Agenda

- Supreme Court Ruling
- Health Benefit Exchange Update
- Affordable Care Act Provisions
  - Medical Loss Ratio and Rebates
  - Health Insurance Rate Review
  - Essential Benefits
  - Actuarial Value
  - The Three R’s
Any day now…….Supreme Court ruling due in June

4 Elements of Affordable Care Act heard by Supreme Court in March

1. Do courts have jurisdiction to decide the constitutionality of the ACA’s individual mandate provision now?

2. If so, is the ACA’s individual mandate provision constitutional?

3. If unconstitutional, is the individual mandate provision severable?

4. Is the ACA’s Medicaid expansion constitutional?

Decision Tree - Supreme Court Decisions

- **Question**: Is the individual mandate constitutional?
  - **Outcome**: Continue planning for health care reform
  - **Decision Tree**:
    - **Question**: AIA bars federal courts from reviewing individual mandate until 2015?
      - **Outcome**: Decisions on the other questions are delayed until 2015
    - **Question**: Is the individual mandate severable?
      - **Outcome**: Certain aspects of PPACA may go away and others may stay.
        - **Decision Tree**:
          - **Question**: Are the Medicaid provisions constitutional?
            - **Outcome**: Certain aspects of PPACA may go away and others may stay.
              - **Decision Tree**:
                - **Question**: Is the individual mandate constitutional?
                  - **Outcome**: Things get complicated with this decision – what stays and what goes – some funds already released with revenue provisions not yet implemented.
                    - **Decision Tree**:
                      - **Question**: Are the Medicaid provisions constitutional?
                        - **Outcome**: The Medicaid decision is not dependent on the individual mandate. However, one has to wonder if the Medicaid provisions will stand if the individual mandate is deemed unconstitutional and is not severable.
November is not far behind........

Whatever Happens....Costs Continue to Increase

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 2000-2010

Notes: Health insurance premiums and worker contributions are for family premiums based on a family of four.

Key Health Plan Strategies Continue

- Affordability focus continues
  - Network strategy
  - Provider partnerships - ACO’s, medical homes
  - Health engagement – value based benefits, wellness promotion
  - Cost containment and medical management
  - Operational efficiency

- Consumer engagement
- Pricing and risk management strategies
- New competitive dynamics - private exchanges and purchasing co-ops
- Market share and surplus management, pressures on margins
- Regulatory positioning with State initiatives
- Exit strategies by line of business
  - How to unravel and repurpose ACA work done so far if needed

The Affordable Care Act (ACA) and Health Benefit Exchanges Update
National View: Competing Forces Create Change

Extensive regulation contained in the ACA Reform law and the trillion dollar subsidies and tax credits expansion will result in unprecedented shifts in coverage sources and a highly dynamic market environment throughout this decade.

Program/Coverage Expansion
- Expansion of Medicaid Eligibility
  - Up to 133% of FPL
  - Expansion of childless adults
- Creation of Health Benefit Exchanges
- Subsidies for incomes between 133% and 400% FPL
- Individual Mandate
- Risk adjustment and reinsurance
- Essential Benefits

Rating Reforms
- Guaranteed issuance and renewability.
- No preexisting condition exclusions

HHS Review of rate increases
- Limited premium variability factors:
  - Community rating
  - Geographic
  - Age, max 3 to 1
  - Tobacco, max 1.5 to 1
  - No gender differentiation
- Minimum Medical Loss Ratios
  - 80% for Individual and Small Group
  - 85% for Large Group
  - Rebating of profits in excess of the MLR

Subsidies
- Tax Credits for Small Business
  - Individuals and families between 133% and 400% of FPL
  - Premium credits ranging between 2% - 9.5% of income on a sliding scale
  - Cost-sharing subsidies increasing Actuarial Present Value of basic benefit plan to 70% - 84%

Penalties
- Individuals not securing coverage pay the up to 1% of income, min $95 in 2014
- Tax penalties to large employers who don’t offer minimum essential coverage to it’s employees
- Tax on employers who offer benefit levels below minimum.

Unintended Consequences
- Potential for Employer “Dumping”
- Market churn between products
- Consumer and employer gaming

Percentage Growth in Medicaid Membership

Source: OptumInsight Member Movement Model – January 2012.
Federal Premium Subsidies – Individual HBE

- Based on the member’s income level
- Calculated using the 2nd lowest cost Silver Plan
- Offered in the form of a tax credit however…..
- Tax credits are refundable and can be “advanceable”
  - Refundable means individual receives the credits even if no taxes are due
  - “Advanceable” means the individual can receive them at the time they are purchasing insurance and not when taxes are filed.

