Individual Market Sustainability Proposal

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Proposal

Solution Summary

The proposed reform would implement separate affordable health insurance solutions to fit three separate markets of individuals who do not purchase health insurance through an employer or another Federal program.

- *"Over 250%" Pool: Middle to Higher Income Individuals (over 250% of Federal Poverty Level):* a primarily state regulated underwritten market focused on reducing out of pocket premium expenses for younger and healthier individuals to encourage participation, while offering economic incentives to all individuals through available tax credits. Plan options will provide both cost sharing and provider network flexibility.
- *"Under 250%" Pool: Middle to Lower Income Individuals (generally 138% to 250% of Federal Poverty Level):* a federally funded, underwritten and subsidized market focused on reducing out of pocket premiums and cost sharing expenses for all income eligible individuals who do not qualify for Medicaid.
- *"Special Needs" (High Risk) Pool:* a federally funded, highly subsidized market to serve individuals with special health care needs and persistently high cost and "uninsurable" conditions.

The overall solution will stabilize the individual insurance market by:

- Lowering premium costs for individuals who may not qualify for subsidies today under the ACA by creating a **separate pool for high risk individuals** from those who are healthy or have manageable chronic conditions (i.e. diabetes, depression.)
- Providing **access for all consumers** to a comprehensive medical plan so long as they **maintain continuous coverage**, by maintaining highly subsidized coverage to lower income individuals
- Creating incentives for insurers to move to **paying providers for managing total cost of care** versus fee-for-service reimbursement
- Incenting consumer accountability and savings toward health behaviors by making **catastrophic options** with higher cost sharing levels available in the market. The ability for higher income individuals to "partially self-fund" their claims will reduce out of pocket expenses and improve participation in the pool
- Establishing **greater tax credit parity across the individual and group markets** by capping employer tax deductions to allow for deductions up to a "bronze" actuarial value level (60%). Individuals will be able to deduct from taxes an identical amount as employer groups for comparable levels of coverage.
- Allowing **higher tax deductible contributions to health savings accounts** than what exist today. The proposal is $6000 for an individual and $10,000 for a family.
- Keeping the popular provisions of the ACA to allow dependents to stay on their parent's plan until age 26 and allow coverage for pre-existing conditions unless these conditions qualify for the special needs pool

Consumer Impact

Access

All individuals with designated high cost conditions will have guaranteed issue access to the Special Needs Pool at any time after documented identification of a condition by a medical professional, as identified by a diagnosis code. Examples of such conditions include, but are not limited to: hemophilia, multiple sclerosis, metastatic cancer, transplant recipients, and HIV/AIDS. All individuals who do not have conditions on this list who qualify based on income will be accepted into the Under 250% pool. All remaining individuals will be accepted into the Over 250% pool. If a private Under 250% and/or Special Needs Pool option is not

available in a market, the states will receive funding to implement a public option to fulfill these market needs. If the states do not implement an option, a Federal public option will be made available.

Plan Designs, Benefits, and Cost Sharing Affordability

Over 250% Pool: Insurance companies have the ability to create and customize designs, with benefits filed with the state. Tax credits for purchasing coverage will be based on estimated national average costs for a 60% actuarial value benchmark plan. In general, designs that will work well in this market will have low co-pays for preferred drugs, preventive visits, and primary care visits and high deductibles, possibly over $10K or $20K for all remaining services. Coverage for elective surgeries, childbirth delivery, and ultrasounds will be only available on an annual basis as a rider benefit in the Over 250% pool (all insurers must make this rider available.) Pregnancy/delivery complications and wellness visits will still be covered until the standard insurance benefit.

Under 250% Pool: states will establish Essential Health Benefit standards subject to Federal approval; plan designs must conform close to an 80% actuarial value, with $5 to $10 primary care and preferred drug co-pays. States at their funding discretion may also provide additional state managed health reimbursement accounts to help individuals cover the remaining 20%.

Special Needs Pool: plan designs will conform to Medicare Advantage standards, which generally have co-pays for all services subject to a reasonable out-of-pocket maximum. A standard benefit design at a 90% actuarial value will be established for premium benchmark purposes.

All three pools may include HMO and PPO plans. HMO options may include out-of-network "Point of Service" plan designs and will require patient attribution to a primary care practice. Both HMO and PPO options may have tiered networks, with lower levels of cost sharing for "high performing" (high quality, cost efficient) providers.

IVF will not be covered and insurers may place a lifetime limit on bariatric surgeries.

Premiums

Allowable rating variables in all pools include age, plan design/product, location (as defined by the insurer), and smoking status. Premiums will be subject to a maximum spread of 5 to 1 for individuals 21 and under to age 65. Gender is not allowed as a rating variable, primarily for political reasons.

Over 250% Pool: health status is also allowed as a rating variable, with a maximum rate-up of 50% for manageable chronic conditions at the time of underwriting, and maximum maternity rider cost of no more than the cost of the core benefit package. Policies are guaranteed renewable to promote stability and individuals who enter the pool are not re-underwritten unless they wish to purchase more generous plan cost sharing.

