Factors Affecting Individual Premium Rates in 2014 for California

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Covered California

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INTRODUCTION AND BACKGROUND

Covered California retained Milliman to evaluate the changes in individual health insurance premium rates that might be expected due to the implementation of the Patient Protection and Affordable Care Act (ACA) in 2014. This report presents factors attributable to the Affordable Care Act, and describes their expected impact on premium rates. This report also puts these changes in the context of the likely underlying medical cost trends.

Section 1 provides a broad overview of our analysis and results. Because the impact on rates varies dramatically depending on a consumer's status, such as whether they will or will not get a premium tax credit to reduce their costs or previously had insurance, we believe it is best to look at the impact on various subpopulations, as the results vary significantly. We have identified potential average changes for specific populations. Even these estimates, however, should be considered with the recognition that within each group the impact on individuals may vary dramatically and many individuals can take specific actions to reduce their premium costs by purchasing less expensive coverage.

Section 2 focuses on the varying impact of the Affordable Care Act on specific individuals in California, including not just the premium charged by insurers, but also the corresponding increase in insurance coverage. In an insured environment, the cost of healthcare to a consumer is divided between the premiums paid to an insurer and the cost sharing paid to providers at the point of service. Where possible, we identify whether factors increase total healthcare costs or increase premiums due to a decrease in cost sharing at the point of service or an increase in covered benefits. We also address the impact on individuals of other Affordable Care Act provisions, such as premium tax credits and cost sharing subsidies.

Section 3 discusses the specific factors affecting costs in 2014, with a focus on those that will affect premiums charged by insurers in 2014. This section is intended to provide a structure for Covered California, carriers, and other stakeholders to evaluate the key drivers of the individual market premiums in 2014, and to inform the design of a market structure and products that address these drivers to maximize the affordability of premiums while addressing the risk taken by insurers.

This report discusses how premiums will change in 2014 under the Affordable Care Act. Our estimates of the pre-Affordable Care Act individual insurance market assume no material change in carrier behavior in 2013 and that all current insureds and uninsureds make their 2014 insurance decisions on January 1, 2014, and hence are subject to the provisions of the Affordable Care Act for the entire year. Even if the assumptions used in our analysis were exactly realized, it is important to note that the actual premiums charged in 2014 will not depend on these estimates, or even actual 2014 costs. Instead, 2014 individual premiums in Covered California and, to a significant degree, premiums off the exchange for non-grandfathered individuals will be based on the carriers' premiums that are submitted to and negotiated with Covered California, and reviewed and approved by each carrier's regulator, either the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC). As a result, 2014 individual premiums will depend significantly on how carriers expect costs to change under the Affordable Care Act. Also, some carriers may price aggressively to gain market share, while others may add margin to account for uncertainty or their belief that the risk adjustment or reinsurance programs will not appropriately address the risks.

In acknowledgment of the carriers' primary role in setting 2014 premiums, and to invite input to aid our analysis, Covered California provided a preliminary draft of this report to the potential bidders for the open Qualified Health Plan procurement. Covered California also provided drafts to the CDI, the DMHC, the Center for Consumer Information and Insurance Oversight (CCIIO), and other key stakeholders. We received comments from several carriers. We also received informal comments from the Department of Managed Health Care and CCIIO, although nothing in this report should be interpreted as reflecting the position of these two regulators. In some cases, based entirely on the judgment of the authors of this report, we reflected comments from these draft recipients in the low, best, and high estimates in Section 2 of this report. In other cases, we documented the comments from the carriers in the text.

The intent of this report is not to estimate premiums, or a set of adjustments, that Covered California and carriers should rely on when setting or reviewing premiums for 2014. Similarly, the premiums and adjustment factors in this report are not intended for Covered California, the Department of Managed Healthcare, or the California Department of Insurance to deem as reasonable when reviewing 2014 rate filings. This report focuses on the individual market and does not consider the impact of the Affordable Care Act on the small group market.

SECTION 1: OVERVIEW OF INDIVIDUAL HEALTH INSURANCE PREMIUM RATE ESTIMATES

There are many factors that will impact premiums due to health care reform. This report identifies key factors and provides estimates based on a variety of sources. We have made distinct estimates of potential changes in premium for different parts of the population.

We categorize the expected changes in average premiums into four components. The first three affect the premiums charged by the carrier, and the fourth affect the member's contribution to these premiums.

Trend from 2013 to 2014: 9.0% average increase to premium

Premiums would have changed from 2013 to 2014 even in the absence of the Affordable Care Act. The primary source of this change is increases in provider reimbursement due to annual contract negotiations, increases in utilization due to new procedures and technology, and increases in prescription utilization and costs. Premium trends in the individual market are higher than the underlying trends in medical costs due to the leveraging effect of the relatively high cost sharing typical in individual policies. We assumed the average increase in premiums from 2013 to 2014, in the absence of the Affordable Care Act changes, to be 9.0%. In recent years, rates filed with the CDI and DHMC have increased by approximately 7-11% for individual insurance products. Absent the 2014 Affordable Care Act changes, we believe the market and regulatory forces that led to these trends would continue at similar levels in 2014.

Affordable Care Act Market Changes: 14.0% average increase to premiums

The influx of newly insured and the related Affordable Care Act provisions affect the overall premium requirements of the carriers and are spread out over all of the current and newly insured members. We estimate this amount to be 14.0%.

Buying More Coverage: 16.9% average increase to premium, offset by reductions to consumer out-of-pocket

Some of the expected increase in average premiums is due to an increase in the amount of insurance coverage purchased by the average insured person. This is a combination of buying coverage for newly covered services due to the Essential Health Benefits requirement, estimated as 4.8%, and a higher average Actuarial Value for existing covered services, estimated as 11.5%. In both cases, the increase in premium is due to post-Affordable Care Act insurance covering costs that would have previously paid out of pocket by the insured.

Premium Tax Credits and Cost Sharing Subsidies: Impact depends on income level

For consumers who are eligible for subsidies, they stand to see their premium decrease substantially. Because the federal subsidies are provided on a sliding scale, many individuals would have premium support that would allow them to pay no premium by choosing a less rich "bronze" plan or to have premium tax credits that allow them to purchase an enhanced silver plan with out-of-pocket cost sharing subsidies for the price of a silver plan. These figures do not reflect the potential actions that consumers can take to reduce their premium costs by choosing a less rich plan.

All of the figures that follow in Sections 2 and 3 reflect "best estimates" and for each the actual premium changes could be higher or lower, as is described in more detail in Section 3. In addition, consumers themselves will have the ability to moderate these potential premium impacts by their selection of plans and benefit designs.

Section 2 focuses on how the various factors affect specific individuals in California, including not just the premium charged by insurers, but also the corresponding increase in insurance coverage. In particular, we discuss how the average impact of a factor masks the wide range of premium changes for specific individuals. Section 2 also addresses the impact on individuals of other Affordable Care Act provisions such as subsidies.

Section 3 of this report provides discussion on each estimate, with a focus on the factors that carriers may reflect in their premium development. Given the high level of uncertainty associated with the 2014 Affordable Care Act provisions and how carriers, providers, and the current uninsured and insured populations will respond to those provisions, we also provide ranges for each estimate in the discussion portion of this report. These ranges were developed using sensitivity testing, and should not be used by regulators to evaluate rates submitted by health plans. It may be appropriate to revise these ranges based on input from interested parties, such as health plans and regulators.

SECTION 2: IMPACT ON INDIVIDUALS

Under the Affordable Care Act, health plans are able to charge different premiums with respect to age, geographic region, and metal level, where metal level is the new standard definition for the relative richness of health plans' cost sharing designs. Health plans will no longer be able to rate based on gender or health status. When reading this report, it is important to keep in mind that numbers shown are averages and do not suggest that these are the changes that will be experienced by all individuals.

Under the Affordable Care Act, all individuals who apply for insurance coverage will be offered coverage at a premium that does not consider their health status, and they can purchase leaner or richer plans at their individual choosing. Low income individuals can receive richer benefits through Covered California if they select a silver plan design that includes subsidized cost sharing. In addition, premiums will be subsidized through tax credits for individuals with incomes up to 400% of the federal poverty limit. This report focuses on the percent change in premiums resulting from the Affordable Care Act. This section puts this change in context by looking at the impact of the Affordable Care Act on the total out-of-pocket costs for the population assumed to buy non-grandfathered health insurance in 2014. We define the total out-of-pocket costs as the total of premiums paid by the individual plus any cost sharing by people with insurance, plus amounts paid to providers by people without insurance. We reduce the individual's out-of-pocket costs to reflect that federal premium tax credits will pay for a portion of the premium, and cost sharing subsidies will reduce out-of-pocket costs for individual members. We look at subgroups whose out-pocket costs will be affected in distinctly different ways by the ACA.

We do not have estimates of the premiums and coverage levels separately for current insureds under and over 400% FPL. For this illustration, we have assumed they are the same. In fact, those with lower income may be likely to have insurance with lower premiums and therefore lower levels of coverage. Similarly, we do not have estimates of the premiums and coverage levels separately for the newly insured in 2014 under and over 400% FPL. For this illustration, we have assumed they are the same.