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Max Premium as a % of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133% FPL</td>
<td>2% of income</td>
</tr>
<tr>
<td>133-150% FPL</td>
<td>3 – 4% of income</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>4 – 6.3% of income</td>
</tr>
<tr>
<td>201-250% FPL</td>
<td>6.3 – 8.05% of income</td>
</tr>
<tr>
<td>251-300% FPL</td>
<td>8.05 – 9.5% of income</td>
</tr>
<tr>
<td>301-400% FPL</td>
<td>9.5% of income</td>
</tr>
<tr>
<td>400% +</td>
<td>Not Eligible for Subsidy</td>
</tr>
</tbody>
</table>

ACA – National View – Population Shifts (in 000s)

<table>
<thead>
<tr>
<th>Current Source of Coverage</th>
<th>Private Coverage Through Exchange</th>
<th>Private Coverage Out of Exchange</th>
<th>Medicaid SCHIP (Excluding Duals)</th>
<th>Medicare, TRICARE &amp; Other</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employer w/ subsidy</td>
<td>Individual w/ subsidy</td>
<td>Employer no subsidy</td>
<td>Individual no subsidy</td>
<td>Employer</td>
</tr>
<tr>
<td>Employer Workers and Dependent</td>
<td>148,922</td>
<td>11,645</td>
<td>6,235</td>
<td>1,695</td>
<td>125,028</td>
</tr>
<tr>
<td>Non-Group</td>
<td>12,040</td>
<td>312</td>
<td>4,499</td>
<td>321</td>
<td>375</td>
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<tr>
<td>Employer Retired</td>
<td>3,288</td>
<td>0</td>
<td>0</td>
<td>2,960</td>
<td>0</td>
</tr>
<tr>
<td>TRICARE</td>
<td>5,344</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicare</td>
<td>32,852</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicare Dual Eligent</td>
<td>8,796</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Medicaid &amp; SCHIP</td>
<td>45,229</td>
<td>467</td>
<td>2,253</td>
<td>0</td>
<td>1,048</td>
</tr>
<tr>
<td>Uninsured</td>
<td>61,831</td>
<td>2,059</td>
<td>9,489</td>
<td>1,349</td>
<td>5,398</td>
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<tr>
<td>Total</td>
<td>308,102</td>
<td>14,502</td>
<td>22,467</td>
<td>3,565</td>
<td>135,209</td>
</tr>
</tbody>
</table>

- Employer and Medicare coverage relatively untouched
- Exchanges pick up Non-group and Uninsured
- Medicaid grows substantially from uninsured shift

Source: OptumHealth Member Movement Model – January 2012
Layer Subsidies and Medicaid Expansion together

Percentage of the Nonelderly Population With Income Up to Four Times the Poverty level Who Were Uninsured or Purchasing Individual Coverage, 2010


Exchange Basics

- A health benefit exchange (HBE) provides qualified individuals or small businesses the ability to compare various options/levels of coverage across multiple carriers to purchase health insurance by January 2014.
- Two exchanges may be offered: Individual Exchange and the Small Business Health Options Program (SHOP) qualified businesses of 1 – 100 (or 50) lives.
- Payers and their plans must complete a certification process in order to offer a qualified health plan (QHP) in the exchange (Note: states may choose to limit participation via rate negotiation or other approaches).
- All QHPs may offer four tiers of coverage: bronze, silver, gold and platinum; payers must offer at least one gold, one silver, and a child only plan.
- Premiums must be the same on plans offered inside/outside the exchange; factors that drive premium rates are regulated equivalently.
- Incentives are only available through the exchanges:
  - Qualified individuals may receive subsidies or premium credits
  - Qualified small businesses may receive premium/tax incentives
- States not electing to establish exchanges or failing to gain certification of operational readiness (or conditional) by 1/1/14, Federal government may operate the exchange or a Partnership model.
Health Plan Exchange Participation: A Local Decision

- QHP network requirements may alter the cost / benefit equation
- Despite membership opportunities, not all payers will participate
- Commoditized benefits will force alternative means to influence price
- Premiums, post-subsidy, will materially influence consumer choice

Timing of Current HHS Regulations

- Health Plan Preparations for Oct 2012
  - Service areas and provider networks
  - Feasibility studies to model projected enrollment and claim costs
  - Administrative budgets
  - Care management and quality programs
  - QHP applications
- Fall 2012 - HHS Notice of Benefit and Payment Parameters
- States decisions – State, Federal, or Partnership
State Progress in Establishing an Exchange (as of 6/6/12)

- **AL**: Studying options
- **AK**: No significant activity
- **AZ**: Decision not to create
- **AR**: Established exchange
- **CA**: Plans to establish
- **CO**: Pending legislation
- **CT**: Established exchange, but not ACA compliant*

*Florida prefers "On-line Marketplace" opposed to "Exchange"


Level 1 Establishment Grant Distribution

Source: Healthcare.gov
States Awaiting Supreme Court Decision

• 12 States halted exchange planning
• 5 States Continue planning but will not pass legislation

<table>
<thead>
<tr>
<th>State</th>
<th>Exchange planning activity prior to announcement</th>
<th>Received federal establishment grant</th>
<th>Designated entity to plan for state exchange or study feasibility</th>
<th>Exchange planning continuing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Moderate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Alaska</td>
<td>Minimal</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Florida</td>
<td>Minimal</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Georgia</td>
<td>Moderate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Indiana</td>
<td>Moderate</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Kansas</td>
<td>Moderate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Maine</td>
<td>Moderate</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Michigan</td>
<td>Moderate</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Missouri</td>
<td>Moderate</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Nebraska</td>
<td>Moderate</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Moderate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Moderate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Moderate</td>
<td>Yes*</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Texas</td>
<td>Minimal</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Virginia</td>
<td>Moderate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Wisconsin</td>
<td>Moderate</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Moderate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

* Grant awarded after state announced they would wait for a Supreme Court decision.

