

## Ten critical considerations for health insurance plans evaluating participation in public exchange markets



Catherine Murphy-Barron, MBA, FSA, MAAA  
Craig Keizur, FSA, MAAA  
Jill Van Den Bos, MA  
Margaret Chance, FSA, MAAA  
Paul Houchens, FSA, MAAA

The Patient Protection and Affordable Care Act (PPACA) will introduce new marketplaces for individual and small group health insurance, effective January 1, 2014, in the form of *public exchanges*. Health insurance plans need to fully prepare and understand the impact that the public exchanges may have on their business. Whether or not a health plan participates, the logjam that blocked reform progress for several months appears to have been cleared; PPACA is now moving forward with weekly releases of regulations and rules (most are preliminary rules and open for comments). This momentum of rule writing brings new terminology and issues to light, which are critical to understand before making decisions on whether or not to participate in the public exchanges. This paper provides 10 critical considerations based on the preliminary rule recommendations published in the last half of November. As these rules are finalized, the considerations and market dynamics may change.

1. **MARKET OPPORTUNITIES.** The first consideration is whether a health plan is going to participate in the new public exchange marketplace or turn down the opportunity. The default structure establishes two exchanges for each state. A health benefits exchange, as the marketplace for individual products, and a Small Business Health Options Program (SHOP) exchange, as the marketplace for small group products. Each marketplace may be established by either the state or federal government.

For the individual market, there is an expectation of expansive consumer participation in the exchange providing additional market opportunities, driven by multiple forces:

- **Subsidies:** The availability of both premium and cost-sharing subsidies to qualifying individuals purchasing health insurance through the exchange may mitigate issues around affordability for previously uninsured or underinsured individuals. The presence of subsidies for low-income eligibles provides an entrance for Medicaid health plans to participate in the individual exchange market.
- **Individual mandate:** The individual penalties for not having health insurance coverage may result in increased sales as uninsured people enter the market.
- **Market shift:** To an unknown degree, a portion of employers currently offering employer-sponsored insurance may terminate coverage in 2014. When evaluating the potential

impact to the individual market of this shift in terms of market lives, it is important to note that currently approximately 150 million non-elderly Americans are covered by employer-sponsored insurance. Therefore, even if only 10% of individuals have their employer-sponsored plan terminated, an additional 15 million lives will potentially enter the individual market. Additionally, although the focus is on how many employers terminate coverage, employers may behave in a more strategic manner, choosing to incent or guide certain segments of employees to the exchanges, such as part-time employees, very-low-income employees, and early retirees. Some employers will also likely offer employer-based insurance for the first time in response to PPACA's employer responsibility requirements.

- **No wrong door:** In addition to providing new marketplaces, the exchange and SHOP are also integrated administrators of Medicaid eligibility to make sure that an individual is enrolled in the correct plan regardless of how that person explores getting health insurance coverage. For Medicaid *churn* (the flow of Medicaid members in and out of Medicaid eligibility, which is due to fluctuations in annual income), the opportunity exists to introduce new products into the individual marketplace to complement the traditional Medicaid offerings, and thereby retain some of the *former* Medicaid membership but in an individual market health plan.

- **Medicaid expansion:** The Medicaid expansion decision should also be carefully watched on a state-by-state basis. The federal government has ruled that a partial Medicaid expansion to 100% FPL cannot occur. Therefore, Medicaid expansion, if it happens in a state, will increase Medicaid eligibility to 138% FPL. If it does not occur, it has significant implications for the individual marketplace. In non-expansion states, households between 100% and 138% FPL will be eligible for premium subsidies. While this will increase the potential size of the individual market, it may also increase the overall morbidity in the individual market risk pool. In addition to re-evaluating premium rates, non-Medicaid health plans may need to develop new approaches and marketing strategies for lower-income households.

