ACTUARIAL CHALLENGE SUBMISSION

TEAM PANOPTIC

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Executive Summary

To achieve sustainability and affordability in the individual market, our proposed solution adopts changes that impact consumers, insurers, providers and government entities. Stakeholders in all of these areas must work together to attain the desired goals of increased access to health insurance markets, lower overall healthcare costs, and increased choices for consumers.

Our program requires all participants in the individual market to buy a benefit plan. This purchase requirement would be enforced through an auto-enrollment program. People who do not choose their own plan will be auto-enrolled in a catastrophic plan. Current eligibility restrictions for the catastrophic plans would be removed. In addition, the small group market would be combined with the individual market to expand the size and stabilize the market. To further stabilize the market, self-funding would not be allowed for these small groups.

The available health plans would be purchased through state based exchanges. Subsidies would be available to purchase these plans. Federal funds for the subsidies would be provided to the states that can then tailor the subsidies to the needs of their citizens. States can add additional funds to the federal funds. A restricted use Health Savings Account (HSA) would be set up for each catastrophic plan enrollee. This account would be card-based and could be used to help pay for out of pocket expenses related to the health plan. This account funding is in addition to the subsidies that some people will be eligible for. Insurance premiums would include the costs to provide, manage, and maintain this restricted use HSA card and they would be in line with the industry standard for this service. The premiums paid by the insured over and above any of their subsidies would be treated similarly to premiums paid in the employer market from a tax standpoint.

To help reduce the financial burden to those who are lower risk, the ratio of the highest to lowest age factors will be increased from three to one to five to one.

To retain and attract insurers to the marketplace, the current minimum loss ratio standards would be eliminated so that carriers could have some expectation of profitability over the long term. In addition, the current risk adjustment program would be continued, and a temporary reinsurance program would be reinstated. Both of these programs would be run at the state level. The states would be the only regulatory body for insurance contracts provided in this market.

To impact cost from the provider side our solution would institute Reference Based Benefit pricing (RBB). This method combined with appropriate price disclosure would provide appropriate incentives in the market for both providers and patients to use low cost quality care.

In addition, providers should participate in risk contracting that has downside risk, not just upside as is common now. This will increase their desire to provide low-cost high-quality

services. To ensure this, penalties for not meeting minimum quality measures for providers would be put in place. The U.S. Department of Health and Human Services would set the quality measures and provide to states. States could then use those measures or adjust them to customize for their own populations.

Telemedicine programs would be part of all plans and would benefit those in rural areas by giving them options for providers where none may exist today. This could additionally lower system costs and increase access to affordable healthcare.

To reduce runaway pharmaceutical costs we would eliminate direct to consumer advertising. In addition, a federal entity would be developed to review and grade the efficacy of new drugs proposed for the market and this data would be made publicly available to help consumers make more informed decisions.

We believe that this direction would result in a sustainable market that would provide cost effective quality care to the consumers in this market. It would also encourage positive competition between providers and insurers, which will motivate each of them to continue to innovate, become more efficient, and control costs. By moving a lot of the regulatory decision making from the federal government to each of the states, that will provide the states with flexibility to adapt the system to fit the needs of their unique population. At the same time, it will free the federal government from these responsibilities.

This proposal has been modeled using the Milliman Health Care Reform Financing Model (HCRFM). Their report is included in this proposal as an Appendix. The reader should review the Caveats and Limitations on Use section of their report before using their information.

As this proposal includes an auto-enrollment requirement, their modeling assumes that there would be no uninsured people after the program went into affect. This would be a reduction in the uninsured population of over 24 million people. To accomplish this would require a coordinated effort of all participants in the system, including employers, insurers, medical providers and government entities. The details of this effort are beyond the scope of this paper.

Other significant results would be a reduction in the average annual individual market premium from $6,736 in the status quo scenario to $4,576 under the proposed scenario, a reduction of 32%. The average premium subsidy required from the government would reduce 24%. The combination of these two would result in a net premium per member of $2,423, down 38% from the status quo net premium of $3,888.

Some of these cost reductions come from a reduction in the average plan actuarial value, which goes on average from 71% in the status quo scenario to 64% under this proposal. This would result in more out of pocket costs from members. When factoring this into these results, the average after-tax total out-of-pocket obligations go from $5,710 per individual member to $3,692, a 35% reduction.

Required funding outlays from government and other sources would go down on a per individual member basis by 2%. However, due to the elimination of all of the uninsured the total number of people receiving subsidies and other outlays rises dramatically. The result would be an increase in these outlays by close to $45 million, a 77% increase over the status quo scenario. It must be remembered that the modeling does not take into account any savings from other government programs that might result from the elimination of the uninsured population, such as uncompensated care programs or Medicaid.

The reader is encouraged to review the entire modeling report in the attached Appendix to understand the assumptions used in coming up with these results.

The Solution

To attain sustainability in the individual market, our reforms are designed to insure more people in the individual market, retain them once they are insured, empower consumers, develop a more stable and predictable market for insurers, and improve provider efficiency and quality of care to lower costs. We believe that all of these factors must be achieved to reach a long-term sustainable market.

Insure and Retain Participants

People in this market would be required to buy a catastrophic plan if they don't choose another plan. The eligibility for this type of plan would be expanded to include everyone. The price of this plan would be much more affordable than the plans generally available today. This would reduce the financial burden to consumers to get healthcare coverage and these plans would give them financial protection from catastrophic events. Grandfathered and grandmothered plans would no longer be allowed.

An auto-enrollment process would be used to assure people purchase coverage. With this auto-enrollment process it is imperative that the requirement to keep insurance in force must be enforced. Without this enforcement the auto-enrollment process would be ineffective.

If people want to elect additional coverage over and above their health plan, supplemental benefit riders would be available and could be purchased as an option. This would allow people to custom fit health insurance plans to their particular needs.

As cost is a major barrier to entry in this market, governmental subsidies would continue, although not necessarily in their current form. For example, using block grants to states would give states flexibility on how they wanted to provide subsidies, including adding to the federal funds from state funds. This flexibility would be used in conjunction with the other changes to make the required purchase of insurance more attractive to those not currently participating.

Additionally, to reduce the net cost of these plans to participants, the premiums paid on these products would get tax deductibility, similar to the employer based market. This would be of particular significance to those not receiving subsidies.

Restricted Health Savings Accounts (HSAs) would be assigned to all people being enrolled in the catastrophic plans, regardless of personal financial history. Funds placed in these card-based accounts could only be used for cost sharing expenses, such as deductibles and coinsurance. The person, their employer, or the government could place funds in these accounts. These funds would be in addition to any subsidies they are eligible for. Money in the account could be carried forward to future years to pay eligible costs as needed.

To help reduce costs to lower risk consumers, the three to one age band would be expanded to five to one. Currently many in this category simply do not see value in the products in today's market at the current levels of premium they are forced to pay due to the subsidization caused by the three to one age band.

We are also proposing that the small group market be folded into the individual market for groups up to 100 employees. This would significantly increase the size of the market and help stabilize the underlying morbidity. However, groups in this size range must be prohibited from self-funding their health coverage for this to succeed. If this were not done, those with lower cost employees would choose to self-fund. This would leave the higher cost groups to enter the individual market and increase the anti-selection risk.

