Actuarial Challenge

A Proposal by The Simplifiers

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EXECUTIVE SUMMARY

Our team has developed a comprehensive recommendation to address many of the individual market issues that have emerged since the rollout of the Affordable Care Act (ACA). Our solutions target the technical aspects of the ACA with the goal of retaining a viable and financially sound individual insurance market into the future. We have focused on regulatory burden, financing, understandability, cost control, and ease of access.

Given the current political climate and the uncertain future roles of the federal government and the states in regulating health insurance, our proposal includes roles for either regulatory approach. We believe a national approach is best, but our recommendations can be adapted to work at the state level as well.

Below is a summary of the key points of our proposed solution. More detail and the rationale behind each of these points can be found in the following sections of this proposal. In the final section of the report, we have included financial modeling results of the proposed solution, prepared independently by Milliman, Inc. (Milliman) based on the Milliman Health Care Reform Financing Model.

COVERAGE

1. All residents (including undocumented individuals and excluding Medicare-eligible individuals) will be covered under a state or federally funded Preventive Plan. These health care services will be free and will be provided outside of individual and group insurance policies. The Preventive Plan will include prenatal care and family planning services.

2. All legally present residents will be required to purchase an Insured Plan for all other coverage and remain in the same plan for an entire calendar year.

3. In the individual insurance market, a standard $500 deductible plan with a $1,500 maximum out-of-pocket must be offered by every issuer. This plan, as well as any other plans offered, must include at a minimum the benefits covered by Medicare Parts A and B and prescription drug benefits plus any additional benefits determined by the state.

4. Other plans may also be offered, up to a maximum out-of-pocket limit of $12,000.

5. The concept of metal plans will be eliminated. States can define the minimum level of coverage allowed in their state, but must comply with the $12,000 maximum out-of-pocket limit. States may limit the number of plans offered by an issuer in their state.

ACCESS

6. Any qualified licensed provider or facility can be accessed for services covered under the Preventive Plan. There will be no designated provider network for preventive services, prenatal care, or family planning services.

7. All certified hospital ~~f~~facilities in an issuer's service area must be included in its individual insurance plan network.

8. Issuers may develop provider (non-facility) networks for its individual insurance plans.

ENROLLMENT

9. There will be an open enrollment period for each calendar year of individual insurance coverage where the member selects an insured plan and must remain covered for the full year.

10. The penalty for not purchasing insurance coverage will be the full annual cost of the lowest cost plan available to the uninsured individual.

11. Consumers eligible for Medicaid may elect coverage through an individual insurance plan instead of Medicaid.

12. A universal Medical ID Card with multiple functionalities will be issued for life upon first enrollment in an individual insurance plan. Plan selection information will be accessible through the card and will be electronically updated each enrollment period. The card will stay with the individual as he/she subsequently enrolls during future enrollment periods.

13. Individuals will enroll independently rather than as a family unit.

14. The Exchange will act as an informational shopping website, displaying benefit and rate information and a link to the issuers' websites for review of the provider directory and enrollment information. The Exchange can be maintained by a state to provide an online shopping service.

QUALITY

15. The universal Medical ID Card will provide secure access to the member's health and health care utilization history. Entities will be chosen for the development, distribution, and maintenance of the technology to collect the health information included on the universal Medical ID Cards, as well as its credit card function.

16. Using the universal Medical ID Card, a provider will be able to access the member's secure health care information at the time of service to see the complete history of health conditions and services, allowing the provider to better treat the patient.

AFFORDABILITY

17. There will be no premium cost for the Preventive Plan, which is not an insurance plan but a benefit provided to all residents.

18. Premiums for individual insurance plans will be held to a targeted range through the Adverse Risk Mitigation (ARM) program described later. The target range will be approximately 50% of the total cost of the insurance plan.

19. The underlying cost of care will be reduced by paying all Preventive Plan services, as well as individual insurance plan hospital facility services, at a rate negotiated by the state but no less than the Medicare reimbursement rate.

20. Prescription drug costs will be lowered significantly by allowing drugs to be purchased via the internet from certain qualified international locations.