In the small group market, consumer participation in the SHOP exchange is less certain. If implemented correctly, SHOP may provide employees choice among benefit plans, with simplified administration for employers. Additionally, the small employer tax credit can only be accessed through SHOP beginning in 2014. However, experience from Massachusetts' and Utah's small group exchanges suggest that employers may be reluctant to purchase insurance outside of the traditional broker distribution model. Additionally, SHOP may be competing against private exchanges that offer enhanced features, such as greater employee plan choice or the ability to purchase non-health insurance benefits. Whatever the outcome, it seems carriers currently involved in the small group market may want to consider participation in SHOP in order to maintain their current market opportunity of employer-sponsored coverage. Additionally, federal exchange requirements indicate that insurers must offer plans both in the individual and SHOP exchanges. In state-run exchanges, similar guidelines may apply.

Many PPACA regulations are applicable to carriers selling both inside and outside the exchange, so the decision to participate is driven by a few key components. If the exchange environment is conducive to participation, it is likely that more health plans will want to participate in the exchanges to have access to this market share. It seems that the primary issues may center around the target population a carrier desires (i.e., selling to the subsidized population or not) and requirements for exchange participation (administrative, financial, etc.).

Once a health plan decides to participate in the exchange, the next major crossroad is determining how to differentiate itself from everyone else in the new competitive landscape. With the requirement of benefit tiers (described later) resulting in somewhat homogeneous benefit choice, product differentiation can rely on only:

- **Price:** Through lean administrative expenses, narrow networks, favorable provider unit cost contracting, competitive distribution fees, and/or strong utilization management programs. Pricing is discussed in more detail below.
- **Quality:** The national rankings for quality are still rather vague.

- **Access:** Including a vast selection of service area and provider choice.

Staking ground during the initial open enrollment period may be essential to having an adequate market share under management in future years.

2. **QUALIFIED HEALTH PLAN.** To sell insurance on the exchange or via SHOP, a health plan will have to be accepted by the state's exchange and deemed a qualified health plan (QHP). A state-based exchange may have some unique requirements because it is not required to follow the federal rules, but for the federally facilitated exchange the proposed requirements are:

Issuer-level QHP certification standard (health plans)

- Licensure and good standing: Licensed in the state and complies with all state solvency and other related requirements.
- Network adequacy.
- Essential community providers: Determine that the network includes sufficient essential community providers.
- Accreditation.
- Program attestations: Compliance with marketing standards, etc.

Plan-level QHP certification standard (products)

- Essential health benefits: Plan design covers all essential health benefits.
- Actuarial value (AV) standards: Ensure compliance with AV and cost-sharing requirements.
- Non-discriminatory benefit design: Review plan for discriminatory benefit designs.
- Meaningful differences: Ensure meaningful differences between different carrier options within benefit tiers.
- Service area: Confirm that service area is big enough (i.e., covers the entire county). Exceptions may be allowed as long as a small area is in the best interest of the member and is non-discriminatory.
- Rate review: Review new rates and renewal rates to ensure they are justifiable.

The exchange oversight of accepting a QHP is in addition to any review and approvals undertaken by the state's insurance department.

With respect to exchange participation, carriers may need to consider the QHP criteria set by the federal and/or state

administrator and weigh the pros and cons of participation. To the extent that the requirements for QHPs—both administrative and those related to benefits and pricing—are not conducive to participation, health plans may elect to sell outside of the exchange only.

**3. ESSENTIAL HEALTH BENEFITS.** Non-grandfathered health insurance plans sold both inside and outside exchanges must offer a minimum package of benefits, known as essential health benefits (EHB). Regulation 45 CFR Part 156 provides additional rule-making clarification around this part of PPACA.

Benefit packages serving as a *benchmark* plan for providing EHB are to be determined for each state, with the final *benchmark-EHB* chosen by U.S. Department of Health and Human Services (HHS) from each state's recommendation. To the extent that a state does not make a recommendation, the default value HHS proposed is the largest plan by enrollment in the state's small group market. Multistate plans will be subject to benchmark standards set by the U.S. Office of Personnel Management, which are intended to be comparable to state EHB standards.