Develop a Stable and Predictable Market

To encourage insurer participation in the market, a number of changes would be needed. The minimum loss ratio requirement would be eliminated or significantly reduced so companies can have flexibility to innovate, and also to recover losses in future years. The individual market has historically been one where profitability is cyclical. Companies need the ability to price for these cycles, making money in some years and losing in others.

Exchanges would be state based. This would save money to help lower premiums, as well as allowing more state specific issues to be addressed. Companies will be able to work with the specific states they are licensed in to provide the types of coverage needed by the state's citizens and within the framework of a localized exchange.

The Federal government would not be involved in insurance regulation. It may need to give states guidance, but states would handle all regulation of insurance products. This elimination of dual regulation would reduce costs in cases where duplicate work was being done by federal and states, and improve the predictability of how companies would be required to operate.

A reinsurance mechanism would be developed to mitigate unpredictable claim costs. The formulas for this program would be based on the 2015 Transitional Reinsurance Program under the ACA. Funding for this program would be developed to be broad based and sustainable. The current risk adjustment programs would continue and both programs would be managed at the state level.

Improve Provider Efficiency and Quality of Care

Insurers will be allowed to establish benefit cost limits on services where there are enough high-quality providers offering lower prices (Reference-Based Benefits, or RBBs). If patients seek care at the higher-cost providers, they would have to pay the amount above the benefit reference point, and the amount paid above the reference point would not count towards a patient's out-of-pocket maximum. Patients would be allowed access to providers who charge outside the reference point without penalty if there are no other providers within a reasonable distance (i.e. rural areas).

Both providers and insurers will be required to provide cost information to patients. Providers must provide billed charge costs to consumers at or before the time of service, or the time of ordering (i.e. lab or x-ray). Insurers must provide provider cost comparison detail to allow patients to understand costs prior to choosing a provider or facility.

Plans will be required to provide access to telemedicine. This will reduce plans costs and provide options to patients, especially during nights and weekends and in rural areas. Even with marginal increases in utilization of telemedicine visits, the prevention of going to an emergency room or a physician's office will pay for many additional telemedicine visits.

Providers and hospitals will be required to submit data for all patients for national scoring which will be shared with the public. Providers and hospitals that do not meet specific quality thresholds according to their specialty or facility type will be charged a fine. Fines collected will be used to help fund innovative payment reforms developed by HHS. HHS will develop a national measure set, as well as threshold levels, and penalties. Penalties will be scaled based on how poorly a provider scored – ranging from 0.25% of gross revenues to 1.00% of gross revenues. This system will be put in place over the first three years on implementation, with the first year being used to develop the measure sets, the second year being used for providers to implement procedures to achieve the quality scores, and the third year being the first time they are measured (leading to the fourth year being the first year that providers could be penalized).

Providers and hospitals would be encouraged to put more of their payment at risk based on their performance. Currently these types of arrangements usually only provide additional payments to providers. Ideally they should reduce payments if minimum standards are not met. As providers take risk, they are incentivized to develop new ways to treat patients and conditions in more efficient ways, changing the focus of reimbursement from volume to efficient care provision. When applied widely and supported with data and analytics, risk contracts have to potential to slow medical trends, potentially bending trends to sustainable levels.

The Federal government will establish a governing body to oversee the grading of pharmaceuticals both currently in the marketplace, and new drug patents that are submitted for approval. Similar to efforts in Europe, this grading will be based on the efficacy of the drug in treating the conditions they are designed to treat. Grades will be made available to the public on a national website that provides tools to help consumers understand drugs and how they can be used to treat various conditions.

Drug advertising will be limited solely to medical professionals. No commercial advertising through media will be allowed. This will reduce the pressure on providers to prescribe drugs that are not in the patient's best interest, simply because the patient believes they need them based on advertising they have seen. This is a significant frustration for providers, as well as a cost driver in the health care system.

Consumer Impact

Consumers will be required to select a plan or will be auto-enrolled in the catastrophic plan. They will be expected to be more involved in the healthcare process by considering costs, providers, and effective treatments.

Restricted Use HSAs

- Our catastrophic plans would require the use of restricted HSAs, allowing consumers to save money for healthcare tax-free across plan years. These HSAs would be partially funded from current cost-sharing reduction program that is currently in place through the ACA. This card-based account can be used to pay coinsurance and deductibles and will help teach the consumer about the value of saving for unexpected (or planned) healthcare costs.
- Anyone in a catastrophic plan would be eligible for this restricted use HSA card. Enrollees could not be turned down due to poor financial histories. Users would not be able to overdraft from the account or access the funds without the card.

Reference Based Benefit Programs

- Pairing RBBs with cost transparency tools aids a patient in identifying providers that are lower cost, higher quality, and will enhance his or her healthcare experience by having lower out of pocket costs, and at the same time helping to lower premiums in the long run for all. Consumers will be expected to play a larger role in their healthcare and in making healthcare choices. Patients would also benefit from increased transparency on the cost of services.
- Plans with RBBs have the potential for larger networks versus what are currently available in ACA plans, giving consumers greater choice in providers.
- Consumers will be able to use insurers' tools to help them decide which provider and/or facility to use for procedures based on relative cost and value. Also, since providers will be required to provide costs of services to consumers prior to care being provided, patients will be much better prepared to make their own out-of-pocket choices in regards to their own care.

Lower Costs

- Expansion of age rating bands will create greater premium cost differences, but with having a stronger mandate, the younger, healthier individuals should lower the average premium needed to fund plans. Having a catastrophic plan as the basic plan in the market place adds flexibility for individuals to obtain affordable insurance to meet their needs. This allowance of lower-than-bronze plans will add plans with more affordable premiums while adding additional cost-sharing responsibilities to the patients.

Enforcing Coverage Mandates

- Having an enforced mandate requires people to purchase a plan. This will impact those currently not purchasing insurance, as they will be required to pay at least some amount to purchase a plan.

- Due to the auto-enrollment feature of this proposal, those who do not enroll in a plan during their enrollment period will be auto-enrolled into the catastrophic plan and will be required to pay for the cost difference between the catastrophic plan premium and the subsidy they receive.
- The auto-enrolling may add lives to Medicare and Medicaid populations if there are currently eligible people not enrolled in those plans, as the auto-enrollment process would redirect them to those markets.
- Outside the auto-enrollment proposal, only the changes mentioned for the individual and small group markets pose any major changes to lives moving from one market to another.

Insurance Impact

As the objective of the proposal is to ensure the long-term financial stability of the individual insurance market, an essential component of the reforms is the impact on health insurance companies. The proposed reforms drive membership into the individual market, impact plan design requirements, expand allowable rating factors, and change the regulatory burden for issuers.