Under 250% and Special Needs Pool: Consumer premiums for a benchmark plan will vary as a percentage of household income, depending on income level and age, with premium subsidies available. The benchmark plan will be the second lowest plan available in a market (i.e. the "standard" 90% for the special needs pool). The Federal government will subsidize the full difference between the benchmark plan total premium and the income cap as an advance tax credit (similar to the ACA APTC). Mechanisms will be put in place to protect consumers from large fluctuations in premiums across plans or as new entrants come into the pools (see examples in Appendix I). Age factors are prescribed by the Federal government for the Under 250% of pool. The Special Needs Pool will have community rates, with a robust risk adjustment program to compensate issuers fairly.

Benefit and Premium Grid:

	FPL Range	**0-150%**	**150%-200%**	**200-250%**	**250-400%***	**400-600%***	**600%+***
% of household income	Under 35	1%	1.5%	1.75%	~2%	~3%	Tax credits phase down to $0 at 150K AGI
	35-54	2%	3%	3.5%	~4%	~6%	
	55 and Over	3%	4.5%	5.25%	~6%	~9%	
	Family Cap	4%	6%	7%	~8%	~12%	
	Benefit Level for Non SNP	Gold Level Base Benefit + State HRA Funding			Bronze Level Benefit		
	Special Needs	90%					

** premium amounts shown below are after tax credits are applied and are representative of the expected national average "cap" (the "Bronze baseline amount" is based on a national average). Special needs tax credits are all advanced, similar to the Under 250% of FPL pool*

Risk Adjustment

All three risk pools will feature a risk adjustment program, designed to compensate insurers within the pool who enroll a larger proportion of high risk individuals than the overall market. The programs will be retrospective in nature and rely on diagnosis codes and prescription drug data to identify conditions. The Over and Under 250% Pools will be "zero-sum" where insurers with higher risk individuals are compensated from insurers with lower than market average risk. The Special Needs Risk pool program will provide for a transfer of funds from the Federal government.

Access to Health Care Providers

States will establish and enforce network adequacy standards which provide for meaningful access to hospital facilities, primary care, and specialist physicians. Insurers will be responsible for maintaining provider networks and negotiating reimbursement levels, except in the Special Needs Pool where reimbursement rates are capped at no more than 125% of Medicare.

Consumer Responsibilities

Individuals must remain continuously enrolled in qualified coverage and pay premiums prior to initial enrollment and within a 60 day grace period. Individuals who do not maintain continuous coverage will be subject to re-underwriting to obtain coverage after a gap of greater than 60 days. Consumers must also select an in-network primary care provider at enrollment. Consumers are responsible for cost sharing provisions in the plan and filing Federal income taxes to obtain credits or subsidies to purchase.

Impact to Other Markets

Medicaid and Medicare are largely not impacted. States are encouraged to expand Medicaid as the Under 250% pool plans are not optimal for a very low income population due to cost sharing. The employer group market will see an increase in overall costs due to the inability to tax deduct greater than a bronze benefit. Employers may reduce benefits or shift more to health savings accounts as a means to provide benefits, but the economic incentives will likely not result in a massive shift from group to individual coverage.

Insurance Impact

The proposal will create more flexibility for insurers, stability of enrollment, and likelihood of consistent profits in the Over 250% pool relative to the current ACA. The level of regulatory burden or financial instability is expected to be no greater for the Under 250 and Special Needs pools relative to the current ACA. These markets will be heavily dependent on a fair, administratively efficient, and effective risk adjustment program to remain viable.

Insurance companies should be able to make a reasonable profit in the individual market under this proposal. Plans must, however, maintain an 80% minimum loss ratio on an annual basis across their entire individual block, with adjustments for quality expenses and taxes similar to the current ACA calculation. Plans that fall below the 80% threshold will pay penalties to the government for non-compliance to help fund the program, except for business with qualified shared savings arrangements with providers. If an insurer arranges to share at least 50% of the savings achieved from a loss ratio below 80% with attributed primary care providers or the integrated health system employing the physicians, the insurer will be able to keep the remaining portion.

This MLR requirement will encourage insurers to participate in the Under 250% and Special Needs Pools where premium revenue levels are higher to balance out the challenge of maintaining an 80% MLR in the Over 250% pool. It will also economically incent value based contracting by allowing insurers to keep up to 50% of profits beyond the 80% threshold.

Healthcare Provider Impact

Providers likely will see some reduction in fee-for-service revenue under this proposal relative to the post-ACA market, since insurers will pay lower than typical commercial reimbursement rates for the Special Needs pool. However, primary care physicians or their integrated delivery systems could see a dramatic increase in revenue through shared savings or value based reimbursement.

Government Responsibilities

States approve plans and form filings. Rate approval authority is with the state for the Over 250% pool. Rate reviews for the Under 250% and Special Needs pools are conducted by states with Federal effective rate review standards or default to the Federal government. Network adequacy standards and essential health benefit standards are also set by the states. States may also fund and manage health reimbursement accounts for individuals in the Under 250% pool. States may manage the risk adjustment program for the Over 250% pool, or choose to cede this responsibility to the Federal government.