21. Premium discounts of 25%, 50%, or 75% will be available to low income individuals based on total household income as verified from the prior year's tax return. The discounts will apply to any individual insurance plan purchased.

22. The state will act as the official source for premium discount eligibility information. It will be accessed from the state's databases or the state can interface with federal databases.

23. The universal Medical ID Card will also serve as a negotiated low-interest credit card to pay for premiums and services.

24. An aggressive fraud detection and prevention program will use the universal Medical ID Card database to identify potential fraud, waste and abuse situations.

FUNDING

25. A state sales tax or alternate funding method in states with no sales tax will be charged to pay for the services covered under the Preventive Plan, fund the Adverse Risk Mitigation Fund for the individual market, and fund the premium discount program for low income individuals in the individual market. Revenue from the sales tax will go into a fund that can only be used for these purposes.

26. Most of the existing taxes specifically associated with the ACA will be discontinued, especially if they contribute directly to higher premium.

ACTUARIAL SOUNDNESS IN RATE SETTING

27. All rate review will be done at the state level and each state will establish and maintain its own approach.

28. The mandated age slope currently in use overstates the rates for younger ages and understates the rates for older ages. A more actuarially sound age table of the state's choice or recommended by the NAIC will be used, which should have the effect of bringing younger people into the market.

29. The current permanent Risk Adjustment Program will be eliminated and replaced with the ARM program to equalize risk amongst issuers.

30. The MLR rebate program will be replaced with standards to be determined at the state level.

THE SOLUTION

More information and the rationale behind each of the 30 points in our proposed plan are described below. We have also included some highlights from the Milliman modeling results, which are included in their entirety in the final section of this report.

COVERAGE

1. A basic component of our recommendation is the creation of a Preventive Plan that covers the preventive services currently covered under the ACA, as well as prenatal care and family planning services for all U.S. residents (including undocumented individuals and excluding Medicare-eligible individuals) at no cost at the point of service. The reasons we believe this is important are:

    a. It will establish a national or state health policy that ensures these basic health care services are available free of charge to anyone who resides in our country as a matter of maintaining public health and safety for its citizens.

    b. The cost of these services is generally relatively low and predictable, and thus the services do not need to be included in insurance policies that are designed to protect individuals from unpredictable health care expenses. The inclusion of these services in current policies increases the cost of insurance and makes it less likely that individuals will actually purchase the policies that provide the coverage, thus lessening the chance that people will get these basic services.

    Milliman Modeling Results: It is estimated to cost $6.4 billion in 2018 to cover preventive services to the 32.6 million people in the individual market.

2. Beyond the free Preventive Plan benefits, all legally present residents who are not covered by an employer's group plan, Medicare or Medicaid, will be required to purchase an individual insurance policy and remain in the plan for the entire calendar year. Remaining in the plan for the entire year is critical to the stability of the market, as it has been observed that special enrollment periods and people dropping out part way through the year has added to the overall cost of individual coverage. Payment will be ensured via the use of the universal Medical ID Card, which is further described below.

3. We are recommending that a $500 deductible plan with a $1,500 maximum out-of-pocket be a required component of each issuer's portfolio of products, all of which cover at a minimum the benefits covered by Medicare Parts A and B and prescription drugs. In today's individual insurance market, this generous level of benefits has generally disappeared due to the very high premium associated with it. However, it is important to recognize that people at the lower end of the income scale are finding the high deductibles associated with today's plans make the plans relatively worthless to them, as they cannot afford the out-of-pocket costs that will be

    Milliman Modeling Results: The $500 deductible plan is expected to have an average monthly premium of $245 over the period 2018 to 2020.

associated with getting sick. Thus they make the economic decision not to purchase the insurance. The premium discount program described below (with discounts up to 75%) will significantly help make this plan affordable for low income people. Those with higher incomes and smaller or no premium discounts are likely to purchase higher deductible plans.

4. We believe allowable maximum out-of-pocket amounts should be increased from the 2018 level of $7,350 per individual to $12,000 and kept at that level for a period of at least five years. The annual changes in these amounts under the current approach seem unnecessary and the level itself too low. Someone taking an expensive drug or having an emergency room visit in January will easily meet the current maximum out-of-pocket in the first month. Raising the maximum out-of-pocket limit will reduce the premium.