Marketplace changes

- Our plan will require auto-enrollment of uninsured individuals into marketplace coverage. As of 2015, approximately 29 million Americans are uninsured. Enrolling this population into the individual market would more than double its size. Since a significant number of these people will be eligible for subsidies, the risk of premium non-payment is reduced. To further incentivize these previously uninsured people to pay their premiums and maintain continuous health coverage, penalties like could be imposed on people who do not keep continuous coverage.
- Insurance carriers will apply to the state to cover these members and submissions will be chosen by the state, with membership being allocated across bidding carriers in an equitable manner, akin to distribution of new membership in the Medicaid program.
- We would establish a five-year reinsurance program identical to the ACA transitional reinsurance program, with sufficient funding to lessen the impact of adverse selection in the individual market. The funds will be provided by insurers for their fully insured groups, and by employers for their self-insured groups. After three years, states will have the flexibility to transition out of the reinsurance program, with a minimum two-year graduated phase-out of the program to minimize the premium impact.

Regulatory burden

- Merging the individual and small group markets will consolidate the number of product and rate filings that insurance companies have to submit.
- Additionally, moving plan management functions to states would reduce overlap between federal and state filings and eliminate redundancies between state and federal filing requirements.
- Establishing Reference Based Benefit pricing and value-based premium rating requires regulators to establish parameters around market average costs and efficiency rates, so carriers will have an increased burden to supply state agencies with data regarding provider cost and quality. Existing reporting requirements may overlap with the required data, so it is possible that using existing resources and processes can alleviate a significant portion of the data submission burden.

Viability of plan offerings

- Insurance companies will be required to introduce a low-cost plan offering that provides at least catastrophic-level coverage. Additional benefits, such as critical illness buy-ups, can be purchased in addition to the catastrophic baseline coverage

as riders, to provide further protection from out-of-pocket costs for consumers who desire this level of coverage.
- Introduce Reference Based Benefit plans, where insurance covers costs up to a reference point corresponding to the cost of services at low-value facilities and/or providers, and the coverage for non-emergent care is paid by the consumer out-of-pocket, without accumulating towards the plan's maximum out-of-pocket limit. This plan design would reward members who select the most efficient facilities and providers and keep premium costs low, since the enrollees take on the risk of extremely high-cost services and facilities.

Pricing & rating requirements

- Merge individual market with small group market up to 100 employees. Increasing the size limit of the small group market and combining this risk pool with the individual market will stabilize the market by providing a larger base across which costs can be spread.
- Additional allowable rating factors for small groups in the merged market would include the following, all restricted to bands of no more than 1.25-to-1: group size, group participation rate, industry, and a factor for associations, otherwise known as a group purchasing cooperative discount. States are granted additional flexibility in the development of new rating factors, pending approval by CMS.
- Insurance companies would have additional flexibility around rating factors in plan pricing, including value-based rating factors, allowing for insurers to rate based on the relative efficiency of the member's assigned PCP. When an individual's premium is directly impacted by the selection of a PCP, the incentive to choose the most efficient providers is significantly strengthened.
- Expand maximum age-rating band to 5:1 to incentivize lower risk enrollment in the individual market. The current limit of 3:1 age bands result in premiums that are not reasonable for the youngest, healthiest potential enrollees, so increasing the allowable age factor range would bring premiums down for younger individuals and induce more members of this low-risk demographic to maintain continuous health insurance coverage.
- Eliminate minimum medical loss ratios and allow competition on price to keep profit margins reasonable. When insurance companies are able to make profits on products, the risk of having an unprofitable year is reduced, since target profit margins can react to long-term revenue cycles instead of being capped due to MLR rebates.
- Allow states access to EDGE server extracts summarizing the data required to simulate risk adjustment transfers. These simulations will be produced quarterly, increasing the stability and reliability of carriers' risk adjustment assumptions and projections.

Healthcare Provider Impact

With these recommended changes, healthcare providers and insurers will reduce costs, increase transparency, increase access, and improve value of care for consumers.

The single greatest challenge to keeping markets stable is healthcare's cost. If costs are not brought in line, the market will not be able to sustain itself. Being that the largest component of healthcare spending is for medical care and drugs, providers and drug companies will need to become more efficient. Quite simply, the nation will have to spend less on healthcare, which means that providers and drug companies will need to survive on less. While these recommended changes do not specify an exact provider reimbursement risk-sharing model, providers putting money at risk will incentivize them to provide high-quality care in more efficient ways, eliminating waste and unnecessary services.

Reference Based Benefit Programs

- Rates negotiated between insurers and providers have largely been based on market share and which party has more leverage. Allowing insurers to establish plans with RBBs can yield great savings to plans. This plan structure allows for greater freedom in network design as higher-cost providers can still be included in a network, but would need to collect more out-of-pocket costs from patients. Also, a provider may be higher cost for some services, but not all services. This would allow for greater patient choice when selecting a provider.
- RBBs paired with providing provider cost information to consumers before services are received will incentivize providers to negotiate contracts with insurers that are based on price, not on increased revenue.
- Additionally, providers would be incentivized to provide care at more efficient sites of service, keeping patients out of hospitals, and finding new, innovative, and more cost-effective ways to provide care.

Risk Contracting

- Today, many risk arrangements with insurers are "upside only" where providers receive additional payments if they perform well on various metrics, such as cost, quality, and patient satisfaction. However, providers should be encouraged to engage in risk contracts where a significant portion of their reimbursement is at risk (i.e. "downside risk") based on performance.
- This proposal is intentionally broad based to allow providers and insurers to innovate on payment methodologies. But if true cost change is going to occur, providers (specifically hospitals), will need to change how they are reimbursed, and performance-based payments are one way to achieve these goals.

Telemedicine

- Telemedicine allows for greater freedom for patients to seek care when and how they desire.
- Patients living in rural areas will have greater access to care with access to telemedicine.

- Additionally, telemedicine can provide cost savings when used after hours or on weekends when patients normally seek care at hospital emergency rooms.

Financial Penalties

- Assessing fines on providers that cannot operate at basic levels of quality will incentivize providers to perform better, while at the same time providing revenue for innovative programs.

Governmental Responsibilities

Under the ACA, the federal government plays a large role in the individual health insurance market. These responsibilities include, but are not limited to, providing subsidies to lower income individuals, administering the premium stabilization/risk mitigation programs and setting the market rules. Our solution recognizes the role of governmental involvement but envisions a greater shift of these responsibilities to state government. We expect that these changes will be cost neutral but will result in a solution that is more responsive to the needs of the state.

Premium Subsidies

- The federal government is best suited to continue the administration of premium and cost-sharing subsidy programs. In our solution, the premium subsidy will be based on a percentage of income only, with the default subsidy level calibrated to be equivalent to the current levels.
- A state will have flexibility to vary the level of subsidy.
- Any subsidies provided in excess of the default amounts will need to be provided from non-federal sources.
- If a state decides to provide subsidies below the default level, any savings will be used to provide enhanced cost-sharing subsidies to individuals in that state.
- It is important to note that currently the premium subsidy is based on the lower of a percentage of family income or the premium for the second lowest silver plan in the applicable rating area. The new premium subsidy will only be based on a percentage of family income.

