DESIGN OPTIONS FOR A HEALTH INSURANCE EXCHANGE - ACTUARIAL ANALYSIS

STATE OF ALASKA
Department of Health and Social Services
Division of Health Care Services

Lewis and Ellis, Inc. – Actuaries & Consultants

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Chapter 1
Introduction

PURPOSE AND SCOPE

The Alaska Department of Health & Social Services, Division of Health Care Services (DHCS) contracted with Public Consulting Group (PCG) to conduct background research, analyze data, identify options and recommend a viable plan for designing, developing and sustaining a Health Insurance Exchange (Exchange) in Alaska. PCG engaged Lewis & Ellis, Inc. (L&E), to provide actuarial analysis and guidance related to establishing an Exchange, as outlined in Request for Proposal No. 2011-0600-0601 *Health Insurance Exchange Consultant Services*.

KEY ISSUES FOR ANALYSIS

The key issues L&E analyzed were:

- The demographics of the current insurance marketplace and the currently uninsured
- The current benefit and cost-sharing structures of the Alaskan insurance market
- The projected remaining uninsured in Alaska after implementation of ACA reforms (with and without the individual mandate)
- The potential impact to the Exchange of Alaskan's health status and demographics
- Health insurance issuers anticipated strategies to sell insurance in an Exchange environment
- Ways to encourage company participation and ways to increase competition in an Exchange environment
- Anticipated consumer behavior and ways to incentivize employer and individual participation
- The advantages and disadvantages of merging Individual and Small Group markets

- ❖ The roles of navigators, producers, and brokers in an Exchange
- ❖ Strategies for coordination of multiple coverage options within one family

This report allows Alaska stakeholders to evaluate both the positive and negative consequences of the objective analysis provided. Stakeholders can then weigh the potential impacts to make the best decisions for Alaskans.

LIMITATIONS OF THIS STUDY

This report has been prepared for the use of the state of Alaska and Public Consulting Group with regard to the development of an Exchange in Alaska. These parties should use this report to understand the actuarial implications of establishing an Exchange. The report is not suitable for any other purposes.

Much uncertainty surrounds many of the projections in this report, primarily due to undecided regulatory requirements and imperfect data. Owing to the complex nature of a health insurance market, it is critical that the state of Alaska continues to solicit input from all healthcare and health insurance stakeholders to properly assess the impacts of establishing an Exchange.

The actuarial guidance and projections in this report should not be considered predictions of what will occur if an Exchange is established. The guidance provided in this report is based on modeling a specific set of assumptions and should be used to evaluate a range of potential outcomes. Actual experience will deviate from these projections.

In performing this study, L&E relied on data and information from many sources, including the Alaska Department of Insurance, Alaska health insurance issuers, and Public Consulting Group. We have not audited the data sources for accuracy, although we reviewed them for reasonableness. If the data or information provided to us were inaccurate or incomplete, then any projections and guidance may also be inaccurate or incomplete.

The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. The guidance and analysis expressed in this report are those of the authors only and do not necessarily represent the opinions of other L&E consultants.

The authors of this report are not attorneys and are not qualified to give legal advice. Users of this report should consult legal counsel for interpreting legislation and administrative rules, specific Exchange features, and other issues related to implementing an Exchange.

The authors of this report are aware that it may be distributed to third parties; however, any users of this report must possess a certain level of expertise in

health insurance, healthcare, or actuarial science so as not to misinterpret the data presented. Any distribution of this report must be made in its entirety. In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E makes no representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

ORGANIZATION OF THIS REPORT

The remainder of this report is organized as follows:

- Chapter 2: Executive Summary
- Chapter 3: Current Marketplace and Uninsured Demographics
- Chapter 4: Projected Transition of Alaskans Between Markets
- Chapter 5: Impact of Healthcare Reforms
- Chapter 6: Alternative Scenario (No Individual Mandate)
- Chapter 7: Additional Topics

Chapter 2
Executive Summary

The Alaska Department of Health and Social Services is engaged in first-year planning for a state Health Insurance Exchange. Public Consulting Group engaged Lewis & Ellis, Inc., to perform actuarial analysis and prepare guidance related to establishing an Exchange. The bulk of L&E's analysis focused on how the insurance reforms of the Affordable Care Act (ACA) would affect both the public and private insurance markets in Alaska.

The ACA was signed into law on March 23, 2010. While some of the changes enacted by the law have already taken effect as of the date of this report, most will take effect in the year 2014.

Some of the reforms that have already taken effect as of the date of this report include the following:

- Extending the coverage for dependents until age 26
- Removing lifetime limits
- Prohibiting pre-existing exclusions for children under 19
- Prohibiting recession of coverage
- Prohibiting cost sharing for preventative care services
- Minimum loss ratio requirements of 80% for individual and small group plans and 85% for large group plans
- Establishing a premium review process to review annual rate increases in premiums

ACA reforms that take effect after 2014 will affect both Individual and Employer-sponsored insurance plans (ESI). These reforms include the following:

- Prohibiting annual limits for Individual and ESI plans
- Prohibiting discrimination based on health status. This includes health status, medical condition, claims experience, medical history, genetic information, evidence of insurability and disability.
- Guarantee issue and renewability for every Individual or ESI plan that applies. Insurers can restrict enrollment to open enrollment periods.

- Each state shall establish an Exchange that facilities the purchase of qualified health plans. Individuals and small employers with up to 100 employees can purchase insurance through the Exchange.

- Essential health benefits for Individual and ESI insurance plans will be defined by HHS. They will include at a minimum ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative services and devices, laboratory services, and preventative and wellness services

- Modified community rating with variations allowed only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1)

- Premium rate consistency inside and outside the exchanges

- Ability of states to merge the ESI-small group and individual health insurance markets

- Ability of states to define small group up to 100 employees (mandatory by January 1, 2016)

- Individual mandate which includes tax penalty if not covered by the defined minimum essential insurance coverage

- Employer tax penalty if not offering qualified insurance coverage (groups under 50 employees exempt)

- Expansion of Medicaid to all individuals under 65 with incomes up to 138% of the Federal Poverty Level (FPL) with the 5% income disregard

- Premium subsidies for individuals with incomes less than 400% of the FPL if purchased through the Exchange

- Tax credits for small employers (25 or less employees) who purchase coverage for their employees through the Exchange. The tax credits will be eliminated after 2015.

These changes will significantly impact the Alaskan insurance market. This report assesses this impact. L&E's assessment takes into account the potential behavior of individuals and small employers based on income levels, health status, and the demographics of Alaskan residents.

Table 2-1 demonstrates Alaska's population by type of insurance coverage. The population data is derived from numerous sources, including but not limited to, the U.S Census Bureau (USCB), the American Community Survey (ACS), the Current Population Survey (CPS), the Kaiser Family Foundation's state health facts website (Kaiser), the Medical Expenditure Panel Survey (MEPS), and the Urban Institute reports on the uninsured (UI).

Table 2-1 Current 2010 Alaska Population (Non-Elderly)

Category	Current AK Population
Employer	368,000
Individual	20,000
Medicaid / CHIP	93,000
Other Insurance (e.g. Military)	35,000
Uninsured	139,000
Total	655,000

Please note that the Medicaid/CHIP population number in Table 2-1 is based on the average number of persons with coverage throughout the year, not the actual number of Alaskans enrolled in Medicaid. The Medicaid/CHIP number in Table 2-1 is only for comparison to other insurance coverage's during the year. These numbers should be considered as an average enrollment for the given year. For example, some enrollees could have Medicaid for half a year and be uninsured for the other half. According to the state of Alaska, the current Medicaid/CHIP enrollment in 2010 for individuals under age 65 was 135,086.

After the implementation of the ACA reforms, L&E's actuarial models project significant insurance coverage changes. *Table 2-2* shows our best estimate of the potential migrations between markets after the implementation of all ACA reforms, using the 2010 Alaskan population as the basis.

Table 2-2 Projected 2014 Enrollment after Implementation of ACA Reforms

Projected Markets	*Current Markets*					Projected Totals
	ESI	Individual	Medicaid + CHIP	Other Insurance	Uninsured	
Medicaid + CHIP	0	1,000	90,000	0	32,000	123,000
Employer in Exchange	6,000	0	0	0	0	6,000
Employer outside Exchange	354,000	0	0	0	0	354,000
Individual in Exchange	8,000	6,000	3,000	0	54,000	71,000
Individual outside Exchange	0	13,000	0	0	10,000	23,000
Other Insurance	0	0	0	35,000	0	35,000
Uninsured	0	0	0	0	43,000	43,000
Total	368,000	20,000	93,000	35,000	139,000	655,000

*Other insurance refers to Individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS).

The results of the projections worth noting include:

- The uninsured population decreases approximately 70%
- Medicaid/CHIP is expected to increase by approximately 30%
- 25% of the Medicaid/CHIP market will be previously uninsured Alaskans.
- The ESI market is not expected to be significantly affected. 2% of the ESI market is expected to join the Exchange. While approximately 2% of this market will transition to the Individual market after the 2014 ACA reforms are fully implemented.
- 5% of the current Individual market is projected to enroll in Medicaid
- The Individual insured market is projected to increase by about 74,000 lives of which 80% will be new enrollees
- The take up rate of the new individual population within the exchange is projected to be around 75%. This is primarily due to the subsidy provided for individuals that qualify.

In addition to the population summarized above, the premiums in the various markets are expected to change significantly from the current markets. Our analysis estimates that the premium may change as follows:

- Individual health insurance market premiums are estimated to increase by 30% to 80% above current market average rates. Providing coverage for

the currently uninsured population, which on average is approximately 36% less healthy than the current insured, is driving the majority of this increase.

- ❖ Average premiums in the ESI-small group market are expected to remain approximately the same after implementation of ACA reforms; however, specific small employers will face premium changes. L&E's models approximate specific premium changes will range from a negative 15% to a positive 25%.

- ❖ Merging the Individual and Small Group markets is expected to decrease premium in the Individual market by approximately 4%. Premium increases for the Small Group market are expected to be approximately 10%. These expectations are primarily due to the relatively healthy status of the current Small Group market and the introduction of the previously uninsured into the Individual market.

- ❖ Expanding the definition of the small group definition from 2-50 to 2-100 is expected to have minimal impact on the overall average premium of the current Small Group market. The estimated average increase is approximately 1%.

The projected population movements and premium impacts are caused by the combination of the ACA reforms that will take effect in 2014. There will be a wide range of significant changes that will affect the majority of Alaskans. This report documents the range of possible impacts and should be reviewed carefully to understand the risks and challenges facing the insurance markets both inside and outside an Exchange.

Chapter 3
Current Marketplace and Uninsured Demographics

A complete understanding of Alaska's current demographics was needed in order to analyze the potential impact of ACA reforms and the introduction of an Exchange in the Alaska market. We reviewed and compiled information from numerous sources including but not limited to the U.S Census Bureau, American Community Survey (ACS), Current Population Survey (CPS), The Kaiser Family Foundation's state health facts website (Kaiser), Medical Expenditure Panel Survey (MEPS) and the Urban Institute reports on the uninsured (UI). The table below shows our estimate of the current non-elderly population in Alaska by insurance status.

Table 3-1 2010 Alaska Non-Elderly Population by Type of Insurance

Category	Current AK Population*
ESI (2 - 50 Employees)	42,000
ESI (51 - 100 Employees)	29,000
ESI (100+ Employees)	297,000
Individual	20,000
Medicaid / CHIP	93,000
Other Insurance	35,000
Uninsured	139,000
Total	655,000

*Non-elderly (under age 65)

About 21% of the Alaskan population is currently uninsured which is higher than the U.S estimate of 17% uninsured. The remaining 79% of the population receives insurance coverage from a combination of ESI plans, the Individual market, or government run programs.

56% of the Alaskan population receives their insurance from employer sponsored plans. About 3% of the population receives insurance coverage through the Individual market. Government programs account for the remaining 19%. Medicaid and CHIP account for approximately 14% (this number also includes under age 65 individuals that are dual eligible for both Medicaid and Medicare). The other insurance programs which account for 5% of the Alaskan population refers to individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE.

MARKETPLACE DEMOGRAPHICS

The Alaska Division of Insurance surveys health insurers each year to gather market share information and to determine who is actively marketing comprehensive health insurance coverage. According to the 2010 survey, there were 10 companies that were actively writing new business. Table 3-2 summarizes insurance company's market share by premium and member months in 2010.

Table 3-2 Individual market share by Insurer Writing Comprehensive Health Insurance in Alaska (Source 2010 Annual statements)

Alaska Insurers	Individual Insurers		Small Group Insurers		Large Group Insurers	
	Premium	Member Months	Premium	Member Months	Premium	Member Months
Aetna Life	6.9%	10.2%	3.1%	1.8%	14.0%	18.6%
Celtic	2.4%	3.1%	0.0%	0.0%	0.0%	0.0%
Connecticut General	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Golden Rule	10.4%	7.6%	0.0%	0.0%	0.0%	0.0%
John Alden Life	1.9%	2.2%	7.6%	6.5%	0.0%	0.0%
ODS Health Plan Inc	2.3%	4.1%	10.6%	10.6%	0.7%	1.1%
Premera BCBS	70.1%	64.5%	73.2%	77.0%	85.2%	80.2%
Time Insurance Company	6.0%	8.3%	0.1%	0.0%	0.0%	0.0%
Trustmark Life	0.0%	0.0%	2.9%	2.0%	0.0%	0.0%
United HealthCare	0.0%	0.0%	2.6%	2.1%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

INDIVIDUAL INSURERS

In 2010, 8 carriers wrote coverage to individuals in Alaska. Premera Blue Cross Blue Shield of Alaska (Premera) accounted for 65 percent of the market as measured by member months, and 70 percent as measured by premiums. The other companies that wrote individual coverage (measured by member months) were:

- Aetna Life Insurance Company – 10%
- Golden Rule Insurance Company – 8%
- Time Insurance Company – 8%
- ODS Health Plan Inc – 4%
- Celtic Insurance Company – 3%
- John Alden Life Insurance Company – 2%.

Table 3-3 below shows a sample of the most prevalent benefit structures available in the Alaska Individual market across the top three insurers.

Table 3-3 Sample of Current Alaskan Individual Benefit Packages

Benefit	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Deductible	$2,500	$5,000	$5,000	$5,000	$2,800	$2,500
Coinsurance	20%	20%	20%	20%	50%	20%
Out of pocket including the deductible	$5,500	$8,000	$12,500	$7,500	$5,200	$5,500
Office visit copay	$0	Visits 1-6: 20% Coins Visits 7+: Subject to ded & 20% coins	Visits 1-2: $40 Copay Visits 3+: Member pays 100%	$40	$0	$20
Emergency care copay	$0	$50	$75	$50	$0	$100
Generic R_x copay	N / A	$0	$20	$15	$0	$15
Generic R_x coins	N / A	20%	0%	0%	50%	0%
Formulary R_x copay	N / A	$0	N / A	$35	$0	$0
Formulary R_x coins	N / A	20%	N / A	0%	50%	50%
Non-formulary R_x copay	N / A	$0	N / A	$65	$0	$0
Non-formulary R_x coins	N / A	20%	N / A	0%	50%	50%

SMALL GROUP INSURERS

Similar to the Individual market, Premera is the dominant carrier in the Small Group market, accounting for 77 percent of member months in 2010. Based on total member months reported in 2010, other carriers in the small group market include:

- ODS Health Plan Inc – 11%
- John Alden Life Insurance Company – 6%
- Aetna Life Insurance Company – 2%
- Trustmark Insurance Company – 2%
- United HealthCare Insurance Company – 2%

Table 3-4 below shows a sample of the most prevalent benefit structures available in the Alaska Small Group market across the top three insurers.

Table 3-4 Sample of Current Alaskan Small Group Benefit Packages

Benefit	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Deductible	$3,000	$1,000	$1,000	$2,000	$5,000	$2,500
Coinsurance	20%	20%	20%	20%	30%	30%
Out of pocket including the deductible	$6,000	$3,500	$4,500	$4,000	$10,000	$7,500
Office visit copay	Visits 1-6: $30 Copay Visits 7+: Subject to ded & 40% coins	Visits 1-6: $25 Copay Visits 7+: Subject to ded & 40% coins	$25	$0	$0	$0
Emergency care copay	$100	$100	$0	$0	$0	$0
Generic R_x copay	N / A	N / A	$10	$20	N / A	N / A
Generic R_x coins	N / A	N / A	0%	0%	N / A	N / A
Formulary R_x copay	N / A	N / A	$30	$40	N / A	N / A
Formulary R_x coins	N / A	N / A	0	0%	N / A	N / A
Non-formulary R_x copay	N / A	N / A	$50	$60	N / A	N / A
Non-formulary R_x coins	N / A	N / A	0	0%	N / A	N / A

LARGE GROUP INSURERS

Premera accounts for 80% of the large group market. Based on the survey data provided, only 2 other carriers actively sell policies in the large group market. These 2 carriers were Aetna Life Insurance Company which accounted for 14% and ODS Health Plan with 0.7% percent.

Large Group plans and benefits are usually substantially similar to benefits in the Small Group market. The primary differences are the methods used to develop premiums and statutory restrictions that apply to small group markets. These differences are summarized later in the report.

ESI MARKETPLACE

As noted above, the ESI market is the dominant source of health insurance coverage for Alaskans. The tables below detail characteristics of the ESI market, including:

- The number of persons covered by an employer plan—size of group, type of plans, percent of employees covered, insured vs. self insured
- The number of persons eligible for employer coverage but not enrolled (insured vs. self insured)
- The number of small employers not offering coverage
- The current regulations covering the Small Group market

- The demographics by gender and age
- The current health status for the current Small Group insured population.
- The current average annual premium of the ESI market (only includes premiums of non-self insured firms)

Table 3-5 Alaska ESI Population Non-Elderly (<65) - Employer Information

Description	Employer 2- 50	Employer 51-100	Employer 100+	Total
Number of firms	13,421	447	3,595	17,463
Percent of number of firms	76.9%	2.5%	20.6%	100.0%
Percent of firms that offer health insurance	29.6%	55.5%	98.3%	44.4%
Number of firms that offer insurance	3,973	248	3,533	7,754
Number of firms that do not offer insurance	9,448	199	62	9,709
Percent of firms that do not offer health insurance	70.4%	44.5%	1.7%	55.6%
Primary Source: Medical Expenditure Panel Survey (MEPS) based on 2009 Data				

Table 3-6 Alaska ESI Population Non-Elderly (<65) - Employee Information

	Employer 2- 50	Employer 51-100	Employer 100+	Total
Total number of employees	82,627	10,703	143,696	237,026
Number of employees at a employer that offers coverage	40,322	7,331	139,597	187,251
Number of employees enrolled in an employer health insurance plan	24,758	4,872	76,167	105,797
Number of those enrolled that are in a self-insured plan	7,823	654	63,147	71,624
Percent of employees covered by employer health insurance	30.0%	45.5%	53.0%	44.6%
Number of individuals eligible for insurance at employers who offer it	31,491	6,079	93,130	130,701
Percent of individuals eligible for insurance at employers who offer it	38.1%	56.8%	64.8%	55.1%
Number eligible but not enrolled	6,734	1,207	16,963	24,904
Percent eligible but not enrolled	21.4%	19.9%	18.2%	19.1%
Primary Source: Medical Expenditure Panel Survey (MEPS) based on 2009 Data				

Table 3-7 Alaska Small Group Current Regulations

Description	Alaska Regulation
Guarantee Issue	Yes
Health Status Underwriting	Yes +/- 35%
Age Rating	Yes
Gender Rating	Yes
Industry Rating	Yes +/- 15%
Group Size	Yes
Area Rating	Yes

Table 3-8 Small Group Market by Gender and Age

Age Group	Male	Female	Total
18 to 24	4%	5%	9%
25 to 29	4%	4%	7%
30 to 34	7%	6%	13%
35 to 39	8%	6%	14%
40 to 44	8%	6%	13%
45 to 49	8%	6%	14%
50 to 54	8%	5%	14%
55 to 59	6%	4%	10%
60 to 64	4%	2%	6%
Total	57%	43%	100%
Primary Source: Alaska Insurers who responded to inquiry requests for this study			

Table 3-9 Small Group Market (Health Status)

Health Status	Population	Factor
Excellent/Very Good	69.6%	0.60
Good	16.4%	1.00
Fair/Poor	14.0%	3.00
Total	100.0%	1.00
Primary Source: Alaska Companies who responded to inquiry requests for this study		