If the state's recommended EHB plan does not include benefits in one or more categories, HHS has outlined a methodology for supplementing the benefits in the regulation. For prescription drugs, it is required that the plan offer a minimum of one drug in every United States Pharmacopeia (USP) category and class, even if the number of drugs in each category and class in the benchmark EHB plan does not meet this minimum.

Final summaries of each state's proposed EHB package (or the default if no selections) can be found at the Centers for Medicare and Medicaid Services (CMS) website.

With respect to a health plan's decision to participate in exchanges, the issue of providing EHB is not a deciding factor because it is required for any health plan inside or outside the exchange. However, there may be differences between EHB and plan requirements (i.e., the QHP). As carriers evaluate their 2014 portfolio benefits and the decision to participate in the exchange, considerations include:

- What modifications are needed to current benefit plans to meet EHB requirements in each state exchange? How much flexibility is allowed in the benefit designs? Many of the EHB requirements will be included in current benefit plans, but certain covered services such as habilitative services and prescription drugs may need greater modification.
- For carriers selling in multiple states, how varied are requirements by state, including pharmacy formulary differences, and how does this impact potential benefit designs?
- What are the differences between benefit requirements for QHPs and EHB and the requirements for exchange participation, and what impact do these differences have?

How is the state exchange handling the additional cost of the premium subsidies associated with the extra benefits?

- The pediatric dental component of EHB may be sold as an optional standalone benefit for plans sold in the exchange, but not outside the exchange. What is the cost and marketing impact of this component as an integrated versus a standalone product, and how might this differentiate carriers selling inside and outside the exchange?
- Do the variations between EHB and QHP drive a different business decision for exchange participation by carriers on a state-by-state basis? A good review of state EHB variation is contained in the Milliman paper *Essential health benefits: Review of the state employee benchmark plans and illustration of possible variation in essential health benefits* by state, by Robert Cosway.

**4. ACTUARIAL VALUE AND BENEFIT TIERS.** Another 2014 market reform required by PPACA is that issuers in the individual and small group markets offer benefit plans that meet specified levels of coverage, or *actuarial value*. The benefit levels, or *metal* tiers, define the proportional value of the EHB claims that are covered by the issuers' premium. The levels are required for health plans both inside and outside the exchanges as a way for the consumer to compare and select plans. The levels and corresponding value of coverage in these tiers are as follows:

- Bronze, 60% actuarial value
- Silver, 70% actuarial value
- Gold, 80% actuarial value
- Platinum, 90% actuarial value

In addition to these benefit tiers, carriers may offer an individual plan providing catastrophic coverage that can be sold to young adults of ages 21 to 30, or anyone who meets certain hardship requirements regarding the inability to find affordable coverage. These catastrophic plans provide first-dollar coverage for preventive visits (up to a specified number), but may have higher deductibles and lower actuarial values than the bronze tier. When these products are purchased, the eligibility requirements must be met by all members of the policy. While the focus has been on the fact that these plans are available to the young and healthy, the catastrophic health plan may also see enrollment of individuals exempted from the individual mandate because of its unaffordability and financial hardship provisions. There is currently no required actuarial value (although 57% is assumed in the risk-adjustment payment transfer formula), but the deductible and out-of-pocket maximum cannot exceed the legal limits, which may make it hard to differentiate these plans from bronze plans.

