Outline of Response to Actuarial Challenge:

Underwriting and Premium Rating using Risk Adjustment

Submitted for

Submitted by

TEAM WAKELY

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EXECUTIVE SUMMARY

Our solution blends elements from pre-ACA into the current environment. Our focus is on the development of an actuarially-sound rating basis where premiums better align with expected costs. We believe that better aligning premiums with expected costs will improve the stability of the individual market by lowering the rates for healthier individuals and therefore keeping them in the single risk pool for a more stable and sustainable mix. Additionally, the ability of insurers to rate for the risk they have and account for market forces and business needs will enable more issuers to participate and increase competition.

- States will risk score the members and use the risk score to assign the members to rating bands. States will decide how many rating bands would exist. We recommend 6 rating bands:
    - Rating Band 6: Penalty box for those who do not maintain continuous coverage -> the subsidies that a member gets in this band would be based on premiums in band 5.
    - Rating Band 5: top 5% of members with the highest risk scores
    - Rating Band 4: Next 10% of the members with the next highest risk scores
    - Rating Band 3: Next 10%
    - Rating Band 2: Next 25%
    - Rating Band 1: Last 50% of the members with the lowest risk scores
- The issuers would be allowed to rate each rating band based on the expected cost of their members in the rating bands. That is, there is no cross subsidization across rating bands as has been the case historically. The issuers would also be allowed to rate geographically. Each issuer would set a premium rating factor for each rating band and the member's premium would be the base rate x area factor x rating band factor. No additional rating factors would be necessary. This would reduce the cost of coverage for virtually every rating band except for the highest rating band.
- The state will decide if a PMPM assessment is necessary for each rating band to cover the cost of members in the highest rating bands. The assessment would the same for all insurers and be paid to the state. The state will use it to fund the subsidies for the highest tier. This assessment will likely be necessary since the members in the top decile by risk scores in our sample of 1 million individual ACA lives comprised of 52% of total claim cost spending across all lives. This would increase premiums for everyone and reduce government subsidies required for the highest rating band and possibly the lower rating bands if the assessment triggers a subsidy.
- Subsidies will be available in the form of premium assistance to anyone for whom the premiums applicable to their rating bands exceed a certain percentage of their income (see Appendix A for affordability schedule). The subsidies would cover the excess premiums.
- The state would define a benchmark plan which is the minimum level of coverage that the state believes its residents must have. It would require coverage for all conditions for which care is unavoidable and require coverage of at least two drugs in each therapeutic class.
- The benchmark plan would have cost sharing reduction versions similar to the CSR plans now for the low-income populations. Issuers would rate these plans higher. Instead of cost sharing reconciliation, the additional cost would be built into the premiums and trigger

additional subsidies for low-income members. We expect this would have no impact on cost to the government but would be less costly to administer.

- Each issuer would be required to offer at least one benchmark plan. The subsidies would be based on the cost of the second lowest benchmark plan for a member's rating tier and the member's income. Since the states can choose a leaner benchmark plan than the EHBs under the ACA, the cost of subsidies would be reduced.
- Plans would not be allowed to offer coverage for only certain rating bands or be allowed to offer different benefits by rating band.
- There would not be any restriction on plan designs. However, anyone buying a very high deductible plan must have 60% of the MOOP in a Health Savings Account (HSA) to qualify for the higher deductible. The minimum High Deductible Health Plan (HDHP) deductible would not require any funding amount in the HSA.
- The market would be guaranteed issue and renewal.

SECTION REQUIREMENTS

1. ***The Solution***

As stated, our solution blends elements from pre-ACA into the current environment. Our focus is on development of an actuarially-sound rating basis where premiums better align with expected costs. Below is more detail on the various components of our solution.

Rating Tiers

The key feature of our proposal is to modify the current allowable rating factors. Instead of utilizing age for rating, we propose replacing age with rating tiers. The assignment of members into rating tiers is based on their risk score.

