2. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), introduces significant changes in covered benefits, premium rating and underwriting, carrier regulation, and the overall issuance of health insurance coverage in the U.S. Certain changes have already occurred, while the majority of the impacts will begin on January 1, 2014. This is the date when all states must have both an individual market exchange and a Small Business Health Options Program (SHOP) exchange in operation, or default to a federally run exchange. This includes significant changes in the benefit offerings and underwriting of insurance policies both inside and outside these required exchanges.

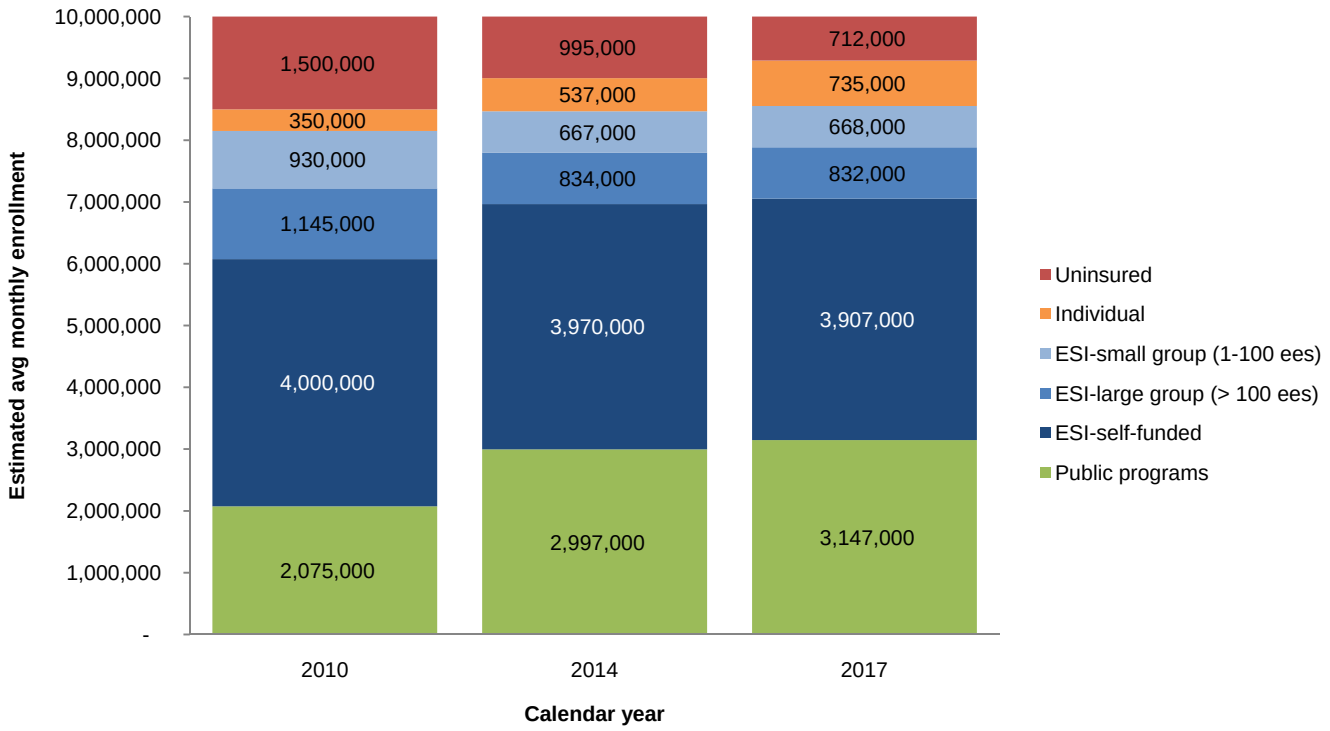
The primary ACA requirements for the commercial employer-sponsored (ESI)-small group and individual health insurance markets, both inside and outside the exchanges, include:

- Guaranteed issue of insurance coverage regardless of pre-existing medical conditions or health status
- Adjusted community rating with premium rate variations 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)
- Definition and requirements for essential health benefits
- Individual tax penalty if not covered by minimum essential insurance coverage
- Employer tax penalty if not offering qualified insurance coverage (groups under 50 employees exempt)