As carriers evaluate their participation in exchanges and the offering of products in the various benefit tiers both inside and outside of the exchange, considerations should include the following:

- The offering of benefit tiers is a requirement of all carriers, not only those sold in the exchange. This limits the potential differentiation of carriers operating inside and outside of the exchange and provides less incentive for carriers to participate exclusively off the exchange.
- Exchange participation requires that carriers offer a minimum of one silver and one gold plan, but this could vary by state to be more expansive. Alternatively, plans outside the exchange must only meet the minimum requirements of bronze-level coverage. How might a carrier's target market considerations vary, both inside and outside the exchange, given these potentially differing requirements?
- Participants qualifying for premium subsidies cannot apply them outside of the exchange, and there is a potential for significant premium and cost-sharing subsidization for these purchasers. How will the effect of subsidies on out-of-pocket premiums impact the competitive positioning of plans sold inside and outside of the exchange?
- For plans within a given benefit tier, regulations allow the actuarial value percentage of coverage to vary by +/- 2% from the target (e.g., for a silver plan, the AV percentage for a given plan can be 68% to 72%). While the range is relatively small, it does allow for flexibility in plan design and differentiation. How will carriers position themselves competitively in this range and how do carrier-specific issues influence these decisions? How might these decisions vary for an exchange versus a non-exchange population?
- How will catastrophic plans compare in actuarial value and price to the bronze tier and how might carriers position these plans to target young insured participants compared to the *metal* benefit tiers? In addition to the *under-30* crowd, the catastrophic plan is an available option to those exempt from

the individual mandate because the premiums exceed 8% of household income (in 2014). Therefore, it is possible that the enrollee mix is not just the *young invincibles* but also early retirees, although it should be noted that the premium subsidies cannot be used with the catastrophic plan.

5. **SUBSIDIES.** For low-income eligibles, the exchange offers meaningful subsidies that will reduce both members' monthly premiums and cost sharing (by way of lower out-of-pocket maximums and additional AV plan options). Premium subsidies are available to enrollees with incomes from 100% of the FPL up to 400% FPL who do not qualify for Medicaid or Medicare and do not have access to employer-sponsored coverage meeting minimum value and affordability standards. Cost-sharing subsidies are available to silver plan enrollees with incomes up to 250% FPL. It is important to note that for states that do not expand Medicaid, PPACA does not provide premium subsidies below 100% FPL.

Premium subsidies will be facilitated as an advance tax credit, so that enrollees benefit by paying the lower premium up front, reflecting the tax credit the following year when taxes are due. Cost-sharing subsidies will be coordinated between the health plan and the federal government, with monthly advance payments made to plans that are reconciled at year's end, similar to the low-income subsidies that CMS provides for the Medicare Part D program.

Figure 1 summarizes the available subsidies (note that the income level description in the left-hand column represents the starting FPL level for the subsidies to the right).

It is important to consider how the subsidies may work as they are indexed off an individual's household income and the silver plan premium, which in terms of cost is the second lowest available in the market. As an illustration, assume an individual with annual income of 200% FPL; based on the table in Figure 1,

**FIGURE 1: PPACA PREMIUM AND COST SHARING SUBSIDY ILLUSTRATION (SINGLE INDIVIDUAL)**

INCOME (% OF FPL)	PREMIUM SUBSIDY			COST SHARING SUBSIDY <sup>3</sup>		
	ANNUAL INCOME (BASED ON TRENDED 2014 FPL <sup>1</sup> )	PREMIUM PERCENT OF INCOME CAP <sup>2</sup>	MONTHLY MAXIMUM PREMIUM AMOUNT	REDUCTION IN MAXIMUM OOP LIMIT	REDUCED MAXIMUM ANNUAL LIMITATION ON COST SHARING (2014)	REQUIRED ACTUARIAL VALUE OF BENEFIT PLAN
<133%	\$15,455	2.00%	\$26	66.70%	\$2,250	94%
150%	\$17,430	4.00%	\$58	66.70%	\$2,250	87%
200%	\$23,240	6.30%	\$122	20.00%	\$5,200	73%
250%	\$29,050	8.05%	\$195	N/A	\$6,400 <sup>4</sup>	70%
300%	\$34,860	9.50%	\$276	N/A	\$6,400 <sup>4</sup>	70%
400%	\$46,480	9.50%	\$368	N/A	\$6,400 <sup>4</sup>	70%