> **Milliman Modeling Results**: A $12,000 maximum out-of-pocket plan is expected to have an average monthly premium of $147 over the period 2018 to 2020, 40% lower than the $500 deductible plan.

5. We have found that the assignment of bronze, silver, gold, and platinum plan levels has not achieved its original intent of simplification and allowing easy comparison between plans. Thus we recommend that it be discontinued. Each year when the actuarial value calculator is updated, there is a flurry of activity by the issuers to revise plan designs or create new ones to stay within the allowed plus or minus range of the target percentages of 60%, 70%, 80%, or 90% as well as the Cost Share Reduction versions. Thus consumers see a lack of consistency in plan benefits from one year to the next, and issuers have extra administrative expense from the work required to modify or create plan designs to meet these artificial targets. States will be allowed to define the minimum level of coverage and establish limits on the number of plans issuers can offer, to prevent some issuers from dominating the virtual shelf space.

ACCESS

6. In our proposed solution, an individual may go to any licensed qualified provider or facility to get preventive care, prenatal care, and family planning services. It is our belief that this will eliminate barriers to essential care and result in a healthier and safer population.

7. We are proposing that all certified hospital facilities in an issuer's service area be included in its individual insurance plan network. Quality information about each hospital will be made available from a central source and will no longer be the responsibility of the issuer, as the information will be the same for all issuers.

8. Issuers will continue to designate provider networks for primary care physicians and specialists, as well as other non-facility care. Reimbursement levels will be negotiated with these providers, and issuers will be able to distinguish themselves from their competitors based on the size, quality, and cost of their non-hospital provider network.

ENROLLMENT

9. There will be a single enrollment period prior to each calendar year for individual insurance coverage. We propose to continue the annual open enrollment period from November 1 through December 15 established for 2018.

   Each individual will select an insurance plan and will be required to stay in the plan for the entire calendar year. We believe that the current practice of special enrollment periods and allowing persons to drop their coverage during the year has resulted in higher insurance costs. We recommend that people not be allowed to change plans or drop coverage during the year unless they are newly eligible for Medicare or if they move to a new residence more than 50 miles away. We also recommend that individuals who miss open enrollment and attempt to secure coverage without a qualifying event later in the year should be allowed to enter but should be billed for an entire year of coverage. The penalty for late enrollment will be administered by the universal Medical ID Card vendor by applying the penalty amount to the members' cards. The penalty amount is determined as the number of months with no coverage times the non-subsidized premium of the plan selected.

10. We believe the current penalty structure for non-compliance with the mandate is not adequate, and that for many people, especially healthy young people, foregoing the coverage and instead paying the penalty is a better economic decision. This has led to higher premium costs in the individual market. Thus we recommend that the penalty be increased to the full non-subsidized annual premium of the lowest cost plan available to the individual. For those who do not purchase an Insured Plan for the entire year, the penalty will be administered by the IRS.

11. A person who is eligible for Medicaid during the open enrollment window will be allowed to elect to forgo Medicaid and enroll in an insured plan. However, once enrolled in the insured plan, they will not be allowed to switch back to the Medicaid plan until the next enrollment period. We believe that there are many low income people who do not want to be in the Medicaid program because of the lack of provider choice and the stigma associated with the program. Allowing them to purchase a plan through the individual market will broaden the market and allow more consumer choice.

12. Upon first enrollment in an individual plan or upon initially obtaining Preventive Plan services, each individual will be issued a universal Medical ID Card in the form of a credit card that will be retained for life by the individual or by a parent or legal guardian for minors. The card will have multiple functions. For enrollment, it will be used to record the plan choice made by the individual along with details about the benefits covered and any cost sharing requirements. Thus the traditional insurance company ID card will no longer be needed. It will also be used as a credit card to pay for premiums, hence, the elimination of grace periods.

13. Each family member will enroll separately eliminating the age 26 limit to be covered under a family unit. The pricing requirement charging for only the first three children in a

family will be eliminated as well as tracking and substantiating many qualified events such as marriage or divorce. This will cut down on administrative costs for the insurance companies and allow for more appropriate rate development.