The Federal government manages the risk adjustment program for the Under 250% and Special Needs pools and provides subsidy funding for these programs. Funding sources include general tax funds, with a principal driver of funding being lower tax deductions allowed for employer health benefit plans. The Federal government also establishes tax credit amounts for the Over 250% pool.

Conclusion

The ability or inability for activation of this proposal only played into its creation sporadically. Carrot Flowers started with a blank sheet of paper, a plethora of half-baked ideas, some actuarial intuition, no particular political agenda, and an obscure song title reference. The proposal is not a reflection of the views of the author's employer, and the author's participation in this challenge was simply that—a challenge, or an opportunity to structure some of those half-baked ideas, collaborate with another group of actuaries to wrap some science around the intuition, and see what worked, and what perhaps needed to be reconsidered.

The Carrot Flowers proposal sought to test the hypothesis that some element of high risk pooling combined with broader tax credits to incent purchase of individual health plans would reduce average underlying premium costs and increase participation in the individual health market without sacrificing access to vulnerable populations or reverting to restrictive eligibility criteria that existed in many individual markets prior to the Affordable Care Act. Reforms to the current tax credit structure included adjustments for age as well as availability of tax credits to consumers over 400% of the Federal Poverty Level. The proposal as outlined did result in slightly higher market participation and a lower uninsured population. The proposal overall did not reduce underlying premium levels in aggregate, however, did significantly reduce underlying premiums versus the status quo for individuals enrolled outside of the "Special Needs Pool" (detailed figures are available in Appendix II, Attachment B). In aggregate, across all three pools in the proposal, member out-of-pocket premium levels were substantially reduced relative to the status quo without increasing member cost sharing amounts. In order to achieve this, the proposal results in over a $30B annual increase to the government funding amount.

Critics of higher public spending may find any proposal resulting in this amount of additional governmental outlay untenable or unsustainable. The budgetary impacts to employer group benefits reforms were outside the scope of this exercise, but presumably could offset a large portion of the $30B increase to keep the program revenue neutral to the Federal Government. A proposal to increase the tax burden to employer groups, however, would surely face a considerable degree of opposition and many employer groups may simply shift costs to employees to minimize the impact of this burden. Proponents of improving individual market affordability may state that increasing funding is a necessary component to provide access to quality care for buyers in the individual market. The practical reality of securing that funding source, whether through legislation, employer market reforms, government funding, or changes to provider revenue lies at the crux of the challenge and is one that will require continued dialogue between actuaries and a wide variety of stakeholders to gain *enough* consensus to get wheels in motion. A challenge, indeed!

APPENDIX I

Premium Examples

Appendix I: Premium Examples

Under 250% Pool Enrollees, ~200% of FPL Single (~$23K household income)

	Full Monthly Premium Age 21	After Subsidy Age 21	Full Monthly Premium Age 45	After Subsidy Age 45	Full Monthly Premium Age 64	After Subsidy Age 64
Gold HMO, Carrier A	$200 (benchmark)	$29	$400 (benchmark)	$57	$800 (benchmark)	$86
Gold POS, Carrier B	$250	$54	$500	$107	$1000	$186
Gold HMO, Carrier C	$175	$16	$350	$22	$700	$36

Over 250% Pool Enrollees, ~400% of FPL Single (~$48K household income)

	Full Monthly Premium Age 21	After Tax Credit Age 21	Full Monthly Premium Age 45	After Tax Credit Age 45	Full Monthly Premium Age 64	After Tax Credit Age 64
Bronze HMO, Carrier A Healthy	$100 (benchmark)	$80	$200 (benchmark)	$160	$400 (benchmark)	$240
Gold POS, Carrier B Chronic	$250	$230	$500	$460	$1000	$840
Catastrophic PPO, Carrier C Healthy	$75	$55	$150	$110	$300	$140

Special Needs, ~400% of FPL Single (~$48K household income)

	Full Monthly Premium Age 21	After Subsidy Age 21	Full Monthly Premium Age 45	After Subsidy Age 45	Full Monthly Premium Age 64	After Subsidy Age 64
Platinum HMO, Carrier A	$2000 (benchmark)	$80	$2000 (benchmark)	$160	$2000 (benchmark)	$240
Platinum PPO, Carrier B	$2200	$88	$2200	$176	$2200	$264
Platinum HMO, Carrier C	$1800	$72	$1800	$144	$1800	$216

APPENDIX II

Financial Modeling Results

Carrot Flowers Proposal
Financial Modeling Results

I. FINANCIAL MODELING

Modeling results for the Carrot Flowers' (Carrot Flowers) health care reform proposal are presented in this section. The results were modeled using the Milliman Health Care Reform Financing Model (HCRFM). It is important for the reader to have an understanding of the HCRFM to appreciate the modeled results for the Carrot Flowers proposal. A brief description of the HCRFM system and its limitations are presented below.