1. Based on 2012 100% FPL of \$11,170 for a single individual, trended two years at 2% annual trend (rounded).  
 2. Premium tax credit percentage are for 2014 and will be indexed in the future.  
 3. Excluding cost-sharing reductions for Indians with household income not more than 300% FPL (see §156.420(b) of proposed rule for cost-sharing reductions).  
 4. HHS estimated 2014 maximum annual limitation on cost sharing. For future years, will be based on IRS dollar limit on cost sharing for high-deductible plans.

that person's premium will be capped at 6.3% of annual income (\$122 per month). If the second-lowest silver plan premium for this individual was \$350 per month (note that premiums will vary by age), a monthly subsidy of \$228 ( $\$350 - \$122 = \$228$ ) toward his or her premium would be available. This means that the person would pay \$122 per month, or approximately 35% of the second-lowest-premium plan. In addition, out-of-pocket costs for this person would be reduced to 80% of the health savings account (HSA) maximum (\$5,200 in 2014), and the plan's overall AV would be 73%, which is 3% higher than a defined silver plan, resulting in 10% less average cost sharing.

If this member were to enroll in a more costly plan with premiums that are significantly higher than the silver plan, then the premium subsidy percentage would be reduced. Assuming an illustrative monthly premium of \$500, the subsidized premium for an individual with household income of 200% FPL would be \$272 ( $\$500 - \$228 = \$272$ ), which is 54% of the premium and 123% higher than the premium for the silver plan in terms of cost.

This makes competitive intelligence a key consideration. How close a health plan thinks its premium will be relative to the silver plan subsidy benchmark will influence the pricing assumptions for enrollment and margin. Those premiums closest to the silver plan subsidy benchmark may attract more subsidy-eligible participants because enrollees can minimize their out-of-pocket premiums. Enrollees in the lowest-cost silver or bronze plans may also have lower premiums with the silver plan subsidies, which will likely be zero for a significant number of households with income below 200% FPL. In the case of the bronze plan purchase decision, this may not be the best consumer choice, particularly for individuals with household income below 200% FPL who are eligible for generous cost-sharing subsidies, because although the monthly premium may be very low, the member may be exposed to significant cost-sharing liability, which is not subsidized at the bronze level. Regardless, zero-dollar net member premiums may be feasible. Conversely, the gold and platinum plans may not be a popular option for subsidy-eligible members because they will have to pay the full difference between the higher gold or platinum premium and the silver plan benchmark premium.

**6. PRICING AND RATE FILINGS.** Pricing for health plans effective January 1, 2014, will need to include numerous considerations for products sold both inside and outside the exchange. Not only does this include items that will impact the actual price being charged, but also planning around the filing requirements with state insurance departments and the exchanges (as applicable).

With respect to the actual prices that will be charged, there are a number of items affecting these determinations, each of which is applicable to products sold both inside and/or outside the exchanges.

- Reflecting the specific rating and underwriting requirements under PPACA.

- Individual vs. family coverage (per-member rating up to three children, or a state can establish tiers and multipliers).
- Rating area (up to seven in a state, unless otherwise requested by state for CMS approval). Service areas as a subset of the rating area must be nondiscriminatory.
- Specified uniform attained age slopes.
  - Ages 21 to 64: One-year age bands with a specified slope to be used for all products that meets the 3:1 requirement. The specified age slope can be established by the state, or the CMS slope will be used as a default. The CMS slope is provided in the preliminary regulations. States can elect to have a tighter range than 3:1.
  - One child rate for ages 20 and younger.
  - One rate for ages 64 and older.
- Tobacco use, which must be within 150% of the non-tobacco rate.
- Guaranteed issue.
  - Small group: No open enrollment period, consistent with current small group laws.
  - Individual: Initial and annual open enrollment period.
- Inclusion of required benefits (EHB, QHP) and at the required cost-sharing levels (AV and benefit tiers).
- The impact at the policy level of risk sharing, subsidies, and medical loss ratio requirements.
- Reflecting all of the applicable fees, including the exchange assessments, Patient-Centered Outcomes Research Institute fee, insurer fee, reinsurance fee, and other needed expenses, including sales (agent/broker) commissions, as applicable.
- *Blind* competitive landscape (i.e., it is new to everyone).
- Competitive strategies, such as provider contracting options (e.g., if health plan is primarily targeting the subsidy eligible population, should provider payment rates be closer to Medicare and Medicaid payment levels, or commercial reimbursement rates?) and narrow provider networks.
- Risk-based capital requirements.