The following two figures show how different types of individuals will be affected in 2014. For consumers, total cost of care is split into premiums and their cost at the time of care, also commonly referred to as out-of-pocket costs or member cost sharing. The two figures show the various factors that affect an individual's total cost of care. Some of the changes in 2014 affect premiums and other changes affect their cost at the time of care. We build up the changes to the premiums separately from the changes to the cost at time of care, and then composite the two factors together assuming that the starting premium reflects a 60% actuarial value plan design and a 20% administrative load.

While shown for specific segments of the population, these numbers reflect averages. A given individual's change in total cost of care depends on their starting insurance coverage and the choices they make when selecting their 2014 insurance coverage.

We also show how the changes in an individual's total cost of care differ by income level. Individuals with incomes lower than 250% of FPL will have federal premium tax credits to reduce their insurance premiums and will also have federal cost sharing subsidies to reduce their cost sharing. Because of these federal tax credits and subsidies, these individuals will pay very little in premiums and out of pocket spending. Individuals with incomes between 250% and 400% of FPL will have federal premium tax credits to reduce their insurance premiums, but will not have federal cost sharing subsidies to reduce their cost sharing. Because of these federal premium tax credits, these individuals will also experience a significant cost reduction. Individuals with incomes greater than 400% of FPL will not receive federal tax credits or subsidies. Individuals with incomes greater than 400% FPL who were previously insured will, on average, experience cost increases, but the previously uninsured will, on average, experience cost decreases compared to the premiums they would have paid in 2013.

Figure 1 shows how individuals currently insured in 2013 will be affected in 2014, separately by income levels. The premium changes identified in this figure tie to the numbers discussed in Section 3. Figure 1 shows that, on average, individuals with income less than 250% of FPL will experience a 76.2% decrease in their contribution to their total cost of care. Despite the factors that contribute to premium increases, especially the health status of the newly insured population, these individuals will experience an average premium rate decrease of 83.8% due to the federal premium tax credits. These individuals will also experience a 61.8% decrease in their member cost sharing, because they will purchase more coverage and receive federal cost sharing subsidies. To determine the aggregate impact on the

individual's total cost of care, we composite the premium change with the member cost sharing change by assuming that the starting premium reflects a 60% actuarial value plan design and a 20% administrative load.

As shown in Figure 1, currently insured individuals with incomes between 250% and 400% of FPL should also expect to see decreases in their total cost of care. Currently insured individuals with incomes greater than 400% of FPL will experience the largest increases.

Figure 1: Summary of Potential Rate Changes for People Currently Insured

		Less than 250% FPL	250% to 400% FPL	Greater than 400% FPL
Premiums				
	Trend from 2013 to 2014	9.0%	9.0%	9.0%
	Affordable Care Act market changes	14.0%	14.0%	14.0%
	Buying more coverage	22.2%	22.2%	4.8%
	Premium tax credits	-89.4%	-64.9%	0.0%
	Composite changes	-83.8%	-46.6%	30.1%
Cost at Time of Care				
	Trend from 2013 to 2014	9.0%	9.0%	9.0%
	Buying more coverage	-33.3%	-33.3%	-7.1%
	Cost sharing subsidies	-47.4%	0.0%	0.0%
	Composite changes	-61.8%	-27.3%	1.2%
Total Cost of Care				
	Composite changes	-76.2%	-39.9%	20.1%

The numbers shown in this table are consistent with our estimates used in Section 3. In particular, we assume that individuals with incomes less than 250% FPL select enhanced silver plans, between 250% and 400% FPL select silver plans, and greater than 400% select bronze plans. We assume that the average member in each of these income categories currently has a plan design similar to a bronze plan.

Total cost of care composite calculation assumes that the starting premium reflects a 60% actuarial value plan design.

In general, we expect the average currently insured to experience premium increases because they will be part of a new risk pool with a higher average health status. The federal premium tax credits and cost sharing subsidies will more than offset these increases for many low income individuals. Individuals may choose to purchase lower levels of coverage, which would also mitigate any premium increase. We expect that the average newly insured will be joining a risk pool with a lower average health status, resulting in a lower premium than they would have paid under 2013 market rules. Both benefit from other temporary Affordable Care Act market provisions designed to mitigate the impact of the new guaranteed issue requirements of the Affordable Care Act.

Figure 2 shows a hypothetical illustration of the impact of the Affordable Care Act on the newly insured population. Since the uninsured do not have current premiums to use as the baseline, we estimated hypothetical 2013 premiums, based on

2013 market rules that allowed carriers to charge higher premiums for individuals with higher expected costs due to their health status.

Figure 2 shows how individuals currently uninsured in 2013 will be affected in 2014, separately by income levels. We assume the split between insurance premiums and member cost sharing will be the same as the average plan design in the current individual market, but we adjust the amounts to reflect the expected health status of our projected new enrollment into the individual market. It is important to note that even though we show a hypothetical insured cost of care for these members, many individuals who are currently uninsured have applied for insurance coverage but have been denied or offered a premium that was more than they could afford. The following figure does not take into account this qualitative value to the current uninsured. Rather, it attempts to demonstrate that this segment of the market will benefit from pooling their risks with the currently insured individual market.

Figure 2: Summary of Hypothetical Rate Changes for People Currently Uninsured

		Less than 250% FPL	250% to 400% FPL	Greater than 400% FPL
Premiums				
	Trend from 2013 to 2014	9.0%	9.0%	9.0%
	Affordable Care Act market changes	-13.0%	-13.0%	-13.0%
	Buying more coverage	22.2%	22.2%	4.8%
	Premium tax credits showing portion of premiums paid by federal subsidies	-89.4%	-64.9%	0.0%
	Composite changes	-87.7%	-59.3%	-0.7%
Cost at Time of Care				
	Trend from 2013 to 2014	9.0%	9.0%	9.0%
	Buying more coverage	-33.3%	-33.3%	-7.1%
	Cost sharing subsidies	-47.4%	0.0%	0.0%
	Composite changes	-61.8%	-27.3%	1.2%
Total Cost of Care				
	Composite changes	-90.5%	-55.4%	0.0%

Figure 2 is similar to Figure 1, except it is for the currently uninsured population that is assumed to enter the individual market in 2014. Since the uninsured do not have current premiums to use as the baseline, we estimated hypothetical 2013 premiums, based on 2013 market rules that allowed carriers to charge higher premiums for individuals with higher expected costs due to their health status. Consistent with Figure 1, we assume that these uninsured individuals would have a 2013 plan design similar to a bronze plan.

We reflect the health status difference between the currently insured and newly insured in the row for the Affordable Care Act market changes. Other than the Affordable Care Act market changes factor, the remaining factors shown in this table are consistent with Figure 1.

Total cost of care composite calculation assumes that the starting premium reflects a 60% actuarial value plan design.

Percent change in premium

The percent change in premium is made up of four components. The fourth component, premium tax credits, does not affect the premiums charged by the carriers, but do affect the member's contribution to these premiums.

- Medical trend from 2013 to 2014
- Buying more coverage
- Affordable Care Act market changes
- Premium tax credits

The first three components are discussed earlier in this report. For the current insured, the value for Buying More Coverage reflects that current insureds have a variety of covered services, including some with limited coverage for prescription drugs. In 2014, all will have coverage for all Essential Health Benefits, which are broader than most current policies. Buying more coverage also reflects our estimate that the average insured will have lower cost sharing, and a higher Actuarial Value, in 2014. This decrease in the required cost sharing for a policy produces a direct increase in the required premium. The increase is larger for the portion of the individuals eligible for premium tax credits that are also eligible for cost sharing subsidies. These individuals can pay the premium for a 70% AV plan and get coverage of 73%, 87%, or 94%, depending on their income. The Affordable Care Act Market Changes are assumed to have the same impact on both types of currently insureds.

Premium tax credits

The premium tax credits will affect a significant portion of the members in the individual market. Many individuals who currently have insurance in the individual market will be able to purchase higher levels of insurance or retain their current level of insurance for a lower monthly cost, since their coverage will be subsidized by federal dollars. Similarly, many currently uninsured individuals will be able to afford insurance coverage in the post-Affordable Care Act individual market.

Our understanding is that premium tax credits are only available to members who purchase their insurance through the Exchange. In our population modeling, a small number of low income members choose to purchase their coverage off the Exchange. We have not estimated any premium tax credits for these individuals purchasing their coverage off of Covered California.

The premium tax credits are calculated based on the second lowest cost silver plan and the individual's income. The tax credits can be used for any of the metal levels. The credits will pay for a larger percentage of the bronze premiums or a smaller percentage of the gold or platinum premiums. Individuals have a strong financial incentive to select the silver plan, because it also maximizes the cost sharing subsidies, discussed in the next section. We relied on federal guidance[1] to estimate the premium tax credits.

Out-of-pocket reductions

Under the Affordable Care Act, members will be required to purchase insurance that covers all Essential Health Benefits and corresponds to one of the four metal levels, with the exception of the catastrophic plan and grandfathered plans offered off of Covered California. For some individuals, this means they will have to purchase higher levels of insurance, both newly covered services and lower cost sharing, but the tradeoff is reduced costs at the point of service.