14. We believe the use of the function of the Exchange should revert to its original intent, which was to be a shopping site for individuals to be able to compare plans and get the information they need to make a plan choice. All other functions will be eliminated. The website will have a link to the issuer of choice, who will take care of subsequent enrollment activities and apply the appropriate rate discount. This will greatly reduce the Exchange fees which have been a component of rising health care costs and simplify administration for the issuers. This will also remove the need for issuers to have on-exchange and off-exchange plans, which add to the complexity of the current regulatory rate review burden as well as consumer confusion.

QUALITY

15. The universal Medical ID Card will allow providers access to the health history of the individual. The development, distribution, and maintenance of the universal Medical ID Cards will be a major undertaking. In order to achieve national conformity, we believe it is necessary to have a national contract with one or more vendors to provide this technology. The creation and maintenance of the universal Medical ID Card function will be outsourced to a vendor who will also negotiate a nominal interest rate for the credit card function for premium, late enrollment penalties, and out-of-pocket expense payment.

    Each time a person seeks health care services or purchases prescription drugs, the information will become part of the individual's medical record which will be accessible via the universal Medical ID Card. At the time of service, the provider will be able to pull up a complete listing of the following:

    - Family history, which will be automatically loaded with parents' and grandparents' data upon birth or upon first encounter with a provider
    - Allergies
    - Immunizations
    - Current and history of drug usage
    - Basic statistics such as height, weight, blood pressure and pulse
    - History of preventive services under the Preventive Plan
    - History of diagnoses
    - History of hospitalizations
    - History of surgeries

16. Having access to this health history will allow doctors to make more informed decisions, therefore increasing the quality of care. Also, a database will be maintained which can be used to access de-identified member data to support research and development of improved protocols for care.

The issues of having individual health history on the internet have been addressed as the ACA requires providers to maintain Electronic Health Records (EHRs). A vendor, however, will need to develop a standard system and supply providers with a programmed card reader so that the same information will be displayed at the provider once the patient enters his/her PIN or thumbprint and the provider can enter information about the services rendered at the time of delivery. It also will need to seamlessly link to issuers to collect billed charges and paid amounts. The current EHR environment has many formats and does not necessarily easily link to issuer claim payment data.

AFFORDABILITY

17. From the consumer standpoint, the Preventive Plan will be free. Commercial insurance plans will not include the cost of preventive care, prenatal care, or family planning services. Those benefits will be funded in a different way. Thus, the premium cost will be lower for the insurance plans.

Milliman Modeling Results: Excluding preventive services from commercial insurance plans is expected to reduce 2018 annual premium costs by about $200 per person.

18. Premiums for individual insurance plans will be held to a targeted range. In order to achieve affordability, we believe the targeted range should be about half of the total cost of the benefits provided by the insured plan.

The other half of the cost will be covered by the ARM program. The program will work like the now terminated Transitional Reinsurance Program, but will be more extensive and permanent. For example, in its first year the original Transitional Reinsurance Program formula covered 80% of an issuer's claims that fell between $45,000 and $250,000. In the ARM program, a similar formula will be used but it might be something like 100% of claims over $25,000 in order to reduce costs by 50%. This approach eliminates the need for commercial reinsurance for the individual market.

Milliman Modeling Results: The ARM program's cost is expected to be $40.3 billion in 2018.

One of the failings of the Transitional Reinsurance Program was the delayed timing for the reimbursement of eligible claims. This led to cash flow problems for the issuers and even some insolvencies. In the ARM program, reimbursement will be made within 30 days of submission of a claim.

Under the insured plans, consumers will continue to have a choice of issuer and plan which leads to some issuers covering a disproportionate share of healthier and less healthy. Due to the inability of the current permanent Risk Adjustment Program to accurately predict health care costs, we have developed this alternate approach to reimbursing the issuers for the actual health care costs of high risk individuals within the insured population..