Cost-Sharing subsidies/Restricted HSA Program

- The federal government will also administer the cost-sharing subsidy program. For people enrolled in the catastrophic plans these funds will be placed into a card-based restricted-use HSA account system to facilitate the distribution of funds for this purpose.
- These restricted HSA accounts will accept governmental cost-sharing subsidy contribution amounts as well as pre-tax consumer contributions, subject to annual HSA maximum contribution amounts. They may also accept after tax employer contributions.
- The accounts may only be used to pay for the consumer's portion of expenses associated with their insurance plans. The use of the amounts accumulated in these restricted HSA accounts will be limited to payment towards deductibles, co-pays and co-insurance amounts. This will eliminate the need for CSR payments to be made to carriers as is done under the current system.
- The amounts that will be contributed by the federal government to these accounts will be income-based and nationally calibrated to be approximately equal to the level of subsidy currently available to CSR-eligible individuals.
- Any contributions not used in a benefit year will be rolled over and accumulated for use in future years without limitation.

Tax Deductibility

- The federal government will administer the tax deductibility of premiums for individuals purchasing insurance in the individual market.
- States may also choose to provide tax deductibility to individuals purchasing insurance in this market.

Risk Mitigation Programs

- The risk adjustment program will continue to be the responsibility of each state, even if the federal methodology is being used and/or the program is federally administered. When the federal model is being used, state-specific calibration will be encouraged to improve the efficacy of the model in each state.
- States will administer reinsurance programs with default parameters that mimic those of the 2015 transitional reinsurance program and will be based on broad-based contributions as established under the 2015 program. States may alter the level of benefits available under the reinsurance program to suit the needs of the state and may need to seek additional funding to support enhanced benefits, if applicable. States will also have full flexibility to make changes to the program.
- Potential changes include, but are not limited to the following: adjusting the reinsurance parameters annually, permitting interim collection of contributions and payments under the program or eliminating the program altogether after three years, with a two-year transition period.
- State administration of the reinsurance program will allow for a more appropriate state-specific solution.

Regulatory Responsibility

- The federal government will maintain responsibility for establishing broad guidelines in the health insurance market, such as the prohibition on pre-existing conditions and lifetime and annual limits.
- States will determine state-specific market rules, including the level of minimum coverage that will be available to individuals purchasing insurance.
- States would continue to approve products available for sale in their state along with the associated rates. The timeframe for rate and form approval will be based on state law rather than on federal timeframes.
- With regard to exchanges, plan management functions, including the certification of plans will be performed by states and the role of the federal government will be limited to that of providing an IT platform (healthcare.gov) which states may choose to use. All other functions performed by states will remain unchanged.
- The Federal Government will establish a governing body to oversee the grading of pharmaceuticals both currently in the marketplace, as well as new drug patents that are submitted for approval. This grading will be based on the efficacy of the drug in treating the conditions they are designed to treat using a standard measurement such as the Quality Adjusted Life Year to compare treatments. Grades will be made available to the public on a national website that provides tools to help consumers understand drugs and how they can be used to treat various conditions.

APPENDIX

Financial Modeling Results

Panoptic Team Proposal
Financial Modeling Results

I. FINANCIAL MODELING

Modeling results for the Panoptic 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 Panoptic 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 Panoptic 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, any tax or funding impacts on results as part of the analysis were not recognized, 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, insurers, 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 five major stakeholder areas connected with the individual insurance market: issuers, members, health care providers, the small group market, and sources for funding. These are averages over the 3-year period of 2018 – 2020. Although the Panoptic proposal is to merge the Individual Market and Small Group Markets (up to 100 employees), the Table 1 comparison shows only the Individual Market, which is the focus of the Actuarial Challenge. Attachment A provides year-by-year detail for each scenario. Attachment B shows the results for the Individual and Small Group markets combined. The impact to the Small Group Market is discussed later in the report.

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

	Status Quo Scenario	Panoptic Scenario	Difference	Percentage Change
Enrollment Results				
Uninsured Count *(thousands)*	24,296	0	-24,296	-100%
Individual Market Enrollment *(thousands)*	17,885	32,334	14,449	81%
Small Group Market Enrollment *(thousands)*	27,423	28,734	1,311	5%
Combined Indiv / SG Market *(thousands)*	45,308	61,068	15,760	35%
Individual Market Only – Issuer Health Plan Results				
Average Premium PMPY	$6,736	$4,576	-$2,160	-32%
Avg. Prem. Subsidy PMPY	$2,848	$2,153	-$694	-24%
Net Member Premium PMPY	$3,888	$2,423	-$1,466	-38%
Average Plan A/V*	71%	64%	-6%	-9%
Loss Ratio after Risk Transfers	80%	75%	-5%	-6%
Issuer Retention				
Total Dollars *($ millions)*	$24,103	$36,588	$12,485	52%
Retention Dollars PMPY	$1,348	$1,132	-$216	-16%
Retention as a Percentage of Premium	20%	25%	5%	24%
Individual Member Obligations PMPY*				
Member Out-of-Pocket Net Premium	$3,888	$2,423	-$1,466	-38%
Member Benefit Cost Share Obligation	$1,821	$1,463	-$358	-20%
Total Member Out-of-Pocket Obligations	$5,710	$3,886	-$1,824	-32%
Average Premium Deductibility Tax Impact	$0	-$194	-$194	n/a
After-Tax Total Out-of-Pocket Obligations	$5,710	$3,692	-2,018	-35%
Health Care Provider Impact – Individual Market Only				
Total Allowed Charges Received ($ millions)***	$168,649	$207,827	$39,179	23%
Allowed Charges per Individual Member PMPY	$5,177	$6,428	$1,250	24%
Required Funding Outlays from Government and / or Other Sources				
Total Dollars of Funding Outlays *($ millions)*	$57,909	$102,499	$44,589	77%
Outlays per Individual Market Member	$3,238	$3,170	-$68	-2%

Table 1 Comparison of the Panoptic Proposal Model Results to Status Quo Baseline Model Results Non-Discounted Averages over the 3-Year Period 2018 - 2020				
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Enrollment Results				
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Combined Indiv / SG Market *(thousands)*	45,308	61,068	15,760	35%
Small Group Market Only *(up to 100 Employees)*				
Small Group Market Enrollment *(thousands)*	27,423	28,734	1,311	5%
Average Premium PMPY	$6,230	$6,197	-$33	-1%
Risk Mitigation Program Costs ($ millions)***	$0	$15,319	$15,319	n/a
Average Plan A/V*	83%	80%	-3%	-4%
Loss Ratio after Risk Transfers	85%	83%	-2%	-2%

** 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. The member's premium obligation is shown above as "Net Member Premium PMPY".*

**** Total dollars transferred to Individual Market in millions; includes both risk adjustment and reinsurance program transfers.*

V. DISCUSSION OF MODELING RESULTS

ENROLLMENT

A key assumption underlying all these results is that all residents will enroll in an Insured Plan, due to a mandatory auto-enrollment program. The proposal does not address the penalty for nonpayment of premiums. The modeling has assumed such penalties would be set equal to the full annual cost of the lowest cost plan available. **While it is certain that some people will still opt to not obtain coverage even though it will cost them at least the same amount in penalties, the model assumes all uninsured people will be auto-enrolled into a health insurance plan in 2018 and later and will pay their premium rates**. Most uninsured people will move to the Individual Market, although some will move to the Employer Group market and a smaller number to Medicaid. Table 2 summarizes the modeled migration of those uninsured to insured markets in 2018 when the Panoptic reforms take place.