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[1] Table on page 50944 of http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf

Members will have reduced out-of-pocket expenses at the point of service for two reasons:

- Buying more coverage
- Cost sharing subsidies

The first item, buying more coverage, is the same item discussed in the report. Individuals will have to purchase a plan that covers Essential Health Benefits and is at least as rich as a bronze plan, with the exception of the catastrophic plan. As a result of buying more coverage, on average, members will pay less at the point of service. Note, however, that while all members will have to pay similar premiums, the amount of costs sharing at the point of service depends on each individual's utilization of healthcare.

The cost sharing subsidies in the post-Affordable Care Act market affect individuals up to 250% of the federal poverty level. Members with incomes less than 150% of federal poverty level can purchase a 94% actuarial value plan for the price of a silver plan. Members with incomes between 151% and 200% of the federal poverty level can purchase an 87% actuarial value plan for the price of a silver plan. Members between 201% and 250% can purchase a 73% actuarial value plan for the price of a silver plan. These plans are called enhanced silver plans.

For our example, we assume that each individual in our population modeling that is eligible for an enhanced silver plan will select this enhanced silver plan. An individual has to purchase a silver plan in order to receive these cost sharing subsidies. According to the distribution of membership projected in our population modeling, 2.3 million individuals are eligible for the cost sharing subsidies.

Age Rating Changes

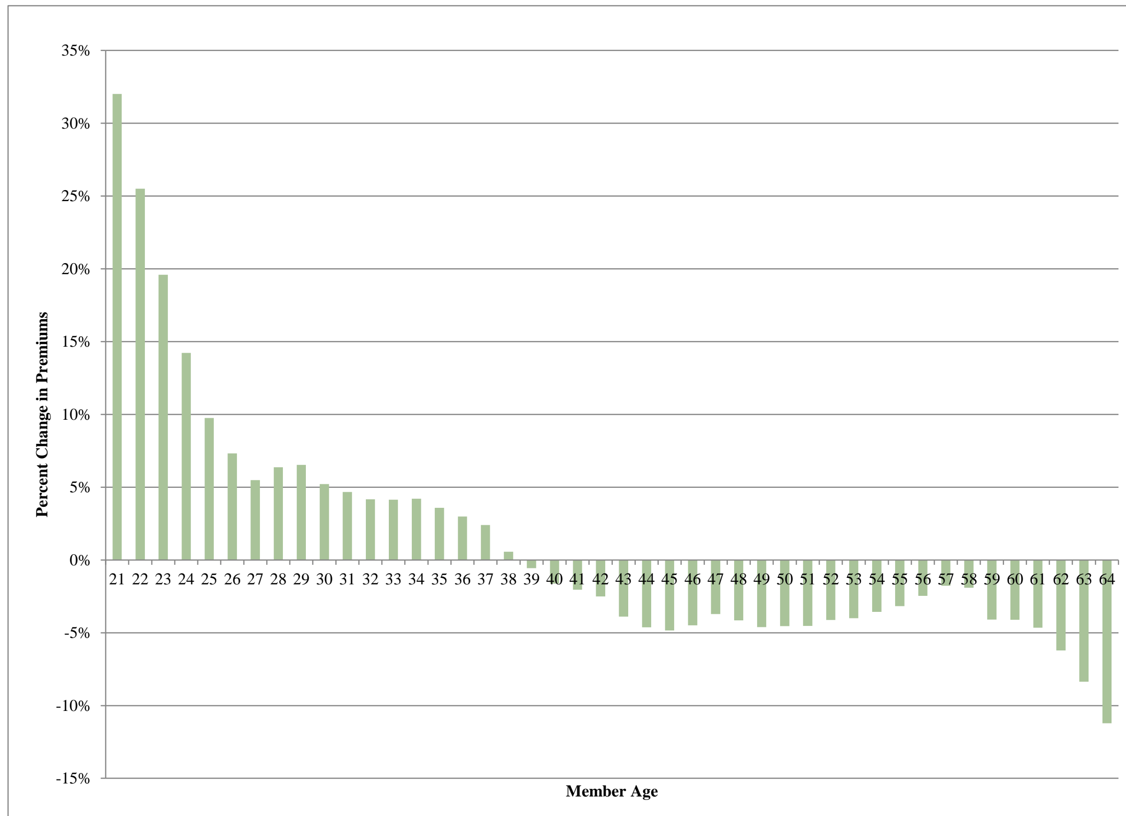
The Affordable Care Act requires that premium rates vary by age by no more than a 3:1 relationship between the age 64 rate and the age 21 rate. Regulations took this one step further by requiring all carriers to use a single set of factors published by CCIIO. These factors follow the 3:1 rule for adults and define a consistent factor for children. The impact of this restriction on average premiums is discussed in the Demographic Age/Health Status Adjustment section of Section 3. Figure 3 below shows the estimated percent change in single premiums due solely to the change from the current age bands to the CMS proposed 3:1 age curve. Younger members will experience a higher percentage premium increase, while older members will experience a decrease due solely to the change in age rating rules. This chart only shows the impact of changing the age curve; it does not factor in any of the other Affordable Care Act changes discussed in this report.

Figure 3 assumes that we enroll the same mix of members by age, and have the same average Exchange premium. For the pre-Affordable Care Act rates, we use age factors from the Milliman Health Cost Guidelines. These factors actually reflect approximately a 4.5:1 relationship between the premium rates for a 64 year old and a 21 year old.

Figure 3 details the average potential impact on rates for individuals because of the change in rating based on a consumer's age. This chart does not reflect additional market changes implemented by the Affordable Care Act that will significantly moderate the impact of premium changes for younger Californians. These include:

- Many younger Californians will be eligible for subsidies;
- The Affordable Care Act makes specific provisions for a lower cost "catastrophic plan" that would only be available to consumers under 30 years old and would reduce premium costs while providing coverage in the event an individual had a catastrophic illness or accident.

Figure 3: Premium Impact Due to Moving to 3:1 HHS Age Curve from Typical Current California Health Plan Age Curve



Low Income Premium and Cost Sharing Subsidies

Though the premiums in the Exchange may seem higher than current individual premiums, a large portion of the population will receive advance premium tax credits subsidizing their out of pocket premium costs. The Health Reform Subsidy Calculator[2] on the Kaiser Family Foundation website shows the actual premiums that members at different income levels may pay, net of these government subsidies. Figure 4 below shows the estimated monthly member contributions to a silver plan premium for a 40-year-old enrollee at various income levels. This assumes a total unsubsidized premium of $450.

[2] http://healthreform.kff.org/subsidycalculator.aspx

Figure 4: Estimated Monthly Premiums for Silver Plan after Advance Premium Tax Credits

Income Level	Maximum % of Income to Pay for Premiums	Member Contribution to Single Premium	Federal Contribution to Single Premium	% of Premium Covered by Federal Subsidy
150% FPL	4.00%	$57.50	$392.50	87%
175% FPL	5.15%	$86.42	$363.58	81%
200% FPL	6.30%	$120.83	$329.17	73%
300% FPL	9.50%	$273.25	$176.75	39%
400% FPL	9.50%	$364.33	$85.67	19%
500% FPL	None	$450.00	$0.00	0%

Figure 4 shows the federal subsidies for silver plans. If those subsidy eligible individuals selected a bronze plan instead, they would receive the same federal contribution calculated in Figure 4, but this would be applied to the lower bronze premium. As a result, the percentage of premium covered by the federal subsidy will be even higher if the member selects the bronze plan. Figure 5 shows the federal contribution to the bronze premium, assuming bronze premiums are equal to 60% ÷ 70% of the estimated $450 silver premium.

Figure 5: Estimated Monthly Premiums for Bronze Plan after Advance Premium Tax Credits

Income Level	Estimated Bronze Premium	Federal Contribution to Single Premium	Member Contribution to Single Premium	% of Premium Covered by Federal Subsidy
150% FPL	$385.71	$385.71	$0.00	100%
175% FPL	$385.71	$363.58	$22.13	94%
200% FPL	$385.71	$329.17	$56.54	85%
300% FPL	$385.71	$176.75	$208.96	46%
400% FPL	$385.71	$85.67	$300.04	22%
500% FPL	$385.71	$0.00	$385.71	0%

Note:

The federal contribution to the single premium at 150% FPL is equal to the single premium amount. This is because the federal contribution to the single premium is capped at the cost of the single premium.

The percentage increases shown in the remainder of this report are based on total premiums, and have not been reduced as a result of the income-based premium tax credits.

Regional Differences

Health care costs vary by region in California. As discussed in the previous section, our best estimate of the change in premiums attributable to trend and the Affordable Care Act market changes is 26.6%. This 26.6% premium increase translates into different dollar amounts in different regions. Our analysis is based on average health care costs for the state of California. Figure 6 below shows the dollar change in monthly premium for regions with health costs 15% lower than the average and regions with health costs 15% higher than the average. The ±15% is based on observed filed rate variations around California.