These rating requirements apply to both individual and small group plans, so the impact of various items on today's rating can vary by market. For example, most individual products already use one-year age bands, while small group products currently use five-year age bands, which are not allowable under PPACA even with a 3:1 ratio.

Recent changes have been proposed to the premium rate review regulations, requiring information to be filed with CMS in a standardized format for all rate increases, not just those exceeding the *unreasonable* rate review threshold (currently 10%). The goal of the proposed changes is to allow a mechanism for HHS to monitor premium activities for issuers both inside and outside the exchange, as required in PPACA. At this time, HHS is seeking comments as to the value of this approach, as opposed to using alternative methods (e.g., auditing). As the proposed regulation changes are currently written, it appears these forms would not be required for new product filings or rate decreases. Carriers will need to track developments on these requirements to see how each state plans to incorporate the federal rate review material in conjunction with requirements that may already be in its state laws and regulations for filing rates. States and exchanges will have specified product and rate filing deadlines, many of which are likely to be set for the spring of 2013 to give adequate time for review and approval in time to be available for sale on October 1, 2013, for policies effective January 1, 2014.

With respect to participation in the exchange, the pricing and rate filing requirements of CMS and state insurance departments may be applicable to all products, thus having no influence on the decision making related to exchange participation. However, there may also be filing requirements set by the exchange, which could be more expansive. In drafting the proposed CMS standards, it was anticipated that the same forms would be used by exchanges for their filing requirements, thus limiting the additional burden to carriers. While this is likely for products sold in a federally facilitated exchange, this may not always be the case for the state-based exchange. Carriers may need to consider if exchange requirements place additional burdens that outweigh the benefits of participating exclusively outside the exchange. Certainly these decisions could vary by state.

## 7. REINSURANCE, RISK ADJUSTMENT, AND RISK SHARING.

For the market reforms, the exchange program is new, and there are significant potential risks surrounding financial performance. Three different risk-mitigation methods are being introduced in programs to help protect the health plans from adverse risk in the individual market, small group market, or both. The programs include:

- **Transitional reinsurance.** This is a temporary federal program (however, states have the option to add additional reinsurance coverage), effective calendar years 2014 through 2016, with a goal of stabilizing only the individual market as a result of the influx of previously uninsured members. All non-government commercial insurance and group health plans (insurance companies, self-insured groups, and third-party administrators, inside and outside the exchanges) will fund the three-year program (2014 funding assessment estimated at \$5.25 per member per month), which will reimburse health plans with members that have claims that exceed a predefined threshold (2014 parameters are 80% coverage for expenses between \$60,000 and \$250,000). Overall, this should reduce a health plan's projected premiums in the first three years of the program, with a large impact in the first

year and lesser impact in years two and three. Health plans can test the impact of the stop-loss levels on current claims experience; however, the potential claims distributions of the uninsured are more difficult to analyze. Note that the program is not intended to cover the full liability of large claimants, and therefore will not eliminate the need for health plans to assess their stop-loss and reinsurance needs.