19. The cost of care will be reduced by paying for all hospital facility care (including inpatient, outpatient, ambulatory surgical center, and emergency room) at Medicare

reimbursement levels or a rate negotiated by the state which is no less than Medicare. We believe that the Medicare approach to paying for inpatient care based on Diagnoses Related Groups (DRGs) is a model that works well to eliminate unnecessary utilization and keep costs lower. It also will make the cost of hospital care transparent, since the total cost will be the same for all insurance plans.

Milliman Modeling Results: The proposed Medicare reimbursement approach and international purchase of prescription drugs is expected to reduce claim costs in the individual market by about 35% to 40%.

20. Until such time as the federal or state government has the authority to negotiate pricing on a national basis for prescription drugs, an exemption will be allowed to the Prescription Drug Marketing Act of 1987, which makes it illegal for anyone other than the original manufacturer to bring prescription drugs into the country. Certain countries will be certified as safe sources of mail order prescription drugs.

21. We propose replacing the Advance Premium Tax Credits (APTC) and Cost Share Reduction (CSR) programs with a simplified Premium Reduction program such that a legally present individual will be eligible for a 25%, 50% or 75% discount applied to their premium based on household income. This significantly broadens the selection of plans for low income individuals as the discount is available regardless of the plan selected. A proposed income range for each level of discount plan is shown in the table below.

Milliman Modeling Results: Eliminating the APTC and CSR programs will reduce federal spending by $49.6 billion in 2018. The proposed premium discount program is estimated to cost $23.2 billion.

Income Range	Premium Discount
0-199% FPL	75%
200-299% FPL	50%
300-399% FPL	25%

22. The state will act as the official source for premium discount eligibility information. Individuals wishing to get a discount will submit a request to the state, which will verify the person's prior year income with a state database or with the IRS, analyze the individual's qualifications and produce a determination of discount eligibility, which will be communicated to the issuer who is issuing the individual's policy. Exemptions for substantial changes in financial circumstances will be considered if sufficient documentation is provided.

23. The universal Medical ID Card will also serve as a low-interest credit card to pay for premiums and services. Credit card bad debt will be handled in the same way it is currently handled for retail credit cards. States can develop alternate methods of handling bad debt situations.

24. The universal database can also be used to detect provider fraud, waste and abuse. As we enter into the era of big data, we do not believe that maintaining such a database is farfetched. Fraud detection programs could access provider data across all payers, which will be very useful in identifying false billings by providers as well as prescription drug over-utilization and other abuses.

FUNDING

25. To meet the goals of simplification and more equitably spread the cost of health care, we propose a state or national sales tax applied perhaps to retail goods and internet sales. We believe the sales tax approach is better than an income tax approach, since it will spread the cost more broadly across all residents, including the undocumented who will benefit from the Preventive Plan. The sales tax amount will be determined based on the amount required to cover the following programs and their administration:

Milliman Modeling Results: The combined cost of the proposed preventive plan, ARM, and premium subsidy program is estimated to be $69.9 billion in 2018.

- The Preventive Plan Program
- The Adverse Risk Mitigation Fund
- The Premium Subsidy Program
- A reserve for economic downturns or in the event that cost of health care increases at a pace greater than the cost of goods

As the cost of goods sold increases, the revenue collected increases to cover cost increases in health care, ideally, never requiring an increase in the tax percent. The design of the funding should result in program solvency.

We believe the amounts collected by the sales tax should be held in a specific fund and expenses for the three programs should be paid out of that fund. The financial condition of the fund should be transparent and should never be allowed to become insolvent. We recommend that the fund also hold a reserve of at least 10% one year's costs to help weather economic downturns and unforeseen medical catastrophes.

26. There are many taxes currently in place to help support the cost of the ACA. Our recommendations regarding the retention or discontinuation of these taxes are as follows:

- 2.3% Tax on Medical Device Manufacturers – eliminate, because this contributes directly to high health insurance premiums
- 10% Tax on Indoor Tanning Services – eliminate, because collections are minimal and administrative burden is high
- Blue Cross Blue Shield Tax Hike – eliminate, because administrative burden is high
- Excise Tax on Charitable Hospitals – eliminate, negligible collections, unnecessary administrative burden

