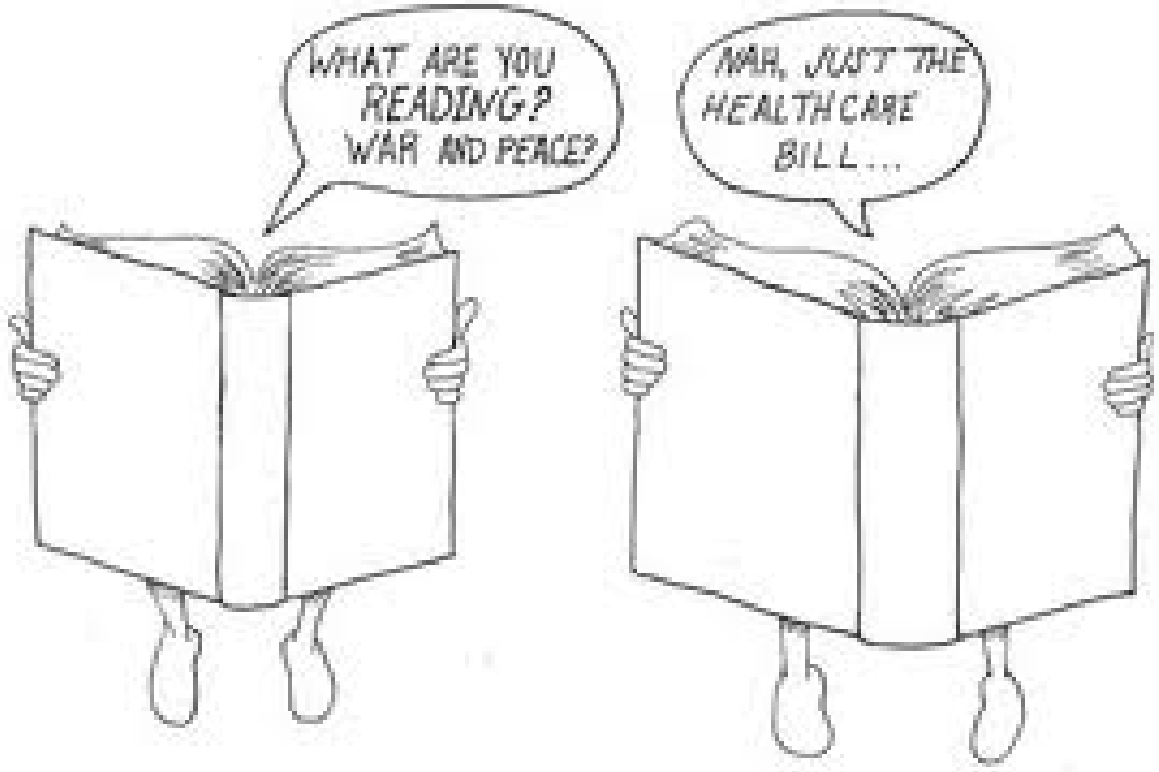
Actuarial Value under the ACA

Kristi Bohn

September 24, 2015


WHAT ARE YOU READING? WAR AND PEACE?
NAH, JUST THE HEALTH CARE BILL...

Small Group and Individual Overview

Individual & Small Group Markets

- Individual
  - Non-Grandfathered versus Grandfathered
  - MNsure use at approximately 20%
- Small Employer Group
  - 2-50 until 2016
  - 1-100 in 2016
  - Exchange use low across the U.S.