Table 2 Uninsured Migration to Insured Market in 2018 (millions)	
Market	**Member Count**
Individual	14.8
Employer Group	6.2
Medicaid	4.5
Medicare	0.3
Uninsured	0.0
Total	25.8

PREMIUM RATES

The model indicates that the Panoptic proposed reforms achieves the goal of significantly lowering premium rates, making coverage much more affordable. This is primarily due to the following:

1. *Provider reimbursement rate change*: the proposal includes reference based benefits pricing for plans. The assumption is made that this will result in a year-by-year reduction in reimbursement levels due to widespread reference pricing implementation. Table 3 shows the year–by-year percentage reductions by service category. The values shown are relative to the previous year reimbursement level.

Table 3
Provider Reimbursement Improvement
Due to Reference-Based Benefits Pricing

Service	2018	2019	2020
Inpatient Facilities	-9.0%	-6.0%	-4.0%
Outpatient Facilities	-11.0%	-8.0%	-6.0%
Professional and Other Non-Rx	-4.0%	-3.0%	-2.0%

This results in a reduction in claim cost levels from the current Individual Market environment (about a 20% reduction in allowed costs by year 2020 from 2017 levels). These allowed charge reductions get even more leveraged for benefit calculations. The model assumes that such repricing will apply to both the individual and small group markets since they are merged markets.

2. *Shifts in plan selection*: as evidenced by the "Paid to Allowed" ratios shown in Table 1, there is an overall average shift toward lower benefit plans. This helps lower allowed costs as well as paid costs, due to lower induced utilization associated with leaner plans. This plan shift is due to several reform changes:

   a. The allowance of catastrophic plans (a plan with less than a 60% actuarial value) available to all enrollees and with members enrolling in this plan eligible for premium and benefit subsidies, unlike the current ACA rules governing the catastrophic plans. The model moves the previously uninsured into the lowest cost plan being modeled, which has an actuarial value of about 50%. In subsequent years, many of these members upgrade coverage, resulting in about 36% of members keeping a catastrophic plan, with the other members purchasing various levels of richer benefit plans. The average AV for 2019 and 2020 is 66.0% compared to 71.5% under the status quo scenario, while the 2018 AV comparison is 61.4% for Panoptic versus 69.5% under the status quo scenario.

   b. There is no longer a requirement to enroll in a Silver plan in order to receive CSR subsidies. The subsidies, while calculated based on expected benefit differences between ACA-type CSR plans and a catastrophic plan, are placed into the member's HSA account and used by the member to pay for his or her cost-sharing obligations under whatever plan they choose, The Panoptic scenario shows a sharp reduction in the number of people enrolled in Silver plans. As noted above, they get spread to other plans, some with richer benefits and others with leaner benefits. As such, the increased utilization associated with CSR plans is no longer spread over the single risk pool, but each plan's expected induced utilization levels are reflected in the actuarial values for those plans.

3. *The reinsurance program*: Panoptic reintroduces a reinsurance program starting in 2018 and continuing for five years. The program is structured to be identical to the ACA program that ended in 2016. As such, it will be funded through commercial insurance plans and self-funded employer plans. The program is set to have a $90,000 attachment point and 80% benefit percentage, capped at $300,000. The resulting

annual funding level ranges is $11 billion, of which the individual market issuers net between $8 and $10 billion from 2018 through 2020 after subtracting their contributions to the program.

The provider reimbursement changes, shifts in plan selection toward leaner plans, and the reinsurance program combine to lower gross premium rates by 32% on average over the three years.

Premium subsidies, while not as generous as those under the ACA on a PMPY basis, lower the consumer's out-of-pocket premiums 47% from gross levels, such that total out-of-pocket premiums for insured members are down a total of 38% compared to status quo scenario results.

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 average premiums under the Panoptic proposal is reduced significantly, while the reforms should result in administrative expense reductions in some areas on a per member basis, the model targeted a retention percentage to result in an average 75% MLR over the 2018-2020 period. Table 1 illustrates that this results in an overall increase of $12.5 billion in retention dollars, but retention per member per year is 16% lower than under the status quo scenario.

A key consideration in making these reforms is whether such a per member retention reduction will generate enough retention revenue for issuers to adequately operate and meet their commitments to servicing their insured members. If retention is not high enough, issuers will decide not to participate in the Individual Market. Conversely though is the issue of what minimum loss ratio standard will states tolerate. The pre-ACA minimum in most states was 55%. However, it is not clear that such a level would again be deemed acceptable, even at these relatively lower premium rates. The model has targeted a loss ratio of 75%. The model assumes that issuers will be able to operate at this level of retention, considering that overhead and other expenses are relatively fixed and the influx of 14 million additional members will help cover these costs as well as the variable expenses of operation.

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; the second is the deductible and other cost-sharing payments they must make for services received by health care providers. In addition, the Panoptic proposal calls for payment of individual market premiums with pre-tax dollars.

- *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 Panoptic proposal offer these types of premium subsidies. The ACA program's subsidy equals premium for the second lowest silver plan less a stipulated percentage of the applicant's household income. The Panoptic's proposed subsidy is a discount from gross premium of a 70% AV plan, varying by household income. It does not apply to people in the Small Group market; only those in the Individual Market. Table 4 summarizes the factors used in the model for the current status quo baseline scenario (ACA) and the Panoptic scenario.

Table 4 Premium Subsidy Structure: ACA vs. Panoptic		
Household Income Range	ACA Cap on Premium as % of Income	Panoptic Subsidy as a % of Premium*
<139%	2.0%	100%
139%-150%	3.0% - 4.0%	90%
150%-200%	4.0% - 6.3%	90%
200%-250%	6.3% - 8.05%	75%
250%-300%	8.05% - 9.5%	50%
300%-400%	9.5%	25%
400%+	No Limit	0%

** Subsidy based on gross premium of a 70% AV plan.*

- *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. Amounts that providers balance bill over and above the fees negotiated between the health plan and the provider would also be benefit out-of-pocket costs to the member, as would responsibility for any services not eligible for coverage. In these projections, the model assumes no balance billing and that all material services are covered

- *Premium Deductibility for Federal Income Taxes:* The Panoptic proposal includes the ability for people purchasing individual market coverage to be able to deduct the premiums they pay for their health plan. The ACA does not include this provision. This calculation was performed outside of the HCRFM system, based on a reduction in adjusted gross income (AGI) and an assumed average tax rate of 8% for people in the individual market. The reader should note that actual applicable tax rate could be higher or lower than this assumption.

Table 5 summarizes the average annual model results over the period of 2018 to 2020 for these components of members out-of-pocket obligations on a per member per year basis. These same results were shown in Table 1.

Table 5 Comparison of the Panoptic 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	Panoptic Scenario	Difference	Percentage Change
Average Gross Premium PMPY	$6,736	$4,576	-$2,160	-32%
Avg. Prem. Subsidy PMPY	-$2,848	-$2,153	-$694	-24%
Member Out-of-Pocket Net Premium PMPY	$3,888	$2,423	-$1,466	-38%
Provider Charges for Services PMPY	$7,600	$6,428	-$1,172	-15%
less Health Plan Benefits PMPY	-$5,389	-$4,142	$1,247	-23%
less Government Benefit Subsidies	-$390	-$823	-$433	111%
Member Benefit Cost Share Obligation PMPY	$1,821	$1,463	-$358	-20%
Total Member Out-of-Pocket Obligations PMPY	$5,710	$3,886	-$1,824	-32%
less Average Premium Deductibility Tax Impact	$0	-$194	-$194	n/a
Total After-Tax Out-of-Pocket Obligations	$5,710	$3,692	-2,018	-35%

IMPACT TO HEALTHCARE PROVIDERS

Healthcare providers are also affected by the Panoptic reforms.