II. ABOUT THE MILLIMAN HEALTH CARE REFORM FINANCING MODEL

The Milliman Health Care Reform Financing Model (HCRFM) was developed by Milliman, Inc. (Milliman) to assist clients with an assessment of the potential impact of particular health care reform changes to be evaluated. The HCRFM simulates on a seriatim basis the potential costs and movements of individuals and the interaction of consumers within and between the various insurance markets that comprise the U.S. health care system for a given proposed health care financing scheme.

The system generates results for a specific set of assumptions. A typical application of the model involves coding a set of assumptions to represent a "status quo" scenario (baseline scenario) and comparing the results based on these assumptions to results that are based on one or more reform scenarios. This is the approach that will be used for this Actuarial Challenge. The baseline status quo scenario models the current ACA environment.

III. CAVEATS AND LIMITATIONS ON USE

The modeling results presented in this summary represent a high-level analysis of the authors' proposed reforms to the individual health care market. This modeling was performed using Milliman's HCRFM adjusted to reflect the proposed insurance financing reforms. When considering the results, the following should be kept in mind:

- While the authors incorporated financial modeling results generated through use of Milliman's HCRFM simulation system, the modeled market changes are solely those proposed by the authors. The authors also provided to Milliman certain underlying assumptions to model various proposed provisions. Milliman has provided similar modeling services for four other papers participating in the Actuarial Challenge, which is funded by the Robert Wood Johnson Foundation, managed by Milliman, and promoted by the American Academy of Actuaries and the Society of Actuaries. The views expressed in this paper do not necessarily reflect the views of the Foundation, Milliman, the American Academy of Actuaries, the Society of Actuaries, or the employers of the Actuarial Challenge participants. The use of the Milliman HCRFM system and involvement of its personnel in conducting the modeling should not be viewed as an endorsement by Milliman of the reforms proposed by the authors.

- Multiple data sources were relied upon to calibrate the baseline for the analysis and develop assumptions for both modeled scenarios. In some instances, the data had gaps in information or indicated conflicting results, which required the modelers to make an assumption to bridge such differences. In those instances, information available was used, as well as the modelers' experience and judgment in setting assumptions. The analyses are based upon Milliman's understanding and interpretation of the Affordable Care Act (ACA) and its related regulations as they existed at the time of development of the baseline status quo scenario. The results are also subject to the limitations of the model in being able to adjust for every aspect of the ACA and the proposal being modeled. The Carrot Flowers scenario results reflect Milliman's understanding of the authors' proposal.

- Reform projections reflect differences in provider reimbursement and / or utilization anticipated based on external sources and judgment based on experience with actual pricing in various markets.

- The impact of changes to provider reimbursement levels are not fully considered herein since potential ramifications of reimbursement changes such as provider cost-shifting to other markets and manufactured increased utilization to compensate for unit cost reductions have not been modeled. Furthermore, the breadth of provider networks and appropriate health care provider access has been assumed to be adequate. These are important caveats when assessing the validity of the reform impacts indicated in this report.

- Expected migration between markets is based on calibrated historical movements and judgment. The migration assumptions vary by several population characteristics such as age, gender, health status, and income level. Therefore, the final impact is influenced by changes in the projected mix of these characteristics over time.

- The analysis uses data reflecting the difference in starting costs between individual health insurance eligibility categories. To the extent the risk characteristics of these populations are different than implicitly assumed and alter utilization or other influences, results may be different.

Since these are illustrative results, a more detailed analysis of these proposals or any aspect of these proposals would likely differ from the results presented.

While the analysis estimates funding needed related to the insurance programs for any proposed reforms, it did not recognize any tax or funding impacts on results as part of the analysis, as this was outside the scope of the modeling parameters. Likewise, while impacts on overall claim costs due to proposed provider reimbursement changes were modeled, any effects that such changes might have on the health care provider supply or non-individual markets were not modeled.

It was assumed individuals would adjust their coverage annually, consistent with the choice available to them at the beginning of each calendar year, as applicable. Different assumptions are possible that could impact results substantially depending on what options were made available or the expected individual reaction to offered options.

No change in the general health status of the current individual market population was explicitly reflected as part of the analysis. However, when people in one market migrate to another market, the resulting average health status will reflect the combined health status of the underlying populations.

The modeling results are intended to provide illustrative impacts of the proposed health care financing reforms to the Actuarial Challenge authors. The results of the analysis are projections, not predictions, and they are dependent upon the sets of assumptions that are used. The results are likely to vary if a different set of assumptions is used. It is almost certain that future experience will not exactly conform to these projected results. As expected for as complex a system as the U.S. health care system, changes in some assumptions can produce significant changes in results, due to the interrelationships of factors and the uncertain nature of predicting market behavior influencing the results. The interaction of consumers, issuers, providers, and regulators strongly influences the choices made in the individual market. Results may also differ from other analyses Milliman may perform due to differences in the timing of model updates, assumptions, and additional information that may be gathered and learned since these analyses were performed.