Table 3-10 Alaska Small Group Current Average Annual Premiums (2011)

Age Group	Male	Female	Total
0 to 30	$528	$648	$590
30 to 39	521	615	561
40 to 44	517	612	558
45 to 49	556	637	591
50 to 54	584	692	625
55 to 59	654	774	699
60 to 64	772	852	800
Total	571	662	610
Primary Source: Alaska Insurers who responded to inquiry requests for this study			

Table 3-11 Alaska Large Group Current Average Annual Premiums (2011)

Age Group	Male	Female	Total
0 to 30	$525	$583	$555
30 to 39	439	542	480
40 to 44	435	529	471
45 to 49	451	539	488
50 to 54	466	583	515
55 to 59	531	670	588
60 to 64	596	695	637
Total	474	576	517
Primary Source: Alaska Insurers who responded to inquiry requests for this study			

INDIVIDUAL MARKETPLACE

Even though the Individual market is significantly smaller than the ESI market, it was important to analyze its characteristics due to potentially significant impacts as a result of the ACA. While the constitutionality of the individual mandate is currently under review, to understand the potential impact of an Exchange, the mandate must be considered. Additional analysis is provided in Chapter 6 which considers the removal of the Individual mandate. The tables below show additional facts for the Individual market, including:

- The current demographics by gender and age
- The current health status
- A sample of the current regulations covering the Individual market in Alaska prior to the enactment of the ACA reforms
- The current average annual premium of the Individual market

Table 3-12 Individual Market by Gender and Age

Age Group	Male	Female	Total
18 to 24	1%	1%	1%
25 to 29	5%	4%	10%
30 to 34	5%	5%	10%
35 to 39	6%	5%	12%
40 to 44	7%	6%	13%
45 to 49	9%	5%	14%
50 to 54	9%	6%	15%
55 to 59	8%	6%	14%
60 to 64	6%	4%	10%
Total	57%	43%	100%
Primary Source: Alaska Companies who responded to inquiry requests for this study			

Table 3-13 Adult Individual Market (Health Status)

Health Status	Population	Factor
Excellent/Very Good	74.2%	0.57
Good	14.6%	0.95
Fair/Poor	11.2%	2.86
Total	100.0%	0.88
Primary Source: Alaska Companies who responded to inquiry requests for this study		

Table 3-14 Alaska Individual Current Regulations

Description	Alaska Regulation
Guarantee Issue	No
Health Status Underwriting	Yes
Age Rating	Yes
Gender Rating	Yes

Table 3-15 Alaska Individual Current Average Annual Premiums (2011)

Age Group	Male	Female	Total
18 to 24	$158	$166	$161
25 to 29	180	212	194
30 to 34	196	217	206
35 to 39	206	218	211
40 to 44	242	241	242
45 to 49	277	308	289
50 to 54	358	440	393
55 to 59	468	503	483
60 to 64	607	643	621
Total	323	347	333
Primary Source: Alaska Insurers who responded to inquiry requests for this study			

OTHER INSURANCE MARKETPLACE

The other insurance market includes individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE. There are approximately 35,000 Alaskans currently enrolled in these programs. While there could be some movement in this market after the implementation of the ACA reforms, it is likely to be immaterial.

ALASKA POPULATION RELATED TO FEDERAL POVERTY LEVEL (FPL)

Enrollment in the Medicaid and CHIP programs are expected to increase significantly due to the ACA reform which allows individuals at or below 138% of the FPL eligible to join Medicaid. *Table 3-16* shows the Alaskan population as a percentage of the FPL.

Table 3-16 Alaska Population Non-Elderly (<65) by Federal Poverty Level

FPL*	ESI	Individual	Medicaid / CHIP	Other Insurance	Uninsured

under 139% FPL	3%	7%	34%	29%	32%
139-250% FPL	7%	8%	33%	30%	23%
251-399% FPL	16%	14%	17%	16%	29%
400% FPL and above	74%	72%	16%	25%	16%
Primary Sources: Kaiser, MEPS & ACS					

* Adjusted for Alaska Poverty Guidelines

It should be pointed out that Alaska and Hawaii have different poverty guidelines then the other 48 states and D.C. *Table 3-17* below shows the 2011 HHS Poverty Guidelines.

Table 3-17 2011 HHS Poverty Guidelines

Persons in Family	Alaska	Hawaii	Remaining 48 States and D.C.
1	$13,600	$12,540	$10,890
2	18,380	16,930	14,710
3	23,160	21,320	18,530
4	27,940	25,710	22,350
5	32,720	30,100	26,170
6	37,500	34,490	29,990
7	42,280	38,880	33,810
8	47,060	43,270	37,630
Each additional person, add	4,780	4,390	3,820

UNINSURED DEMOGRAPHICS

As of 2010, 21% of Alaska's non-elderly population was uninsured. Characteristics of this population are important in performing an appropriate analysis of ACA reforms.

In order to estimate the ACA's impact on Exchange enrollment and future premium level changes, demographic characteristics for this population had to be estimated. The tables below summarize key characteristics for this population, including:

- The current demographics
  - Age
  - Gender
  - Area
  - Employment
  - Income
  - Education

- The current health status

Table 3-18 Alaska Uninsured's Age Demographics

Age Group	Total
18 to 24	17%
25 to 29	15%
30 to 34	17%
35 to 39	9%
40 to 44	10%
45 to 49	11%
50 to 54	8%
55 to 59	8%
60 to 64	6%
Total	100%
Primary Sources: MEPS & ACS	

Table 3-19 Alaska Uninsured's Gender Demographics

Age Group	Percentage
Female	44%
Male	56%
Total	100%
Primary Sources: ACS	

Table 3-20 Alaska Uninsured's Geographical Demographics

Geographical Area	Percentage
Anchorage Municipality	34%
Fairbanks North Star Borough	8%
Juneau City and Borough	4%
Kenai Peninsula Borough	9%
Matanuska-Susitna Borough	13%
Other	31%
Total	100%
Primary Sources: ACS	

Table 3-21 Alaska Uninsured's Employment Status

Employment Status	Percentage
Employed	64%
Unemployed	15%
Not in labor force	22%
Total	100%
Primary Sources: ACS	

Table 3-22 Alaska Uninsured's Household Income

Geographical Area	Percentage*
Under $25,000	17%
$25,000 - $49,999	26%
$50,000 - $74,999	22%
$75,000 - $99,999	15%
Over $100,000	21%
Total Households	100%
Primary Sources: ACS	

*Includes all age groups

Table 3-23 Alaska Uninsured's Educational Attainment

Educational Attainment	Percentage*
Civilian non-institutionalized population 25 years and older	50%
Less than high school graduate	7%
High school graduate, GED, or alternative	20%
Some college or associate's degree	17%
Bachelor's degree or higher	6%
Total	100%
Primary Sources: ACS	

*Includes all age groups

Table 3-24 Alaska Uninsured Population's Health Status

Health Status	Population	Factor
Excellent/Very Good	57.8%	0.75
Good	30.0%	0.93
Fair/Poor	12.2%	4.02
Total	100.0%	1.20
Primary Sources: MEPS & ACS		

Alaska's uninsured population has a worse overall health status than both the Individual and the Small Group health statuses. It's estimated that the Individual population has an approximately 35% better overall health status and the Small Group ESI has an approximately 20% better overall health status. *Table 3-25* shows the average health status for the Individual and Small Group markets compared to Alaska's Uninsured's assumed health status.

Table 3-25 Average Market Health Statuses Compared to Alaska's Uninsured Market

Market	Health Status	Compared to Uninsured
Individual	0.88	135.9%
Small Group	1.00	119.8%
Uninsured	1.20	100.0%

Chapter 4
Projected Transition of Alaskans Between Markets

Alaska's marketplace demographics presented in the previous chapter were used as the starting point in developing the expected Exchange enrollees, the risk factors involved, and projected premium levels of the Exchange participants. This chapter focuses on the expected enrollees inside and outside of the Exchange and the projected Medicaid and CHIP enrollees after implementation of the ACA reforms. The next chapter addresses potential premium and risk changes after the implementation of the ACA reforms. *Table 4-1* illustrates the current non-elderly population and their source of insurance.

Table 4-1 Current Source of Insurance for AK Population and Market Share

Market Type	Current AK Population	Percent of Alaska Market
ESI (2 - 50 Employees)	42,000	6%
ESI (51 - 100 Employees)	29,000	4%
ESI (100+ Employees)	297,000	45%
Individual	20,000	3%
Medicaid / CHIP	93,000	14%
Other Insurance	35,000	5%
Uninsured	139,000	21%
Total	655,000	100%

BASELINE PROJECTION

The following projections are the best estimate for projected population transitions based on L&E's actuarial models. *Table 4-2* summarizes one possible outcome after the introduction of an Exchange in Alaska. The forecasts assume the following:

- The Individual and Small Group markets are kept separate
- The Small Group market only includes employer groups with 50 or fewer employees
- Carrier participation in the Exchange is not mandatory
- All insurers that qualify will be allowed to participate in the Exchange
- Insurers will be allowed to sell insurance both inside and outside of the Exchange
- Carriers must offer the same "metal plans" (i.e., platinum, gold, silver, and bronze) in and out of the Exchange.
- The population only includes people under age 65

Table 4-2 Projected Population Inside and Outside of the Exchange after implementation of ACA reforms

Projected Markets	*Current Markets*					Totals
	ESI	Individual	Medicaid + CHIP	Other Insurance	Uninsured	
Medicaid + CHIP	0	1,000	90,000	0	32,000	123,000
Employer in Exchange	6,000	0	0	0	0	6,000
Employer outside Exchange	354,000	0	0	0	0	354,000
Individual in Exchange	8,000	6,000	3,000	0	54,000	71,000
Individual outside Exchange	0	13,000	0	0	10,000	23,000
Other Insurance	0	0	0	35,000	0	35,000
Uninsured	0	0	0	0	43,000	43,000
Total	368,000	20,000	93,000	35,000	139,000	655,000

*Other insurance refers to Individuals covered through the military or Veterans Administration in federally-funded programs.

Table 4-3 shows the 95% confidence interval for possible population changes as a result of the reforms. This confidence interval was developed by modeling 100,000 simulations based on underlying assumptions, such as changes in premiums and the likelihood consumers will change their coverage type.

Table 4-3 Possible ranges for Projected Population Inside and Outside of the Exchange after implementation of ACA reforms

Projected Markets	*Current Markets*					Totals
	ESI	Individual	Medicaid + CHIP	Other Insurance	Uninsured	
Medicaid + CHIP	0	(0, 4,000)	(85,000, 91,000)	0	(26,000, 37,000)	123,000
Employer in Exchange	(5,000, 8,000)	0	0	0	0	6,000
Employer outside Exchange	(340,000, 357,000)	0	0	0	0	354,000
Individual in Exchange	(4,000, 22,000)	(6,000, 8,000)	(1,000, 7,000)	0	(46,000, 64,000)	71,000
Individual outside Exchange	0	(10,000, 15,000)	0	0	(8,000, 13,000)	23,000
Other Insurance	0	0	0	35,000	0	35,000
Uninsured	0	0	0	0	(34,000, 50,000)	43,000
Total	368,000	20,000	93,000	35,000	139,000	655,000

The results of the projections worth noting include:

- The uninsured population decreases by approximately 70%, which is a result of the following:
  - Medicaid/CHIP enrollment increases as result of ACA reforms that increase coverage up to 138% of the FPL. Approximately 23% of Alaska's uninsured is expected to join Medicaid.
  - Uninsured individuals purchasing coverage due to the individual mandate or the penalty for failure of compliance.
  - Subsidies are available for individuals that qualify. Approximately 50% of the current uninsured market will qualify for a subsidy.
  - The Exchange makes it easier for uninsured to research and purchase health coverage.
- The Medicaid / CHIP population increases are due to the ACA coverage limit increase.
  - The Medicaid population increases by 30%.
  - 25% of the new Medicaid recipients come from the previously uninsured population.

- The remaining Medicaid recipients are expected to be individuals who currently have private coverage and learn that they qualify for Medicaid under new regulations.

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- The number of insureds with employer coverage is not expected to change significantly after the implementation of an Exchange.
  - A small percentage of employers are expected to drop their coverage with the effected individuals likely to join the Individual market. A small percentage of the employer market may join Medicaid or remain uninsured.
  - Approximately 2% of the employer market will join the Exchange. It is expected that this population will come from small employers.
- The Individual market is expected to increase significantly due to the individual mandate, the subsidy provided for Alaskans that qualify, and the large percentage of the current population that is uninsured.
  - The Individual market is projected to increase by about 74,000 lives. Approximately 80% of this increase is expected to be new enrollees.
  - 5% of the Individual market is projected to enroll in Medicaid
  - The take up rate for the individual population within the Exchange is projected to be approximately 75%. This is primarily the result of premium subsidies for those eligible

Chapter 5
Impact of Healthcare Reforms

The federal Affordable Care Act (ACA) mandated several reforms for comprehensive health policies that health insurance insurers sell. Minimum loss ratio requirements and coverage changes, such as removing lifetime maximums, expanding coverage to dependents, and increasing preventative services have already been implemented. Other reforms must be implemented by 2014. Three of the reforms yet to be implemented could have significant impact on insurance premiums:

- Age rating limitations,
- Health status/guaranteed-issue restrictions, and
- Minimum benefit coverage requirements.

The impact of each of these reforms on both the Individual and Small Group markets was analyzed.

INDIVIDUAL MARKET

The impact for each of the three insurance reform provisions was considered separately. The impact of the reforms will be dependent on the arrival of previously uninsured individuals who will be purchasing coverage under the ACA environment.

The number of uninsured who ultimately purchase coverage through the Exchange will cause a myriad of effects. Not only will their inherent risk likely add costs to the system directly, the mix of uninsured individuals who purchase coverage will also affect the decision-making of the currently insured population.

Expected enrollment increases in the Individual market are driven primarily by two ACA requirements: an individual purchase mandate and premium subsidies for individuals between 138 percent and 400 percent of the FPL.

The reform impact analysis presented in this chapter focuses on the insurance-based reforms noted above without accounting for any subsidy effect**.**

The analysis does not include the ACA's Medical Loss Ratio (MLR) requirements which began in 2011. It is assumed that carriers in Alaska not currently meeting minimum requirements will meet them by reducing their administrative

expense loads and by the flexibility afforded them as a result of credibility standards for small enrollment.

The impact of the Risk Adjustment Program has not been included. It is assumed that the risk transfer payments would be designed to be neutral within a market. The impact for a specific carrier could be significantly different from the market average.

The impact of the Risk Corridor Program has not been included. It is assumed that the program will stabilize the results for individual carriers; however, it is assumed that program would be market neutral.

The analysis does not include the effects of the Transitional Reinsurance Program. The program has the potential to alleviate short-term market disruptions; however, since the program has not yet been fully-designed, the impact cannot be appropriately evaluated.

ACA geography and tobacco rating requirements are not included, since these provisions are not materially different from current rating practices.

Some consumers purchase health coverage through what is known as an Association Health Plan (AHP). This type of coverage is typically purchased directly by a consumer, but through a group policyholder, such as a professional organization. We have assumed these individuals come under the Individual market and all corresponding ACA requirements.

Age Rating Limitations

Alaska's insurance rules do not currently limit a carrier's rating practice as it relates to an individual's age. That is, if a carrier's pool of 60–64-year-olds has claim costs that are approximately four times higher than the pool of claims for 25–29-year-olds, the carrier is permitted to charge premiums that reflect this relativity.

The ACA requires that the premium for the oldest policyholder cannot be more than 3 times the premium for the youngest policyholder. Therefore, in general, a carrier may have to increase the youngest policyholder's premium, decrease the oldest policyholder's premium, or both, to comply with ACA requirements.

To model the impact of this requirement, the age rating factors currently in use were reviewed. *Table 5-1* illustrates the weighted average age factors compared with age 42 for the Alaska individually insured marketplace, as well as the current age distribution. These factors indicate what an individual in a certain age range would pay relative to someone who is 42 years old. For example, for every $100 paid by a 42-year-old (factor = 1.0000), a 22-year-old would pay $54.13 (factor = 0.5413), and a 62-year-old would pay $240.29 (factor = 2.4029).

Table 5-1 Average Demographic Effects in the Individual Market

Age	Factor	Distribution
Under 25	0.5413	1%
25–29	0.6279	10%
30–34	0.7170	10%
35–39	0.8342	12%
40–44	1.0000	13%
45–49	1.2371	14%
50–54	1.6770	15%
55–59	2.0036	14%
60–64	2.4029	10%

Based on the collected data, the average premium charged for a 62-year-old is approximately 4.4 times higher than for an adult under 25 (factor 2.4029 divided by factor 0.5413). Therefore, it appears that some carriers will need to adjust their age rating factors to comply with the ACA's 3:1 maximum ratio.

The ACA does not explicitly state how a carrier must meet these requirements. It is likely that the carriers operating in the Alaska marketplace will have different implementation methods. Some carriers may want to keep the premiums for the youngest policyholders as low as possible, while other carriers may keep the premiums as high as possible to cover the claims for the oldest individuals.

To model the anticipated average effect of the age band limitation, it was assumed that any change for the youngest groups will be limited.

In addition, the modified age bands were assumed to be revenue-neutral and that the overall premium rate change for a carrier's block of business will be zero.

The projection includes the enrollment of the previously uninsured who are on average younger than the currently insured population. This particular projection does not include any additional adverse selection effects that could occur based on either the introduction of the age band requirement or the impact of previously uninsured persons. The impact of possible adverse selection will be discussed in the aggregate summary section below.

The projections in *Table 5-2* illustrate one possible scenario for compressing rating factors to comply with ACA requirements.

Table 5-2 Possible Effect of Age Band Compression

Age	Current factor	Current distribution	Projected factor	Projected new distribution	Implied effect
Under 25	0.541	1%	0.596	13%	10.0%
25–29	0.628	10%	0.691	14%	10.0%
30–34	0.717	10%	0.789	16%	10.0%
35–39	0.834	12%	0.918	10%	10.0%
40–44	1.000	13%	1.100	11%	10.0%
45–49	1.237	14%	1.361	12%	10.0%
50–54	1.677	15%	1.725	9%	2.9%
55–59	2.004	14%	1.747	9%	-12.8%
60–64	2.403	10%	1.770	7%	-26.3%
		100%		100%	0.0%

The above projection was based on market averages. It is likely that some young Alaskans would see a change in premium greater than 10 percent based solely on their age, and that some older Alaskans would see their premiums reduced by more than 26 percent.

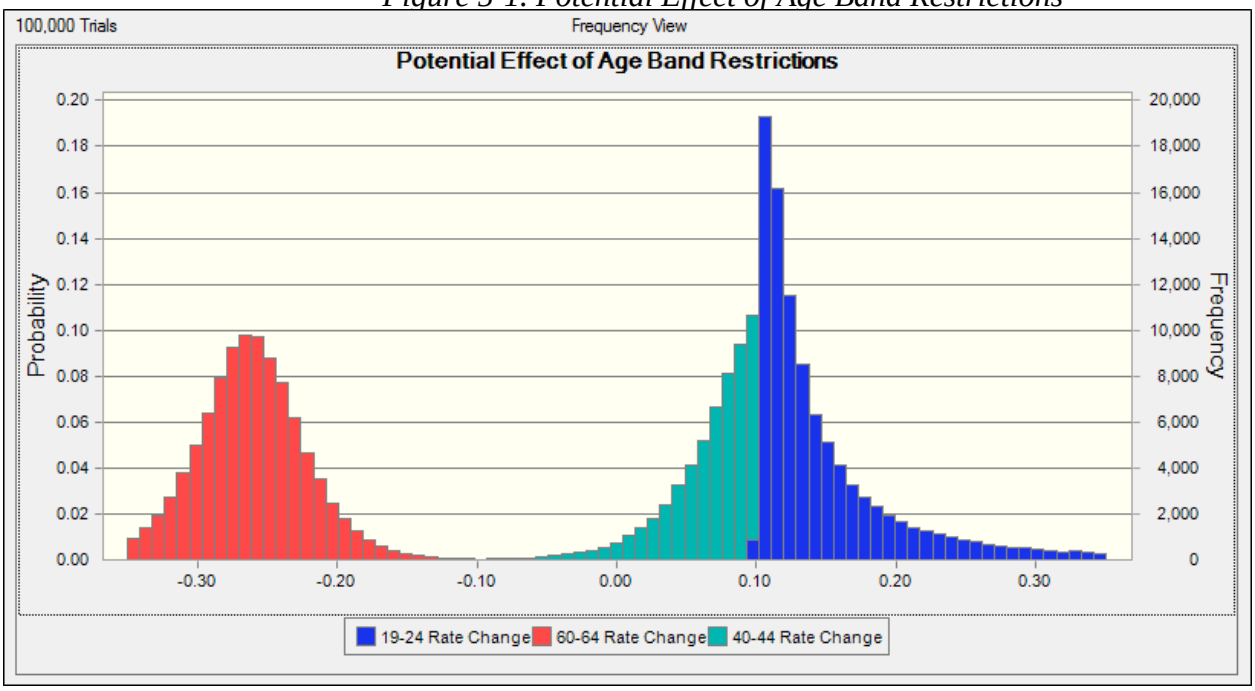
Figure 5-1 illustrates a possible range of premium changes for three age ranges around the expected values listed above. It demonstrates that the oldest and youngest ages face the largest potential changes in their premium, depending on how carriers modify their age bands. Premium changes for individuals aged 60–64 will most likely be between -20 percent and -30 percent. Premium changes for the youngest individuals are most likely to be between 10 percent and 34 percent. The rate effects for the youngest individuals are expected to have the highest variation. The variation in the 40–44 band is representative of possible changes for most other age bands. For these other age bands, we expect the rate changes to be most likely between -2 percent and 14 percent.