As discussed earlier, by 2020 reference-based benefits pricing results in a reduction of around 20% in average fee levels for healthcare providers (it has been assumed that they do not balance bill). Physicians may fair better in this regard than facilities since their fee reductions are not as great (see Table 3).

However, having all previously uninsured people covered under a health plan increases both the utilization of providers' services as well as the fees that providers will receive for those services. . This increased volume more than makes up for the larger discounts providers give under the Panoptic scenario.

Table 6 illustrates a comparison between the status quo scenario and the Panoptic scenario. Since the provider reimbursement changes also affect the Small Group Market as part of the merged market, the results shown include the entire merged market. The model indicates that moving to the new discount structure will result in an increase of revenue to health care providers of $27 billion. Overall, this is an 8% increase in revenue from the status quo baseline scenario.

Table 6
Comparison of the Panoptic Proposal Model Results to Status Quo Baseline Model Results
Average Annual Member Cost Obligations over the 3-Year Period 2018 – 2020
Combined Individual / Small Group Market

Out-of-Pocket Component	Status Quo Scenario	Panoptic Scenario	Difference	Percentage Change
Insured Allowed Charges ($ millions)	$309,214	$371,749	$62,535	20%
Uninsured Allowed Charges ($ millions)*	$35,602	$0	-$35,602	-100%
Grand Total ($ millions)*	$344,816	$371,749	$26,933	8%
Amt per Indiv / Uninsured Mkt Members PMPY*	$5,626	$6,087	$461	8%

** Includes only costs of the 16.1 million uninsured who move to the Merged Market under the Panoptic Scenario.*

Under the Panoptic proposal, issuers would employ reference-based pricing fee schedules. These fee schedules would reflect the relationships from average 2017 allowed fee levels as shown in Table 3. As more issuers use this approach or negotiate equivalent or better discounts for their networks, the reimbursement levels reduce somewhat each year. This approach does not bind providers to accept the reference fees, but, if they do not, then they will need to balance bill their patients for the difference. This analysis assumes that balance billing does not occur since both consumers and providers prefer to avoid it, patients will seek out providers who do not balance bill or whose fee are lower already, or providers will not take patients of such issuers. The ability for issuers to successfully achieve such fee levels will vary.

FUNDING OUTLAYS

The Panoptic proposal increases funding outlays by about $45 billion compared to status quo. These may be funded by the Government, be it state or federal, or a combination of broad public / private funding. This proposal treats the Government as the funding source. There are three areas of impact for these funding outlays:

1. *Premium Subsidies*: Premium subsidies for the 3-year period average about $70 billion under the Panoptic proposal compared to a yearly average of $51 billion expected under the current ACA for 2018-2020. As noted earlier, this increase is due to the large number of uninsured who become covered in the individual market. The premium subsidies on a per member basis actually are 24% lower than that of the status quo scenario, largely due to the much lower gross premiums being charged under the Panoptic scenario.

2. *Benefit Cost-Sharing Subsidies*: The Panoptic proposal restructures government-paid CSR subsidies, as discussed earlier. Under the status quo scenario, the CSR payments to issuers are expected to average about $7 billion per year. Under Panoptic, the projected average annual cost to the Government over the 2018-2020 period is about $27 billion.

3. *Premium Tax Deductibility*: Panoptic proposes that people purchasing coverage in the Individual Market be able to treat their paid premiums as an income tax deduction. While the HCRFM does not model such items, assuming an average 8% income tax rate, such a tax change would reduce government revenues by about an average of $6 billion per year over the 2018-2020 period. The 8% average income tax rate is lower than the nationwide average due to the lower income distribution of those in the individual marketplace. It is assumed that those in the top income brackets are almost all receiving coverage in the group markets. It is quite possible that a lower or higher average rate could prove to be true.

Table 7 summarizes the funding outlays for the Panoptic proposal and compares it to funding under the ACA program. While the increased outlays in total dollars average $45 billion per year over the 2018-2020 period, on a per Individual Market member basis costs decrease by $68 per year or 2%, but, on a Merged Market member basis, they increase by $400 per member.

Table 7
Comparison of the Panoptic Proposal Model Results
to Status Quo Baseline Model Results
Average Annual Funding Outlays

Program	Status Quo	Panoptic	Difference
Premium Subsidies ($billions)	$51	$70	$19
Benefit CSR Subsidies ($billions)	$ 7	$27	$20
Premium Tax Deductibility($billions)	$ 0	$6	$6
Grand Total ($billions)	$58	$102	$ 45
Total per Individual Market Member	$3,238	$3,170	-$68
Total per Merged Market Member	$1,278	$1,678	$400

The Government 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. Other than the tax-deductibility of paid premiums, the Panoptic proposal is silent about other taxes and fees currently required under the ACA. It is beyond the scope of the modeling to review items outside of the direct insurance aspects of the proposal. Additionally, the impact of these reforms on the ACA §9010 health insurance fee or on the ACA §9001 excise tax on high cost employer-sponsored plans (i.e., the Cadillac Tax) has not been modeled. However, any such government revenue gains or losses due to these items would need to be considered in a comprehensive econometric analysis of the proposal. The Milliman model does not address government and non-insurance related revenue sources.

IMPACT TO EMPLOYERS

Employers are affected by these reforms in the following ways:

1. The small employer market is extended to groups of up to 100 employees. This subjects many more groups to current rules governing small employers with 50 or fewer employees. These include modified community rating and other rules to which larger groups are not currently subject. The authors expect such a merged market to operate in a similar fashion to that currently used in Massachusetts.

2. Perhaps more significantly, the small group market (redefined to be up to 100 employees) is merged with the Individual Market. This places them into a single risk pool with the Individual Market, with the hope of providing greater pricing stabilization to the Individual Market. While this lowers the overall risk profile of the merged market compared to a stand-alone Individual Market, it means that premium rates could increase in the small group sector since it has a lower average risk score than the individual market. The authors expect such a merged market to operate in a similar fashion to that currently used in Massachusetts, which allows some premium rate variation by group size.

3. The merged market also results in the two markets being in a single risk pool for risk adjustment program transfers. The model indicates that on average this results in a net average $13.6 billion per year being transferred from small group plans to individual market plans. Additionally, another $1.7 billion is transferred to individual from small group through the reinsurance program. This totals $15.3 billion in transfers.

4. The small groups also receive a slight benefit due to the improved reimbursements. Average allowed PMPY charges decrease by 5%. However, due to the risk adjustment transfers, premiums per member only decrease by 1%.