- **Risk adjustment.** This is a permanent mechanism that will shift premium payments from health plans with favorable risk selection to plans with poor risk selection, for all non-grandfathered health plans in both the individual and small group markets. Risk-adjustment methods typically assign relative expected cost weights to members, based on diagnosis codes. The proposed model will be concurrent, meaning it will use the current year's claims to estimate the current year's expected risk (as opposed to prospective models, which predict the following year's risk). Patients with multiple chronic disease conditions will typically have higher risk scores. From a program standpoint, the risk-adjustment transfers should be revenue-neutral in aggregate within each state. Once the federal risk sharing model is released (at this time the risk coefficients have been released, but not the actual model), health plans can test their current memberships to understand if their groups are healthier or sicker than the average, and how anticipated shifts in populations will impact risk. Unfortunately, it is difficult to assess the full impact. A health plan will only have the diagnoses of its own membership and not all potential enrollees. However, if a health plan believes it is particularly good at managing a population with a certain condition that receives a high risk score, it may focus its marketing efforts on that population. Like most risk-adjustment methods, success is highly dependent on the plan's ability to capture adequate diagnoses and continue to improve the coding each year in the future.
  - **Risk corridors.** This three-year risk protection federal program (for calendar years 2014 to 2016) will protect against uncertainty in annual profit or loss results for QHPs in and out of the individual and small group exchanges. At a high level, if profit or loss exceeds 3%, a portion of the excess (either profit or loss) will be shared equally with the federal government. This adjustment will impact each plan differently, and should be assumed to have no impact on the premium rates in the initial year because it is a retrospective adjustment. This risk-sharing mechanism is not designed to be revenue-neutral and, in theory, every plan could get paid. It is important to note that a QHP is not required to be offered outside of the exchange.
8. **MINIMUM MEDICAL LOSS RATIO.** The minimum medical loss ratio (MLR) provision, implemented in 2011, requires that insurers spend a minimum percentage of adjusted premium revenue on claims and qualified quality improvement expenses. The minimum MLR requirements are 85% for large group and 80% for individual and small group. An insurer must provide

rebates to policyholders (individuals or groups) if its calculated MLR (calculated on a three-year rolling average) is below the relevant threshold (85% for large group, 80% for small group and individual). The first rebates were paid in 2012.

This feature of PPACA applies to all issuers, regardless of whether products are offered in the exchange. MLR is calculated separately for each line of business (large group, small group, individual), within each state, using an adjusted loss ratio calculation as follows:

$$\text{Loss ratio} = \frac{\text{(Incurred claims + increase in reserves + quality improvement expenses + 3 Rs adjustments)}}{\text{(Premiums - federal \& state taxes - licenses \& fees)}}$$

Note that the minimum MLR will be calculated after adjustments made for the 3 Rs. For plans that issue QHPs, all three of the risk-mitigation features will be in play to affect loss ratio calculations. For plans that do not issue coverage on the exchanges, risk adjustment will still apply. For all individual plans, on and off the exchanges, transitional reinsurance is available. Knowing which of the three apply to a carrier's MLR calculation is not the same as knowing the result, however. While a carrier can monitor reinsurance and risk corridor payments to get a sense of their impact on the MLR, risk-adjustment payments are dependent upon other carriers' premium rate filings and diagnosis code experience. Risk-adjustment payments will be made well after the plan year in question is completed and are going to be difficult to influence the pricing the following year. These post hoc adjustments are the least predictable element of the MLR calculation.

Historically, plans have been able to establish a *best-estimate* target loss ratio for the longer-term pricing horizon, understanding that loss ratios will bounce around somewhat and that good years would offset bad years. However, this will no longer be the case; excess gains in any year must be refunded to enrollees. This implies that good years will not be able to balance the bad years because plans lose the ability to store up reserves during years of higher profit.

**9. INFRASTRUCTURE GAPS.** In order to implement healthcare reform, a health plan needs to make sure its current operations are capable of handling all of the changes required to participate in the programs. A health plan should ensure that key work-flow processes are efficient and effective based on the program's requirements, that proper training and education is available to assist with the learning curve for the new programs, and that adequate staffing levels are approved and filled to handle the increased volume from this new world of healthcare. If the gaps cannot be backfilled from other functional units (or reassigned from current resources), they will either need to be recruited and hired, or purchased (i.e., a software vendor or outsourcing company). Areas to assess include:

- Information systems. Communicating with the exchange as well as tracking member cost sharing and subsidy-

related information is new, and the systems will need to accommodate this.