The ACA also includes a significant expansion of the state Medicaid program to include all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

These changes are certain to impact the current source of health insurance coverage for a large number of Ohioans. The key question is, to what extent are the current markets going to be impacted? More specifically, what will the Ohio insurance market look like in 2014 and beyond? While the exact impacts are not known, this report used a model developed to illustrate the potential landscape of the Ohio insurance market in 2014 (initial year) and in 2017 (mature year). The estimates take into account the potential behavior of individuals and employers based on income level, age, and health status. Figure 2-1 illustrates the estimated changes in the source of coverage for 2010 to 2014 and 2017. It should be noted that these results assume that the state does not implement a Basic Health Program.

Figure 2-1: Ohio non-elderly covered lives by source of coverage – changes from 2010 to 2014 and 2017



The primary observations for calendar year 2017 (as compared to 2010) from the model results used to develop Figure 2-1 include:

- The individual health insurance market increases by approximately 110% or 390,000 lives
- The public programs increase by approximately 52% or 1,070,000 lives
- The ESI-small group market decreases by approximately (28%) or (260,000) lives
- The ESI-large group market decreases by approximately (27%) or (310,000) lives
- The ESI-self-funded market decreases by approximately (2%) or (90,000) lives
- The uninsured population decreases by approximately (53%) or (790,000) lives

The premium rates in the various markets are expected to react to the movement of individuals summarized above. This indicates that the model used to develop this report assumed that the healthcare cost of each individual is unique and that as they move to another market segment their associated costs go with them. The minimum benefit standards required in the ACA will also impact the premium rates to the extent they are higher standards than the current markets. Our analysis estimates that the premium rates may change as follows:

- Prior to the application of the premium tax credit subsidy, the individual health insurance market premiums are estimated to increase by 55% to 85% above current market average rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits. Current insured benefit expenses in the individual market are approximately 40% less than the ESI-small group market.[3] This is attributable to today's individual market having leaner covered benefits, such as the exclusion of maternity services, and a lower-cost population relative to the ESI markets.

It is estimated that the post-ACA individual market will have average benefit coverage levels more comparable to the small group market. It is also anticipated that this new individual market will be less healthy compared to the ESI market populations. For these reasons, premiums in the individual health insurance market post-ACA are estimated to be 8%-12% higher than the ESI-small group market, post ACA reforms.

- The ESI-small group market premiums are estimated to increase by 5% to 15% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the remaining ESI-small group market, ACA-imposed insurance carrier fees, and provider cost shifting from the public programs.

- The ESI-large group market premiums are estimated to increase by 3% to 5% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the ACA-imposed carrier fees and provider cost shifting from the public programs.

- It should be noted that these increases will be in addition to regular expected healthcare inflation. The 2011 Milliman Medical Index reported 7% to 8% annual trends for the fourth year in a row.[1]

The premium change estimates illustrated above represent the estimated **average** premium impact to each of the market segments. It is important to note that individual policyholders and ESI-group policy premiums will have significant variability as a result of the ACA requirement for adjusted community rating (ACR). Individuals and smaller employers will observe the greatest impacts since they are more likely to be at one extreme or the other of the total current premium range (i.e. health status tier, age band, and gender category).

- In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%. However, a 60 year old with chronic health conditions may experience a significant premium decrease.

- In the ESI-small group market, rating changes may result in a premium increase of 150% or a premium decrease of nearly 40% for groups at opposite ends of the current rating structure.

- Rate change variability attributable to ACR may result in healthier insured risks leaving the insured risk pool, while attracting a greater proportion of less healthy risks.

This estimated premium impact includes the combination of items impacting the entire market (such as minimum benefits and risk pool composition changes) as well as the items that mainly impact the lowest or highest extremes of the current premium range (such as restriction of age rating to a 3:1 ratio, removal of health status underwriting, and the elimination of gender rating). Similarly, individuals and ESI-small groups who consist of older ages, higher health risks, and higher female concentration will experience lower than average premium rate changes as a result of the subsidies created by ACR.