5. Table 8 summarizes the impacts to the Small Group Market.

Table 8
Comparison of the Panoptic Proposal Model Results to Status Quo Baseline Model Results
Impact to Small Group Market* Only

Program	Status Quo	Panoptic	Difference	% Change
Small Group Market Enrollment *(thousands)*	27,423	28,734	1,311	5%
Average Premium PMPY	$6,230	$6,197	-$33	-1%
Total Small Group Premium Dollars *(millions)*	$170,848	$178,059	$7,211	4%
Risk Mitigation Program Costs ** *(millions)*	$0	$15,319	$15,319	n/a
Average Plan A/V*	83%	80%	-3%	-4%
Loss Ratio after Risk Transfers	85%	83%	-2%	-2%

** Includes Small groups up to 100 Employees.*

*** Total dollars transferred to Individual Market in millions.*

6. Some of the uninsured are expected to enroll in the health plans offered by their employers. The model indicates a 5% increase in group membership. This will add cost to the employers since they usually contribute a significant share of the plan premium. For the small group market, it adds $7 billion more in premiums and premium equivalents.

7. The model assumes that anyone (including dependents) who is eligible for a group plan will not be eligible to enroll in the Individual Market. If this is not the case, to the extent that premium rates after subsidies in the Individual Market are less than the employee share of the group premium, there may be many employees and dependents who would move to the Individual Market. This would likely lower total costs for the employers, but increase costs for the Government due to the additional subsidies and CSR payments it would need to pay. The model shows that the average out-of-pocket premium to large group employees is greater than that in the individual market, although the benefit plans are considerably richer on average for employer groups than for the Individual Market. It would be more likely that dependents might move to the Individual Market from the Employer Group Markets.

8. Without a strong employer mandate, there is a stronger likelihood that some employers would terminate their plans and send their employees to the Individual Market. This would again increase total costs for the Government and put much more pressure on healthcare providers if the members in the Individual Market as a percentage of the total population increased significantly.

None of these impacts on the Large Group market are reflected in the attached exhibits. However, these are significant impacts that may affect these other markets, which again is beyond the scope of this modeling of the Individual and merged market costs.

Attachment A
Summary of Model Results for Years 2018 - 2020
Comparison of Panoptic Scenario versus Baseline Scenario

Individual Market Only

Baseline Scenario Individual and Uninsured Markets Enrollment Results				
Population Segment	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Uninsured Counts (millions)	24.481	24.509	23.899	24.296
Individual Market Enrollment (millions)	18.424	17.608	17.623	17.885

Panoptic Scenario Individual and Uninsured Markets Enrollment Results				
Population Segment	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Uninsured Counts (millions)	0.000	0.000	0.000	0.000
Individual Market Enrollment (millions)	32.609	32.344	32.049	32.334

Baseline Scenario Individual Market Only Issuer Health Plan Results				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium PMPY	$5,920	$6,937	$7,389	$6,736
Subsidies PMPY	$2,345	$2,987	$3,233	$2,848
Premium less Subsidies	$3,574	$3,950	$4,156	$3,888
Allowed Costs PMPY	$6,934	$7,685	$8,212	$7,600
Paid Benefits PMPY	$4,817	$5,484	$5,891	$5,389
Paid to Allowed	69%	71%	72%	71%
Risk Adjustment PMPY	$0.00	$0.00	$0.00	$0
Net Reinsurance PMPY	$0	$0	$0	$0
Raw Loss Ratio	81%	79%	80%	80%
Loss Ratio Net of Reins	81%	79%	80%	80%
Loss Ratio Net of Reins and RA	81%	79%	80%	80%

Panoptic Scenario Individual Market Only Issuer Health Plan Results				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium PMPY	$4,071	$4,778	$4,887	$4,576
Subsidies PMPY	$1,744	$2,408	$2,313	$2,153
Premium less Subsidies	$2,327	$2,370	$2,574	$2,423
Allowed Costs PMPY	$6,307	$6,388	$6,590	$6,428
Paid Benefits PMPY	$3,871	$4,195	$4,364	$4,142
Paid to Allowed	61%	66%	66%	64%
Risk Adjustment PMPY	$385	$427	$450	$421
Net Reinsurance PMPY	$279	$275	$275	$277
Raw Loss Ratio	95%	88%	89%	91%
Loss Ratio Net of Reins	88%	82%	84%	84%
Loss Ratio Net of Reins and RA	79%	73%	74%	75%

Baseline Scenario Individual Market Only Total Insurer Plan Retention				
Retention Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Total Dollars ($ millions)	$20,324	$25,593	$26,390	$24,103
Retention Dollars PMPY	$1,103	$1,454	$1,498	$1,348
Retention as a Percentage of Premium	19%	21%	20%	20%

Panoptic Scenario Individual Market Only Total Insurer Plan Retention				
Retention Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Total Dollars ($ millions)	$28,213	$41,553	$39,997	$36,588
Retention Dollars PMPY	$865	$1,285	$1,248	$1,132
Retention as a Percentage of Premium	21%	27%	26%	25%

Baseline Scenario Individual Market Only Member Cost Obligations				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium after Subsidies	$3,574	$3,950	$4,156	$3,888
Benefit Cost-Share after Subsidies	$1,770	$1,806	$1,889	$1,821
Total Member Out-of-Pocket	$5,345	$5,755	$6,045	$5,710
Avg. Premium Deductibility Tax Impact	$0	$0	$0	$0
After-Tax Out-of-Pocket Obligations	$5,345	$5,755	$6,045	$5,710

Panoptic Scenario Individual Market Only Member Cost Obligations				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium after Subsidies	$2,327	$2,370	$2,574	$2,423
Benefit Cost-Share after Subsidies	$1,463	$1,467	$1,458	$1,463
Total Member Out-of-Pocket	$3,790	$3,837	$4,032	$3,886
Avg. Premium Deductibility Tax Impact	-$186	-$190	-$206	-$194
After-Tax Out-of-Pocket Obligations	$3,604	$3,648	$3,826	$3,692

Baseline Scenario Individual and Uninsured Markets Only Total Provider Reimbursement				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Insured Allowed Charges ($ millions)	$127,742	$135,311	$144,709	$135,921
Uninsured Allowed Charges ($ millions)*	$31,405	$32,959	$33,819	$32,728
Grand Total ($ millions)*	$159,148	$168,270	$178,528	$168,649
Amt per Indiv / Uninsured Mkt Members*	$4,790	$5,189	$5,566	$5,177

* Includes only costs of the 14.8 million uninsured who move to the Indivdiual Market under the Panoptic Scenario

Panoptic Scenario Individual and Uninsured Markets Only Total Provider Reimbursement				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Insured Allowed Charges ($ millions)	$205,649	$206,626	$211,208	$207,827
Uninsured Allowed Charges ($ millions)	$0	$0	$0	$0
Grand Total ($ millions)	$205,649	$206,626	$211,208	$207,827
Amt per Indiv / Uninsured Mkt Members	$6,307	$6,388	$6,590	$6,428

Baseline Scenario Individual Market Only Average Annual Costs to the Government				
Program	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium Subsidies ($millions)	$43,212	$52,604	$56,975	$50,930
Benefit Subsidies ($millions)	$6,388	$6,959	$7,590	$6,979
Reinsurance Program ($millions)	$0	$0	$0	$0
Premium Tax Deductibility ($millions)	$0	$0	$0	$0
Grand Total ($millions)	$49,600	$59,563	$64,565	$57,909
Total per Individual Market Member	$2,692	$3,383	$3,664	$3,238