Figure 6: Potential Regional Differences in Premiums due to Affordable Care Act Market Changes

	Low (85% of Average Premium)	Average Premium	High (115% of Average Premium)
2013 Monthly Premiums	$267	$314	$361
Percent Change in Premium due to Trend and Affordable Care Act Market Changes	26.6%	26.6%	26.6%
2014 Post-Affordable Care Act Monthly Premiums	$337	$397	$456
Dollar Change in PMPM Premiums	$70	$83	$95

This table suggests that if premiums range from 85% to 115% of the average premiums, the increase in average premiums PMPM ranges from $70 to $95.

The regional rating differential exists for a variety of reasons, including differences in covered benefits, provider practice patterns, provider reimbursement levels, and existing patient resources by region. The ±15% regional rating differential is based on current observed rate filings around California. This variation may increase or decrease in future years as regions are redefined and provider contracting is modified.

SECTION 3: DISCUSSION OF FACTORS ATTRIBUTABLE TO CHANGES FROM THE AFFORDABLE CARE ACT

We estimate the increase in individual health insurance premiums due to the implementation of 2014 Affordable Care Act provisions by starting with estimates of 2013 premiums without these provisions, and then making the adjustments described in this section.

The percent change in premium is made up of four components. The three components shown in Figures 7 – 9 affect the premiums charged by the carrier, and are discussed in detail in Section 3. The fourth component, premium tax credits, does not affect the premiums charged by the carriers, but do affect the member's contribution to these premiums. We include these in Figure 10.

The results of our analysis are summarized in Figures 7 – 10. Figure 7 shows our estimate of the premium trend from 2013 to 2014 that would have occurred in the absence of the Affordable Care Act. Figure 8 shows our best estimates for premium adjustments attributable to Affordable Care Act market changes. Figure 9 shows our best estimates for premium adjustments attributable to buying more coverage. Figure 10 summarizes the results of Figures 7 - 10. We also show an estimated range for each factor. More detail about each of the factors is provided in the remainder of this section.

Figure 7: Premium Rate Trend from 2013 to 2014

Trend from 2013 to 2014	Low	Best Estimate	High
Trend	7%	9%	11%

Figure 8: Premium Rate Adjustments due to Affordable Care Market Changes

Affordable Care Act Market Changes	Low	Best Estimate	High
Health Status	15%	26.5%	40%
Provider Contracting Changes	-9.0%	-6.0%	1.0%
Benefit Coverage Adverse Selection	1.0%	1.9%	2.9%
Cost Sharing Induced Utilization	3.7%	4.1%	5.0%
Reinsurance Protection	-12.0%	-9.1%	-8.0%
Increased Taxes and Fees	2.3%	4.1%	7.2%
Pent-up Demand	0.0%	2.1%	2.2%
Change in Administrative Expenses	-7.0%	-4.5%	0.0%
Composite – Affordable Care Act Market Changes	See note.	14.0%	See note.
Note:			
Some of these factors are not independent, so the reader should use judgment in using these factors to estimate the low or high composite values.			

Figure 9: Impact on Average Premium due to Buying More Coverage

Buying More Coverage	Low	Best Estimate	High
Covered Benefits	3.5%	4.8%	6.5%
Change in Actuarial Value	8.7%	11.5%	16.9%
Composite – Buying More Coverage	12.5%	16.9%	24.5%

Note:

(1) Buying more coverage can also be defined as reducing the cost at time of care.

(2) The change in Actuarial Value is partially offset by the reduction in the member cost at time of care.

(3) Individuals can choose what level of coverage they would like to purchase, so the change in Actuarial Value depends on consumer choice. If a member already has a bronze plan, they are not required to purchase any higher levels of coverage, and so will have a change in Actuarial Value of 0%.

Figure 10: Summary of Percent Changes in Average Premium, 2014 versus 2013

Percent Change in Premiums	Low	Best Estimate	High
Trend	7%	9%	11%
Affordable Care Act Market Changes	See note (2).	14.0%	See note (2).
Buying More Coverage	12.5%	16.9%	24.5%
Premium Tax Credits			
Income less than 250% FPL	See note (4).	-89.4%	See note (4).
Income between 250% and 400% FPL	See note (4).	-64.9%	See note (4).
Income greater than 400% FPL	0.0%	0.0%	0.0%

Notes:

(1) The percent change shown applies to the premium costs prior to the federal subsidies. The estimated subsidies for subsidy eligible individuals are shown in Figure 3.

(2) Some of these factors are not independent, so the reader should use judgment in using these factors to estimate the low or high composite values.

(3) As discussed in Section 2, many individuals are eligible for federal premium tax credits and cost sharing subsidies. To the extent that the federal government subsidizes the premiums, members will experience decreases in their contribution to the premiums. More detail is provided in Figure 1.

(4) An individiual's premium tax credit as a percentage of their premium depends on the individual's income level and their choice of metalic plan. Our best estimate reflects the mix of membership by income level from our population modeling, and a silver plan. We do not show a range because of how much this factor depends on an individual's circumstances.

Premium Rate Trend from 2013 to 2014

Premiums would have changed from 2013 to 2014 even in the absence of the Affordable Care Act. The primary source of this change is increases in provider reimbursement due to annual contract negotiations, increases in utilization due to new procedures and technology, and increases in prescription utilization and costs. Premium trends in the individual market are higher than the underlying trends in medical costs due to the leveraging effect of the relatively high cost sharing typical in individual policies. We assumed the average increase in premium from 2013 to 2014, in the absence of the Affordable Care Act changes, to be 9%.

Demographic Age/Health Status Adjustment

The 2014 individual market demographics will exhibit differences in the distribution of age, gender, and health status when compared to the distributions of these characteristics prior to the implementation of the Affordable Care Act. The influx of high-risk participants from the Managed Risk Medical Insurance Program (MRMIP), the Pre-existing Condition Insurance Program (PCIP), and the AIDS Drug Assistance Program (ADAP), as well as individuals previously unable to obtain insurance due to existing conditions or high premium costs will be partially offset by the influx of low-risk enrollees choosing to obtain health insurance for the first time. Some of these high-risk participants may go into Medi-Cal with the Medicaid expansion.

The Milliman / Society of Actuaries (SOA) report suggests that the utilization and health status of members in the individual market varies widely between states prior to the implementation of the Affordable Care Act.[3] These differences are largely due to the variation in regulatory environment between states. Individual market average health status cost relativities range from 0.806 for "Least Restrictive" states to 1.231 for "Most Restrictive" states. This wide variation demonstrates that under the guaranteed issue provision of the Affordable Care Act, there is a significant potential for demographic adjustments to affect utilization and premiums.

Underwriting regulations that allow carriers to consider an applicant's health status when deciding to offer coverage or setting premiums tend to result in an individual insured population that is healthier than the average population. Under both CDI and DMHC regulation, carriers can gather information about an applicant's medical history. Based on that information, carriers can:

- Offer the applicant a policy at the Standard premium rates filed with the State. Standard rates are allowed to vary by age, family size, and region.
- Offer the applicant a policy at a multiple of the Standard premium rate, where the multiple is based on actuarially determined factors that reflect the expected cost impact of the applicant's medical history.
- Decline to issue a policy to the applicant, based on actuarially determined factors that reflect the expected cost impact of the applicant's medical history.

This type of underwriting for the individual market falls into the "Least Restrictive" category in the Milliman / Society of Actuaries study. States with less restrictive underwriting laws allow carriers more flexibility in underwriting, and so will have larger changes in health status due to the 2014 provisions of the Affordable Care Act. Since individuals are only underwritten in the first year they obtain coverage, there is an effect called underwriting wear-off, where the health status of the underwritten population tends toward the health status of the average population over time. For this reason, the duration of the currently insured populations should be taken into consideration when applying this underwriting restriction factor.

The Affordable Care Act requires that premium rates vary by age by no more than a 3:1 relationship between the age 64 rate and the age 21 rate. Regulations took this one step further by requiring all carriers to use a single set of factors published by CCIIO. These factors follow the 3:1 rule for adults and define a consistent factor for children. We include the impact of this provision in both of the Age Factor and Health Status Factor, Not Explained by Age. The effect of this provision, holding other factors constant, will be that younger members will experience a higher percentage premium

[3] http://www.soa.org/files/research/projects/research-health-aca-risk-mitigation.pdf

increase, while older members will experience a decrease due solely to the change in age rating rules. This will cause relatively more young members to drop coverage and relatively more old members to retain or add coverage.

We use the term "health status" to refer to the total claims costs of enrollees. Often the terms "allowed costs" or "morbidity" are used interchangeably. If a member self-identifies as being in "Excellent" health status, we expect that their claims costs will be lower than a member who self-identifies as being in "Poor" health status.

We believe this adjustment is the one with the most uncertainty, since no one knows for sure who will participate in the individual market post-Affordable Care Act, even with the individual mandate. For this reason, we suggest considering other sources of information, including carrier-specific data, when assessing the potential health status factor. Other sources are discussed below. We used a Milliman population model for our best estimate of the health status factor, shown in the table below. The population model uses membership sources to populate pre-Affordable Care Act membership by market segment, age and gender, income level, self-reported health status, and family size. The model shifts the population among the market segments based on take-up rates and summarizes risk scores for each market pre- and post-reform to determine the change in morbidity. The risk scores are developed by assigning Milliman Advanced Risk Adjusters (MARA) scores to MarketScan experience, and then mapping into five health status categories based on 2012 census data.[4]

Figure 11 shows ranges of health status factors. Our best estimate uses Milliman's population model with external sources to determine the health status factor of the high risk pools. The low end of the range shown in Figure 11 assumes a disproportionately higher proportion of enrollment for uninsureds with premium subsidies, and a higher proportion of current insureds in the individual market retaining their coverage despite premium insurances, based on the past evidence of the value they place in having health insurance. The high end of the range shown in Figure 11 is based on a review of the reports for other states, discussed below, and a review of alternative models by Milliman and other sources for the California market. As with all ranges in this report, it is possible that the actual result could fall outside this range.