The variation in outcomes is primarily a result of two factors:

- The flexibility allowed an insurance carrier in implementing the reform
- Each carrier's specific age-curve and demographic distribution

It should be noted that the shape of the possible outcomes vary by age because the current industry-wide average age factors are not evenly distributed from the lowest to highest ages.

Figure 5-1. Potential Effect of Age Band Restrictions



Health Status/Guaranteed-Issue Restrictions

Alaska does not currently prevent or limit an insurance carrier's use of an individual's health status to develop that individual's premium rate. A carrier is allowed to charge a higher or lower premium if it believes that the individual has a corresponding higher or lower claim risk. In addition, a carrier is allowed to deny coverage to an individual if it determines that the individual has an extremely high expected claim risk.

Since a carrier can choose to offer coverage to the best risks and charge more for unhealthier risks, and decline coverage to the unhealthiest, the average health status of a consumer covered in the Individual market is typically better than in other markets.

As a result of the ACA, in 2014 carriers will not be permitted to deny coverage or charge different rates based on an individual's health status. Carriers that now use such rating practices will have to eliminate them. As a result, it is expected that the average claim risk of a carrier's individual block of business to increase as unhealthier consumers purchase coverage.

The ACA's guaranteed-issue requirement will also impact the Individual market. Since carriers will no longer be able to deny coverage to high-risk individuals, premiums may be modified to compensate for the worsening of the average health status of the individual risk pool.

Based on the Department of Health and Human Services (HHS) Medical Expenditure Panel Survey (MEPS) and claims experience for Alaska insurers, the

average health status of Alaska's individually insured market and the uninsured above 138 percent FPL was estimated. *Table 5-3* below excludes the currently uninsured with incomes below 138 percent FPL since they will be eligible for expanded Medicaid coverage under ACA reforms.

Table 5-3 Average Health Status of the Individually Insured and Uninsured in Alaska

Current population	Number	Risk factor
Uninsured (>138% FPL)		
Good to excellent health	82,163	0.81
Fair to poor health	11,402	4.02
Subtotal	93,566	1.20
Individually insured		
Good to excellent health	18,066	0.63
Fair to poor health	2,276	2.86
Subtotal	20,341	0.88
Combined		
Good to excellent health	100,229	0.78
Fair to poor health	13,678	3.83
Subtotal	113,907	1.14

This data implies that policyholders in the Individual market are approximately 13 percent healthier than an average Alaskan (1.00/0.88–1). Alaska's uninsured population is approximately 20 percent riskier than an average Alaskan and approximately 36 percent riskier than a policyholder in the Individual market (1.20/0.88–1). This relationship results from a carrier being allowed to deny coverage to an individual if it determines that the individual has an extremely high expected claim risk.

If every uninsured individual eligible to purchase coverage through the Exchange did purchase coverage, the addition of the previously uninsured with the currently individually insured would create a risk pool that would have an average health status approximately 14 percent higher than the average status across all Alaskans. However, it is not expected that all of the healthy eligible uninsured will purchase coverage within the Exchange or that all individuals who are below the 138 percent FPL will use Medicaid.

L&E's projections assume that the risk profile of someone who joins the Exchange will be worse than a person who is eligible to join. We expect that a larger percentage of the unhealthy would join the Exchange to receive insurance coverage as compared to the healthy who may decide to apply for an affordability waiver, ignore the mandate, or purchase coverage elsewhere.

The projections also assume that unhealthy individuals who purchase coverage in the Exchange will have a worse risk profile than the unhealthy that are eligible for the Exchange. L&E projected that a portion of the healthiest high-risk uninsured individuals will decide to forgo coverage in the Exchange.

A myriad of scenarios were modeled in which uninsured individuals with different health statuses would enter the Individual market. *Table 5-4* illustrates the approximate health status distribution of the current individually insured market compared to a possible scenario after uninsured individuals are allowed to join the individual risk pool.

Table 5-4 Current and Modeled Population Risk Factors

Status	Current population		Modeled population	
	Number	Risk factor	Number	Risk factor
Individually insured				
Good to excellent health	18,066	0.63	47,382	0.76
Fair to poor health	2,276	2.86	8,613	3.79
Subtotal	20,341	0.88	55,994	1.23

The models project that the new Individual market, which includes previously uninsured individuals, will be approximately 23 percent riskier than an average Alaskan and approximately 39 percent riskier than a policyholder in the pre-reform individual market (1.23 / 0.88 - 1).

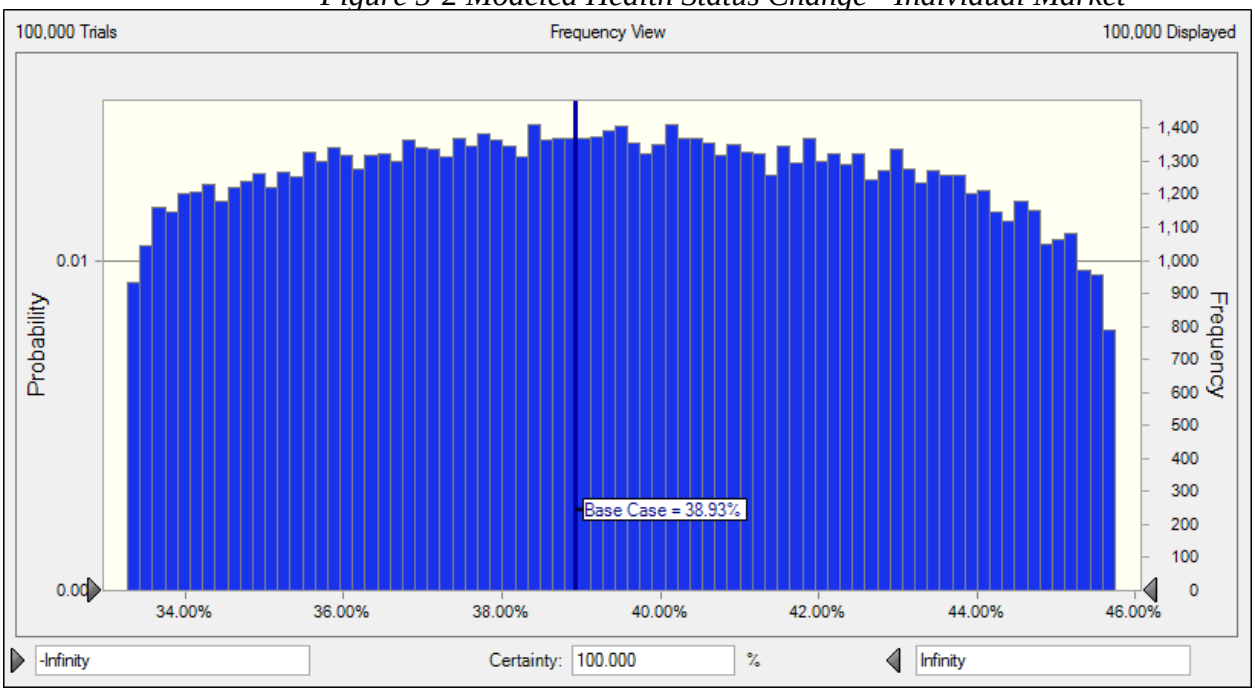
The above results do not include the additional adverse selection that could occur as a result of the currently insured individuals reacting to any negative impacts as a result of the previously uninsured worsening their risk pool. The impact of this type of adverse selection will be discussed in the summary section below.

It should be noted that this projected worsening of the risk pool might not affect premiums in an Exchange in the same magnitude, at least initially. Other ACA reforms, such as the temporary reinsurance and risk corridor mechanisms, are expected to alleviate some of the initial market disruption that would otherwise be caused by an increase in risk factors.

Figure 5-2 illustrates the range of likely outcomes for the worsening in health status for the individual risk pool around the expected change of 39 percent. The likely range around the base case scenario was defined as plus or minus one standard deviation. The likely outcomes for the worsening in health status are expected to be from 33 percent and 46 percent. The variation in outcomes is a result of two primary factors:

- How many uninsured individuals ultimately decide to purchase coverage
- The average risk for the pool of uninsured individuals who purchase coverage

Figure 5-2 Modeled Health Status Change - Individual Market



Minimum Benefit Coverage Requirements

An individual's premium rate can vary greatly based on the level of benefit coverage purchased.

Policyholders purchasing more comprehensive benefits will be charged a correspondingly higher premium, all other things equal. In order to assess the value of the benefits purchased in the Alaska Individual market, we obtained outlines of coverage for plans sold.

The ACA has two primary definitions concerning the level of required benefits. It requires that Qualified Health Plans (QHPs) provide at least the "minimum essential benefits." To date, this benefit package has yet to be specified by HHS. The second definition centers on the four "metal" levels of benefit, which correspond to different values of benefits expected to be paid by the carrier.

This benefit measurement is based on an Actuarial Value (AV), which represents the average amount of medical expenses that would be paid by the insurance carrier, expressed in terms of a percentage. A high AV implies a rich benefit plan, while a low one indicates a health plan where a consumer may have substantial cost-sharing requirements. The four "metal" benefit levels defined by the ACA as measured by AVs are:

- Bronze: 60 percent AV
- Silver: 70 percent AV
- Gold: 80 percent AV
- Platinum: 90 percent AV

A fifth plan, the catastrophic plan, would cover individuals up to age 30 or who are otherwise exempt from the individual mandates. This plan will provide coverage for essential health benefits and have deductibles equal to the amounts specified as out-of-pocket limits for HSA-qualified HDHPs. Its benefits are defined by specific cost-sharing provisions rather than an AV. The impact of this plan has not been modeled.

Policyholders whose current benefits are less than the ACA defined Bronze benefit package will face premium changes to compensate for the ACA minimum benefit requirements. In order to model the likelihood of this occurring, an assessment of the outlines was made. The average AV for the current Alaska Individual market was estimated to be 0.64. That is, insurance carriers now pay an average of approximately 64 percent of policyholders' medical expenses.

The current plans sold in Alaska were classified by the "metal" categories they would fall into under ACA requirements (*Table 5-5*). Policies that do not meet Bronze benefit requirements were assigned to a "Low" category.

Table 5-5 Distribution of Current Alaska Individual Insurance Plans by ACA "Metal" Categories

Benefit Category	2010 Distribution	Average Value	Benefit Increase
Low	12.0%	0.48	26.3%
Bronze	79.0%	0.61	0.0%
Silver	9.0%	0.68	0.0%
Gold	0.0%	0.78	0.0%
Platinum	0.0%	0.88	0.0%
	100.0%	0.60	3.2%

Table 5-5 shows that across the aggregate Individual market, benefit levels would need to be increased by approximately 3 percent on average.

For the 12 percent of Alaskans who do not meet the Bronze benefit requirements, they would have to purchase benefit plans with approximately 26.3 percent richer benefits than their current plan. These individuals would likely face a corresponding change in premium.

It is estimated that 88 percent of the current Alaska individual market consists of benefit plans that appear to meet ACA minimum requirements based solely on AV.

Based on the information provided, it appears that most of the low benefit plans are sold through Association Health Plans, and not sold through the regular Individual market.

Please note that even though a plan may have an AV that meets at least Bronze level requirements, the plan might still require changes to comply with other ACA requirements, such as for covered benefits and out-of-pocket maximums.

TOTAL EFFECT OF INSURANCE REFORMS

Table 5-6 summarizes the average aggregate effect of the three primary insurance reforms that will affect the Individual market. This summary does not yet account for the additional adverse selection that could occur as a result of currently insured individuals reacting to any negative impacts of the coverage expansion.

Table 5-6 Aggregate Effects of Three Insurance Reforms

Reform	Average impact
Age	0.0%
Health status / Guaranteed Issue	39.5%
Benefits	3.2%
Combined	43.9%

In order to assess the variability of the estimated aggregate impact of the three reforms, a simulation model that combines the analysis for each reform was created.

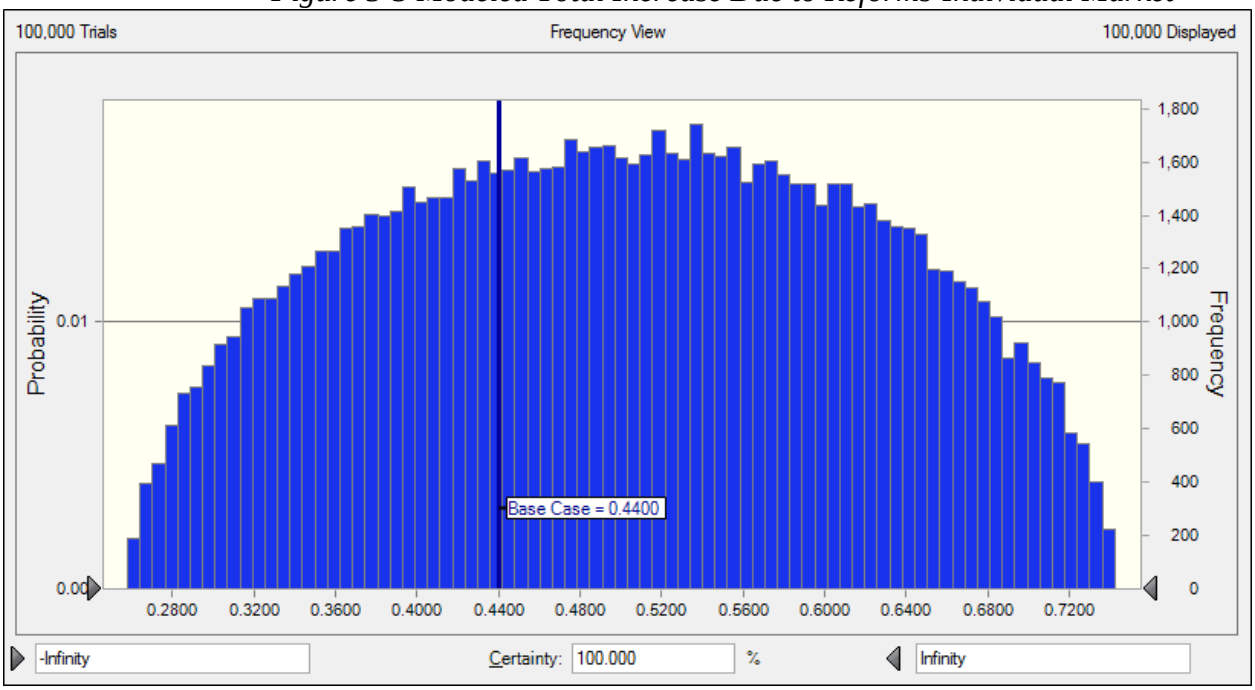
The variation in the outcomes is related to the uncertainty surrounding how the reforms will be implemented by each carrier and the uncertainty regarding the decision-making process for each consumer. The variables include:

- How each carrier implements the age band restriction
- Each carrier's demographic mix
- The consumer's decision regarding the chosen level of benefits
- How many uninsured individuals decide to purchase coverage as a result of all of the reforms
- The average risk for the pool of uninsured individuals who purchase coverage

In general, consumers who are expected to benefit the most from the insurance reforms will be older people in poor health. In general, those who are expected to be disadvantaged by the insurance reforms will be young, healthy individuals. As noted previously, these projections do not include other possible reform impacts such as reinsurance and risk adjustment programs.

Figure 5-3 illustrates significant variability in how these reforms might affect a specific consumer. The range of likely outcomes around the base case scenario was defined to be plus or minus one standard deviation.

Figure 5-3 Modeled Total Increase Due to Reforms-Individual Market



ADVERSE SELECTION

In addition to modeling the impact of the combination of these three reforms, a variable to adjust for potential adverse selection based on consumer behavior of the currently insured population was added. Based on the projected changes as a result of the reforms themselves and the risk profile of the previously uninsured population, it is expected that younger, healthier individuals would face the largest possible changes as a result of the insurance reforms. It is expected that a portion of these individuals may decide to drop coverage for financial reasons, even in an environment with an individual mandate.

The models project that the percentage of healthy persons who drop coverage will be approximately equal to one half of a typical one-year claim cost trend. After this projected 5–6 percent drop in enrollment, the premium change needed for the remaining enrollees that would keep the drop in enrollment revenue-neutral was modeled.

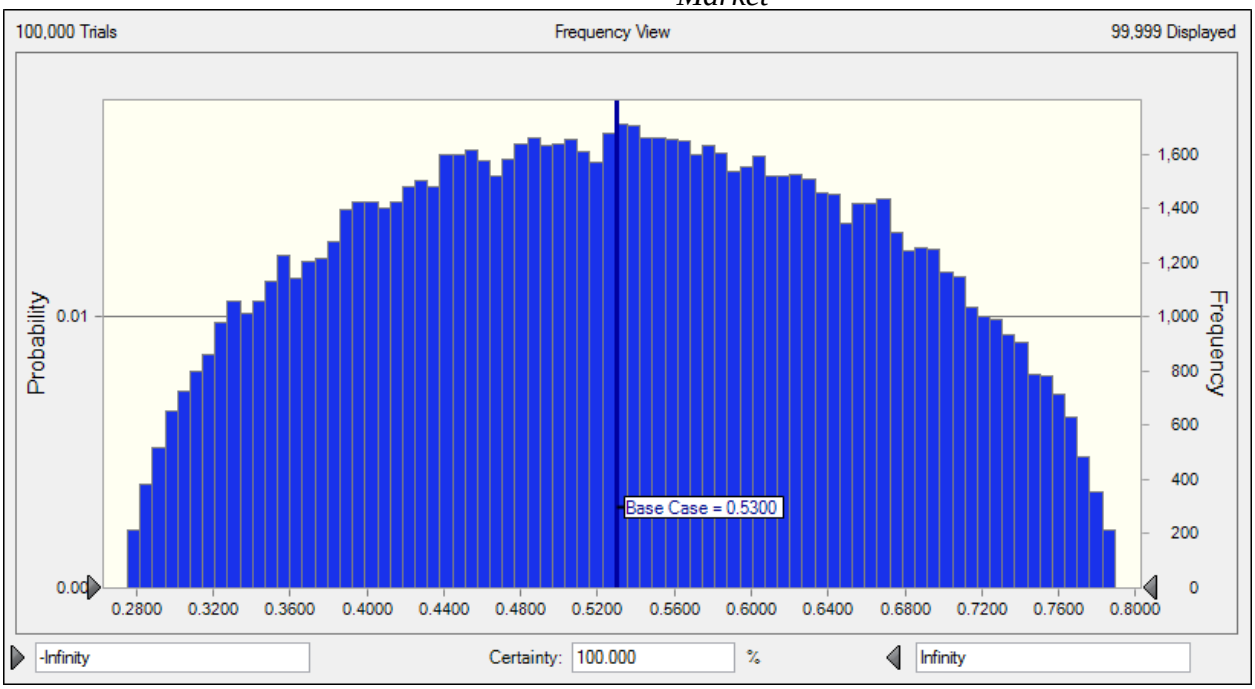
This resulted in an additional marketplace rate change of approximately 8 percent that may be needed to counteract adverse selection. *Table 5-7* summarizes the average aggregate effect of the three primary insurance reforms, including the anticipated additional adverse selection.