Individual & Small Group Markets

- Most reforms only affect Non-Grandfathered Plans
  - Grandfathered: plans issued prior to March 23, 2010
    - Only slight plan design changes allowed (deductibles, co-pays, coinsurance)
    - Needed to be declared by insurer (or self-insured employer), including disclosures to plan members
    - Not open to new entrants (with the exception of family member additions)
  - Minnesota has Grandfathered individual plans, but not small group

Guaranteed Issue Started in 2014

- Must offer coverage to and accept any individual or employer that applies for coverage
  - Individual exception: illegal for carrier to sell individual policies to someone enrolled in Medicare, though individual policies cannot be terminated/rescinded for this reason
  - Small group exception: carrier's unique participation/contribution rules can be applied outside of Nov. 15-Dec. 15 window
  - Guarantee issue applies to large employers as well

Guaranteed Renewability

- Coverage must be renewed or continued at the option of the individual or employer with the exceptions of nonpayment of premiums, fraud
- New Uniform Modifications rules provided for 2016 that allow carriers liberality in changes allowed to continuing plan while still calling the plan “renewed”
- However, Minnesota is very unique in its continuing renewal rules applicable to our individual market

Comprehensive Coverage

- The ACA requires coverage of broad categories of Essential Health Benefits (EHBs), but left the specific details to each state, providing state-specific defaults
- States must finance new benefit mandates within or outside these categories

1. Ambulatory Patient Services	6. Prescription Drugs
2. Emergency Services	7. Rehabilitative and Habilitative Services
3. Hospitalization	8. Laboratory Services
4. Maternity and Newborn Care	9. Preventive and Wellness Services
5. Mental Health & Substance Abuse	10. Dental and Vision Pediatric Services

Small Group and Individual Plan Design Standardization

Plan Design Standardization

- All carriers across the U.S. use the same tool (called the Actuarial Value Calculator) to set deductibles, coinsurance, co-pays and OOP Maximums in order to demonstrate compliance with the metal tiers
  - Special actuarial adjustments for features the calculator does not handle
- The Actuarial Value Calculator is based on large employer claims across the U.S., adjusted by HHS, data provided by Blues
- Targets plan share, not necessarily actuarial value, since HHS adjusted the underlying data source to remove induced demand
- Could be adjusted by HHS as frequently as annually
  - 13.5% trending applied to Actuarial Value Calculator data for 2016

Plan Design Standardization

Metal Tier	AV Target	Allowance
Bronze	60%	+/- 2%
Silver	70%	+/- 2%
Gold	80%	+/- 2%
Platinum	90%	+/- 2%
Catastrophic	N/A	N/A

- Preventive benefits are always covered at 100%, regardless of metal level, or even market type (large employers must follow this rule if the plan is non-grandfathered)
- Catastrophic plan always follows the OOP Max limitation, as annually adjusted, with the first 3 office visits either free or with co-pay
  - For example, in 2016 deductible = OOP Max = $6,850 with first 3 office visits free, 100% preventive is common

Plan Design Standardization

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		$6,450.00
		80.00%
		$6,850.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$57.00	☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑	0%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	0%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	0%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.06%
Metal Tier:	Bronze

Sample Plan Designs (2016)

Metal Level	Design Examples (a myriad of possibilities exist)
Bronze	Deductible = OOP Max = $6,850 (Single) Deductible = OOP Max = $6,300 (Single) Deductible = $4,700 OOP Max = $6,550 (Single) 20% coins
Silver	Deductible = OOP Max = $4,000 (Single) Deductible = OOP Max = $3,250 (Single) Deductible = $1,300 OOP Max = $5,450 (Single) 40% coins Deductible = $0 OOP Max = $6,500 50% coins
Gold	Deductible = $1,300 OOP Max = $2,350 (Single) 30% coins Deductible = $0 OOP Max = $2,800 50% coins
Platinum	Deductible = $650 OOP Max = $1,000 (Single) 20% coins Deductible = OOP Max = $750 (Single)

Plan Design Subsidization

- Silver Plan Foundation for Cost Sharing Reduction Plans
  - Also uses Actuarial Value Calculator
  - ALL exchange silver plans must file all variants
  - Minnesota only has enrollees in the 73% variant (unique)
    - Triage to MinnesotaCare makes 87% and 94% variants irrelevant