- Risk scores would be based on a prospective risk adjustment methodology used to categorize individual risks into multiple rate tiers. The states will decide how many rating bands would exist. We recommend 6 rating bands:
    - Rating Band 6: Penalty box for those who do not maintain continuous coverage
    - Rating Band 5: top 5% of members with the highest risk scores
    - Rating Band 4: Next 10% of the members with the next highest risk scores
    - Rating Band 3: Next 10%
    - Rating Band 2: Next 25%
    - Rating Band 1: Last 50% of the members with the lowest risk scores
- The data and methodology would be uniform for all carriers in a state and would build off of currently existing Edge server submissions.
- Risk adjustment methodology would be changed to a prospective model with some change in the condition weights as the concurrent model would move from identifying current costs to identifying future costs. Risk adjustment would no longer be needed as an equalizing process after the fact as it is today which will reduce the current level of uncertainties in an issuer's financials.
- Tiers would be assigned at the state level by the state and all carriers would use the same tier determination. This would minimize cherry picking by carriers as they could not modify

the tier assignment or change a risk score as occurred with the traditional pre-ACA underwriting approach.

- Each state would determine how many rating bands to allow.
- The state would also determine the PMPM assessment on each of the rating bands to pay for the rating band with the sickest members. The PMPM assessment must be small enough so as to not discourage the healthy members from enrolling but large enough to make a sizeable contribution towards the claim cost of the sickest. The uniform PMPM assessment protects insurers from the risk of getting too many unhealthy members or too few healthy members from what was assumed in their pricing. It also protects insurers from adverse selection as each rating band is priced in an actuarially-sound manner with consumer protections in place to make the premiums affordable. Depending on the success of this plan in enrolling the young and healthy, we believe a PMPM assessment of $30-75 on all rating bands 1-4 should provide sufficient dollars to reduce subsidies required on rating band 5 such that the government liability is no more than what it is under the ACA, if not less.
- Individuals would be encouraged to obtain insurance based on the structure of the rating bands and a penalty for re-entry should they drop coverage. For the first open enrollment period, newly insured members without a certificate of creditable coverage will be assigned a rate tier based on a demographic risk score. For subsequent open enrollments, newly insured members without historic data must have a certificate of creditable coverage to receive a standard risk score based on demographics. Otherwise, if they have no creditable coverage, then newly insured would be put in the highest rating band (a 6th rating band that doesn't trigger additional subsidies).
- Special enrollment period entrants would be strictly monitored and also require creditable coverage after the first year.
- Geographic rating factors would continue.

Subsidies for Low Income Members

In our proposal, subsidies would continue and be based on the cost of the second lowest benchmark plan applicable to a person's income level and health status rating band. Each income level and rating band would have a cap on premium as a percent of income with the subsidy filling in the difference. Higher income would also have a cap on premium expected to pay but would likely only hit the cap when the individual was in a higher rating tier.

Individuals purchasing a lower priced plan than the cost of the applicable benchmark plan and therefore not using up the maximum subsidy dollars available to them would have the excess subsidy dollars deposited into an HSA account. That is, if a member buys a plan that's cheaper than the applicable benchmark plan, then the government liability does not decrease but the member can use the savings on the premiums to pay for cost sharing.

A benchmark plan design would be determined by the state based on their determination of covered services, cost sharing, and network requirements. The plan would provide coverage for all medical conditions with no discrimination by health status.

Reduced cost sharing versions of benchmark plans would be available for low-income members. We propose that a pre-determined amount of additional subsidies be made available to low-

income members so they can buy-up from a benchmark plan to a plan with an affordable cost sharing levels.

Plan Design Requirements

We propose an allowing wider choice in plan designs, no longer requiring a minimum actuarial value and removing some EHB restrictions. Leaner plan designs would be allowed with the goal to bring in additional healthy members into the risk pool.

An individual could purchase any deductible level if they have an HSA or other designated funds that could be put in an HSA covering the MOOP balance. This requirement is designed to protect providers from bad debt with higher deductibles & MOOP. HSA regulation would need to be revised to enable contributions even if specific plan design elements of an HDHP are not met. We expect that allowing individuals to buy higher deductibles will cause premium leakage in the high income healthy bucket and recognize that this could be an issue.