The results are not to be relied on for any pricing or experience analysis. The modeling results are to be used by the authors to augment their Actuarial Challenge papers with high-level impacts. Any conclusions or recommendations presented in the Actuarial Challenge papers are solely those of the authors.

This paper should only be distributed to and considered by third parties in its entirety. The authors and Milliman do not intend to benefit, or create a legal duty to, any third-party recipient of these papers.

IV. FINANCIAL MODELING RESULTS

Table 1 summarizes key results compared to the baseline status quo scenario. The table addresses each of the four major stakeholder areas connected with the individual insurance market: issuers, members, health care providers, and sources for funding. These are averages over the 3-year period of 2018 – 2020. Attachment A provides year-by-year detail for each scenario. In addition, details for premiums, subsidies and cost sharing are provided for each of the risk pools created by the Carrot Flowers proposal in Attachment B.

Table 1
Comparison of The Carrot Flowers Proposal Model Results to Status Quo Baseline Model Results
Non-Discounted Averages over the 3-Year Period 2018 – 2020

	Status Quo Scenario	Carrot Flowers Scenario	Difference	Percentage Change
Enrollment Results				
Uninsured Count *(thousands)*	24,296	22,723	-1,573	-6%
Individual Market Enrollment *(thousands)*	17,885	19,543	1,659	9%
Individual Market Issuer Health Plan Results				
Average Premium PMPY	$6,736	$6,964	$228	3%
Average Premium Subsidy PMPY	$2,848	$4,326	$1,478	52%
Net Member Premium PMPY	$3,888	$2,638	-$1,250	-32%
Average Plan A/V*	71%	75%	5%	6%
Loss Ratio after Risk Transfers	80%	80%	0%	0%
Issuer Retention				
Total Dollars ($ millions)	$24,103	$27,715	$3,612	15%
Retention Dollars PMPY	$1,348	$1,418	$70	5%
Retention as a Percentage of Premium	20%	20%	0%	2%
Member Obligations PMPY				
Member Out-of-Pocket Net Premium	$3,888	$2,638	-$1,250	-32%
Member Benefit Cost Share Obligation**	$1,821	$1,808	-$13	-1%
Total Member Out-of-Pocket Obligations	$5,710	$4,446	-$1,264	-22%
Health Care Provider Impact				
Total Allowed Charges Received ($ millions)***	$139,258	$143,731	$4,474	3%
Allowed Charges PMPY	$7,185	$7,354	$170	2%
Funding Outlays from Government and / or Other Sources				
Total Dollars of Funding Outlays ($ millions)	$57,909	$84,546	$26,637	46%
Funding Outlays per Indiv. Market Member per year (PMPY)	$3,238	$4,326	$1,088	34%

** A/V as measured by the ratio of insured benefits paid to allowed costs per member per year.*

*** This represents the cost-share obligation for the member after any reduction for CSR subsidies.*

**** Includes costs of only those uninsured who migrate to the Individual Market.*

V. DISCUSSION OF MODELING RESULTS

ENROLLMENT

A key reform structure underlying these results is that the Individual market (including ACA and Grandmothered plans) will split into three separate risk pools: the Special Needs Pool, the Under 250 Pool, and the Over 250 Pool. There are no provisions that specifically encourage full participation in the market by the currently uninsured. However, given the enhanced subsidies and the option to customize covered services to create leaner plans, increased participation in the market from the uninsured population is expected. The modeling assumes that Grandfathered plans can continue as currently allowed.

ACCESS TO COVERAGE

The proposed coverage approach is intended to better match the population enrolled in each risk pool to needed coverage levels. The risk pools are outlined below:

1. *Special Needs Pool Market*: Members qualify for this market based on the diagnosis of high cost conditions (e.g., hemophilia, metastatic cancers). The modeling approximated this diagnosis cut-off with a high health status proxy. Furthermore, members enrolled in one of the other two Individual sub-markets (Under 250 or Over 250) can qualify for the Special Needs Pool in future years if they are diagnosed with a high cost condition. Enrollees in the Special Needs Pool market receive a platinum plan design for which the costs of the richer benefits are offset by provider reimbursement levels set to 125% of Medicare fee schedules.

2. *Under 250 Market*: Members qualify for this market based on the absence of a high cost condition and a qualifying income level (income below 250% of the federal poverty level (FPL)). Members enrolled in this market receive a gold plan design.

3. *Over 250 Market*: Members qualify for this market based on the absence of a high cost condition and a qualifying income level of 250% of FPL and above. Members enrolled in this market can choose among a variety of plan designs (which go beyond those offered in the ACA, including a $10,000 deductible plan). Plans are offered on a guaranteed issue basis, but if members lapse coverage, they are first mapped to the $10,000 deductible plan for a year (after which time they can select another plan). Moreover, if people elect to buy up coverage after entering the market, they are subject to medical underwriting with a potential premium load up to a maximum of 50%.

Each of these three markets constitutes a separate self-contained risk adjustment pool among all issuers within a state.

The richer mix of plans results in a 4.5% higher paid-to-allowed ratio, and the broader plan mix coupled with the improved affordability of coverage outlined below results in a 9% increase in the individual market enrollment.