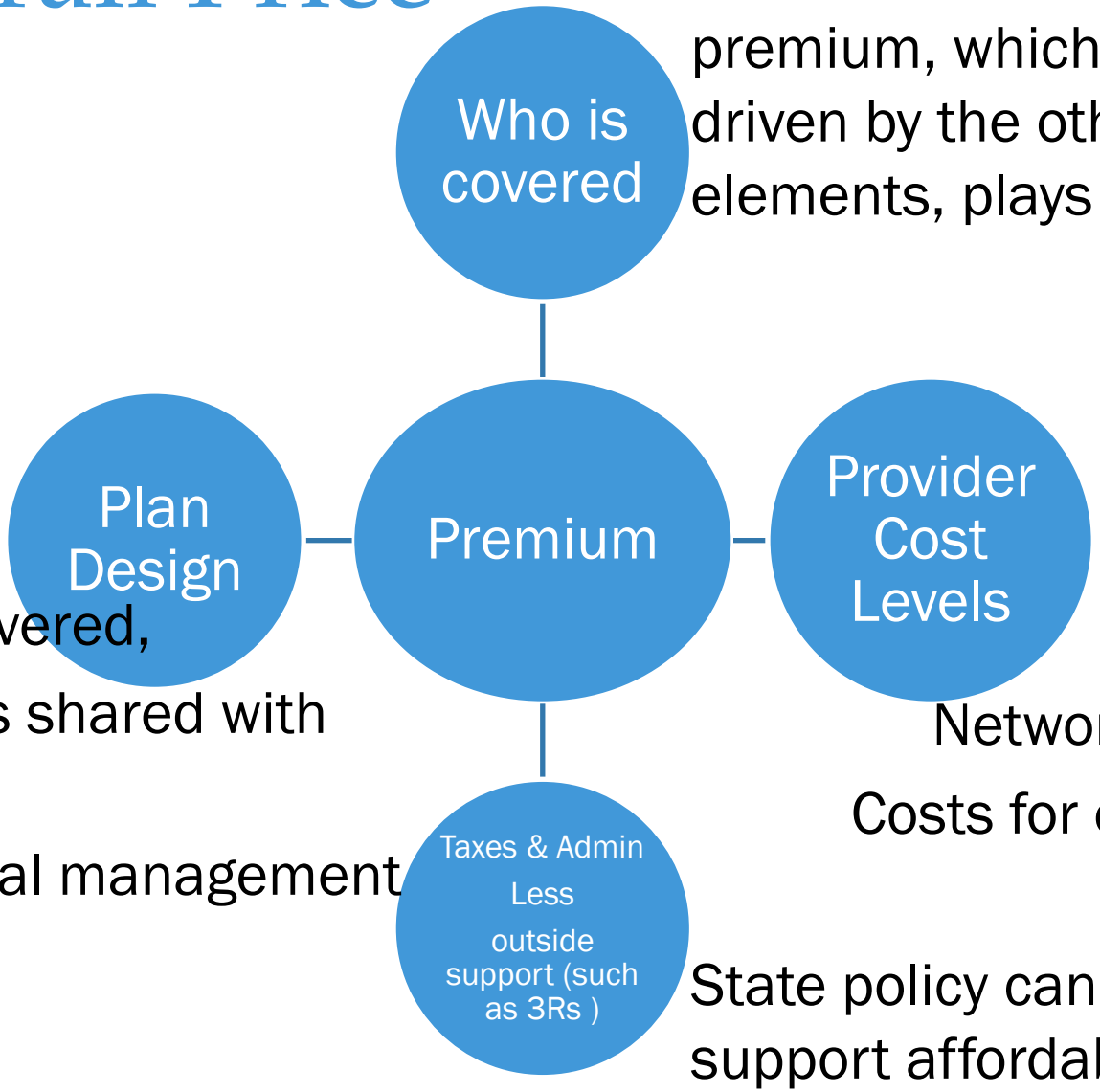
Income	AV Target	Allowance
< 150% FPL	94%	+/- 1%
151-200% FPL	87%	+/- 1%
201-250% FPL	73%	+/- 1%
Native Americans less than 300% FPL	100%	N/A