Table 5-7 Effect of Insurance Reforms, Including Adverse Selection

Reform	Average impact
Age	0.0%
Health status / Guaranteed Issue	39.5%
Benefits	3.2%
Additional adverse selection	6.4%
Combined	53.2%

Figure 5-4 illustrates the variability in how these reforms might affect a specific consumer. The variables that affected the results in *Figure 5-3* also affect the range of outcomes shown in *Figure 5-4*.

Figure 5-4 Modeled Increase Due to Reforms with Adverse Selection – Individual Market



SMALL GROUP MARKET

Many of the ACA reforms that impacted the Individual market could also affect those in the Small Group market, including the three mentioned above: age rating limitations, health status/guaranteed-issue restrictions, and minimum benefit re-

quirements. Due to different governing regulation for the small employer market, the ACA reforms are expected to impact this market differently.

Under current Alaska regulations, a small group is defined as an employer with 2–50 eligible employees. The primary difference with the Individual market is that carriers currently cannot deny coverage to small groups that seek it. In addition, there are limits on using health status to develop premiums. Carriers can increase or decrease an employer's rate by 35 percent based on the average health status of the group.

The ultimate premium impact will also be shaped by previously uninsured consumers who purchase coverage in the small employer market. We expect that some employers will drop coverage, others will begin to offer coverage, and some individuals who previously declined coverage will purchase coverage. However, due to the nature of the ACA reforms, it is not expected that the net enrollment change in the small employer market to be dramatic.

Age Rating Limitations

Like the Individual market, Alaska's insurance rules allow carrier's to fully rate for age. Because Alaska allows an insurer to rate for age, the age factors for most plans sold in Alaska were obtained to analyze the affect of the new ACA age band regulations. *Table 5-8* illustrates the average age factors compared to age 42, as well as the current age distribution.

To model the impact of this requirement, the age rating factors currently in use were reviewed. *Table 5-8* illustrates the average age factors compared with a company with an average age of 42 for the Alaska small group marketplace, as well as the current age distribution. These factors indicate what an employer would pay for a census with a certain average age relative to an employer with an average age of 42 years old. For example, for every $100 paid by an employer with an average age of 42-years-old (factor = 1.0000), an employer with an average age of 22-years-old would pay $60.64 (factor = 0.6064), and an employer with an average age of 62-years-old would pay $279.88 (factor = 2.7988).

Table 5-8 Average Demographic Effects on Small Group Market

Age	Average Factor	Average Distribution
Under 25	0.6064	9%
25–29	0.7569	7%
30–34	0.7820	13%
35–39	0.8704	14%
40–44	1.0000	13%
45–49	1.2150	14%
50–54	1.5876	14%
55–59	2.1390	10%
60–64	2.7988	6%

Based on the collected data, the average premium charged for an employer with an average age of 62-years-old is approximately 4.6 times higher than for an employer with an average age under 25. Therefore, it appears that some carriers will need to adjust their age rating factors to comply with the ACA's 3:1 maximum ratio.

As with the Individual market, the ACA does not explicitly state how a carrier must meet these requirements. The impact of the anticipated average effect of the age band limitation was modeled the same way as the Individual market modeling.

The projections in *Table 5-9* illustrate one possible scenario for compressing rating factors to comply with ACA requirements.

Table 5-9 Possible Effect of Age Band Compression

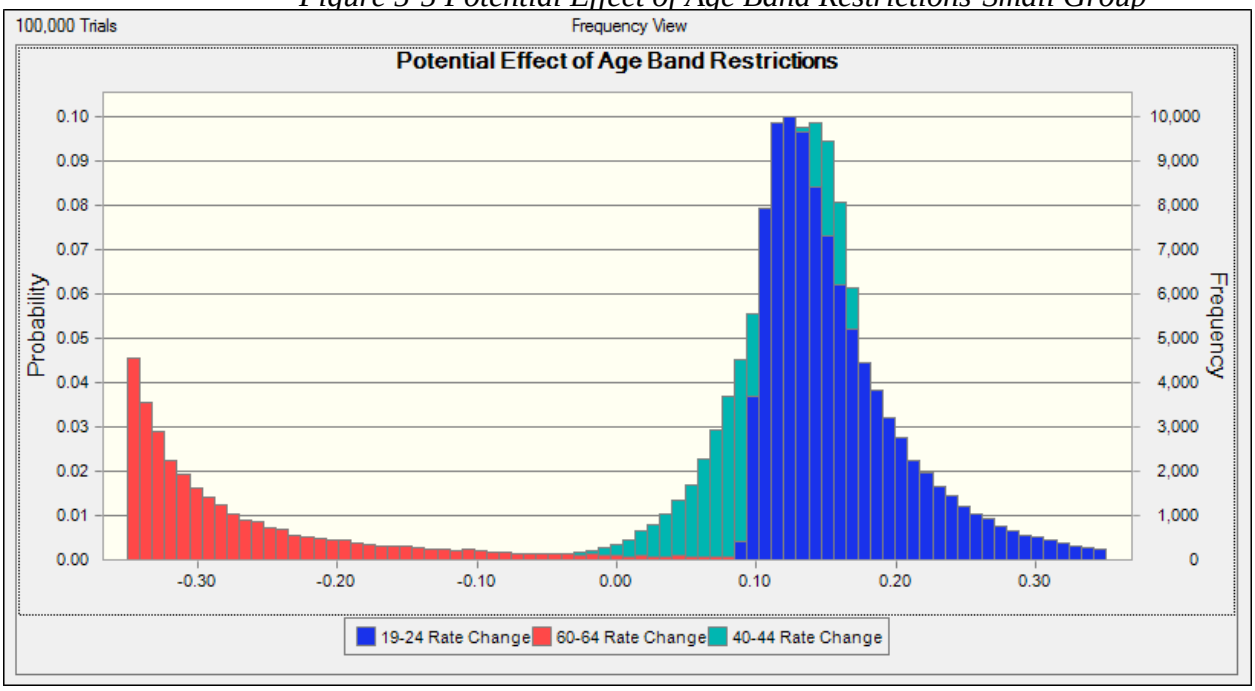
Age	Current factor	Current distribution	Projected factor	Projected new distribution	Implied effect
Under 25	0.606	9%	0.663	9%	9.4%
25–29	0.757	7%	0.828	8%	9.4%
30–34	0.782	13%	0.855	13%	9.4%
35–39	0.870	14%	0.952	14%	9.4%
40–44	1.000	13%	1.094	13%	9.4%
45–49	1.215	14%	1.329	14%	9.4%
50–54	1.588	14%	1.687	13%	6.3%
55–59	2.139	10%	1.950	10%	-8.9%
60–64	2.799	6%	1.971	6%	-29.6%
		100%		100%	0.0%

The above projection was based on market averages. It is expected that some small employers with a young average age would see a change in premium greater than 9 percent based solely on their average age, and some employers with older average ages to see their premiums reduced by more than 29 percent.

Figure 5-5 illustrates a possible range of premium changes for three age ranges around the expected values listed above. It demonstrates that the employers with the oldest and youngest ages face the largest potential changes in their premium, depending on how carriers modify their age bands. Premium changes for groups with employees with an average age of 60–64 will most likely be between -20 percent and -40 percent. Premium changes for small groups with the youngest average employees are most likely to be between 10 percent and 30 percent. As with the Individual market, the rate effects for employers with the youngest average age employees are expected to have the highest variation of potential effects. The variation in the 40–44 band is representative of possible changes for most other age bands. For these other age bands, we expect the rate changes to be most likely between -2 percent and 18 percent.

It should be noted that the shape of the possible outcomes vary by age because the current industry-wide average age factors are not evenly distributed from the lowest to highest ages.

Figure 5-5 Potential Effect of Age Band Restrictions-Small Group



Health Status/Guaranteed-Issue Restrictions

As previously mentioned, Alaska limits a carrier's rating practice as it relates to using health status for a small employer group seeking coverage. An insurance carrier is allowed to adjust the premium rate of an employer by plus or minus 35 percent based on the average health status of the employees in a small group.

Additionally, Alaska requires an insurance carrier to cover a small group regardless of the health status of the employees of that group. That is, the carrier cannot deny coverage to that employer. Due to these regulatory restrictions, the average health status of a consumer covered in the small employer market is typically worse than the average health status of consumers in the Individual market.

In 2014, carriers will not be permitted to use health underwriting for small employer coverage. Therefore, carriers that currently use rating band adjustments will have to eliminate the practice.

The impact of the ACA's guaranteed-issue requirement for the Small Group market is expected to be small on average. However, there may be significant rate increases or decreases depending on the current health status of the group. Since carriers will no longer be able to charge the appropriate premium to high-risk groups, premiums may be modified to compensate.

Based on MEPS and claims experience for Alaska insurers, the average health status of Alaska's Small Group market was estimated. *Table 5-10* below shows the estimated health status for the current Small Group market.

Table 5-10 Health Status of the Current Small Group Market Alaska

Current population	Distribution	Risk factor
Small Group insured		
Excellent	50.9%	0.53
Very Good	18.7%	0.80
Good	16.4%	1.00
Fair	13.9%	2.90
Poor	0.1%	16.00
Subtotal	100.0%	1.00

This data implies the health status risk in the Small Group market is approximately the same as an average Alaskan. However, it is not expected that all of the healthy eligible small groups will purchase coverage within the Exchange.

L&E's projections assume that the risk profile of the groups who joins the Exchange will be the same as the groups who do not purchase in the exchange. This is due to requirement of insurers to pool all small groups. However, small employers with very healthy employees may choose to self insure as oppose to purchasing insurance. This anti-selection will be addressed later in this section.

As noted above, the impact of the ACA's guaranteed-issue requirement for the Small Group market is expected to be small on average. However, some groups could see an increase as high as 70% and a decrease as low as 45%. An example of an extreme case would be a small company with 5 male employees, with an average age around 62, with the highest area and industry factors, extremely poor health would see an extremely high decrease in premiums after all ACA reforms are implemented.

Minimum Benefit Coverage Requirements

As in the Individual market, premium rates in the Small Group market can vary greatly based on the level of benefit coverage purchased. Small groups that purchase more comprehensive benefits are charged a correspondingly higher premium. In order to assess the value of the benefits purchased in the Alaska small employer market, outlines of coverage for plans sold were obtained.

Based on these benefit outlines, the average AV for the current Alaska small employer market was approximated to be 0.62. That is, the carrier will pay for approximately 62 percent of medical expenses.

Table 5-11 summarizes the AV of current small group plans by the "metal" benefit category under ACA requirements. Policies that did not meet Bronze benefit requirements were assigned to a "Low" category.

Table 5-11 Distribution of Current Small Group Alaska Insurance Plans by ACA "Metal" Categories

Benefit Category	2010 Distribution	Average Value	Benefit Increase
Low	5.0%	0.50	21.2%
Bronze	70.0%	0.60	0.0%
Silver	24.0%	0.69	0.0%
Gold	1.0%	0.77	0.0%
Platinum	0.0%	0.88	0.0%
	100.0%	0.62	1.1%

Based on the current distribution of benefit packages sold, benefit levels in the Small Group market would need to be increased by approximately 1.1 percent on average.

Approximately 95 percent of Alaskans covered in the small employer market have benefit plans that would meet the ACA's Bronze level of benefits. The remaining 5 percent would need to purchase plans with approximately 21 percent richer benefits to reach a Bronze level of coverage. These employers would likely face a corresponding change in premium.

Please note that even though a plan may have an AV that's at least a Bronze benefit level, the plan might still require changes to comply with other ACA requirements, such as for covered benefits and out-of-pocket maximums.

Total Effect of Insurance Reforms

In the absence of anti-selection, the ACA requirements are not likely to dramatically change the premiums in the small employer market. *Table 5-12* shows L&E's estimate of the overall effect for the Small Group market.

Even though significant changes are not expected for the small employer market, some employers and employees will nevertheless be impacted since a small percent of employers will need to increase benefit offerings to meet minimum requirements.

Table 5-12 Aggregate Effects of Three Insurance Reforms-Small Group Market

Reform	Average impact
Age	0.0%
Health status / Guaranteed Issue	0.0%
Benefits	1.1%
Combined	1.1%

In order to assess the variability of the estimated aggregate impact of the three reforms, a simulation model that combines the analysis for each reform was created.

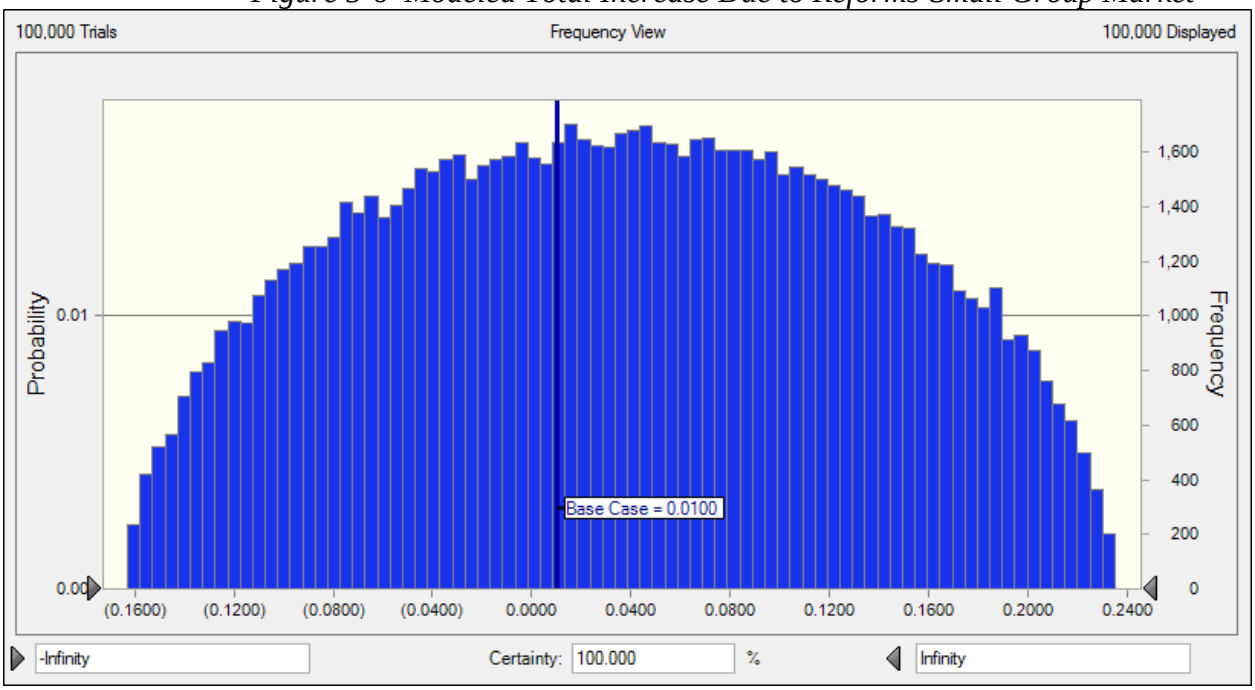
The variation in the outcomes is related to the uncertainty surrounding how the reforms will be implemented by each carrier and the uncertainty regarding the decision-making process for each consumer. The variables include:

- How each carrier implements the age band restriction
- Each carrier's demographic mix
- The consumer's decision regarding the chosen level of benefits
- How many Small Groups decide to self insure or drop coverage as a result of the reforms

In general, consumers who are expected to benefit the most from the insurance reforms will be the employers with the oldest average people in poor health. In general, those who are expected to be disadvantaged by the insurance reforms will be employers with young, healthy individuals. As noted previously, these projections do not include other possible reform impacts such as reinsurance and risk adjustment programs.

Figure 5-6 illustrates significant variability in how these reforms might affect a specific consumer. The likely range around the base case scenario was defined as plus or minus one standard deviation.

Figure 5-6 Modeled Total Increase Due to Reforms-Small Group Market



ADVERSE SELECTION

In addition to modeling the impact of the combination of the three primary reforms, a variable was added to adjust for potential adverse selection based on consumer behavior of the currently insured population. Based on the projected changes as a result of the reforms themselves, it is expected that some employers with younger, healthier individuals would face the largest possible changes as a result of the insurance reforms. It is possible that a portion of these small groups may decide to drop coverage for financial reasons or drop coverage altogether.

The models project that a small percentage of the small groups will drop coverage or self insure. After this projected drop in enrollment, the premium change needed for the remaining small groups that would keep the drop in enrollment revenue-neutral was modeled.

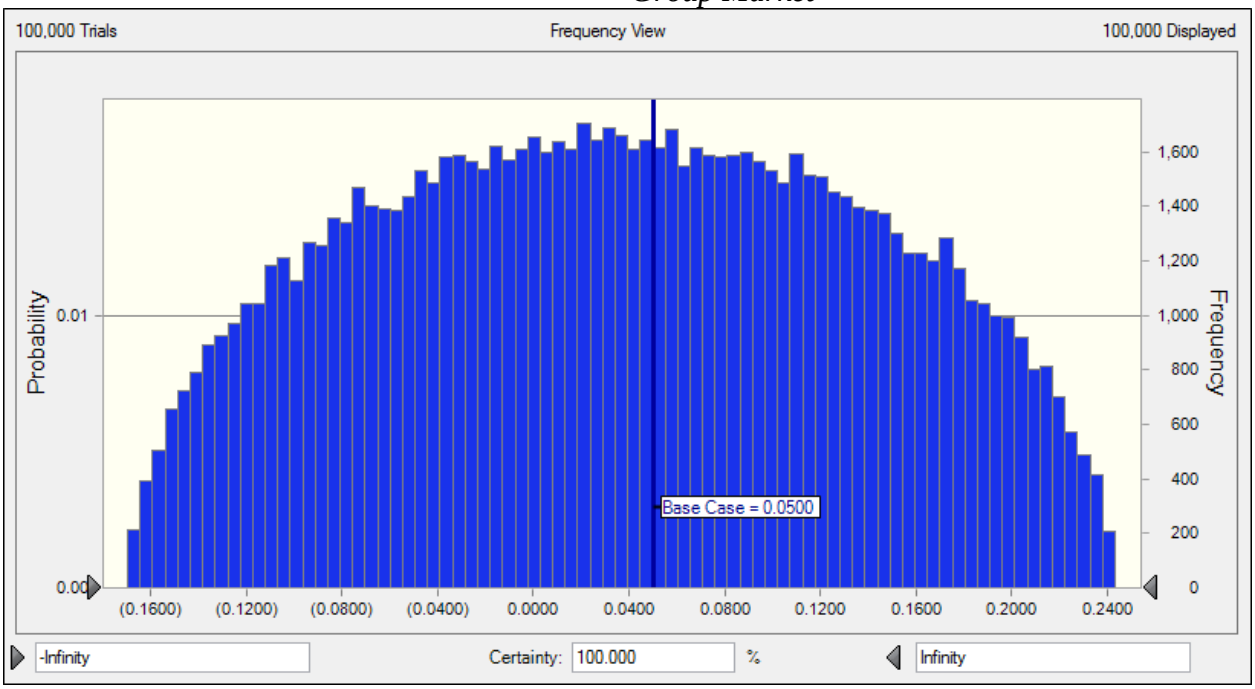
An additional marketplace rate change of approximately 4 percent that may be needed to counteract adverse selection. *Table 5-13* summarizes the average aggregate effect of the three primary insurance reforms, including the anticipated additional adverse selection.

Table 5-13 Effect of Insurance Reforms, Including Adverse Selection – Small Group Market

Reform	Average impact
Age	0.0%
Health status / Guaranteed Issue	0.0%
Benefits	1.1%
Additional adverse selection	3.6%
Combined	4.7%

Figure 5-7 illustrates the variability in how these reforms might affect a specific small employer. The variables that affected the results in Figure 5-6 also affect the range of outcomes shown in Figure 5-7.

Figure 5-7 Modeled Increase Due to Reforms with Adverse Selection – Small Group Market



Chapter 6
Alternative Scenario (No Individual Mandate)

ALTERNATIVE SCENARIO – POPULATION PROJECTIONS (NO INDIVIDUAL MANDATE)

Officials in Alaska have publicly stated the position that the individual mandate in the ACA is unconstitutional. Because of this position, L&E was asked to adjust the actuarial models to account for the possible removal of the individual mandate. If the individual mandate is eliminated as part of the reform package, effects on Exchange enrollment and premium levels will likely be significant.

Table 6-1 shows the best estimate of future migrations of the current population in Alaska assuming the same assumptions as the base projection except the individual mandate has not been included.