Figure 11: Estimated Premium Impact Due to Change Health Status Factor

	Low	Best Estimate	High
Health Status Factor	15%	26.5%	40%

The increase in the average premium resulting from the change in age mix may not affect the needed premium for an individual, but will shift the average premium because the mix of people buying insurance will change. Under our population modeling, the change in the age mix is estimated to increase average premiums by 0.1%. This increase is included in the estimates of the health status factors in Figure 11. For example, our best estimate is that average premiums will increase by 0.1% due to the increased average age of the 2014 individual market, and 26.4% due to the increased average health status not explained by age. Note that factors are multiplicative, not additive.

We expect that the merger of the high risk pools with the individual market will have a significant impact on the average health status of the individual market. The Managed Risk Medical Insurance Board (MRMIB) manages two of these programs, the Managed Risk Medical Insurance Pool (MRMIP) and the Pre-Existing Condition Insurance Pool (PCIP). While there are differences in benefits, premiums, and eligibility requirements for these programs, both programs aim to provide affordable health care coverage to Californians with pre-existing medical conditions. As of July 2012, there were 5,957 members enrolled in the MRMIP.[5] As of August of 2012, there were 13,255 members enrolled in the PCIP program.[6] The California Department of Public Health estimates that there will be 39,146 members enrolled in the AIDS Drug Assistance Program (ADAP) in fiscal year 2013. Of these ADAP members, 7,667 have some private insurance

[4] http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[5] http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_071812/Agenda_Item_10_a_MRMIP_Board_Report_Summary_for_June_2012.pdf

[6] http://www.pcip.ca.gov/pcip_program/pcip_mrmip_comparison.aspx

coverage and 10,249 have Medi-Cal or Medicare coverage.[7] We assumed 80% of these high risk pool members would enter the individual market.

COBRA, Conversion, and Guaranteed Issue HIPAA

Our model includes the effect of persons entering the individual market who previously would have been covered under a COBRA or Cal-COBRA policy. These individuals are thought to make up less than 1% of total group membership, but if all future COBRA members moved to the individual market, they could represent a more material percentage. Health costs for these individuals are generally twice the health costs of the average large group commercial member. This is the result of adverse selection, since COBRA premiums are equal to 102% of the total employer cost, so only former employers with ongoing health issues tend to purchase coverage. This selection may decrease if the individual market becomes the primary source for terminating employees losing employer coverage. Healthier employees that currently decline COBRA benefits between jobs will be more likely to purchase individual insurance, especially if they are eligible for subsidies on Covered California. Since COBRA rates charged by employer group plans do not vary by age, retaining COBRA coverage may continue to be attractive for older individuals.

Our model assumes that conversion policies and HIPAA policies are included in our estimates of the baseline individual premiums.

The health status estimates for the 2014 individual insurance market include the grandfathered population for both pre- and post-ACA. We were not able to identify a reliable source to identify the number of currently grandfathered insureds and their health status relative to the entire market. Nor were we aware of a credible methodology to estimate the number of current grandfathered insureds that drop those policies and enroll in non-grandfathered plans in 2014. A closer analysis of this issue might have affected the results of this report.

Relationship of Individual to Large Group Market

One way to assess the current and future health status of the individual market is relative to the health status of the current large group market. The large group market is similar to the ACA individual market because new insureds are not underwritten in either market. The effect of selection on the ACA individual market is more transparent, but is also part of the large group market to the extent that employees that have health issues, or dependents with health issues, may be more likely to stay in existing jobs, or seek jobs from large employers, in order to have health insurance.

The Excel file accompanying the Optum/SoA Report estimated that the current California individual market health costs were about 50% of the current large group (100 + employee) market health costs. Carriers commenting on a previous draft of this report provided estimates of this value from 75-85%. This percentage will vary from carrier to carrier for a variety of reasons, including their underwriting methods, the average duration of their individual policies, the effect of "underwriting wear-off," the methods used to calculate the health status of the two populations, and the treatment of current grandfathered and guaranteed issue policies in the calculation.

The population model used for this report estimates a current average health status in the individual market that is approximately 85-90% of the average large group health status.

Other Data Sources

Given the uncertainty associated with 2014 enrollment and health status/morbidity estimates, insurance carriers should review all available pubic analyses, and perform their own analysis, when setting their premium assumptions. Commenters on this report noted the following available reports:

[7] http://www.cdph.ca.gov/programs/aids/Documents/OAADAPFY2012_13NovEstPkg.pdf

Research Report	State	Morbidity Change Best Estimate
Wakely Consulting Group Actuarial Analysis: Impact of the Affordable Care Act on Small Group and Individual Market Premiums in Oregon[8]	Oregon	15% (ranging from 10-25%)
Milliman Individual and Small Group Premium Changes Under the ACA in Indiana[9]	Indiana	Impact of high risk pool is 35-45%
Milliman Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange[10]	Ohio	35-40%
Gorman Actuarial Nevada Health Insurance Market Study[11]	Nevada	11-30%
Optum/Society of Actuaries Cost of the Future Newly Insured under the Affordable Care Act	California Nationwide	61.6% 31.5%

Of the studies listed in this table, only the March 2013 Optum/Society of Actuaries Report (Optum/SoA Report) provided an estimate of the health status change for California. The Optum/SOA report estimated the effect of the Affordable Care Act on the average morbidity for each state's individual insurance market. It used simulation models similar to those used for this report and other industry studies of this issue. Their estimate of "morbidity" corresponds to the "health status" impact measured in this report. The Optum/SoA Report estimated an increase in morbidity for California of 61.6%. All studies of this type involve a large number of interdependent methods and assumptions, so it is difficult, and potentially misleading, to isolate the sources of differences between the two models. However, we noted several differences:

- The Optum/SoA Report states "Although the costs shown in the tables are at projected 2014 levels, the actual enrollment and percentage increases in costs reflect an "ultimate" or steady-state" environment, which we assume corresponds to about 2016 or 2017."[12] Our analysis focused on the 2014 market.
- The Optum/SoA Report attributes about 10% of the 61.6% increase to large employers with higher than average healthcare costs dropping insurance coverage, and a disproportionally expensive subset of their employees purchasing individual insurance. The report notes that their assumptions reflect "steady-state" enrollment after three years of exchange operations. While large employers may explore this alternative over time, we do not see evidence that this will be a material issue in 2014.
- The Excel file accompanying the Optum/SoA Report estimated that the morbidity (health status) of the current California individual market was about 50% of the current large group (100 + employee) market. This is a significantly lower starting point than we have used in our work and observed in other models. This issue is discussed further below above.

[8] http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf

[9] http://www.in.gov/aca/files/Individual_SmallPremium_Increases.pdf

[10] http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf

[11] http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Reports/Nevada%20Health%20Insurance%20Market%20StudyGormanActuarialLLC.pdf

[12] http://cdn-files.soa.org/web/research-cost-aca-report.pdf

It is important to note that except for the Optum/SoA Report, these reports pertain to other states, and the impact of the ACA can vary significantly by state. Also, these and other similar reports do not always break out the health status impact from other impacts in the same way.

Provider Contracting Changes

The Affordable Care Act may affect incurred medical costs in 2014 by changing the average provider unit costs for the individual market.

Figure 12: Estimated Premium Impact Due to Provider Contracting Changes

Low	Best Estimate	High
-9%	-6%	1%

Our best estimate of the effect of provider contracting changes assumes that 20% of the Exchange population will be low income members that enroll in an Qualified Health Plan sponsored by a current Medi-Cal carrier that will reimburse providers at somewhere between current Medi-Cal and commercial levels. This would be consistent with the Bridge Plans that are currently being discussed.

Our best estimate also includes some savings from narrow network plan designs. According to the "Managed Care and Providers Wrap-Up" from the January 2013 J.P. Morgan Health Conference, carriers are expecting to offer narrow network plans with hospital contracts that are 10-15% lower than current commercial rates.[13] Milliman does not have independent knowledge of the likelihood or prevalence of this type of hospital contracting, or whether similar results will apply to physician contracting. The best estimate assumes that narrow network plans could reduce premiums by 8% for 40% of the enrollment.

Our lower estimate is a 9% reduction in premiums, and assumes a higher percentage of savings through narrow network plan designs. The upper end of the range assumes that Affordable Care Act related provider contracting changes may be gradual over time, and that 2014 rates will be affected by the limited supply of providers and the increased demand for medical services.

In the remainder of this section we discuss the possible ways in which the Affordable Care Act could affect average provider reimbursement in 2014.