- Tax on Brand Name Drugs – eliminate, because this contributes directly to high health insurance premiums
- Tax on Health Insurers – eliminate, because this contributes directly to high health insurance premiums
- 40% Excise Tax on Cadillac plans – eliminate
- Individual Mandate Tax – retain and change as described elsewhere
- Advance Premium Tax Credits – eliminate and replace with premium discounts described elsewhere

ACTUARIAL SOUNDNESS IN RATE SETTING

27. It is our belief that the Unified Rate Review Template (URRT) and the Part II and Part III actuarial memorandums do not include all of the rating details used by issuers to develop the rates or the insurance regulators who review the appropriateness of the rates. These forms provide a vast amount of information not necessary for rate filing review and often contain incorrect data. They add to the issuers' administrative costs because they have to be prepared yet are of minimal use to the state regulators. Instead, we propose that a simplified methodology be developed by the states or by the NAIC to provide only the information regulators need to understand how the rates were developed so they can provide adequate oversight of the actuarial soundness of rates and the financial solvency of issuers.

28. The mandated age slope currently in use overstates the rates for younger ages and understates the rates for older ages. A more actuarially sound age table developed by the states or by the NAIC will more accurately reflect that older ages are more costly than younger and reduce the younger age premiums by reducing their subsidy amount for the older ages. This premium reduction should help attract the young and healthy into the risk pool. An example of such a table is shown below.

Age	Factor	Age	Factor	Age	Factor	Age	Factor
0 – 14	0.765	27	1.253	40	1.767	53	2.873
15	0.833	28	1.315	41	1.834	54	3.089
16	0.859	29	1.370	42	1.903	55	3.320
17	0.885	30	1.427	43	1.964	56	3.570
18	0.913	31	1.487	44	2.019	57	3.734
19	0.941	32	1.494	45	2.076	58	3.934
20	0.970	33	1.502	46	2.134	59	4.135
21	1.000	34	1.509	47	2.180	60	4.346
22	1.041	35	1.516	48	2.229	61	4.567
23	1.079	36	1.523	49	2.275	62	4.642
24	1.112	37	1.575	50	2.323	63	4.729
25	1.145	38	1.641	51	2.371	64+	4.816
26	1.180	39	1.703	52	2.630		

29. The current permanent Risk Adjustment Program has failed to predict risk accurately, has contributed to a diagnosis optimization frenzy, and has led to financial hardship or insolvency for new or small issuers. The Risk Adjustment Program complicates the rate setting process due to the timing of rate setting and the impossible task of predicting risk adjustment transfers in a market where issuers are entering and exiting and populations are not stable from one year to the next. It is also difficult to estimate the amount of reserves that issuers need to hold and report in the issuer financials due to the timing of determination and payment of the transfers.

    We propose that the Risk Adjustment Program be eliminated and replaced with the ARM program described earlier. The ARM program will accurately measure financial risk based on actual claim payments and will reimburse issuers in a timely manner to prevent cash flow problems and potential insolvencies.

30. And finally, we believe that the MLR rebate program should be eliminated. It is very difficult in today's health insurance market to make excessive profits. There is more extensive rate review than ever before, and the market is very unstable due to issuers entering and exiting the market and populations changing. Profits might occur in the first year an issuer enters the market, but rapidly change the following year when the covered population matures.

    Also, any rebates returned to the members have generally been small at the member level. Thus, there is a significant administrative burden for the issuer to produce and distribute thousands of checks for small dollar amounts. The current rebate program is very one-sided. In years of financial loss, there is no way for the issuer to request additional premium, but in the years of financial gain, the profit is limited. At this point in history, the individual market needs the participation of financially solvent issuers.

    We do believe, however, that loss ratio standards are relevant and should be set by the states and considered during the rate review process.

CONSUMER IMPACT

The premise of our proposal is to simplify all aspects of the individual health insurance market, from shopping for coverage to the payment of services rendered. A positive consumer reaction results if consumers can see the provider they want, when they want, paying an amount known up front with a known maximum financial exposure in the case of an unfortunate health experience. We believe our proposal will be positively received on all of these fronts by those seeking individual healthcare coverage. Consumer reactions described below assume a comparison to the current ACA environment.

Coverage and Access to Care

Our proposal includes today's comprehensive coverage and choice of plan options; however, choice of provider has been expanded.