Table 6-1 Projected Population Inside and Outside of the Exchange after implementation of ACA reforms without an Individual Mandate

Projected Markets	*Current Alaska Market*					Projected Totals
	ESI	Individual	Medicaid + CHIP	Other Insurance	Uninsured	
Medicaid + CHIP	0	0	90,000	0	25,000	115,000
Employer in Exchange	6,000	0	0	0	0	6,000
Employer out of Exchange	354,000	0	0	0	0	354,000
Individual in Exchange	8,000	3,000	3,000	0	40,000	54,000
Individual out of Exchange	0	13,000	0	0	7,000	20,000
Other Insurance	0	0	0	35,000	0	35,000
Uninsured	0	4,000	0	0	67,000	71,000
Total	368,000	20,000	93,000	35,000	139,000	655,000

*Other insurance refers to Individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE.

Table 6-2 shows possible variations in population movement around the best estimate shown in *Table 6-1*. The range below is the expected 95% confidence interval.

Table 6-2 Possible ranges for Projected Population Inside and Outside of the Exchange after implementation of ACA reforms without an Individual Mandate

Projected Markets	*Current Markets*					Totals
	ESI	Individual	Medicaid + CHIP	Other Insurance	Uninsured	
Medicaid + CHIP	0	(0, 3,000)	(86,000, 91,000)	0	(20,000, 29,000)	115,000
Employer in Exchange	(5,000, 8,000)	0	0	0	0	6,000
Employer outside Exchange	(340,000, 357,000)	0	0	0	0	354,000
Individual in Exchange	(4,000, 22,000)	(3,000, 4,000)	(1,000, 7,000)	0	(32,000, 54,000)	54,000
Individual outside Exchange	0	(10,000, 14,000)	0	0	(6,000, 9,000)	20,000
Other Insurance	0	0	0	35,000	0	35,000
Uninsured	0	(3,000, 5,000)	0	0	(53,000, 75,000)	71,000
Total	368,000	20,000	93,000	35,000	139,000	655,000

In this alternative scenario, there are several differences versus the baseline scenario.

- The uninsured population is expected to decrease by approximately 50% compared to an expected 70% reduction in the baseline scenario.
    - It is expected that healthy uninsureds that are not eligible for a subsidy will mostly remain uninsured. The reduced number of healthy uninsureds obtaining coverage will have a significant impact on the overall rate increase expected for the individual market. This will be discussed later in this section.
    - It is expected that fewer consumers will purchase insurance with the absence of a financial penalty.
- The Medicaid / CHIP population is expected to still increase by approximately 25% under the alternative scenario.
- The employer market is not expected to be materially affected by the removal of the individual mandate.
- It is expected that the Individual market will still increase by a significant amount on a percentage basis. This is the result of the subsidy provided

for eligible Alaskans and the small number of Alaskans currently enrolled in the Individual market.

- The insured market is projected to increase by about 54,000 lives. 78% of this increase will be new enrollees.

- The take up rate for the new individual population in the exchange is projected to be around 73%. This is primarily due to individuals being eligible for a subsidy.

ALTERNATIVE SCENARIO - PREMIUM EFFECT (NO INDIVIDUAL MANDATE)

Under the alternative scenario, it was found that there was limited change from the baseline projection except for the Health Status/Guaranteed Issue reform in the Individual market.

It is expected that a larger percentage of unhealthy individuals would join the Exchange as compared to healthy individuals with the removal of the individual mandate. The projections assume that unhealthy individuals who purchase coverage in the Exchange will have a worse risk profile than the unhealthy that are eligible for the Exchange but don't purchase coverage. L&E projected that a portion of the healthiest high-risk uninsured individuals will decide to forgo coverage in the Exchange.

Age Rating Limitations (No Individual Mandate)

In the alternative scenario, it was still assumed that the ACA would require that the premium for the oldest policyholder cannot be more than 3 times the premium for the youngest policyholder. A key difference in the alternative scenario is that without the individual mandate the younger, healthier uninsureds will be less likely to purchase coverage.

This portion of the projection does not include any additional adverse selection effects that could occur based on either the introduction of the age band requirement or the impact of previously uninsured persons. This will be discussed in the aggregate summary section below.

The projections in *Table 6-3* illustrate one possible scenario for compressing rating factors to comply with ACA requirements under the assumption that the individual mandate is not included.

Table 6-3 Possible Effect of Age Band Compression

Age	Current factor	Current distribution	Projected factor	Projected new distribution	Implied effect
Under 25	0.541	1%	0.605	10%	11.7%
25–29	0.628	10%	0.701	12%	11.7%
30–34	0.717	10%	0.801	15%	11.7%
35–39	0.834	12%	0.932	10%	11.7%
40–44	1.000	13%	1.117	11%	11.7%
45–49	1.237	14%	1.382	13%	11.7%
50–54	1.677	15%	1.745	11%	4.1%
55–59	2.004	14%	1.769	11%	-11.7%
60–64	2.403	10%	1.793	8%	-25.4%
		100%		100%	0.0%

For the Age reform only, premium rates for the various age groupings are expected to increase by approximately 2% with the removal of the individual mandate.

The above projection was based on using market wide averages. It is expected that some young Alaskans would see a change in premium greater than 11 percent based solely on their age, and some older Alaskans would see their premiums reduced by more than 25 percent.

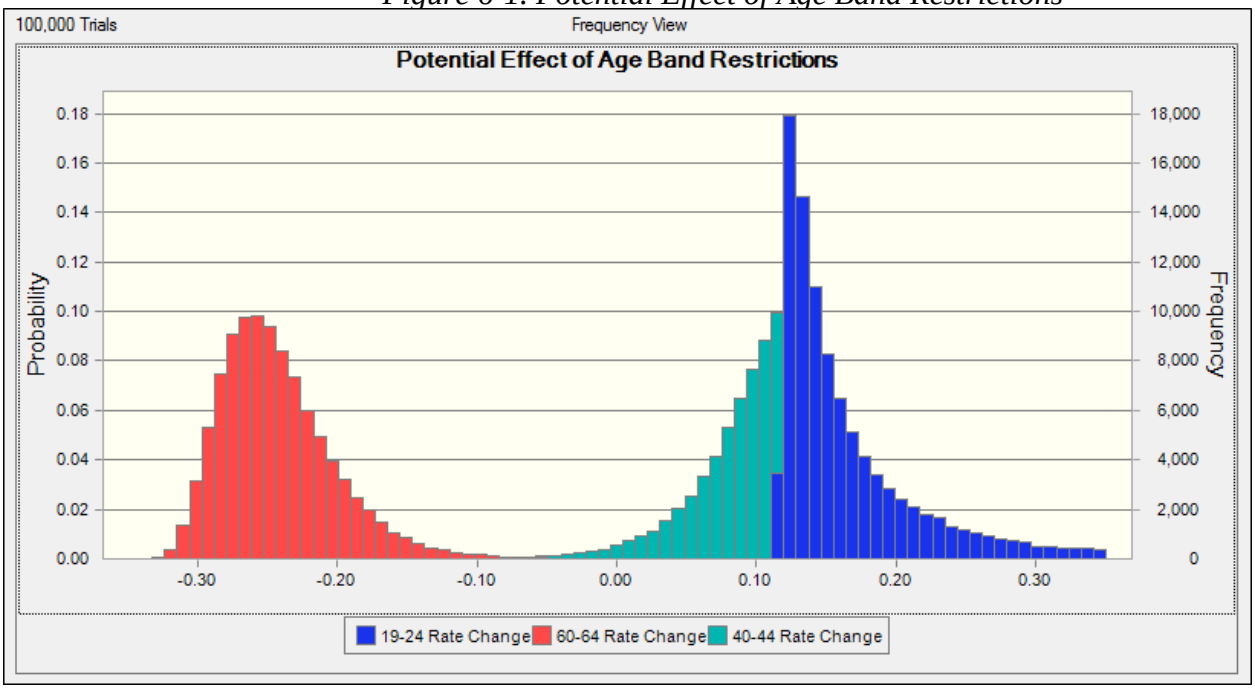
Figure 6-1 illustrates a possible range of premium changes for three age ranges around the expected values listed above. It demonstrates that the oldest and youngest age ranges face the largest potential changes in their premium, depending on how carriers modify their age bands. Premium changes for individuals aged 60–64 will most likely be between -20 percent and -30 percent. Premium changes for the youngest individuals are most likely to be between 11 percent and 34 percent. The rate effects for the youngest individuals are expected to have the highest possible variations. The variation in the 40–44 band is representative of possible changes for most other age bands. For these other age bands, we expect the rate changes to be most likely between -2 percent and 14 percent.

The variation in outcomes is primarily a result of two factors:

- The flexibility allowed an insurance carrier in implementing the reform
- Each carrier's specific age-curve and demographic distribution

It should be noted that the shape of the possible outcomes vary by age because the current industry-wide average age factors are not evenly distributed from the lowest to highest ages.

Figure 6-1. Potential Effect of Age Band Restrictions



Health Status/Guaranteed-Issue Restrictions (No Individual Mandate)

The Health Status/Guaranteed-Issue restrictions will have the largest impact on premiums in an environment without an individual mandate.

100,000 scenarios were modeled in which uninsured individuals with different health statuses would enter the Individual market. *Table 6-4* illustrates the approximate health status distribution of the individually insured market after uninsured individuals are allowed to join the individual risk pool in the alternative scenario.

Table 6-4 Current and Modeled Population Risk Factors

Status	Current population		Modeled population	
	Number	Risk factor	Number	Risk factor
Individually insured				
Good to excellent health	18,066	0.63	36,018	0.74
Fair to poor health	2,276	2.86	8,613	3.79
Subtotal	20,341	0.88	44,630	1.33

The models estimate that the new individual market without a mandate, which includes previously uninsured individuals, will be approximately 33 percent riskier than an average Alaskan and approximately 51 percent riskier than a policyholder in the pre-reform individual market (1.33 / 0.88 - 1).

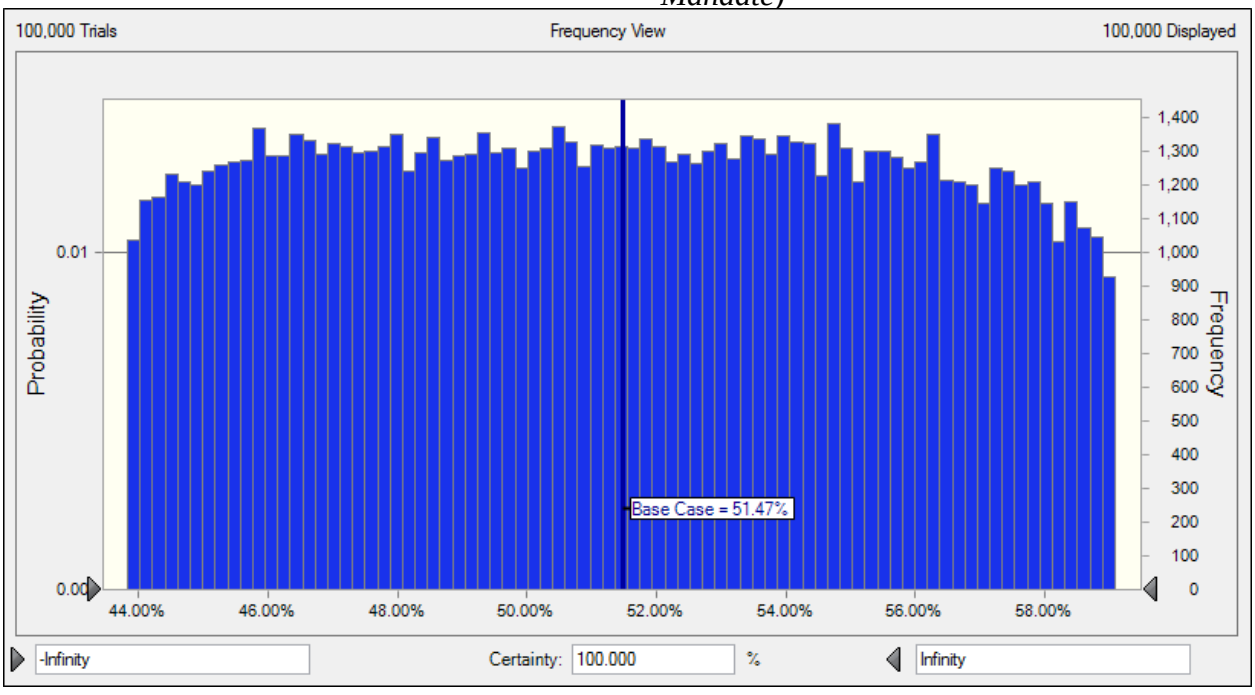
The above results do not include the additional adverse selection that could occur as a result of the currently insured individuals reacting to any negative impacts as a result of the previously uninsured worsening their risk pool. The impact of this type of adverse selection will be discussed in the summary section below.

It should be noted that this projected worsening of the risk pool might not affect premiums in an Exchange in the same magnitude, at least initially. Other ACA reforms, such as the temporary reinsurance and risk corridor mechanisms, are expected to alleviate some of the initial market disruption that would otherwise be caused by an increase in risk factors.

Figure 6-2 illustrates the range of likely outcomes for the worsening in health status for the individual risk pool around the expected change of 51 percent. We defined the likely range to be plus or minus one standard deviation. The likely outcomes for the worsening in health status are expected to be from 45 percent and 60 percent. The variation in outcomes is a result of two primary factors:

- How many uninsured individuals ultimately decide to purchase coverage
- The average risk for the pool of uninsured individuals who purchase coverage

Figure 6-2 Modeled Health Status Change - Individual Market (No Individual Mandate)



Minimum Benefit Coverage Requirements (No Individual Mandate)

The minimum benefit coverage requirement reforms for ACA will remain the same under this alternative scenario assuming no individual mandate. *Table 6-5* shows that across the aggregate individual market, benefit levels would need to be increased by approximately 3 percent on average.

Table 6-5 Distribution of Current Alaska Individual Insurance Plans by ACA "Metal" Categories (No Individual Mandate)

Benefit Category	2010 Distribution	Average Value	Benefit Increase
Low	12.0%	0.48	26.3%
Bronze	79.0%	0.61	0.0%
Silver	9.0%	0.68	0.0%
Gold	0.0%	0.78	0.0%
Platinum	0.0%	0.88	0.0%
	100.0%	0.60	3.2%

For the 12 percent of Alaskans who do not meet the Bronze benefit requirements, they would have to purchase benefit plans with approximately 26.3 percent richer benefits than their current plan. These individuals would likely face a corresponding change in premium.

We estimate that 88 percent of the current Alaska individual market consists of benefit plans that appear to meet ACA minimum requirements based solely on AV.

TOTAL EFFECT OF INSURANCE REFORMS (NO INDIVIDUAL MANDATE)

Table 6-6 summarizes the average aggregate effect of the three primary insurance reforms assuming the individual mandate is not included. This summary does not yet account for the additional adverse selection that could occur as a result of currently insured individuals reacting to any negative impacts of the coverage expansion.

Table 6-6 Aggregate Effects of Three Insurance Reforms (No Individual Mandate)

Reform	Average impact
Age	0.0%
Health status / Guaranteed Issue	51.5%
Benefits	3.2%
Combined	56.3%

In order to assess the variability of the estimated aggregate impact of the three reforms, a simulation model was created that combined the analysis for each reform.

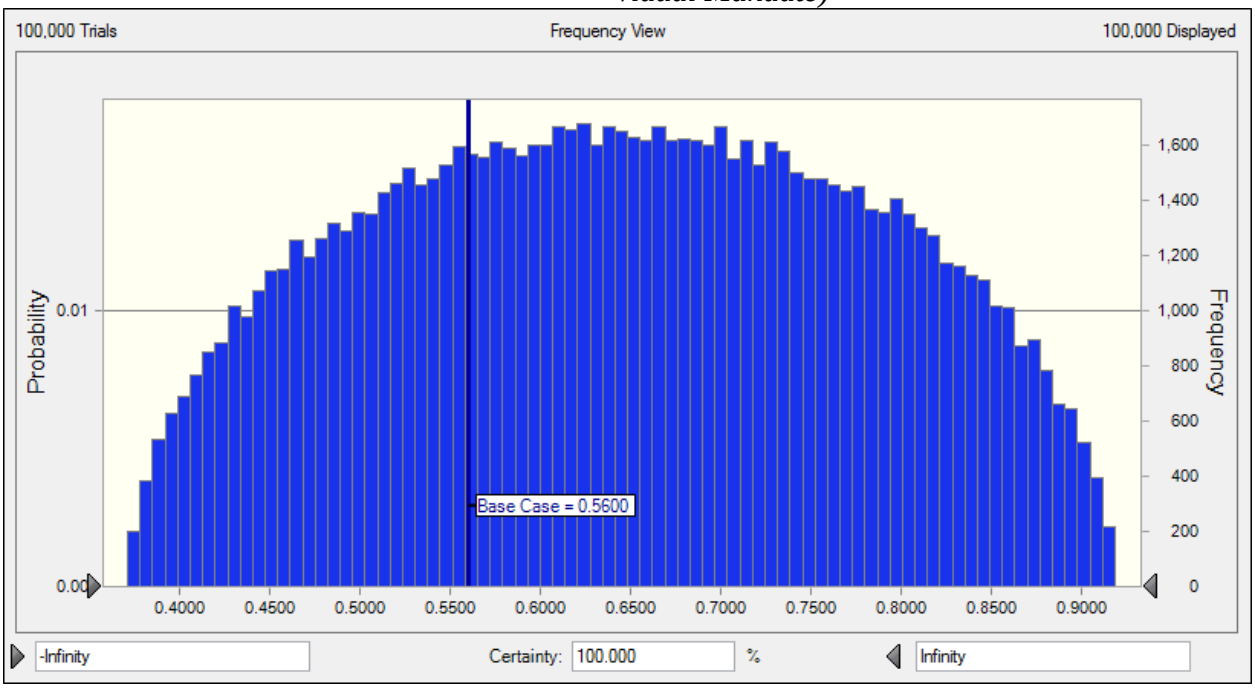
The variation in the outcomes is related to the uncertainty surrounding how the reforms will be implemented by each carrier and the uncertainty regarding the decision-making process for each consumer. The variables include:

- How each carrier implements the age band restriction
- Each carrier's demographic mix
- The consumer's decision regarding the chosen level of benefits
- How many uninsured individuals decide to purchase coverage as a result of all of the reforms
- The average risk for the pool of uninsured individuals who purchase coverage

In general, consumers who are expected to benefit the most from the insurance reforms will be older people in poor health. In general, those who are expected to be disadvantaged by the insurance reforms will be young, healthy individuals. The projections in this alternative scenario have taken into account the fact that many of these young, healthy individuals will not purchase insurance without the individual mandate provision. As noted previously, these projections do not include other possible reform impacts such as reinsurance and risk adjustment programs.

Figure 6-3 illustrates significant variability in how these reforms might affect a specific consumer. We defined the range of outcomes to be the base case scenario plus or minus one standard deviation.

Figure 6-3 Modeled Total Increase Due to Reforms-Individual Market (No Individual Mandate)



ADVERSE SELECTION (NO INDIVIDUAL MANDATE)

Based on the projected changes as a result of the reforms themselves and the risk profile of the previously uninsured population, it is expected that younger, healthier individuals would face the largest possible changes as a result of the insurance reforms.

The models project that the percentage of healthy persons who drop coverage will be approximately equal to one half of a typical one-year claim cost trend. After this projected 5–6 percent drop in enrollment, the premium change needed for the remaining enrollees that would keep the drop in enrollment revenue-neutral was modeled.