- Sales and marketing. Services to attract, sell, and retain members.
- Membership, enrollment, and billing.
- Customer service and claims.
- Medical management and provider network strategy.
- Accreditation status, e.g., National Committee for Quality Assurance (NCQA), URAC.
- Financial and analytics.
- Government relations, legal, and contracting.
- Administration services.

A traditional gap approach reviews the current state, defines the future state, and develops recommendations for transitioning the current state to the future state. These analyses are not completed in a vacuum. They require input from all areas of an organization in order to understand what is working and what could work better.

**10. DO NOTHING?** An insurer can choose not to offer any products in the exchanges—the do nothing scenario. By sidestepping the exchange, an insurer may avoid issuing coverage to a population with unknown, and potentially unfavorable, risk characteristics. While future employer behavior with regard to providing health coverage is uncertain, the exchanges may attract a disproportionate share of the population with pent-up demand and poor health overall. On the other hand, members seeking subsidies to make insurance affordable may include a mix of young adults and families whose health status is average or better. The composition of the exchange risk pool may be a mix and may change materially from year to year, and the impact of the individual mandate is difficult to gauge.

Note also that the opportunity to reach a new market by participating in the exchange *land grab* could be a very quick way to increase the size of an insurer's covered population. For the first three years of the new marketplace, starting in 2014, there will be three risk-mitigation mechanisms in place to ease the transition to this larger population, which has never been available before. Initially, the transitional reinsurance and risk corridor programs are in place to hedge against pent-up demand of this population. For members with longer-term chronic health challenges, the permanent risk-adjustment program will compensate for the higher-than-average claim levels. Plans offered on the exchange will have an unprecedented opportunity to enroll these members with reduced financial risk.

It could also be prudent to stay out of the exchanges for a year or two, and then join and offer products after the dust has settled, so to speak. This strategy, again, misses the initial land grab and such a move might mean that an insurer will have a difficult time gaining traction as a latecomer and may not be able to enroll a large volume from the exchange.

Many of the features of PPACA will impact insurers whether they participate in the exchanges or not. Examples include the conversion to adjusted community rating; minimum MLR, EHB, and benefit tiers (bronze, silver, gold, platinum) for the individual and small group markets; as well as other coverage requirements, such as adults up to age 26 and preventive services at first-dollar coverage. These market reforms put a cost even on the decision to do nothing in regard to exchange participation.

The above discussion does not replace a comprehensive reading of all of the emerging regulations and the business strategy implications of healthcare reform. This list is intended to touch on the major topics that are important to understand in the evaluation of a health plan's participation in a public exchange. Final regulations and future

guidance released by the federal government should be monitored closely in the upcoming months when developing products and strategies for the new 2014 exchange landscape.

Catherine Murphy-Barron, MBA, FSA, MAAA, is a principal and consulting actuary with Milliman's New York office. Contact her at [cathy.murphy-barron@milliman.com](mailto:cathy.murphy-barron@milliman.com).

Craig Keizur, FSA, MAAA, is a principal and consulting actuary with Milliman's Seattle office. Contact him at [craig.keizur@milliman.com](mailto:craig.keizur@milliman.com).

Jill Van Den Bos, MA, is a senior consultant with Milliman's Denver office. Contact her at [jill.van.den.bos@milliman.com](mailto:jill.van.den.bos@milliman.com).

Margaret Chance, FSA, MAAA, is a consulting actuary with Milliman's Chicago office. Contact her at [margaret.chance@milliman.com](mailto:margaret.chance@milliman.com).

Paul Houchens, FSA, MAAA, is a consulting actuary with Milliman's Indianapolis office. Contact him at [paul.houchens@milliman.com](mailto:paul.houchens@milliman.com).

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