PREMIUM RATES

The model indicates that the Carrot Flowers proposed reforms achieve the goal of making coverage more affordable by increasing subsidies for premiums to more individuals. This is primarily due to the following:

1. *Increases premium subsidies*: The proposed premium subsidy program is outlined in Table 2 below. The proposed premium subsidies are more generous than those of the current ACA for most people, especially for younger individuals. They expand subsidies through the 600% of FPL (subject to a $150,000 limit for single, $250,000 for a family). Since the modeling is not optimized for premium caps that vary by FPL and

age, the 2018 enrollment by age in each FPL bucket was approximated and used to create blended premium caps (as a percent of household income). The modeling assumes that the increased subsidies will attract more members in the 250% to 400% FPL range and add members in the 400% to 600% range up to the income limit.

Table 2
The Carrot Flowers Proposal
Premium Subsidy Program
Individual Premium Obligation as a Percentage of Household Income

Age	FPL Household Income Range					
	0-150%	150%-200%	200-250%	250-400%	400-600%	600%+
Under Age 35	1.00%	1.50%	1.75%	2.00%	3.00%	Tax credits
Ages 35-54	2.00%	3.00%	3.50%	4.00%	6.00%	phase down
Ages 55 and Over	3.00%	4.50%	5.25%	6.00%	9.00%	to $0 at
Family Cap	4.00%	6.00%	7.00%	8.00%	12.00%	$150K AGI
Benefit Level for Non-SNP	Gold Level Base Benefit + State HRA Funding			Bronze Level Benefit		
Special Needs Market	90% Actuarial Value (Platinum Plan)					

2. *Shifts in plan design and rider benefits*: The proposal sets the plan design for the Special Needs and Under 250 markets at a consistent level for all enrollees in those markets. The plan designs for the Over 250 market are more flexible, allowing various plan designs and cost sharing levels. The proposal also allows the Over 250 plans to make certain services such as elective surgeries, maternity delivery, and ultrasounds available through riders that must be offered by all issuers. In the modeling, these services are still included at the market level but it is assumed that the ability to offer leaner benefits will attract more members to the individual market across all FPL levels.

Please also note that all three Individual sub-markets are subject to a 5:1 age curve.

ISSUER RETENTION

Issuer retention is the amount of premium that is used for administration and operations of the insurance plans, along with amounts for profit and risk margins. Typically, as premium rates decrease, retention as a percentage of premiums needs to increase in order to be able to provide the same level of service to insured members and continue to meet regulatory requirements and other business commitments. The ACA requires a minimum medical loss ratio (MLR) of 80%.The MLR formula allows for recognition of certain taxes and fees and risk transfer amounts. Since the gross average premiums under the Carrot Flowers proposal increase by only 3% on average and no changes are proposed to the 80% MLR requirement, no adjustments for issuer retention were modeled. The results show a 15% increase in total retention dollars. This increase is in part due to the 9% growth rate for the individual market. The average retention per member per year increased 5%. Issuers could decide to operate at an MLR greater than 80% shown in Table 1 for this scenario.

MEMBER OUT-OF-POCKET OBLIGATIONS

Members have two main areas in which they need to spend their own money in order to have a medical health care plan. The first is the out-of-pocket premium they must pay for coverage and the second is the amount of benefit cost-sharing required of them based upon the health plan design chosen.

- *Premium Out-of-Pocket Costs*: This is the gross premium charged by the health plan less any premium subsidy or premium tax credit that is paid to the health plan from outside sources like the government. Both the current ACA program and the Carrot Flowers proposal offer premium subsidies. Both the ACA program's subsidy formula and that for Carrot Flowers place a cap on the amount of out-of-pocket premium required of a family. As discussed earlier, the Carrot Flowers formula is more generous for most income levels, adds eligibility to families with incomes up to $250,000, and varies the percentage caps by age, which gives increased encouragement to younger people. The Carrot Flowers percentage caps were presented in Table 2.

  Premium subsidies average about 56% to 65% of gross premium under Carrot Flowers compared to 40% to 44% under the status quo scenario. On a per member per year basis, premium subsidies are projected to be 52% higher than that of the status quo scenario on average.

- *Benefit Out-of-Pocket Costs*: Benefit out-of-pocket costs include the member's responsibility for sharing the costs of the services that he or she receives. This cost-sharing responsibility generally includes any deductibles, coinsurance, or copayments the insured person must pay for the eligible health care services they receive.

  Member cost sharing obligations are expected to decrease slightly (1%) on a PMPY basis. Note that the member cost sharing obligation under the status quo model is offset by expected cost sharing reduction (CSR) subsidies.

Table 3 summarizes the average annual model results over the period of 2018 to 2020 for these two components of members out-of-pocket obligations on a per member per year basis.