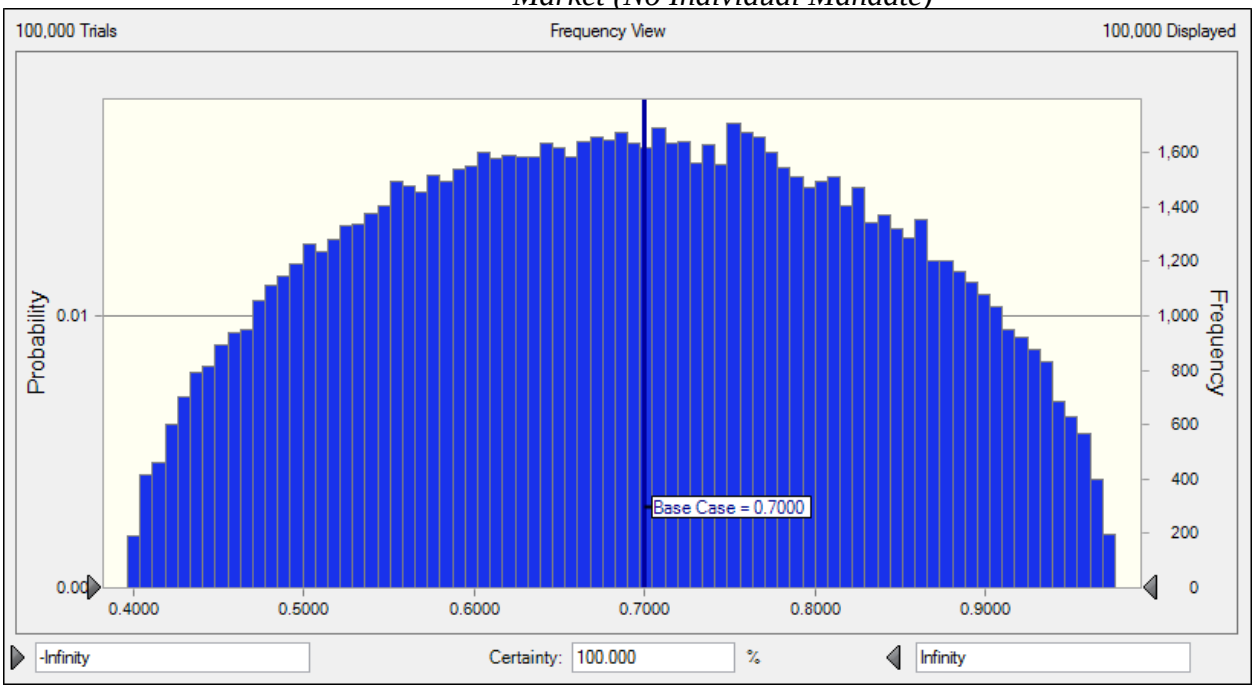
An additional marketplace rate change of approximately 9 percent may be needed to counteract this adverse selection. *Table 6-7* summarizes the average aggregate effect of the three primary insurance reforms, including the anticipated additional adverse selection.

Table 6-7 Effect of Insurance Reforms, Including Adverse Selection (No Individual Mandate)

Reform	Average impact
Age	0.00%
Health status / Guaranteed Issue	51.47%
Benefits	3.16%
Additional adverse selection	8.94%
Combined	70.2%

Figure 6-4 illustrates the variability in how these reforms might affect a specific consumer. The variables that affected the results in Figure 6-3 also affect the range of outcomes shown in Figure 6-4.

Figure 6-4 Modeled Increase Due to Reforms with Adverse Selection – Individual Market (No Individual Mandate)



Chapter 7
Additional Topics

Pros and Cons of Merging Individual and Small Group Markets

Under the current Alaska health insurance system, the Individual and Small Group markets are treated as two completely different blocks of business. For purposes of setting premium rates, the underlying risk pools are kept separate. A carrier typically sets individual premium rates based on the claims experience of its individual policies only and sets small group rates based on that pool of claims experience only. Therefore, a consumer who has the opportunity to purchase coverage in either market could be offered very different premiums for a similar benefit offering based on the different market characteristics.

The ACA allows a state to require insurance carriers to "merge" the Individual and Small Group markets. It is expected that a merger would help stabilize premium levels in the Individual market. This is highlighted by the modeling discussed in the previous section. Based on that modeling, it is expected that ACA reforms could have a significant effect on the individual market. Conversely, our review suggests that the small employer market may not be materially affected by the ACA reforms discussed above. A merger of the two risk pools could potentially help alleviate disruptions to the Individual market. As measured by enrollment, the current individual market in Alaska is approximately 5-6 percent of the size of the Small Group market.

Issues Posed by Merging Risk Pools

Alaska must consider several issues in evaluating whether it should require carriers to merge their risk pools. Characteristics for each approach are outlined to help the State assess what is best for its health insurance market.

Potential characteristics of separate risk pools:

- Less premium rate stability and greater need for risk adjustment due to the smaller risk pools
- Different premium rates for someone who is eligible to purchase coverage in both markets within an Exchange
- More benefit variation and a wider range of benefit options between the two markets

- ❖ Premium rates developed in a more typical approach based on sound risk classification methods
- ❖ No cross-subsidies across the two markets

Potential characteristics of merged risk pools:

- ❖ Increased rate stability for carriers that operate in both markets
- ❖ Enrollment shifts due to likely higher premiums for small employers and likely lower premiums for individuals
- ❖ Less variability in premiums between the two markets
- ❖ Higher premiums for policyholders in one market to help subsidize the claims experience of policyholders in the other market
- ❖ Disincentives for carriers that write only in the individual market, since they would not receive any anticipated positive impacts of a merger
- ❖ Possible added benefit for carriers that write only small group coverage, since they would not be pooling their experience with an individual risk pool

Impact of Merging Markets

As previously discussed, it is expected that the ACA insurance reforms will have a more dramatic impact on the Individual market. One expected impact is a worsening of the average health status, a result of increased enrollment of the previously uninsured population.

Once the Individual market has been reformed, it is anticipated that merging the risk pools could result in higher risk for the Small Group market and lower risk for the Individual market. This would primarily result from the remaining differences in the health status between the Individual and Small Group risk pools after the reforms take effect.

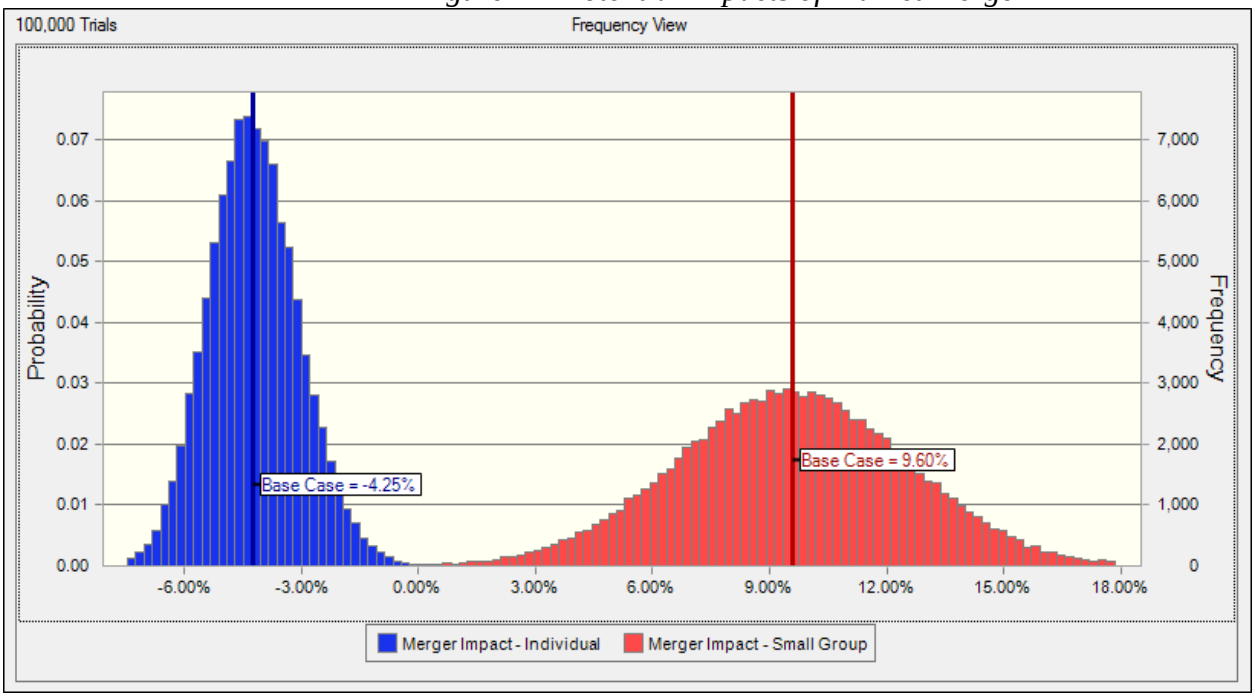
Table 7-1 Impact of Merging Small Group and Individual Markets

Market	Modeled Population	Modeled Average Risk Factor	Modeled average merger effect
Individual	83,000	1.15	-4.2%
Small Group	42,000	1.00	9.6%
Combined	126,000	1.10	—

Figure 7-1 illustrates the potential variability in assessing the impact of a market merger. For the Small Group market, it is expected that range of possible impacts to be between 3 percent and 17 percent. For the Individual market, it is expected that the range of possible impacts to be between -6 percent and -2 percent.

It is expected that the modeled range of impacts ultimately to be widened by anti-selective behavior. In cases where the Small Group market is negatively impacted, it is expected that a percentage of small groups to drop their health coverage. In cases where Individual market is negatively impacted, we would expect a percentage of the healthiest, youngest policyholders to drop their coverage.

Figure 7-1 Potential Impacts of Market Merger



INCREASING SMALL GROUP TO EMPLOYERS WITH UP TO 100 EMPLOYEES

Under current Alaska regulations, a small group is defined as an employer that has no less than 2 and no more than 50 eligible employees. The ACA requires that these small groups be able to purchase coverage through an Exchange by January 1, 2014. It also stipulates that by January 1, 2016, the Exchange must be open to employers with 51 to 100 eligible employees. The ACA allows states to transition these groups previously defined as large into the small group market before 2016. Expanding the definition of a Small Group before 2016 has potential consequences for both enrollment and the cost for employers in both the 2–50 and 51–100 markets, both inside and outside an Exchange.

Typically, insurers establish premiums in the small group and the large group markets using different methods. They calculate premiums in the small group market using the cost and utilization experience of the entire small group market adjusted for the demographic characteristics of the group. In the large group market, insurers establish premiums in a variety of ways due to the lack of regulation. Generally speaking, a large employer's premium is based on a blend of its own claims experience and that of the entire Large Group market. The smaller the employer, the more likely that the experience of the carrier's entire block of business will be used in developing the premiums.

Issues Posed by Expanding Small Group Definition

Alaska must consider several factors in determining whether it should expand the small group definition to include groups of up to 100 employees before 2016.

Issues posed by expanding to 100 employees before 2016:

- Increasing the existing small group risk pool in and outside the Exchange should create more stability and predictability in expected benefit costs
- Improved stability and predictability of costs could result in less significant risk adjustments among carriers
- Expanding the definition in 2014 could reduce the number of times the Exchange sees enrollment disruptions
- Exchange administration costs per member could be lowered by an increase in enrollment
- Employers with younger, healthier employees within the 51–100 market might experience premium changes that could produce an incentive to drop coverage or move to a self-insured program

Issues posed by not expanding to 100 employees before 2016:

- ❖ Carriers might be more cautious about participating in the Exchange with a smaller risk pool
- ❖ Fewer carriers might offer coverage outside an Exchange if an increased percentage of the total insurance market is sold within an Exchange
- ❖ Not expanding could produce more benefit plan innovation and less standardization

Impact of Expanding Small Group Definition

To evaluate whether material impacts could be expected from small group expansion, the health status characteristics of the 2–50 and 51–100 markets were reviewed. *Table 7-2* shows the average risk for the two market segments based on provided claims information. Based on the data reviewed, the 51–100 market appears to be less healthy than the 2–50 market. Therefore, if the two markets were combined in their entirety, we might expect a slight decrease in the risk to the 51–100 market segment and a slight increase in the risk to the 2–50 market segment are expected. *Table 7-2* illustrates the potential impact to the two market segments.

Table 7-2 Risk Factors for the 2–50 and 51–100 Small Group Markets

Employer 51–100		
Health Status	Population	Average Risk Factor
Good to excellent health	23,000	0.700
Fair to poor health	5,000	3.000
Subtotal	28,000	1.117

Small Group 2–50		
Health Status	Population	Average Risk Factor
Good to excellent health	36,000	0.676
Fair to poor health	6,000	3.000
Subtotal	42,000	1.002

Market	Population	Average Risk Factor	Estimated impact
Employer 51–100	28,000	1.117	-6.2%
Small Group 2–50	42,000	1.002	4.6%
Combined	71,000	1.048	—

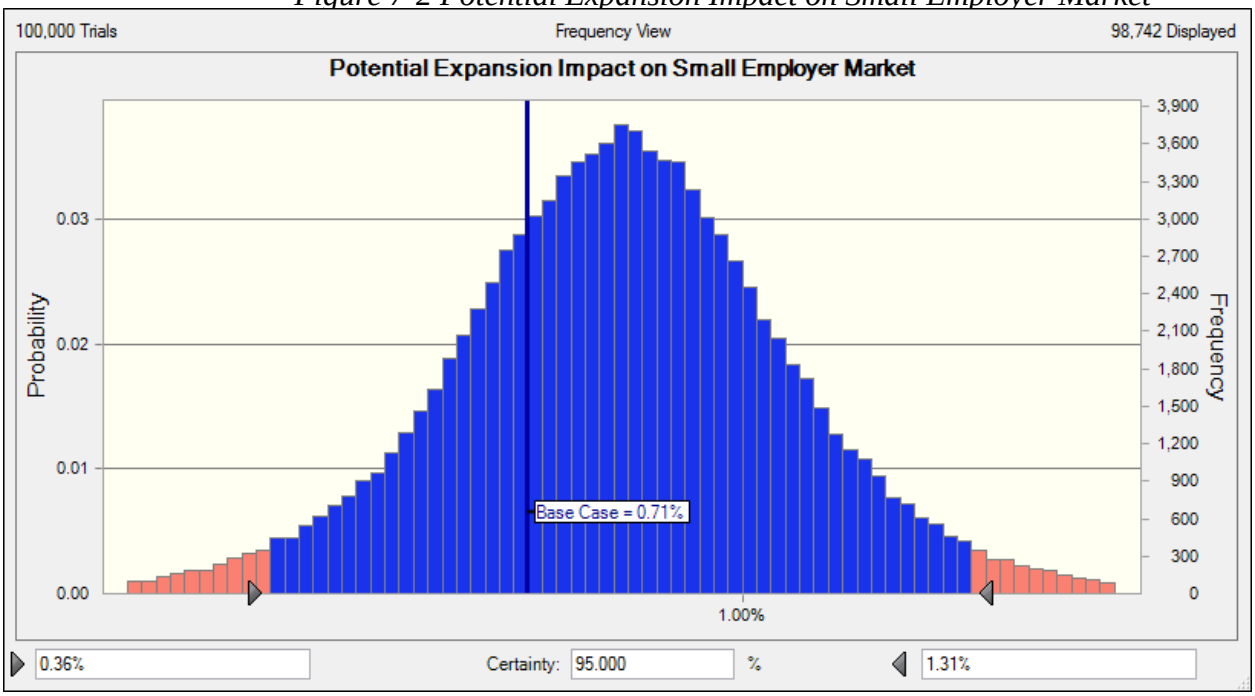
Employers with a relatively healthy workforce in the 51–100 market segment might choose to drop coverage or move to self-insurance if their rates increase. Therefore, our modeled range of outcomes assumed that only the unhealthiest segments of the 51–100 market would enter a combined risk pool with the 2–50 market. *Table 7-3* shows the projected increase to the current Small Group market is approximately 0.7% after the increase of employers from the 51-100 market (1.009/1.002-1).

Table 7-3 Modeled Risk Factors for the 2–50 and 51–100 Small Group Markets

Market	Modeled Population	Average Risk Factor
Employer 51–100	1,000	1.244
Small Group 2–50	42,000	1.002
Subtotal	44,000	1.009

Figure 7-2 illustrates the potential variability in assessing the impact of these potential scenarios. The variation in outcomes depends on the number of employers of 51–100 who ultimately decide not to purchase coverage within the fully insured small group market.

Figure 7-2 Potential Expansion Impact on Small Employer Market



IMPACTS OF THE SELF-INSURED MARKET ON AN EXCHANGE

As stated previously, premium rating methods can vary significantly by the size of an employer. Generally speaking, developing a premium rate for a large employer includes consideration of its actual claims experience. For the smallest of large employers who do not have statistically credible experience, their actual claims are pooled and blended with the experience of other employer groups of similar size. This pooled experience is typically considered the base or manual rate. As a large employer increases in employee size, less of the premium rate is due to the manual rate and more of it is attributable to its actual experience.

After an employer evaluates benefit options and premiums available in the private market, the largest of employers who have favorable and statistically credible claims experience may decide to self-insure. This strategy would typically lead to a premium lower than in the private market. However, under today's current health system, it is unusual for the smallest of large employers to self-fund their group medical benefits due to volatility in healthcare claims.

For both the insured and self-insured approaches, benefit packages and cost-sharing are usually customized for a large employer. A large employer typically enjoys considerable flexibility in designing its employees' medical coverage.

Benefit plans that will ultimately be sold through an Exchange will offer much less customization and flexibility. As discussed elsewhere in this report, Exchange benefit packages will resemble the "metal" benefit categories, which have defined levels of AV for the benefits provided.

In addition, the plans to be offered through an Exchange could be considered a manual rate for employers seeking coverage. That is, the premiums will be based on standardized products and the experience of an insurer's entire block of business.

If a large employer ultimately decides to choose a health plan with less benefit flexibility and premiums based on a manual rate, adverse selection likely will occur. If Alaska allows large employers to purchase coverage through the Exchange, it is expected that an employer with high-cost claims experience and an employer with older workers would purchase in the Exchange to take advantage of adjusted community rating and to take advantage of a rate that includes claims experience better than theirs.

If a large employer's claims experience is favorable and statistically credible, it would likely self-insure. This would allow the employer to take advantage of its favorable experience and negotiate correspondingly lower premium levels.

If only large employers with poor claims experience enter the Exchange, carriers operating in the Exchange may have to raise their premiums for all plans to compensate for the riskier consumers entering the risk pool.

We expect the availability of self-insured arrangements outside an Exchange ultimately to influence the relative risk of the population within it. In evaluating this impact, Alaska must consider both the employers leaving and those entering the self-insured market: healthy employer groups leaving the Exchange by self-insuring, and unhealthy self-insured groups deciding to purchase coverage within the Exchange.

Employers of 51–100

Typically, employers with a workforce of 51–100 do not self-insure, even if it appears favorable, due to the volatility inherent in the claims experience for groups of this size. This dynamic could change once employers of this size can purchase through an Exchange. If employers of this size join the Exchange and have several good years of claims experience, they may determine that it is worth the risk to self-insure, if the rates in the Exchange are higher than what they would pay for their own self-insured coverage even with the potential for high claims variability.

Our modeling in the small group expansion section assessed the impact of employers of 51–100 leaving the combined risk pool. If some firms of this size elect to self-insure and leave the combined risk pool, the small group market could be negatively impacted.

Similarly, if unhealthy self-insured employers decided to purchase a policy through the Exchange, material impacts to the average health status of the small group risk pool would not be expected.

Employers of 100 or More

Self-insurance is a common practice for employers with more than 100 employees. If the Exchange is ultimately opened to large employers, it could affect the risks and costs of the Exchange.

The average health status for the large employers in the state was not available. Therefore, a detailed analysis on the potential negative impact of the large group market on the Exchange risk pool could not be performed. The Large Group factors used in this model are based on L&E proprietary client files and actuarial judgment.

Table 7-4 illustrates the current average health status of the 100-plus market compared with that of a combined 2–100 market.

Table 7-4 Current Average Health Status of 2–100 and 100-plus Groups

Market	Population	Average risk factor
Employer 2–100	71,000	1.048
Employer 100–plus	297,000	0.960
Combined	368,000	0.977

If the two risk pools were combined in the entirety, the average health status would be slightly healthier than the health status across all Alaskans. However, it is expected that only the unhealthy 100-plus employers would likely enter the risk pool with the 2–100 market.

Only large employers with poor claims experience would be expected to enter the Exchange market because of the current rating flexibility available in the large group market. Due to the relatively large size of the 100-plus market, if unhealthy self-insured large employers decide to purchase an Exchange policy, there could be material impacts to the average health status of a carrier's risk pool.

It is expected that similar negative impacts would occur if large employers were allowed in the Exchange and then allowed to leave after experiencing several years of positive claims experience.