Small Group and Individual Pricing

Single Risk Pool

- Each carrier uses own data source for actuarial equivalence for premiums
- HHS maintains the single statewide risk pool for Non-Grandfathered plans
  - Includes MNsure and direct purchase enrollees
    - Risk adjustment makes this happen, retrospectively
    - Thus, all carriers' premiums and claims experience matter to each carrier's pricing expectations and financial experience
  - Separate pools for individual versus small group
    - States can merge individual and small group (DC, MA, VT)
  - Health risk differences by metal level selections is not allowed to be considered (fully pooled), but induced demand can be
  - Catastrophic plan participants are in a separate pool

Overall Price



Attractiveness of premium, which is driven by the other elements, plays a role

What is covered,

how cost is shared with enrollees,

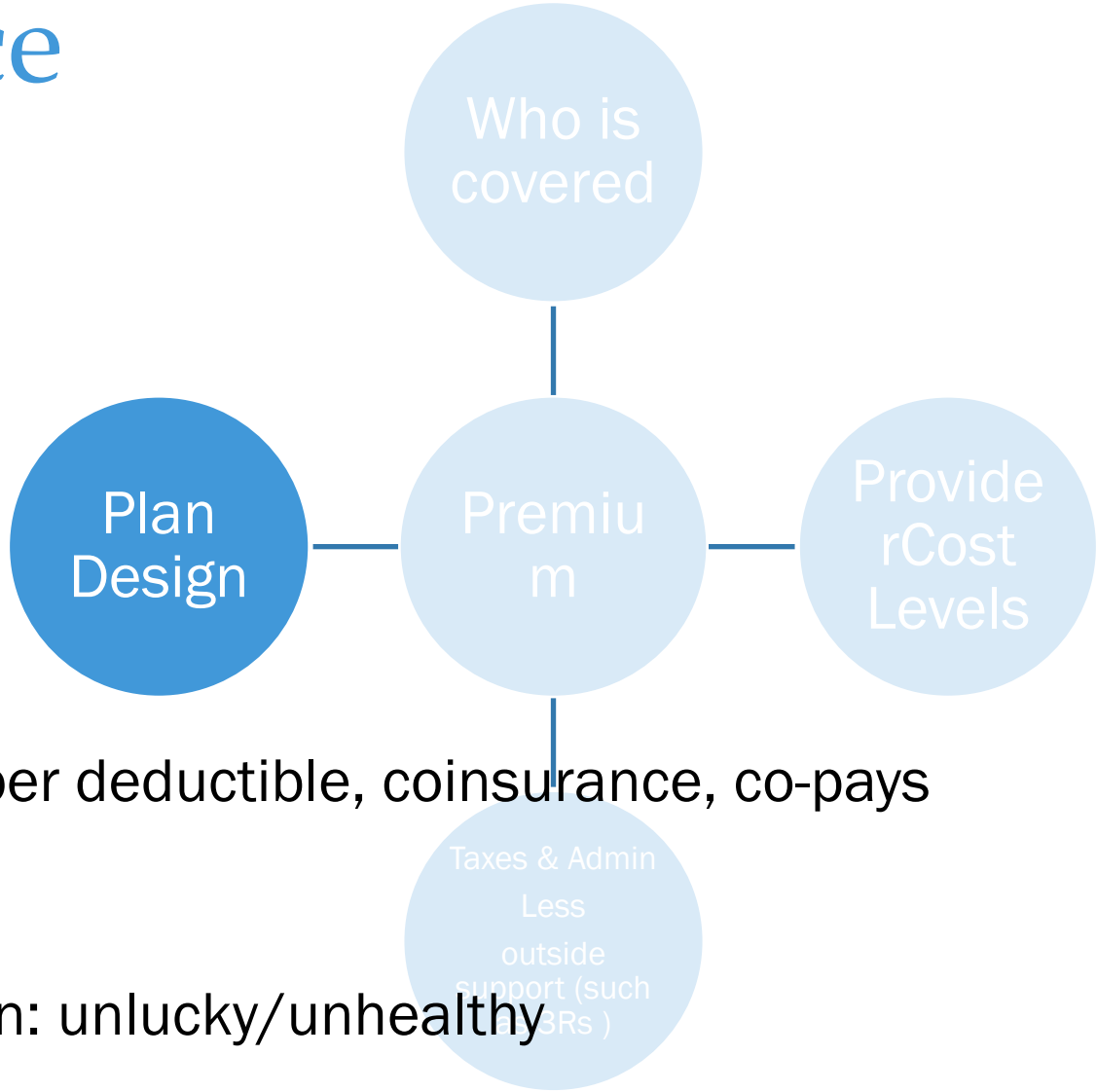
and medical management

Network decisions,

Costs for each service

State policy can support affordability

Overall Price



Premium or member deductible, coinsurance, co-pays

Burden: all burden: unlucky/unhealthy

Induced demand makes the higher premium/richer plan more expensive

Premium stabilization Programs

- 3Rs
  - Risk Adjustment - permanent
  - Reinsurance - temporary
  - Risk Corridor - temporary


Fair Health Insurance Premiums

- Adjusted community rating
  - 2014 and beyond: prohibited rating factors (Non-Grandfathered)
    - Health status / Medical history
    - Gender
    - Industry
    - Block of Business
  - Allowed rating factors (c
    - Minnesota age curve
      - Family policies
    - Tobacco use
    - Geography (9 regions in MN)
    - Network
    - Plan design (deducible, coinsurance, co-pay, OOP Max)

Pricing Considerations

- Different Populations
  - Uninsured – Estimating morbidity of entrants
  - High risk pool
  - For some individuals – based on income - very generous premium subsidies and even plan design subsidies paid for by the federal governm many went to MinnesotaCare
  - Pent up demand
  - 2015 nearly as blind as 2014 pricing
  - Guaranteed Availability
  - Expect earliest enrollment to be more anti-selective
  - Movements from group market – whether instigated by the employer or the individual