As described below, the states would define a benchmark plan and variants of this plan for low-income enrollees. Each issuer would be required to offer the benchmark plans and the variants and these plans would be used by the state to set subsidies.

Guarantee Issue/Individual Mandate

Our proposal includes guarantee issue with the sickest individuals going in the highest rating band. We do have concerns that there may still an issue with anti-selection, pushing premiums upward for the highest band and potentially jeopardizing the pricing stability of the highest rate band. Note, however, there is a mitigating factor of premium subsidy for members who cannot afford the higher premiums in this rate band. The intention is that the premium subsidy and competition for the benchmark members will keep the rate band stable.

The individual mandate is eliminated in our proposal, with an additional premium penalty on re-entry into the insurance market and potential for medical-based bankruptcy as premiums would not be fully subsidized.

Other

We eliminate the exchange in our proposal. Health plans would verify enrollment and subsidized premiums using the applicant's prior year tax returns. Health plans work directly with the federal government to collect subsidies. We also assume that anyone over 100% of FPL will be eligible for subsidies, thereby eliminating the state specific decision of Medicaid expansions. Without exchanges, consumers would have a more difficult time comparing plan options. States would be highly encouraged to have a website page that would summarize plan offerings and premiums with links to each health plan's website.

Medical Loss Ratio requirements and rebates would continue to avoid excessive profit targets.

2. ***Consumer Impact***

Under this plan, consumers would maintain adequate access to health insurance since the guaranteed issue provisions of the ACA would remain intact. With five rating bands (+ penalty

band) representing health status, those members, presumably healthier than average risks, who have until now chosen to remain uninsured will perhaps be convinced to purchase coverage. The actuarially sound rates will now represent their health status with the expectation that the lowest band will provide an appealing option to the young and healthy. The expected result of five health status bands is that access will likely be enhanced for this group of consumers who had previously chosen to remain uninsured.

Additionally, insurers will be more likely to participate in an individual market that has less restrictions and will likely offer a broader portfolio of products since they are permitted to develop actuarially sound rates using the five health tiers. Increasing participation of insurers will enhance health insurance access for consumers overall.

Consumers not eligible for subsidies will pay premiums based on their relative health. As an example, two individuals of the same age and significant different health conditions will pay different premiums. Although this concept might be viewed as inequitable by consumers, it is important to understand that the rate tiers largely serve as a replacement to age rating. For the majority of the individual population who do not have conditions, the rate tiers will be based on demographic factors (primarily age), which has historically been a very acceptable rating variable. Additionally, states may allow a simplified health risk assessment to capture any significant known conditions in the rating band determination.

For those consumers classified in the highest rating band, the federal subsidies will protect their access to coverage by making premiums more affordable for members. Since subsidies will be based on the second lowest benchmark plan, high risk members may not truly have access to broad network plans which may be a drawback for those persons who will qualify for the highest rating band.

Those consumers who choose to opt out of coverage will face much higher premiums in the future, if and when they choose to enroll. This plan places members who have gone more than eight months without health insurance coverage in the highest rating band (a sixth band, higher than even the sickest members) when they decide to enroll in the future. To reward continuous coverage, these members can be underwritten and moved into their appropriate rating band after two years of maintaining continuous coverage.

More plan design flexibility will be allowed in our proposal than under the ACA, thereby providing more choice for consumers. Should members decide to choose a high deductible health plan that is less expensive than the subsidy amount they qualify for, they may place the excess funds in an individual HSA to be used on future health claim costs or premium payments. Many consumers will value this option to begin funding their future health costs.

Since subsidies will be available to all consumers above 100% of FPL (assumes no Medicaid expansion), all members will have the option to purchase the second lowest benchmark plan for a contribution level equal to a prescribed percentage of their gross annual income. That is; premiums, even for the highest rating band, should remain affordable.