OPERATIONALIZING ACTUARIAL VALUES

As discussed previously, the ACA establishes four primary levels of coverage for a health plan sold within an Exchange. The AVs for these coverage levels are as follows:

- Bronze = 60 percent AV
- Silver = 70 percent AV
- Gold = 80 percent AV
- Platinum = 90 percent AV

A fifth plan, the catastrophic plan, would cover individuals up to age 30 or who are otherwise exempt from the individual mandates. This plan will provide coverage for essential health benefits and have deductibles equal to the amounts specified as out-of-pocket limits for HSA-qualified HDHPs. Its benefits are defined by specific cost-sharing provisions rather than an AV.

In February 2012, HHS released a bulletin that defines Actuarial Value (AV) for individual and small group health plans. HHS has determined the AV calculation is based on the cost sharing provisions for a set of benefits. The brief describes the HHS's proposed approach for implementation of the AV calculation by addressing the following:

- Calculation of AV
  - The Centers for Medicare & Medicaid Services (CMS) would develop a data set based on claims for a standard population, weighted for expected market enrollment
  - The claims would reflect average unit prices and utilization patterns
  - The data would be used to calculate AV based on a broad range of benefit design parameters, such as deductibles and copayments

While the recommendation is to have CMS develop a set of standard population claims data, the brief also states that in order to promote state flexibility and to account for variation in prices, utilization and benefits across states, HHS plans to allow states to develop state standard populations based on state claims data. HHS plans to propose that states choosing not to supply their own standard population may modify the national standard population developed by HHS using demographic and other adjustors in accordance with sound actuarial practices.

- Operational Method for AV calculation using standard data

  In order to provide plans with the national standard population described above, HHS is planning to develop an AV calculator that all plans would use. By providing a calculator, HHS will ensure a consistent set of assumptions and methods for the calculation of AVs. The calculator would be based on a limited set of benefits offered in a plan because only a limited number of cost-sharing plan features have a large impact on AV. These include items like the deductible, co-insurance, maximum out of pocket costs, and various copayments.

- De Minimis Variation Standards

  HHS realizes that in order to give plans the ability to be innovative and create multiple market-friendly plan designs there must be a little flexibility. In order to help plans have this ability it intends to propose a de minimis variation of 2 percentage points in AV. Therefore, a plan that has an AV of 68 could still be considered a Silver plan.

Possible Benefit Packages

Table 7-5 illustrates representative benefit packages that would satisfy the AV requirements for each of the four main benefit offerings in 2014. The table provides two different scenarios, indicated by A and B, for cost sharing.

Table 7-5 AV of Sample Benefit Packages

	Platinum A	Platinum B	Gold A	Gold B	Silver A	Silver B	Bronze A	Bronze B
Deductible	0	75	0	400	2,000	1,000	4,500	6,350
Coinsurance	5%	10%	10%	10%	10%	15%	10%	5%
Out of Pocket including the deductible	6,350	1,000	6,350	5,000	6,350	6,350	6,350	6,350
Office visit copay	5	5	20	15	15	15	10	10
Emergency care copay	25	50	75	100	100	100	100	100
Generic R_x copay	10	10	10	10	10	10	10	10
Formulary R_x copay	20	20	20	20	20	20	20	20
Non-formulary R_x copay	40	40	40	40	40	40	40	40

It is important to note that a benefit plan having an AV of 70 percent in the first year may have an AV of more than 70 percent in the second year. This is due to the leveraging effect of the ongoing annual percentage increase in claim costs on fixed dollar cost sharing features, such as deductibles and copays.

For example, the AV of a Silver plan with no cost-sharing other than a $1,000 deductible and a claim cost trend of 10 percent could see its AV increase from 70 percent to 72.7 percent.

This implies that if Alaskans were to allow only standardized benefit designs within the Exchange, it would need to develop a process for regularly adjusting benefit plans to offset the leveraging effects of trend. This might include an indexation approach where fixed dollar cost sharing features such as the deductible are allowed to increase each year.

Additionally, an AV can change based on differing mixes of covered populations, due to items such as health status and how consumers respond to varying levels of cost-sharing in their use of services. Because AV can vary dramatically based on several underlying variables, any AV test would need to be modified to comply with the ACA requirement that it be based on a standard population.

Monitoring AVs

Even though HHS has not finalized the method of calculating AV, previous issue briefs provided by HHS did provide a framework for the type of information that a carrier will have to submit to a state to meet minimum certification requirements for a QHP. As part of the certification process, carriers will have to meet the newly defined benefit design standards. A carrier will have to show that the QHP meets the following standards for products sold in the Exchange:

- Essential health benefits
- Appropriate cost-sharing limits
- Qualification as a Bronze, Silver, Gold, or Platinum level of coverage

To show compliance with these requirements, the carrier must annually inform the Exchange of the premiums, cost sharing, and covered benefits for each QHP. The form or method of this submittal will need to be determined once the actuarial valuation method is established. The CMS guidance states that this compliance requirement will not necessarily increase the amount of reporting a carrier needs to produce if this information is available elsewhere, such as in a rate increase justification filing.

Alaska will need to decide what it wants to require in terms of supporting the AV for the level of coverage provided. This could take various forms, ranging from an actuarial certification stating that the AVs meet the requirements, to requiring a submission of the actual calculations used in the AV determination.

Currently CMS uses variations of both approaches for its Medicare Advantage and Medicaid programs. In both cases, the actuary that developed the rates must provide an actuarial opinion stating that all requirements were met. Additionally,

the actuary must provide sufficient detail for CMS to determine the reasonableness of calculations. If CMS cannot determine reasonableness, it can request additional follow-up data for further evaluation by an independent actuary.

In both cases, CMS provides the submitting actuaries with guidelines for the extent of data needed for an evaluation. Once an AV methodology is determined, Alaska can prepare similar guidance, which could include templates for submission, so that the state can provide each carrier with a standardized documentation package.

COST OF STATE-MANDATED BENEFITS

The ACA defines an "essential health benefits package" (EHBP) as coverage that provides for essential health benefits as defined by the secretary of HHS. At the time of this report, the EHBP has not been specified by HHS. Generally, the EHBP will provide the following general categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including
    - Behavioral health treatment
    - Prescription drugs
    - Rehabilitative services and devices
    - Laboratory services
    - Preventative and wellness services and chronic disease management
    - Pediatric services, including oral and vision care

Estimated Cost

A key financial provision within the ACA is that if a state requires small group and individual plans to cover certain state mandated benefits (SMBs) above the federally required benefit package, then the state must reimburse the cost of those additional services for enrollees in an Exchange plan. Therefore, it is important for Alaska to weigh the potential financial cost of requiring additional SMBs versus their potential value for policyholders.

However, since the EHBP has not yet been defined, it is unknown whether any or all of Alaska's currently defined SMBs will be included in the EHBP.

Without knowing which Alaska mandates would be considered in excess of the EHBP, a precise estimate for the potential cost to the state of Alaska for requiring any of those excess mandates cannot be determined.

Nevertheless, to illustrate possible costs to the State, estimated costs to provide the mandates as compared to a health benefit plan without any mandates are included in *Table 7-6*. The cost for each specific mandate was estimated independently from the others. Since some of the mandates may have a few benefits that overlap, the aggregate impact of the mandates is likely to be less than the sum total cost of each mandate. These estimates are based on proprietary client data as well as the publication *Health Insurance Mandates in the States 2010*, published by the Council for Affordable Health Insurance.

Table 7-6 Estimated Cost of Selected Mandated Offers/Benefits/Providers

Mandated offer/benefit/provider	Estimated cost
Adopted Children	0% - 1%
Alcoholism / Substance Abuse	1% - 3%
Breast Reconstruction	0% - 1%
Cervical Cancer/HPV Screening	0% - 1%
Chemotherapy	0% - 1%
Colorectal Cancer Screening	0% - 1%
Diabetic Self Management	0% - 1%
Diabetic Supplies	0% - 1%
Drug Abuse Treatment	0% - 1%
Hearing Aids for Minors	0% - 1%
Mammography Screening	0% - 1%
Minimum Maternity Stay	0% - 1%
Mental Health	6% - 12%
Naturopath	0% - 4%
Newborns	1% - 3%
Newborn Hearing Screening	0% - 1%
Nurse Midwife	0% - 1%
Nurse Practitioner	0% - 1%
Occupational Therapist	1% - 3%
Off - Label Drug Use	0% - 1%
Osteopaths	1% - 3%
PKU/Metabolic Disorder	0% - 1%
Prostate Cancer Screening	0% - 1%
Chiropractor	0% - 1%

Table 7-6 Estimated Cost of Selected Mandated Offers/Benefits/Providers

Mandated offer/benefit/provider	Estimated cost
Dentist	1% - 2%
Drug Abuse Counselor	0% - 1%
Nurse Anesthetist	0% - 1%
Optometrist	1% - 2%
Pharmacist	0% - 1%
Physician Assistant	0% - 1%
Physical Therapist	1% - 3%
Podiatrist	0% - 1%
Psychologist	1% - 3%
Social Worker	1% - 3%
Speech/Hearing Therapist	0% - 1%
All	15% - 65%

Based on preliminary guidance in the ACA, it is expected that many of the above Alaska mandates will be included in the EHBP (such as mental health benefits). Therefore, these benefits have been excluded from the range of estimated costs. A reasonable range of costs for potential excess mandates is 1 to 5 percent.

If a sample average premium of $400–$425 per member per month for 2016 is assumed, this implies the possible cost of the excess mandates to be in the range of $4–$21 per member per month. Approximately 56,000 Alaskans were expected to be eligible for subsidies in an Exchange. It was also estimated that approximately 6,000 currently individually insured and uninsured Alaskans would be eligible to participate in the Exchange without subsidies.

If all eligible consumers participate in the Exchange, the State could face a potential annual cost of $3.0–$15.8 million for the excess benefits.

Once the EHBP is defined, these estimates should be recalculated so the state can properly evaluate the potential impact.

Future Reassessment

Once the EHBP has been defined, Alaska may decide to reassess the financial impacts of the current SMBs that will be considered "excess" beyond the EHBP.

In order to reassess the financial impact, Alaska may decide to conduct a more detailed study. Cost studies can be resource intensive for both the department and the carriers responding to the study. However, if the State ultimately decides to require the additional SMBs, a process will have to be in place to annually calculate the financial costs for which it will be responsible.

In addition to assessing the financial impact of paying for the additional benefits, Alaska would need to consider the potential adverse selection that could occur if the mandates are required within an Exchange. If plans outside the Exchange also include those benefits, there could be a situation where a consumer could pay less for the same level of benefits as a result of the state paying for the mandates within the Exchange.

STRATEGIES FOR COORDINATION OF MULTIPLE COVERAGE OPTIONS WITHIN ONE FAMILY

Even in the current insurance environment, many families have to deal with multiple coverage options for individuals within their family. This issue will need to be addressed within the ACA framework. Some of the reasons for this scenario occurring includes:

- ESI coverage can be expensive for dependents. Families might find it cheaper to cover only the employee under the ESI plan while purchasing individual insurance for the remaining family members.

- Some family members might qualify for the Medicaid or CHIP programs while others do not qualify or have coverage from their employer. This will be an issue primarily for lower income families that are close to the qualification requirements for these types of public programs, which could cause them to change between public and private insurance frequently.

- Family members might have or foresee a medical problem where a more expensive plan would be more beneficial.

Some of the problems caused by multiple insurance coverages within a family are:

- Insurance Company requirements could force family members to see different doctors.

- Differences in pharmacy benefits and contractual differences with pharmacies could require family members to utilize different pharmacies and have different cost-sharing requirements.

- Different plans will have different deductibles (some have family deductibles). This could cause significant confusion and misunderstanding to a family.

Potential ways for this issue to be addressed are:

- ❖ Encourage health plans to participate in public programs (e.g. Medicaid). This will make it possible for families that have multiple coverages to have the same provider networks. This should help make the transitions across programs simpler and prevent gaps in coverage.

- ❖ Exchanges should simplify the process of determining what coverage consumers are eligible to receive:

    - o Determining what programs and subsidies the enrollee might be eligible for in the Exchange.

    - o Have a simple application that gathers all necessary enrollee to make the eligibility determination for the consumer.

    - o Aligning eligibility and enrollment processes to ease transitions if a consumer's eligibility status changes during the year.

- ❖ Making sure a Navigator is available to assist with any questions that an individual might have concerning their plan options.

- ❖ If the Individual and Shop Exchanges are not merged into one Exchange, public programs (e.g. Medicaid and CHIP) are included in both. Employment turnover is not uncommon for low wage employees. The transition into Medicaid or CHIP should be simple after losing ESI coverage.

ROLES OF BROKERS, PRODUCERS AND OTHERS INCLUDING COMPENSATION STRUCTURE

The ACA and the establishment of an Exchange will significantly affect the current roles of many insurance industry participants. Those affected include brokers and producers.

Brokers & Producers

The current insurance market utilizes brokers and producers to a large degree. Their primary role is the intermediary between the insurance companies and the insureds, both in the individual and employer markets. After determining the needs of the consumers, they assist in helping them choose the best insurance products for their particular needs for the best price. Producers assist consumers with setting up and completing insurance applications and contracts which can be quite confusing for individuals who are not used to dealing with them.

Brokers and producers are paid a commission by the insurance companies if a consumer purchases their insurance product. The Kaiser Foundation compiled the

annual amount spent by private insurance companies on health insurance broker and agent compensation in 2010 (see *Table 7-7*).

Table 7-7 Health Insurance Broker Compensation in Alaska, 2010

Broker Compensation ($) Per Member Per Month - Individual Market	$ 16.29
Broker Compensation ($) Per Member Per Month - Small Group Market	$ 18.86
Broker Fees (as a Percent of Premiums) in the Individual Market	5.5%
Broker Fees (as a Percent of Premiums) in the Small Group Market	4.9%
Primary Source: Kaiser Foundation	

After the implementation of ACA reforms and the introduction of an Exchange, the role of brokers and producers could be reduced significantly depending on how a state decides to address their role. There are two ways to look at the potential role of the producers after an Exchange is opened. The first viewpoint is that the producer may not be needed as much if the Exchange is set up and is user friendly. This could help reduce non-benefit costs for employers and could potentially help increase enrollment. Conversely, the experience that brokers and agents have and the relationships they have built over the years could prove to be useful in convincing individuals and employers to join an Exchange. In order to utilize them an appropriate compensation system would have to be implemented to prevent consumers from being steered to coverage outside of an Exchange.

Navigators

Navigators will be a new role after the implementation of an Exchange. This role would be designed to act like a broker and producer. The ACA states that navigator's duties will be the following:

- Conduct public education activities to raise awareness of the availability of qualified health plans
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost - sharing reductions under section 1402
- Facilitate enrollment in qualified health plans
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage

- ❖ Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange

As stated in the ACA, to be eligible to receive a grant as a Navigator, an entity shall demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

Navigators are expected to include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities capable of carrying out the duties and meeting the standards for navigators.

CARRIER BEHAVIOR

Encouraging Participation

The primary incentive for carriers to participate in an Exchange is a large marketplace with many potential customers. However, just having a large marketplace will not be sufficient to attract a large number of new carriers. Some additional items that will be necessary to encourage participation are as follows:

- ❖ Keeping Exchange participation requirements to a minimum. These include reporting requirements, system capabilities, and possible fees.

- ❖ Setting Exchange rules that mitigate possible anti-selection from participants.

- ❖ Actively seeking out carriers to participate.

The following sections of this chapter address possible ways to increase participation from individuals and employers which is the primary incentive for carrier participation.

Increasing Competition

One of the main goals of the Exchange is to offer affordable premium rates. To obtain this goal, it is likely that competition between carriers will be needed. Potential ways to help increase competition in the development of an Exchange includes:

- ❖ Require all insurance be sold through the Exchange.

- ❖ Reduce the overhead expenses that insures typically incur. Since ACA regulates how much insures can use premiums for non-benefit expenses, an Exchanges will become an attractive option for a carrier if the expenses are reduced and savings can be offered.

- ❖ Increasing the risk pool to include healthy participants. While the individual mandate could assist with this goal, making the Exchange as user friendly as possible is necessary, especially if the mandate is not ultimately included.

- ❖ Setting Exchange rules that mitigate possible anti-selection from participants.

- ❖ Allowing insurers as much flexibility in plan designs options as possible.

Just having an Exchange can give previously small insurers a chance to compete with the larger insurers for market share. The more insurance companies that can be enticed to participate in the market, it is expected that lower premium rates will result.

CONSUMER BEHAVIOR

Incentivizing Employers

Potential ways to encourage employers to participate in an Exchange will need to include the following:

- ❖ Setting up the SHOP exchange in a way that allows employers the ability to offer multiple plans for their employees. As discussed in previous sections of this report, there will be 4 different plan tiers. Employers may want to give employees the option from any one of these tiers, including multiple options with a tier.

- ❖ Providing an atmosphere that is attractive to employers. This could include taking over responsibilities that the employer currently has to do for their employees, such as taking over the human resources duties and provide customer service to their employees, billing responsibilities and enrollment functions.

- ❖ Setting up a system that allows employers to have input regarding plan design. This will help ensure that the company receives the benefits they want to provide for their employees.

- ❖ Making sure the rates are as competitive by having as many insurance companies in the Exchange as possible.

- Educating small employers of the possible tax incentives that will be available. However, these tax breaks will only be available for the first two years.

Incentivizing Individuals

Potential ways to encourage individuals to participate in an Exchange will need to include:

- A user friendly exchange is very important to attract individuals to participate. The website must be designed appropriately and easy to use.

- Having education systems in place and Navigators to assist consumers is essential in making the Exchange an attractive marketplace for individuals to shop for coverage.

- Making sure the rates are as competitive as they can possibly by having as many insurance companies in the Exchange as possible.

ADVERSE SELECTION IMPACTS OF LEGISLATIVE AND POLICY DECISIONS

Adverse selection occurs when consumers purchase certain insurance benefit packages based on the knowledge of their current and expected health status. This can introduce significant additional costs into a health insurance market. Insurers currently use a variety of techniques in an attempt to reduce the effect of adverse selection, such as medical underwriting, premium rate structuring, and benefit design.

The ACA will restrict the ability of carriers to use many of these techniques. These restrictions will prohibit medical underwriting and rate structures that have large premium differences by age. Although the ACA includes several strategies to mitigate adverse selection, such as risk adjustment, reinsurance, and risk corridors, adverse selection will not be eliminated. Other areas within an Exchange that must be considered include allowable benefit design for health plans, participation in the Exchange, and network requirements.

If a significant amount of adverse selection is allowed, premium rates in the Exchange could be dramatically higher than outside it. Although the ACA requires claims experience from both inside and outside an Exchange to be pooled for premium rate setting, carriers might consider exiting the Exchange if the Exchange is significantly less profitable and more difficult to manage.

If the state of Alaska decides to operate an Exchange, it will have the opportunity to design features to help mitigate adverse selection. Below, a few key issues are summarized that could help minimize adverse selection and assist Alaska in making key decisions. Some of the approaches could trigger other consequences that may not ultimately be desired, such as creating an environment where carriers decide to leave the market.

The ideas listed here are in addition to other adverse selection mitigation techniques discussed elsewhere:

- Require all health insurance to be sold only in the Exchange.
    - Eliminating the non-Exchange market would create less opportunity for consumers to select against the plans offered in the Exchange.
    - Healthy people could still choose to not purchase any health coverage.
    - Smaller carriers and carriers that only write coverage in one market might exit the market, possibly creating even further consolidation in the health insurance market.
    - Consumers would have fewer coverage options.
- Require all carriers to participate in the Exchange, but allow the carriers to sell products outside the Exchange.
    - Adverse selection would still exist based on the relative benefit richness of plans offered outside the Exchange compared with the plans offered inside it.
    - Even with this additional flexibility, carriers might still decide to exit the market.
- Require carriers to use consistent rating methodologies.
    - Varied rating practices can lead to varied risk pools, which can cause adverse selection if material differences occur.
    - Standardization could include a requirement that premiums for qualified plans be based only on benefit differences and no positive selection effects.

- Require carriers participating in the Exchange to offer plans at all "metal" benefit categories.
    - This would prevent a carrier from offering only rich plans in the Exchange and reduced benefits outside of the Exchange.
    - This should reduce incentives for only unhealthy consumers to enter the Exchange.
- Place restrictions on benefit plans offered outside the Exchange.
    - This could include requiring that only those plans offered in the Exchange may be offered outside it. For example, if a carrier offered a Platinum plan within the Exchange, it would have to offer a Platinum plan outside the Exchange.
    - Benefit differences in and out of the Exchange could be restricted to differences that are not expected to attract lower risk individuals outside the Exchange.
- Restrict the ability of carriers to exit and reenter the Exchange. Reentry limitations, such as a 5-year waiting period, would prevent a carrier from dumping an unhealthy pool of business with the idea of rewriting a new population of enrollees.
- Prohibit carriers that operate in the Exchange from having affiliates that operate only outside it. This would prevent the carriers from segmenting their populations into separate risk pools.
- Require the richest benefit plans to be coupled with the most restrictive provider network a carrier offers, while lean plans could be coupled with the least restrictive network a carrier offers.