Source: Kaiser Family Foundation, Timing Matters: States Waiting for a Supreme Court Decision to Plan an Exchange, May 2012

Other Significant Reform Provisions
Medical Loss Ratio Provision - 2011

• Medical Loss Ratio (MLR) thresholds:
  – 80% Individual and Small group
  – 85% Large Group
  – Some states have waivers with different thresholds for individual
  – Adjustments to traditional MLR calculation

• Preliminary Results for 2012
  – Experience from 2011 – first year for rebates
  – Kaiser Family Foundation studied Supplemental filings due 4/1
  – Total 1.3 billion
  – Actual rebate filing will vary
  – Rebates reported to HHS 6/1/12 for distribution by 8/1/12

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Preliminary MLR Results for 2011 Experience

<table>
<thead>
<tr>
<th>Segment</th>
<th>Average rebate</th>
<th>Impacted Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Group</td>
<td>$72.31</td>
<td>7.5 Million</td>
</tr>
<tr>
<td>Small Group</td>
<td>$76.37</td>
<td>4.9 Million</td>
</tr>
<tr>
<td>Individual</td>
<td>$126.81</td>
<td>3.4 Million</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation, “Insurer Rebates under the MLR: 2012 Estimates, April 2012
Health Insurance Rate Review - 2011

- Additional review and public disclosure of rate increases above 10%
  - Determined “reasonable” or “not reasonable” by State or Fed
- Federal review of rates in States without “Effective Rate Review”
- 43 States are “Effective” for non-Association rate filings
- 30 States are “Effective” for all Association filings
- Expect continued pressure on rate increases

Essential Benefits - 2014

- Essential Benefits determine what services are covered
  - vs. the level of coverage / cost sharing – Actuarial Value
- Required coverage for all plans in the individual and small group market – both inside and outside the exchange
- Determined at the state level

- States choose one of the following benchmark health insurance plans:
  1. One of the three largest small group plans in the state by enrollment;
  2. One of the three largest state employee health plans by enrollment;
  3. One of the three largest federal employee health plan options by enrollment;
  4. The largest HMO plan offered in the state’s commercial market by enrollment.

- If a state does not choose a benchmark plan, HHS will propose that default benchmark plan will be the largest plan by enrollment in the largest product in the state’s small group market
Actuarial Value and “Metallic” Benefit Levels - 2014

- Applicable to Individual and Small Group Market
- Inside and Outside Exchange
- 4 “Metallic” Levels available

<table>
<thead>
<tr>
<th>Metallic Level</th>
<th>% Actuarial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
</tr>
</tbody>
</table>

- HHS intends to propose variation of +/- 2%
- Actuarial Value Calculator – options under consideration
- Participating insurers must offer at least 1 Silver and 1 Gold
- Also available catastrophic plan for < age 30 individuals

The “Three R’s” - 2014

<table>
<thead>
<tr>
<th>Program</th>
<th>Risk Adjustment</th>
<th>Reinsurance</th>
<th>Risk Corridor</th>
</tr>
</thead>
<tbody>
<tr>
<td>What</td>
<td>Transfers fund from low risk plans to high risk plans</td>
<td>Provides funds to insurers for high individual claimants</td>
<td>Limits issuer losses (and gains)</td>
</tr>
<tr>
<td>Operation</td>
<td>State option if the State establishes an Exchange (otherwise Federal)</td>
<td>State option regardless of whether a State establishes an Exchange (otherwise Federal)</td>
<td>HHS</td>
</tr>
<tr>
<td>Who</td>
<td>Redistribution among Non-grandfathered individual and small group plans inside and outside the Exchange</td>
<td>All issuers and TPAs on behalf of group health plans contribute</td>
<td>Qualified Health Plans – individual and small group exchange</td>
</tr>
<tr>
<td>Why</td>
<td>Protects against adverse selection</td>
<td>Offsets high cost outliers</td>
<td>Protects against inaccurate rate setting</td>
</tr>
<tr>
<td>When</td>
<td>Before 6/30 of the calendar year following the benefit year</td>
<td>Throughout the year</td>
<td>After reinsurance and risk adjustment</td>
</tr>
<tr>
<td>Time Frame</td>
<td>Permanent</td>
<td>3 years (2014-2016)</td>
<td>3 years (2014-2016)</td>
</tr>
</tbody>
</table>

Programs are designed to help the issuers stabilize premium and mitigate risk
Thank You

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