- Preventive coverage, family planning and prenatal care remain covered at 100%.
- Members are ensured comprehensive coverage under the Insured Plan as the list of items covered is required to include all that Medicare covers. States may add to the required coverages. Consumers will be able to more easily find what Medicare covers versus today's state specific Essential Health Benefit (EHB) list. In addition, consumers will not be surprised due to issuers eliminating benefits to reduce their costs.
- Plan coverages will no longer need to change from year to year as the concept of metal levels is eliminated. Consumers will not have to worry about seemingly arbitrary increases in cost sharing each year.
- Every issuer must offer a $500 deductible plan which is virtually non-existent in today's market. Consumers will be relieved to have a plan option that will not break the bank to cover today's increasingly high deductibles and out-of-pocket maximums.
- Access to care is greatly expanded for preventive services as a member can choose any licensed qualified provider for these services. Although networks will still exist for the Insured Plans, consumers will positively react to the open choice for the most common services.
- All qualified hospitals are included in all issuer networks, eliminating the need to confirm that the member's hospital of choice is considered in-network when selecting a plan.
- All undocumented residents will have access the Preventive Plan services.

Enrollment and Participation

Moving the enrollment process to the issuers should reduce errors in coverage due to data transfers between the Exchanges and the issuers. Under our proposal, the use of the universal Medical ID Card will allow providers to accurately determine a member's coverage on January 1st.

- There will be a single 45-day open enrollment period each year starting November 1st running through December 15th, giving ample time for consumers to enroll.
- Shopping websites will allow comparison of coverage levels and premiums of Insured Plans, and will provide links to the provider networks. Upon selection of a plan, a direct link to the issuer website will allow the consumer to easily enroll.
- Removing the Exchange as the middle man for coverage will reduce consumer frustration as they can go directly to the issuer with any questions.
- The consumer will no longer need to estimate income for the year, because the income verification process to determine the level of premium subsidy will be seamless and instantaneous based on already filed tax returns. Consumers will have the right to appeal the state's subsidy determination.
- The number of plans offered by an issuer may be capped by the state so that consumers will not have to sift through hundreds of plans to find the one that is right for them.
- Consumer and broker confusion over where to purchase coverage will be eliminated as there will no longer be identical plans offered both on-exchange and off-exchange.
- Each family member will be able select their own plan that best meets their needs. This allows for easy comparison of costs and the ability to select a plan that includes the desired providers. For example, if a member's pediatrician and OBGyn are not in the same network, one plan can be selected for the child and a different plan for the mother.
- Mid-year plan changes will not be required for events such as birth, marriage, divorce, and so forth, as enrollment is by individual with the subsidy for all family members being calculated based on the household income.
- Mid-year plan changes will be allowed under certain circumstances such as moving a certain distance or becoming eligible for Medicare. Coverage cannot be dropped mid-year as annual participation is required for no penalty to be incurred.
- Mid-year enrollment will be allowed in certain situations such as loss of group coverage with no penalty or loss of subsidy.
- Upon initial enrollment (year one of rollout), consumers will receive their universal Medical ID Card that they retain for life. Consumers will not have to worry about waiting for and keeping track of new ID cards each year as enrollment information will be automatically updated on the card.
- As today, individuals will be required to purchase an Insured Plan; however, the penalty will be set to the lowest cost plan available to that consumer for those who never enroll. The penalty will be collected through their federal and/or state income tax filing and remitted to the state's fund to pay for these programs.

- Individuals may enroll at anytime during the year outside of the open-enrollment period at unsubsidized rates. The penalty for late enrollment without a qualifying event will be calculated as the number of months of no coverage during the plan year times the unsubsidized monthly premium of the plan selected. This penalty amount along with the requirement to purchase an insured plan and the requirement to remain in the plan for the entire year are the least favorable aspects of this proposal from a consumer's perspective. However, the reduction in the premiums as described below should help offset this reaction.

- Those eligible for Medicaid during the open enrollment period will have a choice between Medicaid coverage and purchasing subsidized coverage in the individual market. Once the choice is made, it cannot be changed until the next open enrollment other than for a qualifying event. This provides broader choice of providers for those who opt to enroll in the individual market as opposed to Medicaid.