Table 3
Comparison of Carrot Flowers Proposal Model Results to Status Quo Baseline Model Results
Average Annual Member Cost Obligations over the 3-Year Period 2018 – 2020

Out-of-Pocket Component	Status Quo Scenario	Carrot Flowers Scenario	Difference	Percentage Change
Average Gross Premium PMPY	$6,736	$6,964	$228	3%
less Avg. Prem. Subsidy PMPY	$2,848	$4,326	$1,478	52%
Member Out-of-Pocket Net Premium PMPY	$3,888	$2,638	-$1,250	-32%
Provider Charges for Services PMPY	$7,600	$7,354	-$245	-3%
less Health Plan Benefits PMPY	$5,389	$5,547	$158	3%
less Government Benefit Subsidies	$390	$0	-$390	-100%
Member Benefit Cost Share Obligation PMPY	$1,821	$1,808	-$13	-1%
Total Member Out-of-Pocket Obligations PMPY	$5,710	$4,446	-$1,264	-22%

The member premium cost decreases under the Carrot Flowers proposal due to higher subsidies available. The member cost sharing is expected to decrease slightly consistent with changes in the expected coverage levels in the three risk pools.

IMPACT TO HEALTH CARE PROVIDERS

Health care providers will be impacted by the Carrot Flowers proposal in that any physicians providing care to the Special Needs Pool members are assumed to accept reimbursement for services at 125% of Medicare. This change was modeled as a 10.6% reduction to the allowed medical costs within this market (there was no assumed change for drug claims as there is not a corresponding Medicare fee schedule for drugs).

Since the change represents a relatively minor reduction in reimbursement on a small portion of physicians' expected patient base, it is expected that these costs could be shifted to other patients. As such, physicians would likely be willing to accept this reimbursement reduction. No change in reimbursement or utilization in other segments of the individual market or any other market was modeled.

On the other hand, the incentives for shared savings initiatives and other means to incent providers to manage the total cost of care could offset the revenue reductions noted in the paragraph above. Due to the long-term nature of these initiatives (i.e., they take several years to develop and implement) and difficulties quantifying the savings impact, savings resulting from the shared savings programs or other means intended to manage the cost of care were not modeled.

Table 4 illustrates a comparison between the status quo scenario and the Carrot Flowers scenario. In total, providers receive $4.5 billion or 3% more in revenue in the individual market under Carrot Flowers.

Table 4
Comparison of Carrot Flowers Proposal Model Results to Status Quo Baseline Model Results
Average Annual Impact to Health Care Providers over the 3-Year Period 2018 – 2020

Market Source	Status Quo Scenario	Carrot Flowers Scenario	Difference	Percentage Change
Insured Allowed Charges ($ millions)	$135,921	$143,731	$7,811	6%
Uninsured Allowed Charges ($ millions)*	$3,337	$0	-$3,337	-100%
Grand Total ($ millions)*	$139,258	$143,731	$4,474	3%
Amt per Indiv / Uninsured Mkt Members PMPY*	$7,185	$7,354	$170	2%

** Includes only costs of the 1.5 million uninsured who move to the Individual Market under the Carrot Flowers scenario.*

FUNDING OUTLAYS

Required funding outlays increase under the Carrot Flowers proposal compared to the status quo. These may be funded by the Government, be it state or federal, or a combination of broad public / private funding. The Carrot Flowers proposal results in significant additional funding outlays compared to status quo. Specifically, the premium subsidy program and federal funding of the Special Needs Pool Market is expected to be about 56% more expensive than the combination of the APTC and CSR programs currently in place and is expected to cost an average of $90.3 billion annually between 2018 and 2020. Table 5 summarizes the dollars of funding, indicating that the Carrot Flowers proposal would require an additional $32 billion per year over the 3-year period of 2018 to 2020. This also translates into a 43% increase on a per member basis.

Table 5 Comparison of The Carrot Flowers Proposal Model Results to Status Quo Baseline Model Results Average Annual Funding Outlays 2018-2020			
Program	**Status Quo** ($billions)	**Carrot Flowers** ($billions)	**Difference** ($billions)
Premium Subsidies (billions)	$50.9	$84.5	$33.6
CSR Subsidies (billions)	$7.0	$0.0	-$7.0
Grand Total (billions)	$57.9	$84.5	$26.6
Total per Member (PMPY)	$3,238	$4,326	$1,088

The status quo costs shown do not include current outlays for Medicaid and other programs requiring funding under current law. Only costs associated with commercial business are reflected, as noted in Table 5. The modeling does not assume any changes to the taxes required under current law. Any change in government revenue would need to be considered in a comprehensive econometric analysis of the proposal. It is beyond the scope of the modeling to review items outside of the direct insurance aspects of the proposal. The Milliman model does not address government and non-insurance related revenue sources.

IMPACT TO EMPLOYERS

A few provisions of the Carrot Flowers proposal directly affect the group market. Most notably, the proposal would cap the employer tax deductions at a bronze actuarial value plan – the same plan level used to establish subsidies in the Individual Over 250 market. In addition, the proposal would allow for higher tax-deductible contributions for HSAs – setting the level at $6,000 for an individual and $10,000 for a family. Changes to the employer market were not explicitly modeled as the focus of the Actuarial Challenge is on the individual market.