Regarding cost sharing affordability, this plan allows issuers to charge more for CSR variation plans to reflect the lower cost sharing levels. The government will continue to subsidize member cost sharing, but in the form of premium subsidies for these plans. Cost sharing reconciliation will not be necessary going forward. Premium rates should come down for younger/healthier

members, but will likely increase for older/sicker members (limited up to a prescribed percentage of their gross annual income).

As mentioned, members may be limited in terms of choice of health care providers to the extent that they can only afford the second lowest benchmark plan, to which the federal subsidies will be linked. Carriers may develop tighter provider networks for some plans, causing them to achieve second lowest premium status.

When considering consumer responsibilities, it is imperative that consumers enroll and maintain continuous health coverage in order to avoid potentially being priced out of coverage. If consumers go more than eight months without coverage, they face the sixth tier which is the highest rating tier when they choose to enroll in the future, regardless of their actual health status. This penalty (higher premium) will remain with them until they can show continuous coverage for a period of at least two years. After two years, insurers can underwrite these members and move them to a more reasonable premium level. This provision should be communicated to the public to ensure an understanding of non-action, or not purchasing health insurance.

A downside of this plan is that as consumers get diagnosed with a condition, they may experience large rate increases the following year especially if the condition triggers movement from the lowest to the highest premium rating band. However, members are protected from bankruptcy to the extent that the premium subsidies succeed in limiting the member's financial exposure.

3. ***Insurance Impact***

We anticipate this plan will be favorable to insurers since they will have greater flexibility in determining actuarially-sound premium rates and plan design development.

With more variability in rates to attract the healthy, insurers should benefit from a more viable and stable risk pool. However, the interim impact of market changes could result in some short-term mis-pricing. Although the concern historically would have been one of too aggressive pricing, the lack of reinsurance and risk corridors in our proposal, along with the recent lessons learned in the ACA, likely will result in conservative pricing.

The pre-ACA underwriting function would be simplified using standard risk scores to lessen the administrative burden. The focus on use of risk scoring for pricing accuracy instead of additional revenue generation may lessen the burden on risk score optimization functions. We view risk score optimization and chart reviews as functions that are not directly tied to care delivery nor financing and hence, must be eliminated or minimized. We do anticipate that the rate tier assignments will have to include some kind of appeals process, either within the state or with insurers which would be an additional complexity.

By eliminating the exchange and adding complexity to subsidies with rating tiers, insurers could see additional administrative requirements to manage the enrollment and subsidy determination and collection process.

Plan design development would be more flexible for carriers enabling innovative designs without the actuarial value constraint. Without an exchange, the rate filing deadline could be moved later

in the year to enable using the latest experience. Without risk adjustment reconciliation, insurers have less exposure to financial uncertainty and last minute rate filing changes.

4. ***Healthcare Provider Impact***

Relative to the current economic environment, we do not anticipate our proposal to have significant impact on providers. With the continuation of the premium subsidies outlined in our proposal, we believe that the overall amount of care under the ACA will remain semi-constant, and any loss of membership in current plan designs being mitigated with enrollment in new plan designs available in the system.

Since premiums will be based primarily on risk adjustment results, it is possible that physicians may receive patient requests to not code all of their diagnoses or individuals may forego non-essential care in order to maintain their current premium level. This will be an offset to the existing incentives and direction from issuers to fully code all conditions which result in increased premiums.

We do anticipate that providers will be encouraged to effectively manage costs for the highest tier. These members have a higher premium and this segment has the most potential for cost savings. Any actual savings will be evident in the premiums a health plan charges for this tier and it is possible the high cost members could become profitable for issuers and providers if they are managed well.

We don't see a change in the overall direction of provider risk-sharing contracts or quality of care. In fact, we believe risk sharing administration will be more straightforward without the CSR pass-throughs.

5. ***Government Responsibilities***

<u>Fiscal Responsibilities</u>

The government will continue to be responsible for premium subsidies. The subsidy will still be calculated based on a combination of an enrollee's contribution cap (equal to at most 9% of their income) and the cost of the second lowest benchmark plan. However, the cost of the second lowest benchmark plan will now vary by the enrollee's rating band. Low-income enrollees with higher risk adjustment scores will now receive higher subsidies compared to the current market. However, many enrollees will face lower premiums due to relaxation of restrictions on benefit designs and health status rating and no longer need subsidies. The goal is to let insurers price the premiums and then use subsidies to make premiums affordable.