The Affordable Care Act has the potential to reduce the costs for commercially funded health services by reducing the impact of "cost shifting." Providers currently argue that they are underpaid for Medicare and Medi-Cal patients, and not paid for uninsured patients. In order to cover their costs and achieve target total revenue, the only reimbursement rates that the providers can negotiate are for commercial members. If providers believe that their revenue for services provided to Medi-Cal and for currently uninsured patients will increase in 2014, they may be willing to accept lower reimbursement for commercial patients, or possibly just for Exchange patients. It is possible that they will take a wait-and-see approach, and wait until 2015 to assess the impact of the Affordable Care Act on their revenue for services provided to Medi-Cal and currently uninsured patients.

It is possible that Local Initiative plans and other current Medi-Cal managed care plans will submit Qualified Health Plan bids to Covered California. These types of health plans currently provide safety net coverage to the Medicaid and low income populations in their counties, and tend to reimburse providers at levels comparable to Medi-Cal. The entry of these plans into the individual market could reduce average premiums by having provider reimbursement significantly lower than typical commercial reimbursement. Plans will need to negotiate new payment terms with their providers. It is unlikely that providers will accept Medi-Cal rates for commercial plans, though these plans may be able to negotiate rates

[13] Justin Lake, Andrew Valen, Michael Newshel, J.P. Morgan Securities LLC, "Managed Care and Providers Wrap-Up," J.P. Morgan Health Conference, (January 2013).

that are lower than current commercial rates. Note that this would bring down the average premium by introducing new insurers with a lower cost basis, not by bringing down the premiums for all existing carriers.

We have not reflected this factor in our analysis. Estimating this impact would require at least the following assumptions:

- How many of these new health plans will be available?
- How will these plans determine their premium rates?
- What percentage of Covered California participants elect these plans? Will enrollees in these plans be limited to people that are currently lower income and uninsured?
- Do these plans have sufficient provider capacity to add new members? If not, will the cost for services in an expanded network be higher than their current costs?
- How much of a reduction below current commercial rates will Exchange plans be able to negotiate with providers?

The plan designs offered on the Individual market, both Covered California and non-Covered California, must fit one of the Affordable Care Act metallic levels. To meet the bronze, silver, and gold levels, plans must have actuarial values of 60%, 70%, and 80%, respectively, with a ±2% allowed variance in each level. These actuarial values are likely not achievable unless the plan's cost sharing includes some combination of deductible and coinsurance. This type of cost sharing does not fit well with provider capitation. In several regions of California, physician capitation is thought to be a cost effective way for health plans to pay physicians. The inability of these higher cost sharing plans to finance care through capitation may increase the premiums. However, much of the current individual market is already in high deductible plans, so the relative impact may not be significant.

Benefit Coverage Adverse Selection

When members are presented with the opportunity to choose between metal levels in Covered California, sicker people will tend to choose higher metallic plans, ignoring the impact of subsidies. By definition, this means healthier people will choose lower metal plans. The Affordable Care Act requires that a carrier's premiums for each metallic tier reflect only the actuarial value relativities between metal levels, and not the impact of adverse selection. This requirement was confirmed in the final regulation on Market Rules. As a result, carriers must increase their entire premium rate structure to account for this type of adverse selection.

The need for this adjustment can be illustrated by viewing the metallic plans as a bronze base plan with riders in increments of 10% to increase the base plan up to silver, gold, and platinum. All insureds will purchase at least the bronze plan. Each of these plans covers 60% of an insured's health costs. The total premium required is the amount needed to pay 60% of all the expected individual market costs in 2014. For simplicity, let's assume this premium is $600 per person per month.

Some individuals will choose to buy additional coverage in the form of riders. For example, an individual could buy a 10% rider that would bring their total coverage up to 70%. If we knew that everyone was going to buy this rider, the required premium would be $100. We know that a $600 monthly premium is enough to cover 60% of gross health costs for all Exchange members, so one-sixth of that, $100, would cover another 10%.

The problem is that a disproportionate number of sicker individuals will voluntarily choose to buy additional coverage. If, for example, the average person that bought this silver rider was 20% sicker than average, the premium for the rider would have to be $120 to be sufficient to cover the additional costs. We call this benefit coverage selection. The Affordable Care Act does not allow carriers to charge more than $100 for this rider. To avoid losing money, the carrier would have to raise its premiums for all metallic levels, including bronze, by a small percentage, to cover these excess costs.

We estimated the impact of benefit coverage adverse selection by assuming that half of the Exchange members with self-reported "Poor" or "Fair" health status will choose the gold plan and all other members choose a plan with an average actuarial value similar to a bronze level plan, resulting in a 1.9% impact on the medical portion of the health premium.

The estimated impact shown does not take into account any adverse selection already reflected in current premiums, and should be interpreted as 1.9% additional selection in 2014.

Figure 13: Estimated Premium Impact Due to Benefit Coverage Adverse Selection

Low	Best Estimate	High
1.0%	1.9%	2.9%

We developed a low estimate by assuming that 25% of the members with self-reported “Poor” or “Fair” health status will choose the gold plan and all other members choose a plan with an average actuarial value similar to a bronze level plan. This results in an adjustment factor of 1.0%. For the high end, we assume that 75% of the members with self-reported “Poor” or “Fair” health status will chose the gold plan and all other members choose a plan with an average actuarial value similar to a bronze level plan. This results in an adjustment factor of 2.9%.

Cost Sharing Induced Utilization

Many plans will be required to change their cost sharing in 2014 due to the requirement that all plans provide an actuarial value of at least 60%, with the exception of the catastrophic plan. Current national and state surveys suggest that the average individual market plan offers an actuarial value of 55% - 60%, with many plans falling well below the 60% threshold.[14,15,16]

Consumers tend to utilize higher levels of care when their cost sharing at the point of service is lower. For example, consumers are more likely to visit a doctor if their copay is $5 than if it is $50. We call this behavioral impact cost sharing induced utilization.

Changes in actuarial value and cost-sharing subsidies are likely to cause increases in induced utilization, thereby affecting incurred claims and premiums. An induced utilization factor reflects the changes in health care consumption by a particular member when they are exposed to different levels of member cost sharing. We estimate a 4.1% impact on the medical portion of the health premium due to induced utilization.

Figure 14: Estimated Premium Impact Due to Cost Sharing Induced Utilization Adjustment

Low	Best Estimate	High
3.7%	4.1%	5.0%

The best estimate of induced utilization is the estimated impact when moving from the pre-ACA average actuarial value pre-Affordable Care Act to an average actuarial value of 75% post-Affordable Care Act. This is the actuarial value we estimate if we assume that all of the membership on Covered California below 250% FPL selects the enhanced silver plan, all of the membership on Covered California between 250% and 400% FPL selects the silver plan, and all the remaining membership on and off Covered California selects the bronze plan. To the extent that people choose to buy

[14] http://www.chcf.org/publications/2011/04/ca-individual-small-group-eve-reform

[15] http://www.chcf.org/publications/2008/11/actuarial-value-a-method-for-comparing-health-plan-benefits

[16] “More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014,” by Jon R. Gabel et Al. Health Affairs 31, No. 6, 2012.

more coverage, the increased premium cost will, in large part, be offset by the decrease in out of pocket expenses at the point of service.

The lower end of the range shown in Figure 14 is the estimated impact of induced utilization when moving from the average actuarial value pre-Affordable Care Act to an average actuarial value of 73% post-Affordable Care Act. This is the actuarial value we estimate if we assume that all of the membership on Covered California below 250% FPL selects the enhanced silver plan and all the remaining membership selects the bronze plan. The higher end of the range is the estimated impact of induced utilization when moving to an average actuarial value of 78% post-Affordable Care Act. This is the actuarial value we estimate if we assume that all of the membership on Covered California below 250% FPL selects the enhanced silver plan and all the remaining membership selects the silver plan.

Reinsurance Protection

The Reinsurance Program enacted in the Affordable Care Act will reimburse carriers for 80% of claim costs in excess of $60,000, up to a reinsurance cap of $250,000. This program is financed through a fee on all insurance policies, including large group employer policies, with the resources only used for reinsurance for the non-grandfathered individual market, both on and off Covered California. While the fees are likely to be passed through as increased premiums, the presence of reinsurance is likely to reduce Covered California premiums, as carriers will not be responsible for the full costs of claims for these individuals.

The regulations released December 7, 2012 outline a reinsurance design with a $60,000 attachment point, 80% coinsurance, and a $250,000 reinsurance cap.[17] We estimate that the ratio of the individual market net reinsurance subsidy to total individual market benefit costs in 2014 will be 9.1% of total individual market benefit costs. Therefore, our best estimate is that the reinsurance protection will reduce the medical portion of the health premium by 9.1% in 2014.

Figure 15: Estimated Premium Impact Due to Reinsurance Protection Adjustment

Low	Best Estimate	High
-12.0%	-9.1%	-8.0%

The pool of money available for this reinsurance program is fixed, so there is a risk that not all reinsurance will be recoverable. We have not reflected this possibility in our analysis.

The reinsurance estimates reflect current average cost levels in California, and do not reflect the interaction of other factors identified in this report, such as the lower provider reimbursement levels and higher health status factors.