Nevertheless, the employer market could see some minor downstream impacts of changes to the individual market. Specifically, the high level of premium subsidies available may make the individual market more attractive to some group members or entire groups willing to lapse coverage and go to the Individual market. It is also possible that providers could cost-shift some of their revenue reduction in the Special Needs Program to the group market. This impact is not reflected in the attached exhibits as the scope of the modeling was limited to individual market costs.

Attachment A
Summary of Model Results for Years 2018 - 2020
Comparison of Carrot Flowers Scenario versus Baseline Scenario
Market: Total Individual Market (Includes Grandfathered Plans)

	Status Quo Model				Carrot Flowers			
	2018	2019	2020	3-year Average	2018	2019	2020	3-year Average
Enrollment Results								
Individual Market Enrollment *(thousands)*	18,424	17,608	17,623	17,885	19,192	19,676	19,762	19,543
Uninsured Count *(thousands)*	24,481	24,509	23,899	24,296	23,694	22,581	21,894	22,723
Individual Market Issuer Health Plan								
Average Premium PMPY	$5,920	$6,937	$7,389	$6,736	$6,557	$6,872	$7,452	$6,964
Average Premium Subsidy PMPY	$2,345	$2,987	$3,233	$2,848	$3,701	$4,432	$4,827	$4,326
Net Member Average Premium PMPY	$3,574	$3,950	$4,156	$3,888	$2,855	$2,439	$2,625	$2,638
Average Plan AV*	69%	71%	72%	71%	75%	75%	76%	75%
Loss Ratio After Risk Transfers	81%	79%	80%	80%	79%	81%	80%	80%
Issuer Retention								
Total Retention Dollars ($millions)	$20,324	$25,593	$26,390	$24,103	$26,698	$26,225	$30,186	$27,715
Retention PMPY	$1,103	$1,454	$1,498	$1,348	$1,391	$1,333	$1,527	$1,418
Retention as a % of Premium	19%	21%	20%	20%	21%	19%	20%	20%
Member Obligations PMPY								
Member Out-of-Pocket Net Premium	$3,574	$3,950	$4,156	$3,888	$2,855	$2,439	$2,625	$2,638
Member Benefit Cost Share Obligation**	$1,770	$1,806	$1,889	$1,821	$1,695	$1,819	$1,906	$1,808
Total Member Out-of-Pocket Obligations	$5,345	$5,755	$6,045	$5,710	$4,550	$4,258	$4,531	$4,446
Health Care Provider Impact								
Total Allowed Charges Received ($millions)***	$130,944	$138,671	$148,157	$139,258	$131,666	$144,779	$154,749	$143,731
Allowed Charges PMPY	$6,569	$7,253	$7,759	$7,185	$6,861	$7,358	$7,831	$7,354
Funding Outlays from Government and/or Other Sources								
Total Dollars of Funding Outlays ($millions)	$49,600	$59,563	$64,565	$57,909	$71,035	$87,214	$95,388	$84,546
Funding Outlays per Indiv. Market Member per year (PMPY)	$2,692	$3,383	$3,664	$3,238	$3,701	$4,432	$4,827	$4,326

** A/V as measured by the ratio of insured benefits paid to allowed costs per member per year.*

*** This represents the cost-share obligation for the member after any reduction for CSR subsidies.*

**** Includes costs of only those uninsured who migrate to the Individual Market.*

Attachment B
Carrot Flowers
Demonstration of 2018-2020 Cost and Enrollment Figures
By Proposed Risk Pool

Market: Special Needs Pool	2018	2019	2020	3-year Average
Enrollment *(thousands)*	282	578	625	495
Average Premium PMPY	$80,050	$80,923	$84,920	$82,438
Average Premium Subsidy PMPY	$69,566	$71,099	$74,980	$72,440
Net Average Premium PMPY	$10,484	$9,824	$9,940	$9,998
Average Plan AV	94%	94%	94%	94%
Member Benefit Cost-Sharing Obligation PMPY	$3,675	$3,821	$3,824	$3,794

Market: Under 250	2018	2019	2020	3-year Average
Enrollment *(thousands)*	6,931	7,169	7,443	7,181
Average Premium PMPY	$4,901	$4,255	$4,399	$4,512
Average Premium Subsidy PMPY	$4,478	$3,801	$3,912	$4,057
Net Average Premium PMPY	$422	$454	$487	$455
Average Plan AV	74%	70%	71%	72%
Member Benefit Cost-Sharing Obligation PMPY	$1,398	$1,402	$1,484	$1,429

Market: Over 250	2018	2019	2020	3-year Average
Enrollment *(thousands)*	9,654	9,659	9,488	9,600
Average Premium PMPY	$5,996	$4,747	$5,161	$5,302
Average Premium Subsidy PMPY	$2,109	$1,951	$2,048	$2,036
Net Average Premium PMPY	$3,887	$2,796	$3,113	$3,266
Average Plan AV	74%	68%	69%	70%
Member Benefit Cost-Sharing Obligation PMPY	$1,683	$1,840	$1,934	$1,818