RISK ADJUSTMENT METHODOLOGIES

The ACA includes provisions to help protect against adverse selection due to the new rating limitations that will take effect in 2014. One of these provisions is the Risk Adjustment Program. Since carriers will set their Exchange premiums based on plan design and community rating only, some carriers could receive a disproportionate share of unhealthy individuals. The Risk Adjustment Program is designed to compensate those carriers with risk adjustment payments, which compensate for health status differences not fully reflected in premiums. Correspondingly, carriers that enroll an inordinate number of healthy individuals will be contributing their "excess" premiums to help alleviate the claim burden of the other carriers.

This risk adjustment mechanism could help encourage insurer participation and create financial stability for carriers.

ACA Framework

The HHS secretary, in consultation with the states, must establish criteria and methods for states to use in determining the actuarial risk of plans within a state. If a state decides to not operate an Exchange, HHS will establish a Risk Adjustment Program for it. A state operating an Exchange can either establish its own Risk Adjustment Program or have a third party or HHS perform that function. Risk adjustment will apply to insurers in both the individual and small group market for non-grandfathered plans within a state, both inside and outside the Exchange.

HHS will develop and authorize a federally certified risk adjustment baseline method that can be used by a state. If a state has an alternate method that it believes can achieve similar or better results, that alternate method could be used in place of the HHS method. The state alternate method can become a federally certified risk adjustment method through the HHS certification process. Once a state alternate method has been federally certified, it can be used in that particular state and any other states. To assist states in assessing a potential alternate risk adjustment method, HHS will publish the basic standards that any such method must meet.

The ACA requires substantive federal oversight of the risk adjustment process; hence, HHS must first review and approve every alternate state method. The state method must clearly identify the risk pools to which it will apply. The proposed method must also fully describe the risk adjustment model, including

- the factors employed in the model
- the weights associated with each factor
- the data collection method
- the schedule for data collection and risk adjustment factor calculation
- the calibration method

If a state wants to use a federally certified risk adjustment model based on state-specific weights, the state would only need to provide HHS with the state-specific weights, a description of the calibration method, and an attestation that all other model attributes will be implemented consistently with the federally certified method.

If a state ultimately decides to propose an alternate method, HHS will evaluate it based on how well it:

- accurately explains cost variation within a given population
- chooses risk factors that are clinically meaningful to providers
- encourages favorable behavior and discourages unfavorable behavior
- uses data that are complete, high in quality, and available in a timely fashion
- provides stable risk scores over time and across plans
- minimizes administrative burden

Technical Framework and Considerations

Technically speaking, risk adjustment refers to the statistical process of estimating the expected health insurance costs of individuals. These estimates draw on demographic, pharmaceutical, or medical information. The results for each individual are accumulated to determine an aggregate risk score for a carrier's segment of the population.

If it is assumed that the overall health insurance market equates to an average health status factor of 1.0, a particular health plan might enroll a riskier population with an average health status of 1.15. After risk adjustment, the health plan would ultimately receive a 15 percent subsidy to compensate for the extra risk borne.

There are three basic measures for characterizing health risk, and two basic time period methods for calculating it. The three health risk measures are:

- Demographic—these measures indicate the expected medical costs according to population averages for age, gender, and location.
- Medical diagnosis—these measures refer to actual diagnostic or treatment information collected from claims data. This method generally assesses expected total costs based on typical treatment for a specific diagnosis.
- Pharmaceutical—this method generally assesses the relative risk of a population based on treatments associated with specific medications.

The two basic time period calculation methods are:

- Prospective—this assessment uses risk information from a prior period to model likely costs in the upcoming year.
- Concurrent—this assessment uses current information to measure an expected healthcare cost for that year.

Many of the existing risk adjustment tools were designed to fit specific populations, such as commercially insured, Medicare, or Medicaid populations. They were also designed for different applications—some for focusing on specific medical conditions, others with a more global perspective.

A 2007 study performed for the Society of Actuaries by Milliman, Inc. highlighted many of the commercially available risk assessment tools (*Table 7-8*).

Table 7-8. Risk Adjustment Methods/Tools

Risk adjuster tool	Developer	Type
ACG	Johns Hopkins	Diagnosis
CDPS	Kronick/UCSD	Diagnosis
Clinical Risk Groups	3M	Diagnosis
D_xCG DCG	D_xCG	Diagnosis
D_xCG R_xGroups	D_xCG	R_x
Ingeni$_x$ PRG	Ingenix	R_x
MedicaidR_x	Gilmer/UCSD	R_x
Impact Pro	Ingenix	Diag+R_x
Ingeni$_x$ ERG	Ingenix	Med+R_x
ACG with prior cost	Johns Hopkins	Diag+$$R_x$
D_xCG UW	D_xCG	Diag+$Total
MEDai	MEDai	All

A key consideration in the above study was that there are many uses for health-based risk-adjustment by purchasers and plans. When selecting a health-based risk-adjustment method, two primary features differentiate the applications:

- Does using the tool involve payment to providers and plans?
- Is the focus on targeted subpopulations or on a global population?

Using a risk adjustment tool in an Exchange would fall under a global population focus that involves payments to health plans. For this type of application, the Society of Actuaries-Milliman study concluded the following:

- Diagnosis-based methods would likely be preferred, since they are good predictors and offer less chance of manipulation than pharmacy-based models.
- Prior cost models should not be used.
- Using actual utilization data, such as prescriptions, to indicate a disease and increase payment should be avoided or approached with caution.

A risk adjustment conference conducted by Mark J. Hall in conjunction with the Commonwealth Fund concluded that there does not appear to be a single accepted best method. This conference did offer the following consensus guidelines:

- Adjustment based on demographic factors alone is insufficient.
- Collecting diagnostic information is possible for most health plans; however, it may be a burden for carriers with a limited infrastructure.
- Using diagnostic information may lead to some degree of upcoding, which could be addressed by audits and recalibrations.
- Pharmacy-based adjusters are more accurate than demographic-based methods, but less accurate than encounter-based diagnostic information.
- A combination of diagnostic and pharmacy data is only moderately more accurate than using diagnostic information alone.
- Pharmacy-based methods can be used as a transition method until diagnosis data collection methods improve.

The following are additional considerations:

- Pharmacy data are usually easier to obtain than diagnostic data but could create incentives to increase risk scores.
- Prospective risk adjustment requires a longer enrollment history to generate an accurate risk score than does concurrent risk adjustment.
- Prospective risk adjustment gives advance notice of financial obligations.
- Concurrent risk adjustment can more accurately reflect actual spending among plans, especially with large amounts of membership turnover.
- Concurrent adjustment can delay final reconciliation, possibly substantially, depending on the type of data used.

Based on previous literature and industry-wide discussions, Alaska should consider a goal of implementing a concurrent diagnosis-based approach. This would address the global nature of an Exchange and help account for enrollment changes that may occur within an Exchange over time.

However, since risk adjustment models currently have had limited use in Alaska and carriers may not have the infrastructure in place for many methods, the state may want to follow the federal model or if the state decides that a state-specific model is preferred, Alaska could implement a basic method initially, with a planned transition to a more complex, permanent method if needed.

If a state-specific model is desired, the initial approach could involve adjusting for demographic information immediately upon enrollment, with pharmaceutical information used as an interim measurement. Ultimately, medical encounter data measured throughout the experience period would be used to determine overall risk adjustment at the plan level.

OPEN ENROLLMENT STRATEGIES

ACA Framework

On July 11, 2011, the Centers for Medicare & Medicaid Services (CMS) released a Notice of Proposed Rule Making (CMS-9989-P) to provide guidance on implementing certain provisions of the ACA. The proposed rule lays out an annual enrollment period during which individuals would make their insurance selections. In addition, it sets the framework for special enrollment periods.

Consumers would not be able to apply for health insurance coverage outside these defined periods, which aim to mitigate adverse selection in a guaranteed-issue environment.

In preparation for the Exchange commencing January 1, 2014, the initial open enrollment period would be October 1, 2013–February 28, 2014. Applications would have to be submitted on or before December 22, 2013, for coverage to be effective on January 1, 2014. Coverage for applications received between December 22, 2013, and February 28, 2014, would be rolled in on a monthly basis.

Considerations

Beginning with the second year of coverage and for all later years, the annual open enrollment period is proposed to be October 15 to December 7 of the previous year. Coverage would be effective the first day of the following benefit year. CMS has asked for industry comments regarding the possibility of a longer open enrollment period of November 1–December 15.

A special enrollment period would allow people to enroll in a health plan or change from plan to another at the same level of coverage under certain circumstances. Rule 9989 proposes a period of 60 days from a triggering event. These triggering events include the following:

- A qualified person or dependent loses minimum essential coverage.
- A qualified person gains a dependent or becomes a dependent through marriage, birth, or adoption.
- A person attains U.S. citizenship.

- A person's enrollment or non-enrollment results from an error, misrepresentation, or inaction by the Exchange.
- A health plan violates material provisions of the policyholder contract.
- A person makes a permanent geographical relocation.
- A person experiences other exceptional circumstances beyond that person's control, such as natural disasters.
- A person's eligibility for advance payments of the premium tax credit or cost-sharing changes (These persons will be able to change their level of coverage).

Significant adverse selection can take place in a guaranteed-issue market that prohibits risk classification based on health status if people can purchase coverage when they need it and drop it when they do not. The proposed rule identifies procedures for an Exchange to help mitigate the impact of adverse selection. However, Alaska should consider additional enrollment restrictions to further deal with this issue.

One additional approach would be a late enrollment penalty. This could be similar to Medicare's Part B and Part D programs. If consumers wait to obtain coverage until after they are first eligible, they may have to pay a penalty to obtain it later, depending on their circumstances. A key consideration is that the penalty surcharge would attach to all future premiums, not just the initial one.

Another approach would be to prohibit or limit benefit plan changes. If plan changes are prohibited between open enrollment periods, adverse selection could be reduced by not allowing consumers to immediately "buy up" to better coverage once they are faced with a health condition. A further, related limitation would be to require any benefit increases at that next enrollment period to be limited to only one benefit step. That is, a consumer covered under a Bronze plan could buy up to a Silver plan at the next open enrollment, but not a Platinum plan.

The state of Alaska should consider the above or similar options to minimize adverse selection in and outside of the Exchange.

REINSURANCE OPTIONS

Transitional Reinsurance Program

Reinsurance for people with large healthcare expenses will be an essential component for mitigating the impact of adverse selection. The ACA includes a provision to establish a Transitional Reinsurance Program for years 2014–2016. Its purpose is to help reduce the uncertainty of risk in the health insurance market before the Exchange is fully mature.

On July 11, 2011, CMS released a Notice of Proposed Rule Making (CMS-9975-P) to provide preliminary guidance and propose standards requiring all health insurers and third-party administrators of self-insured group plans to contribute to a not-for-profit reinsurance entity to support reinsurance payments to issuers in the individual market. These payments will help cover the cost of high-risk individuals in non-grandfathered individual plans.

Reinsurance payments will be based on items and services within the EHBP for an individual enrollee that exceeds a yet to-be-determined attachment point. The Transitional Reinsurance Program was not established to replace commercial reinsurance or internal risk mitigation strategies. Therefore, the program will include a reinsurance cap that will be set at the attachment point of traditional commercial reinsurance. The reinsurance payment would be set as a percentage above the attachment point and below the reinsurance cap. Federal thresholds and coinsurance percentages will be communicated annually; however, states can decide to set their own reinsurance parameters.

Alaska could ultimately make adjustments to the federal parameters based on:

- The level of initial federal funding available.
- The desire to offset the declining funding pattern.
- The short-term and long-term implications in the private reinsurance market.

The ACA requires that aggregate contributions from carriers and TPAs for the reinsurance program across all states to be $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. In addition, funding will include a proportionate share of $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016 from the U.S. Treasury.

HHS will define a national contribution rate based on a percentage of premium for insured business and total costs for self-funded business. Alaska will have the option to require additional contributions amount if it believes the allocated contributions will not be sufficient to fund the mandated reinsurance payments and the administrative expenses of the reinsurance program.

Further details regarding the Transitional Reinsurance Program are included in the proposed rule as published in the *Federal Register* 45 Code of Federal Regulations (CFR) Part 153.

Risk Corridor Program

Another ACA provision for mitigating the impact of adverse selection and uncertainty surrounding an Exchange is the Risk Corridor Program (RCP), a temporary, 3-year program that applies to QHPs offered in the Exchange. The ACA estab-

lished risk corridors as a federal program, to be operated under federal rules with no state variation. Its purpose is to protect against rate-setting uncertainty in the early years of an Exchange.

Due to uncertainty about the population during the first years of Exchange operation, plans might not be able to predict their risk accurately, and their premiums could reflect costs that are ultimately much lower or much higher than predicted, as reflected in overall profitability. For these plans, risk corridors would shift cost from plans that overestimate their risk to plans that underestimate it. Therefore, the RCP will limit an issuer's excessive losses (or excessive gains).

The threshold for risk corridor payments and charges is reached when a QHP issuer's allowable costs reach plus or minus 3 percent of the target amount. An issuer of a QHP plan whose gains are greater than 3 percent of projections must remit charges to HHS, while HHS must make payments to an issuer of a QHP plan that experiences losses greater than 3 percent of projections.

Further details regarding the RCP are included in the proposed rule cited above, as published in the *Federal Register* 45 CFR Part 153.

2016 and Beyond

Reinsurance and risk corridors are being established to help stabilize the insurance markets while allowing the markets to mature after the Exchanges begin operation. Many states, however, are interested in maintaining market stability beyond 2016 and are considering continuation of the Reinsurance Program or something similar beyond the 2016 federal expiration date. Similar programs have been shown to have this stabilizing effect in other states such as New York.

A key issue for Alaska to consider as it evaluates reinsurance options is that the state would potentially play in role in redistributing funds through the reinsurance mechanism. In this role, Alaska would have to consider the allowable time period for fund settlements and document the methods in place.

See Appendix A for a summary of other state reinsurance programs currently in place that Alaska should evaluate further to assess alternatives beyond 2016.

STANDARDIZING AND ENFORCING MLR REQUIREMENTS

ACA Framework

The ACA requires minimum MLRs of 85 percent for large group products and 80 percent for small group and individual products effective January 1, 2011. Insurers who pay out less must make rebates to policyholders. The ACA requires carriers to submit a report to HHS for each plan year concerning earned premiums

and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve healthcare quality, and all other non-claims costs.

In December 2010, HHS released an Interim Final Rule (OCIIO-9998-IFC) that lists uniform definitions and standard methods for carriers to use in calculating MLRs. The rule also provides guidance regarding timelines for annual reporting.

In addition to the HHS federal reporting requirements, some states are considering additional reporting and enforcement requirements. A few key issues surrounding the methods that could be used to enhance the enforcement of MLR provisions are highlighted below.

Considerations

Before implementing the ACA, several states already had laws and regulations governing MLR requirements for portions of the health insurance market (primarily for individuals). The enforcement methods used to confirm compliance varied.

- Audits
  - State departments perform audits to assess whether insurance carriers comply with regulatory requirements.
  - Penalties can be assessed if non-compliance is determined.
  - MLR audits can be combined with other audits required by state departments, such as triennial financial examinations, to reduce the cost and administrative burden.
  - States could require that the MLR provisions be audited annually as part of the company's regular financial audit.
  - States could require the carrier to conduct an MLR-specific audit at their own expense.
- Rate review
  - States have proposed that insurers must demonstrate compliance with the MLR requirement at the time of a rate review.
  - This process would allow the Department of Insurance to combine two ACA requirements into one administrative procedure.
  - This method is intended to reduce the amount of future rebate payments.
- Additional documentation

- Some states have proposed that any rebate must be prorated based on the direct premium earned for the year among all current and former policyholders.

- Carriers must document their reasonable efforts to identify and locate former policyholders.

- If a carrier cannot locate former policyholders, it must provide documentation demonstrating one of the following:

    a. Premium rates have been prospectively adjusted.

    b. Rebates have been allocated to existing policyholders.

    c. Rebates have been deposited in a fund for standardized individual enrollee direct payment contracts.

    d. It has used another method to offset the amount of the credits.

Even though the National Association of Insurance Commissioners and HHS have worked to develop standards and best practices for calculating and reporting federal MLR requirements, Alaska must decide whether additional enforcement is necessary. The cost of ongoing monitoring should be weighed against the potential added value for Alaskan residents.

Appendix A
Reinsurance Program Options

Publicly Subsidized Model: Healthy New York

Healthy New York, launched in 2001, is a state-sponsored program designed to provide lower cost health insurance to uninsured workers and their families. The standardized benefit packages must be offered by all HMOs in the state.

The program targets small groups with fewer than 50 employees, sole proprietors, and low-wage individuals who were previously uninsured.

It provides risk corridor reinsurance (subsidized by state funds) through contracted health plans by paying a percentage of claims that an individual incurs between two attachment points. The insurer pays 10 percent and the state pays 90 percent of medical claims incurred during the year for individual medical claims between $5,000 and $75,000. The insurer assumes the risk for paying actual claims above the upper level.

As a result of the state subsidies, Healthy New York has been successful in lowering premiums for small groups, in some cases by as much as 20 percent to 30 percent. It should be noted that some of the premium savings result from shifting medical costs to the state, not necessarily from reduced medical claims.

The participating carriers are also reinsured though a state stop-loss reinsurance pool, which is funded by assessments on insurance premiums and other state funds dedicated to state insurance programs.

Non-Publicly Subsidized Individual Market Model: Idaho's Individual High-Risk Reinsurance Pool

In Idaho, all individual market health insurers must offer five standardized health benefit plans to individuals on a guaranteed-issue basis. Premiums are established by a board and are the same regardless of the insurer. As required by the Idaho statutes, insurers add a surcharge for these standardized plans that can range from 125 percent to 150 percent of premiums charged to healthier individual market enrollees. The insurers pay the first $5,000 of claims, and the Reinsurance Program pays 90 percent of the next $25,000. After $30,000, the Reinsurance Program pays all remaining claims up to the lifetime limit of the benefit plan.

The program is financed through a portion of the premium taxes paid by all insurers, reinsurance premiums set by the board, and assessments from participating carriers if losses occur.

A key point regarding the financing is that all Idaho licensed insurance carriers (life, health, disability, property, etc.) support the pool through the portion of premiums they pay to help finance the program. In traditional high-risk pool reinsurance arrangements, the assessment for the high-risk pool is levied against only health insurers.

NON-PUBLICLY SUBSIDIZED COMPREHENSIVE MODEL: MASSACHUSETTS CONNECTOR

Within the Massachusetts Connector, reinsurance methods are used to minimize adverse selection that could occur in the Commonwealth Care portion of the Massachusetts exchange. This segment of the Connector provides subsidies to low-income enrollees. No reinsurance is used for the non-subsidized portion of the exchange (Commonwealth Choice).

The concern when establishing the Connector was that one carrier might attract a disproportionate share of unhealthy individuals. This could lead to disruption and instability in the premium structure of the connector and could disadvantage one or more carriers because of adverse selection. The reinsurance programs used by the Massachusetts Connector are very similar in concept to those enacted by the ACA.

- *Reinsurance*: Each of the participating plans in the Connector pays a portion of the premiums they receive into a fund used to reimburse plans that have individual enrollee claims above a specified level. The pool pays the plans at the end of the year based on their pro-rata share of the total eligible claims. No additional funding is provided, so only the funds collected are redistributed to the plans.

- *Risk corridor*: The second mechanism uses a risk corridor to transfer premium dollars to plans whose losses exceed 103 percent of expected claims from plans whose losses are less than 97 percent of expected claims. As with the Reinsurance Program, it involves a transfer of premium dollars from one plan to another; no additional funds are added to the pool.

No additional public money subsidizes these programs; funding is shifted from one plan to another, using the Connector as the intermediary. The objective is to provide for adjustments to premiums based on risk or claims experience, so that no plan is disadvantaged because of selection issues in the enrollment process.