The provisions of the Affordable Care Act reinsurance program change significantly after 2014. The estimated reductions in premiums, compared to premiums in the absence of any reinsurance, drop to 3% in 2015, and to 1-2% in 2016. The short-term nature of this program mitigates the premium increases in 2014, but will be a material source of higher increases in 2015, 2016, and 2017.

The Affordable Care Act has established three programs to manage risk to the carriers: reinsurance, risk adjustment, and risk corridors. There is some discussion among carriers of introducing additional margins in premiums due to lack of confidence in these programs. In this report, we have assumed that carriers will not make this type of adjustment.

[17] http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

Increased Taxes and Fees

The Affordable Care Act introduces new taxes and fees in 2014. These include the health insurer assessment, reinsurance fee, Exchange user fees, and fees on pharmaceutical and medical device manufacturers. It is likely that most, if not all of these fees will be passed on to the consumer through the inclusion of these costs in premiums. This factor is for the taxes and fees that we expect to flow through in the medical claims costs or those that are removed from the premium before the medical loss ratio is calculated.

Figure 16: Estimated Premium Impact Due to New Taxes and Fees

	Low	Best Estimate	High
Health Insurer Assessment	0.7%	1.4%	2.2%
Reinsurance Fee	0.9%	1.1%	1.3%
3% Covered California Fee	0.7%	1.0%	2.3%
Manufacturer Taxes and Fees	0%	0.5%	1.2%
Combined Taxes and Fees Factor	2.3%	4.1%	7.2%

The Health Insurer Assessment depends on each carrier's status as a for-profit or non-profit entity, and also depends on the carrier's volume of commercial business relative to Medicare and Medi-Cal business. For example, for a for-profit carrier with 100,000 members, we estimate the tax to be 1.4% of premium, without an adjustment for federal income taxes. After adjusting for federal income taxes and non-profit plans with lower health insurer assessment fees, we estimate that the average effect of this tax among all carriers is 1.4%. The ends of the range reflect the expected tax for non-profit and for profit carriers.

CCIIO has released the estimated reinsurance fee for 2014 as $5.25 PMPM.[18] We estimate this to result in a 0.9% to 1.3% increase in premiums. As discussed in the section on reinsurance, this program is financed through a fee on all insurance policies, including large group employer policies, with the resources only used for reinsurance for the non-grandfathered individual market, both on and off Covered California.

Covered California will collect 3% of premiums for plans offered on Covered California to cover Exchange administrative operations. This 3% will be spread across the plans on and off of Covered California. We estimate that roughly one-third of the enrollment in the individual market will be on Covered California, resulting in an average Covered California fee of 1.0% per plan. If 25% of the enrollment in the individual market is on Covered California, then this factor is 0.7%, and if 75% of the enrollment is on Covered California, this factor will have a 2.3% impact.

This fee is intended to cover Exchange services related to marketing and customer acquisition. Insurers will continue to pay brokers and agents out of their own administrative budgets. Covered California announced that by 2017, this fee will be reduced to 2% on Qualified Health Plans sold on Covered California and 1.5% on Qualified Health Plans sold outside of Covered California. Exchange user fees will be subtracted from premium prior to calculating a health plan's medical loss ratio,[19] so health plans may increase premiums to cover this fee.

It is possible that that the manufacturer taxes and fees could be absorbed by the manufacturers by reducing their profit margins. However, an actuarial research study prepared by the CMS Office of the Actuary suggests that medical device fees would be passed on to consumers as higher device prices, and ultimately higher insurance premiums.[20] We calculate our best estimate assuming that this 2.3% tax on medical devices will apply to 20% of medical expenses. The

[18] http://cciio.cms.gov/resources/files/proposed-hhs-payment-notice-11-30-2012.pdf

[19] http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf

[20] http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf

low end assumes that manufacturers absorb all of the fees by reducing their margins. The high end of the range assumes that this 2.3% tax will affect 50% of medical expenses.

Utilization Adjustment due to Newly Insured (Pent-up Demand)

The uninsured population may have pent-up demand for healthcare services. When consumers are uninsured or underinsured, they may put off non-emergent healthcare services. Once the currently uninsured obtain coverage in 2014, there may be an increase in utilization for this population, as they will be more likely to be able to afford to utilize non-emergent services that they avoided while uninsured. We estimate that the pent up demand for the newly insured population will be 2.1%.

Figure 17: Estimated Premium Impact Due to Newly Insured Utilization Adjustment

Low	Best Estimate	High
0%	2.1%	10.7%

A Massachusetts Institute of Technology economic research report supports the assumption that there will be no change in health costs due to pent-up demand.[21] We used this estimate for the low end of our range.

A University of Minnesota report identifies a study that suggests the previously uninsured had health costs 15% higher than a comparable insured group.[22] Under our best estimate population modeling, enrollment increases by 3.2 million members. If we assume that all of these new members have health costs 15% higher than the current individual market, we calculate the high end of our range to be 10.7%. If we assume that 20% of these new members have health costs 15% higher than the current individual market and the remaining have health that are comparable to the current individual market, we calculate the best estimate to be a 2.1% increase in premiums due to the pent up demand.

Administrative Expenses

Covered California is expected to have an impact on the administrative expenses for insurance companies offering products through the Exchange. Administrative costs for products offered on and off the Exchange may be different due to differences in the cost structure of the distribution channels. We have not made any explicit estimates about the mix of membership on and off the Exchange. If carriers expect any administrative savings from Covered California, these effects will be dampened because of this mix of membership on and off the Exchange.

Under the Affordable Care Act, some current carrier administrative tasks will be performed by Covered California. Some carrier administrative expenses will decrease or be eliminated, such as medical underwriting. There are some administrative expenses that will be new post-Affordable Care Act, such as the expense of preparing claims data to be submitted for risk adjustment analysis.

A few specific areas where Covered California may impact insurer's administrative expenses are described below.

Potential Reductions in Administrative Expenses

- Underwriting. Under the Affordable Care Act, medical underwriting will be forbidden, and thus the costs associated with this activity will be eliminated for all health plans.

[21] http://economics.mit.edu/files/6796

[22] http://www.azahcccs.gov/reporting/Downloads/HRSAgrant/publications/SHADAC_FINAL_REPORT.pdf

- Marketing and sales. Covered California will market the Exchange, which could result in some marketing savings for carriers. Unless forbidden to do so, however, plans may still advertise their brands and conduct brand-building activities so that their brands and products are top-of-mind when the consumer goes to Covered California to shop for coverage.
- Broker and agent commissions. Currently, broker-driven sales represent a large portion of individual health insurance sales in California. Covered California estimates that up to 80% of this business will transition from the broker distribution channel to the Exchange. Brokers perform a variety of administrative services for purchasers, and thus it may take several years before this level of Exchange penetration is achieved, if ever. Whereas broker driven business is subject to broker commissions and sales incentives, Exchange business will be subject to Covered California's fixed "certified assisters" fee. The Exchange shared anecdotal information with us that in the current California individual health insurance market, commissions are in the range 13-15% of premiums. Our independent research identified 8-12% first year commissions and 4-6% annual renewal commission for a major California carrier depending on volume. Other sources of anecdotal information suggest commissions may be even less than these data points. Commission levels vary significantly depending on the product distribution strategies used by the insurers (e.g. broker sales, captive agent sales, private exchange sales, telesales, etc.). Covered California estimates that 20% of Exchange enrollment will be subject to plans paying agents' commissions and 80% will be subject to Covered California paying a fixed "certified assisters" fee. If these assumptions are borne out, then this shift could drive a reduction in administrative expenses.
- Streamlined plan designs. There may be some savings in plan design administrative costs because Covered California has prepared a set of standard plan designs that satisfy each of the Affordable Care Act metallic levels for use both inside and outside of Covered California. There may not be savings associated with streamlined plan designs in the first year, but there is the potential for savings over time.

Potential Increases in Administrative Expenses

- Exchange interface. Insurers will need to develop infrastructure to support interfaces and data exchange with Covered California. For example, the Exchange may collect enrollment information from the purchaser and transmit that information to the insurer for loading into their core information systems. Similarly, insurers need to develop capabilities to submit data to the Exchange. Insurers have options for how they will build these interfaces, however regardless of the strategies used, investments will be required for start-up and ongoing activities.
- Reporting requirements. Post-Affordable Care Act, plans will be required to prepare claims data and submit other reports for risk adjustment, reinsurance, and risk corridor analyses.

Figure 18: Estimated Premium Impact Due to Change in Administrative Expenses

Low	Best Estimate	High
-7%	-4.5%	0%

As described above, we expect the Exchange will contribute to both increases and decreases in carriers' administrative expenses. Given the uncertainty of these recent and upcoming changes, we have not assumed any change in the percentage of premium allocated for administrative expenses due to changes in the cost of operations. We believe, however, that changes in distribution channel, such as movement away from brokers to the Exchange, may result in lower overall administrative fees. The best estimate assumes an 8% average commission rate (blended first year and renewal commissions) and 60% of sales being through Covered California. In our experience, plans are not expecting any short-term administrative savings from the Exchange, but there is potential for longer term savings as the market stabilizes and infrastructure investments are amortized.