Taxes & Fees

- Mandate
  - Called mandate but Supreme Court decided that not having health insurance does not break the law – but a non-coercive penalty tax is fine
  - Fines individuals who do not obtain minimum essential coverage – began in 2014
  - Fines employers with 50+ full-time employees who do not provide affordable coverage with a minimum value – begins in 2015
- Health Insurance Exchange Fee
  - Used to fund Exchanges – begins in 2014
  - Roughly 3.5% of premium, but varies for State exchanges and non-profits pay less
  - Spread evenly throughout off an on exchange products, so generally less than 3.5%, but varies by carrier
    - At 20% use of MNsure, average burden is app. 20% x 3.5% = 0.7%

Taxes and Fees

- State premium tax/Medicaid surcharge
- Risk adjustment/reinsurance user fees
- Patient-Centered Comparative Effectiveness Research Fee (PCORI)
- Health Insurance Industry Fee
  - Begins in 2014
  - Globally budgeted – creating risk and unknowns for carriers
  - 1.5% - 3.0% of premium in 2014 and 2015, slightly higher thereafter
- Temporary reinsurance fees that help support the individual market

Effective Rate Review Program

- States must review all proposed rate increases of 10% or more
- CMS determines whether a State has an Effective Rate Review Program for both the Individual and Small Group Markets
- CMS reviews the State's law to determine if the State has an Effective Rate Review

Minnesota Very Unique

- MinnesotaCare (our Basic Health Plan)
  - Exchange use relatively lower than other states
  - No 87% and 94% CSR enrollees
  - Impact of uninsured on individual rates
  - Impact of high risk pool more acute, since less enrollees
- Largest high risk pool (MCHA)
- Unique guarantee renewability rules in the individual market
- Unique age curve (child factor = 0.890, not 0.635)
- Certain rating rules were close to the ACA beforehand (gender neutral rates, 3:1 age curve, tobacco rating)
- Large, competitive health systems in the metro area
- Highly-sought world class providers

Filings

- 2014 and 2015 filings are publicly visible on SERFF
  - Healthcare.gov already shows 2016 proposed rates over 10%
- 2016 filings will become public on October 1, 2016