If enrollees purchase a plan that is less expensive than their premium subsidy, the difference will be deposited into an HSA. If the member chooses an HSA qualified plan, they will be required to have an HSA balance equal to some percent of the cost of the maximum out of pocket (say 60%) for the chosen plan. Premium subsidies will be financed through direct premium from members, and federal and state tax revenue.

We expect the government liability under this plan to be similar to the ACA. This plan exposes the government to the risk of medical inflation exceeding wage increases, and the required subsidies increasing year over year at a leveraged rate.

We are not proposing anything specific regarding Medicaid expansion. Currently, the proposed subsidies reflect that any enrollees who are not eligible for Medicaid (or another healthcare program) will be eligible for premium subsidies. However, the proposal could easily be modified to only include those above a certain FPL level from being subsidy eligible. The proposal, as submitted, currently fills the current gap in states that haven't passed Medicaid expansion.

Cost sharing reduction versions of the benchmark plans still exist. Premiums will be funded as they are currently, but the cost-sharing reconciliation process will not be. However, for simplification, they will be changed such that subsidies for low income would be based on these cost sharing reduction versions of the benchmark plans.

The government will continue to have a role in risk adjustment (as described in “Regulatory Roles”), but will have no additional responsibilities in programs such as reinsurance or high risk pools.

Regulatory Roles

State governments will be responsible for deciding whether there will be a limit to the number of health rating bands allowed.

The assignment of each enrollee into a rating band is based on the enrollee’s risk score (calculated using the enrollee’s experience using a prospective model). A new member will receive a risk score based only on demographics or on a health risk assessment. The state or federal government will be responsible for calculating and distributing the risk score information to each carrier upon a member’s enrollment.

State governments will restrict premium rate increases for carriers that achieved a high level of profit in the prior year. The Federal government will serve no role in evaluating rate increases.

Other

State governments will determine a benchmark plan based on a definition of minimum coverage (including covered services, cost sharing, and network requirements) similar to the current market. Each carrier will be required to offer a comprehensive and non-discriminatory benchmark plan with CSR variations for low-income enrollees.

There will no longer be an individual mandate, so the government no longer needs to track an enrollee’s health coverage. Each individual will be responsible for providing proof of previous coverage to a new insurer (or be placed into the separate rating tier as previously discussed).

Appendix A

Percent of Gross Household Income Considered Household's "Fair Share" of Premium Contribution