Under the Affordable Care Act, individual plans are required to have a minimum loss ratio of 80%. We calculate administrative costs as a percentage of premiums. Our 0% high estimate for the change in premium due to the change in administrative expenses should be interpreted as plans having the same medical loss ratio before and after the implementation of the Affordable Care Act's 2014 provisions. This constant medical loss ratio does translate into higher administrative costs on a PMPM basis.

Covered Benefits

Due to the Affordable Care Act requirement that Qualified Health Plans (QHPs) cover all Essential Health Benefits (EHBs), many individual plans will be required to cover services in 2014 that they did not cover in 2011. As noted above, our source for baseline 2012 Individual premium rates, CHBRP, used 2011 premium and coverage data for its estimates. Health plans generally do not currently cover Habilitative, pediatric vision and dental services, as required by the EHB. The addition of these services is included in our estimated increase in covered benefits.

One source of newly covered services is prescription drugs. Many individual market products do not include broad coverage of prescription drugs, and will have to expand this coverage in 2014. In other states, maternity services will be newly covered in 2014 in many individual plans. In California, however, AB 210 required all individual plans to cover costs related to maternity, starting with policies issued or renewed after July 1, 2012. Because this law predates the implementation of the January 1, 2014 Affordable Care Act provisions, in our analysis we do not attribute the expansion of maternity coverage to the Affordable Care Act. We estimate an increase of 4.8% of the medical portion of the health premium due to an increase in covered benefits.

We estimated that approximately 5% of CDI-regulated plans had no prescription drug coverage and 18% of these plans had generic-only drug coverage. Adjustments were made to account for this increase in covered benefits.

Figure 19: Estimated Premium Impact Due to Change in Covered Benefits

Low	Best Estimate	High
3.5%	4.8%	6.5%

The lower end of the range shown in Figure 19 is the amount we estimate to be attributable to the increase in covered benefits to adhere to the new EHB requirements. The higher end of the range is the amount we estimate to be attributable to the increase in covered benefits due to EHB and the addition of brand drugs to generic-only coverage. Carriers will base their premiums on their own estimates of how their current covered services differ from the EHB benchmark plan.

This factor will affect individuals differently depending on their insurance coverage pre-Affordable Care Act. Individuals who already have coverage for all services covered under the Essential Health Benefit will not experience rate increases due to the Essential Health Benefit. Individuals who have generic-only prescription drug coverage will experience rate increases as their insured benefits increase to cover brand prescription drugs.

Change in Actuarial Value

Many plans will be required to change their cost-sharing in 2014 due to the requirement that all plans provide an actuarial value at least 60%, with the exception of the catastrophic plans. Current national and state surveys suggest that the average individual market plan offers an actuarial value of 55% – 60%, with many plans falling well below the 60% threshold. Also, because plans must be offered at specific “metal” levels, currently offered plans may need to alter their benefit designs to provide cost-sharing at one or more of these pre-defined levels. For instance, a plan that currently provides 75% actuarial value may choose to change its cost-sharing and either increase its coverage to 80% (gold) or decrease its coverage to 70% (silver). It is difficult to determine how such a plan will choose to market itself in the future. These changes in actuarial value will affect premiums as plans adjust premiums to account for changes in cost sharing. Catastrophic plans will be available to individuals under 30 and will provide an actuarial value less than 60%. The availability of a catastrophic plan will potentially offset some of the increases in actuarial value due to the minimum threshold of 60%.

We have provided our estimate of the actuarial value of the current individual market as an average, but the actuarial values for the current plans span a much wider range. A California Healthcare Foundation report provides an example for Los Angeles County in 2006, with actuarial values ranging from 34% to 86%.[23]

We estimate that the average actuarial value in the individual market will change from 60% without the implementation of Affordable Care Act reforms in 2014 to 67% with the implementation of Affordable Care Act reforms. We estimated this change by assuming that all of the membership on Covered California below 250% FPL select the enhanced silver plan, all of the membership on Covered California between 250% and 400% FPL selects the silver plan, and all the remaining membership on and off Covered California selects the bronze plan. For calculating how the average premium will change, we assume that the members who select an enhanced silver plan will be responsible for paying only the silver premium, as the federal cost sharing subsidies should cover the enhanced portion of the plan. For this reason, we use different post-Affordable Care Act estimated actuarial values when calculating this factor and the cost sharing induced utilization factor.

Figure 20: Estimated Premium Impact Due to Change in Actuarial Value

Low	Best Estimate	High
8.7%	11.5%	16.9%

The lower end of the change in actuarial value is the estimated change when moving from the average actuarial value pre-Affordable Care Act to an average actuarial value of 65%% post-Affordable Care Act. This is the actuarial value we estimate if we assume that all of the membership on Covered California below 250% FPL selects the enhanced silver plan and all the remaining membership selects the bronze plan. The higher end of the range is the estimated change when moving to an average actuarial value of 70% post-Affordable Care Act. This is the actuarial value we estimate if we assume that all of the membership on Covered California below 250% FPL selects the enhanced silver plan and all the remaining membership selects the silver plan.

Similar to the change in covered benefits, the change in actuarial value will affect individuals differently depending on their insurance coverage pre-Affordable Care Act. Individuals in plans that have an actuarial value greater than 60% will not need to purchase higher levels of insurance. Individuals in plans that have actuarial value less than 60% will pay higher premiums in exchange for reduced cost sharing. The average premium will also depend on what levels of coverage members choose to purchase.

[23] http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthPlanActuarialValue.pdf

OTHER FACTORS FOR DISCUSSION

Other factors that are important to consider, but which may not have a material impact on the changes in 2014 expected premiums due to the Affordable Care Act, include risk adjustment, risk corridors, and minimum medical loss ratio requirements.

Risk Adjustment

The risk adjustment program enacted in the Affordable Care Act will credit or charge Qualified Health Plans participating in the individual and small group markets based upon the risk scores of their enrolled population relative to the average Covered California population. This program will mitigate the risks of carriers from adverse risk selection. However, some carriers and actuaries believe that variations in healthcare expenditures relative to premium revenue cannot be fully mitigated by current risk adjustment methodologies. As a result, carriers may introduce additional margins in premiums despite the presence of the risk adjustment program. In this report, we have not estimated an increase in premium due to carriers' concerns about risk adjustment.

Risk Corridors

In addition to the reinsurance and risk adjustment programs, the federal government will also mitigate the risks to Qualified Health Plans participating in the individual and small group markets on Covered California by applying retrospective charges and credits to carriers. These charges and credits depend on the difference between a carrier's allowable costs and its target amount for these costs. Allowable costs include incurred claims and expenditures on activities to improve health care quality. Because the risk corridor program could potentially provide an influx of federal funds to a carrier that exceeds its target for allowable costs (medical claims and quality improvement expenditures), and to Covered California as a whole, it is possible that this program could potentially encourage carriers to participate in Covered California at competitive rates despite concerns over whether the carrier will receive sufficient earned premiums to meet medical expenditures. This program combined with the competitive nature of Covered California could potentially discourage carriers from projecting unreasonably high medical expenditures and charging high premiums in the post-Affordable Care Act environment. In this report, we have not estimated a decrease in premium due to the dampening effect of risk sharing on a carrier's net financial results.

Minimum Medical Loss Ratio Requirements

Qualified Health Plans (QHPs) will be limited by the imposition of an 80% minimum Medical Loss Ratio (MLR) on all plans offered on the individual market. This effectively limits the amount of money that a plan can spend on marketing and administration to 20% of gross premiums, and will potentially decrease premium rates. Since this Affordable Care Act mandated item has already been implemented, we assume that our baseline 2014 premiums, before reflecting the 2014 provisions of the Affordable Care Act, already are compliant with the 80% MLR requirement. We assume no further changes in premiums due to this requirement in 2014 and later years, and have not included it with the changes going into effect in 2014.

LIMITATIONS

In developing our projections, we relied on data and other information provided by Covered California and other public sources of information. We have not audited or verified this data and other information. We performed a limited review of the data used directly in our analysis for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. In many cases there has not been adequate experience data upon which to develop assumptions, and we have had to rely on judgment.

The analysis included in this report is based on our understanding of the Affordable Care Act and its associated regulations issued to date. Forthcoming Affordable Care Act related regulations and additional legislation may materially change the impact of the Affordable Care Act, necessitating an update to the projections included in this report. For this reason, this report should be considered time-sensitive material which may change as new information becomes available. Note that the authors are not attorneys, and that Milliman does not provide legal advice to clients.

The views expressed in this report are made by the authors of this report and do not represent the opinions of Milliman, Inc.

The enclosed estimated premium increases reflect projections of utilization rates and costs that will occur if the underlying assumptions are realized precisely. Actual experience will differ from these projections due to a variety of influences, including random variation in the need for healthcare services. We have conducted limited sensitivity testing of our results to changes in assumptions. Changes in some assumptions can produce significant changes in results, due to the interrelationships of factors influencing the results.

The intent of this report is not to estimate premiums, or a set of adjustments, that Covered California and carriers should rely on when setting or reviewing premiums for 2014. Similarly, the premiums and adjustment factors in this report are not intended for Covered California, DMHC, or CDI to deem as reasonable when reviewing 2014 rate filings.

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