Panoptic Scenario Individual Market Only Average Annual Costs to the Government				
Program	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium Subsidies ($millions)	$56,876	$77,883	$74,117	$69,625
Benefit Subsidies ($millions)	$31,720	$23,476	$24,621	$26,606
Reinsurance Program* ($millions)	$0	$0	$0	$0
Premium Tax Deductibility** ($millions)	$6,071	$6,132	$6,600	$6,268
Grand Total ($millions)	$94,667	$107,491	$105,338	$102,499
Total per Individual Market Member	$2,903	$3,323	$3,287	$3,170

* The Panoptic reinsurance program is funded by the Commercial Market insurers and TPAs

** Assumes an average tax rate of 8%

Attachment B
Summary of Model Results for Years 2018 - 2020
Comparison of Panoptic Scenario versus Baseline Scenario

Individual and Small Group Markets Combined

Baseline Scenario Individual and Uninsured Markets Enrollment Results				
Population Segment	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Uninsured Counts (millions)	24.481	24.509	23.899	24.296
Combined Market Enrollment (millions)	46.148	45.035	44.740	45.308

Panoptic Scenario Individual and Uninsured Markets Enrollment Results				
Population Segment	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Uninsured Counts	0.000	0.000	0.000	0.000
Combined Market Enrollment (millions)	61.616	61.086	60.502	61.068

Baseline Scenario Individual and Small Group 1-100 Markets Combined Issuer Health Plan Results				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium PMPY	$5,843	$6,507	$6,958	$6,430
Subsidies PMPY	$936	$1,168	$1,273	$1,124
Premium less Subsidies	$4,906	$5,339	$5,685	$5,306
Allowed Costs PMPY	$6,328	$6,843	$7,318	$6,825
Paid Benefits PMPY	$4,882	$5,340	$5,733	$5,314
Paid to Allowed Ratio	77%	78%	78%	78%
Risk Adjustment PMPY	$0.00	$0.00	$0.00	$0
Net Reinsurance PMPY	$0	$0	$0	$0
Raw Loss Ratio	84%	82%	82%	83%
Loss Ratio Net of Reins	84%	82%	82%	83%
Loss Ratio Net of Reins and RA	84%	82%	82%	83%

Panoptic Scenario Individual and Small Group 1-100 Markets Combined Issuer Health Plan Results				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium PMPY	$5,025	$5,443	$5,553	$5,339
Subsidies PMPY	$923	$1,275	$1,225	$1,140
Premium less Subsidies	$4,102	$4,168	$4,328	$4,199
Allowed Costs PMPY	$5,958	$6,048	$6,260	$6,087
Paid Benefits PMPY	$4,153	$4,362	$4,542	$4,351
Paid to Allowed Ratio	70%	72%	73%	71%
Risk Adjustment PMPY	$0.00	$0.00	$0.00	$0
Net Reinsurance PMPY	$119	$118	$118	$118
Raw Loss Ratio	83%	80%	82%	81%
Loss Ratio Net of Reins	80%	78%	80%	79%
Loss Ratio Net of Reins and RA	80%	78%	80%	79%

Baseline Scenario Individual and Small Group 1-100 Markets Combined and Uninsured Total Insurer Plan Retention				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Total Dollars ($ millions)	$44,319	$52,565	$54,819	$50,568
Retention Dollars PMPY	$960	$1,167	$1,225	$1,116
Retention as a Percentage of Premium	16%	18%	18%	17%

Panoptic Scenario Individual and Small Group 1-100 Markets Combined Total Insurer Plan Retention				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Total Dollars ($ millions)	$61,087	$73,238	$68,316	$67,547
Retention Dollars PMPY	$991.41	$1,198.93	$1,129.15	$1,106
Retention as a Percentage of Premium	20%	22%	20%	21%

Baseline Scenario Individual and Small Group 1-100 Markets Combined Member Cost Obligations				
Measure	2018	2019	2020	Avg. 2018-2020
Premium after Subsidies	$4,906	$5,339	$5,685	$5,306
Benefit Cost-Share after Subsidies	$1,308	$1,349	$1,415	$1,357
Total Member Out-of-Pocket	$6,214	$6,688	$7,100	$6,663

Panoptic Scenario Individual and Small Group 1-100 Markets Combined Member Cost Obligations				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium after Subsidies	$4,102	$4,168	$4,328	$4,199
Benefit Cost-Share after Subsidies	$1,289	$1,302	$1,311	$1,301
Total Member Out-of-Pocket	$5,392	$5,470	$5,639	$5,499

Baseline Scenario Individual and Small Group 1-100 Markets Combined and Uninsured Total Provider Reimbursement				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Insured Allowed Charges ($ millions)	$292,039	$308,197	$327,406	$309,214
Uninsured Allowed Charges ($ millions)*	$34,163	$35,853	$36,789	$35,602
Grand Total ($ millions)*	$326,202	$344,050	$364,194	$344,816
Amt per Merged/ Uninsured Mkt Members*	$5,240	$5,626	$6,024	$5,626

Panoptic Scenario Individual and Small Group 1-100 Markets Combined and Uninsured Total Provider Reimbursement				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Insured Allowed Charges ($ millions)	$367,079	$369,432	$378,736	$371,749
Uninsured Allowed Charges ($ millions)	$0	$0	$0	$0
Grand Total ($ millions)	$367,079	$369,432	$378,736	$371,749
Amt per Merged/ Uninsured Mkt Members*	$5,958	$6,048	$6,260	$6,087

* Includes only costs of the 16.1 million uninsured who move to the Combined Individual / Small Group Market under the Panoptic Scenario

Baseline Scenario Individual and Small Group 1-100 Markets Combined Total Costs to the Government Under Base Scenario ($millions)				
Program	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium Subsidies ($millions)	$43,212	$52,604	$56,975	$50,930
Benefit Subsidies ($millions)	$6,388	$6,959	$7,590	$6,979
Reinsurance Program ($millions)	$0	$0	$0	$0
Premium Tax Deductibility ($millions)	$0	$0	$0	$0
Grand Total ($millions)	$49,600	$59,563	$64,565	$57,909
Total per Merged Market Member	$1,075	$1,323	$1,443	$1,278

Panoptic Scenario Individual and Small Group 1-100 Markets Combined Total Costs to the Government Under Panoptic Scenario ($millions)				
Program	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium Subsidies ($millions)	$56,876	$77,883	$74,117	$69,625
Benefit Subsidies ($millions)	$31,720	$23,476	$24,621	$26,606
Reinsurance Program* ($millions)	$0	$0	$0	$0
Premium Tax Deductibility** ($millions)	$6,071	$6,132	$6,600	$6,268
Grand Total ($millions)	$94,667	$107,491	$105,338	$102,499
Total per Merged Market Member	$1,536	$1,760	$1,741	$1,678

* The Panoptic reinsurance program is funded by the Commercial Market insurers and TPAs

** Assumes an average tax rate of 8%