The changes which will result from to ACA will be significant. The task of implementing these regulations will require a significant amount of leadership and collaboration among the state, carriers, employers, consumers, brokers and agents, and providers. The key will be finding the issues that can be regulated by policy and using that authority to ensure as much market stability as possible through this period of change.

I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA) – requires states to establish an American Health Benefit Exchange (Exchange) that after December 31, 2014 will be financially self-sustaining or default to a federally-run exchange.

Table 1.1 below presents our estimate of the annual non-IT operating costs[1]) to run an Exchange that Ohio might establish, expressed as a total dollar amount, as per member per year costs, and as a percentage of premiums. These costs are for the year 2015 – the first year in which the Exchange must be self-sustaining – in current (2011) dollars, and are shown for two Exchange design scenarios: a "Baseline" scenario and a "Robust" scenario. Under the Baseline scenario, the Exchange provides the minimum services required under ACA; whereas under the "Robust" scenario the Exchange provides more intensive Exchange services.

Item	Baseline scenario	Robust scenario
A. Exchange participation		
Members (thousands)	**530**	**640**
Annual premiums (thousands)	**$ 2,263,000**	**$ 2,722,000**
B. Annual non-IT operating cost		
Total (thousands)	**$ 19,162**	**$ 33,766**
Per member per year (excluding IT)		
For Exchange members	**$ 36**	**$ 53**
For all private fully-insured members	**$ 9**	**$ 17**
Percentage of premiums (excluding IT)		
For Exchange members	**0.8%**	**1.2%**
For all private fully-insured members	**0.2%**	**0.4%**

Table 1.1: Estimated annual Exchange operating costs for 2015 (excluding IT maintenance and support)

In Table 1.1, Exchange participation for the Baseline scenario corresponds to the "best-estimate participation scenario" in the companion Milliman report.[2] Because the Robust design scenario in Table 1.1 includes more intense marketing and outreach for the Exchange, its Exchange participation corresponds to the "high participation scenario" of the companion report. For both scenarios, money

[1] The costs of maintaining and supporting the IT infrastructure of the Exchange (including, but not limited to, the core transaction processing systems, database and analytics systems, and website) are intentionally excluded from this analysis. The State has contracted with another vendor to estimate these costs, and to avoid duplication, has requested that Milliman exclude these costs from this report.

[2] The companion report was prepared in August 2011 for the Ohio Department of Insurance, and is titled, "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefits Exchange."

amounts are in thousands of current dollars (to facilitate comparison between years, no inflation is assumed).

The annual revenue that the Exchange will require to be financially self-sustaining is equal to the annual operating cost amount (or perhaps slightly greater than the annual operating cost amount, in order to build up an operating reserve). The State may decide to collect revenue from health insurers participating in the Exchange based on covered members in the Exchange, either as a per member fee or as a percentage of premium. To spread the costs over a wider population, the State could also decide to collect revenue from all health insurers based on all private fully-insured members in the State.

However, there are other potential sources of revenue that could supplement revenue based on covered members, such as insurer Exchange participation fees, general revenue, excise taxes, and ACA penalty income.

Note that the costs above are only the operating costs needed to run an Exchange. They do not include the start-up costs of planning or establishing an Exchange. Such start-up costs may be substantially higher than one year of operating costs for running the Exchange.

Regarding the maintenance of financial sustainability for Ohio's Exchange, we make the following recommendations:

1. **Use a defined process, with specified decision criteria, to select a financing method.** Because the means of funding the Exchange are complex, we suggest using a defined process to select a financing method, a process that involves healthcare stakeholders and specific decision criteria.
2. **Establish a financial surplus.** Because Exchange membership may build slowly and may experience considerable volatility in the early years until it reaches a steady state, and because operating expenses cannot be immediately adjusted to reflect membership changes, we suggest establishing a financial surplus of 20 to 25 percent of the annual operating budget. We further suggest starting to establish this surplus in 2014.