		Average								
Income	Income	Household	Family Size							
Low	High	Income	1	2	3	4	5	6	7	8	9 or More
$0	$0	$0	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$0	$0	$0	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$2,500	$5,000	$3,750	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$5,000	$7,500	$6,250	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$7,500	$10,000	$8,750	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$10,000	$12,500	$11,250	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$12,500	$15,000	$13,750	0.25%	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$15,000	$17,500	$16,250	0.50%	MCD	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$17,500	$20,000	$18,750	0.75%	0.25%	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$20,000	$22,500	$21,250	1.00%	0.50%	MCD	MCD	MCD	MCD	MCD	MCD	MCD
$22,500	$25,000	$23,750	1.25%	0.75%	0.25%	MCD	MCD	MCD	MCD	MCD	MCD
$25,000	$27,500	$26,250	1.50%	1.00%	0.50%	0.25%	MCD	MCD	MCD	MCD	MCD
$27,500	$30,000	$28,750	1.75%	1.25%	0.75%	0.50%	MCD	MCD	MCD	MCD	MCD
$30,000	$32,500	$31,250	2.00%	1.50%	1.00%	0.75%	0.25%	MCD	MCD	MCD	MCD
$32,500	$35,000	$33,750	2.25%	1.75%	1.25%	1.00%	0.50%	0.25%	MCD	MCD	MCD
$35,000	$37,500	$36,250	2.50%	2.00%	1.50%	1.25%	0.75%	0.50%	MCD	MCD	MCD
$37,500	$40,000	$38,750	2.75%	2.25%	1.75%	1.50%	1.00%	0.75%	0.25%	MCD	MCD
$40,000	$42,500	$41,250	3.00%	2.50%	2.00%	1.75%	1.25%	1.00%	0.50%	MCD	MCD
$42,500	$45,000	$43,750	3.25%	2.75%	2.25%	2.00%	1.50%	1.25%	0.75%	0.25%	MCD
$45,000	$47,500	$46,250	3.50%	3.00%	2.50%	2.25%	1.75%	1.50%	1.00%	0.50%	0.25%
$47,500	$50,000	$48,750	3.75%	3.25%	2.75%	2.50%	2.00%	1.75%	1.25%	0.75%	0.50%
$50,000	$52,500	$51,250	4.00%	3.50%	3.00%	2.75%	2.25%	2.00%	1.50%	1.00%	0.75%
$52,500	$55,000	$53,750	4.25%	3.75%	3.25%	3.00%	2.50%	2.25%	1.75%	1.25%	1.00%
$55,000	$57,500	$56,250	4.50%	4.00%	3.50%	3.25%	2.75%	2.50%	2.00%	1.50%	1.25%
$57,500	$60,000	$58,750	4.75%	4.25%	3.75%	3.50%	3.00%	2.75%	2.25%	1.75%	1.50%
$60,000	$62,500	$61,250	5.00%	4.50%	4.00%	3.75%	3.25%	3.00%	2.50%	2.00%	1.75%
$62,500	$65,000	$63,750	5.25%	4.75%	4.25%	4.00%	3.50%	3.25%	2.75%	2.25%	2.00%
$65,000	$67,500	$66,250	5.50%	5.00%	4.50%	4.25%	3.75%	3.50%	3.00%	2.50%	2.25%
$67,500	$70,000	$68,750	5.75%	5.25%	4.75%	4.50%	4.00%	3.75%	3.25%	2.75%	2.50%
$70,000	$72,500	$71,250	6.00%	5.50%	5.00%	4.75%	4.25%	4.00%	3.50%	3.00%	2.75%
$72,500	$75,000	$73,750	6.25%	5.75%	5.25%	5.00%	4.50%	4.25%	3.75%	3.25%	3.00%
$75,000	$77,500	$76,250	6.50%	6.00%	5.50%	5.25%	4.75%	4.50%	4.00%	3.50%	3.25%
$77,500	$80,000	$78,750	6.75%	6.25%	5.75%	5.50%	5.00%	4.75%	4.25%	3.75%	3.50%
$80,000	$82,500	$81,250	7.00%	6.50%	6.00%	5.75%	5.25%	5.00%	4.50%	4.00%	3.75%
$82,500	$85,000	$83,750	7.25%	6.75%	6.25%	6.00%	5.50%	5.25%	4.75%	4.25%	4.00%
$85,000	$87,500	$86,250	7.50%	7.00%	6.50%	6.25%	5.75%	5.50%	5.00%	4.50%	4.25%
$87,500	$90,000	$88,750	7.75%	7.25%	6.75%	6.50%	6.00%	5.75%	5.25%	4.75%	4.50%
$90,000	$92,500	$91,250	8.00%	7.50%	7.00%	6.75%	6.25%	6.00%	5.50%	5.00%	4.75%
$92,500	$95,000	$93,750	8.25%	7.75%	7.25%	7.00%	6.50%	6.25%	5.75%	5.25%	5.00%
$95,000	$97,500	$96,250	8.50%	8.00%	7.50%	7.25%	6.75%	6.50%	6.00%	5.50%	5.25%
$97,500	$100,000	$98,750	8.75%	8.25%	7.75%	7.50%	7.00%	6.75%	6.25%	5.75%	5.50%
$100,000	+	$100,000	9.00%	8.50%	8.00%	7.75%	7.25%	7.00%	6.50%	6.00%	5.75%