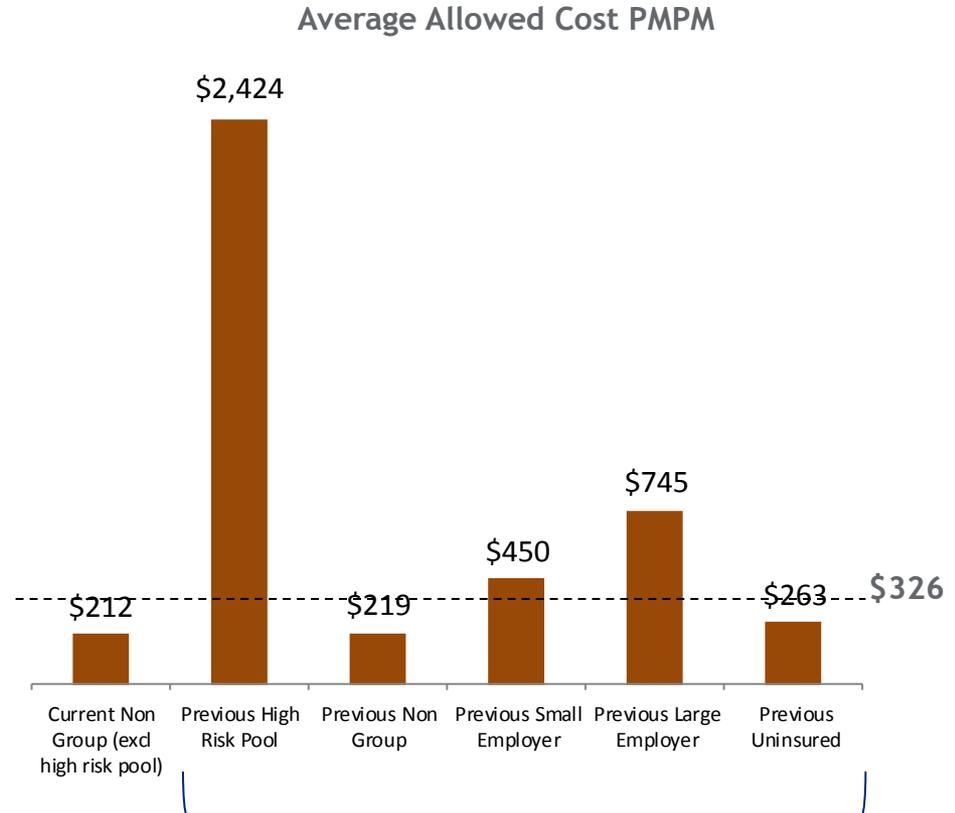
Non-Group under ACA

Quantifying Uncertainty

Impact of ACA on the Individual Market in Texas



Total in Non Group under ACA
2.421 Million



Non-Group under ACA