Affordability

Our proposal significantly reduces the consumer cost of coverage. Consumer reaction should be favorable to all aspects of the cost reduction measures.

- As today, preventive care, family planning and prenatal care is covered at no cost to the consumer.

- Through the ARM program, our proposal is targeted to reduce the premium by 50% making plans much more affordable.

- As our proposal recommends eliminating most ACA required taxes, healthcare premiums will be directly affected and reduced.

- Consumers will be able to apply their premium discounts to any plan, including lower cost high deductible plans.

- Through the ARM program, the $500 plan will be more affordable, especially when combined with the subsidy.

- By allowing the purchase of prescription drugs via the internet from certain qualified international locations, drug cost sharing amounts will be greatly reduced. This also contributes to reduced premium.

- The premium subsidy determination will be greatly simplified as the consumer will not have to estimate their annual income for the following year which could lead to a refund situation. Consumers gain comfort knowing there is a subsidy appeal process if they can provide sufficient documentation that financial circumstances have changed.

- As today, premiums will be based on age; however, we propose the distribution be more actuarially sound. Therefore, the premiums for the younger ages will decrease even more. This should result in greater enrollment of the young, healthy population.

- Through the use of a universal Medical ID Card, consumers will be able to make payments over time at a low interest rate for medical expenses, including premiums and late entry penalties.

- Although consumers do not pay for Preventive Plan coverage, our proposal recommends this program be funded by all consumers through a sales tax.

Quality of Care

The universal Medical ID Card allows providers to see the family medical history as well as a history of all procedures and test results at the point of service. Consumers greatly benefit through the use of the universal Medical ID Card as described below.

- All family medical history is accessed through the universal Medical ID Card eliminating the need for the consumer to annually report this information to every provider they visit.

- All procedures, lab results, immunizations, prescription drug usage, and so forth, are accessible through the universal Medical ID Card, eliminating the need for the consumer to recall or find the records for these events. Repetitive and/or unnecessary procedures should be reduced.

- As the medical history is available to the provider at the point of service, the consumer benefits through more targeted care and treatments.

- This information will be accessible by providers across the country if needed in emergency or other situations.

INSURANCE IMPACT

In the proposal's continued effort to simplify the process, insurance companies will realize the greatest benefits through the reduction of many administrative burdens.

Coverage and Access to Care

Eliminating several of the current restrictions in the plan design requirements will simplify the issuers' decisions as to what plans to offer each year as well as allow more consistency in plan design from year to year.

- The Preventive Plan services, family planning and prenatal care no longer need to be included in the Insured Plan design, reducing the administrative burden of tracking utilization and paying claims for these services.
- Although states may limit the number of plans offered in a market, the plan designs will no longer be required to fall within a certain percentage of targeted actuarial values (metal levels) which opens the door for issuers to develop more a broader spectrum of plan designs. In addition, annual tweaking of the plan design to maintain a metal level will not be necessary as is the case today each time the standard Federal AV Calculator is updated.
- Creating and administering identical plans to offer both on-exchange and off-exchange will be eliminated. Again, this will reduce the administrative cost built into premiums.
- Catastrophic plans can be created with only the $12,000 individual out-of-pocket maximum limitation to consider (or minimum AV determined by the state). Blurred lines between catastrophic and the current Bronze level plans will be eliminated. We recommend the $12,000 maximum not be changed for at least five years.
- Currently, each state selects the Essential Health Benefits (EHBs) that are required to be included in all plans offered in their state. Switching to the Medicare list of benefits standardizes the plans across the country, again simplifying the plan design process. Variations by state may not be entirely eliminated due to state mandates or states that opt to add coverage for services over and above the Medicare covered services.
- Issuers' enrollment may increase if membership was lost due to the non-inclusion of a hospital facility as all hospital facilities will be included in the Insured Plans' networks.
- Issuers will need to submit information on all plan offererings to the appropriate shopping website to populate the site. This is no different than today although ideally the current template formats will be simplified.

Enrollment

A significant impediment to stability in pricing is the movement in and out of the insured market during Special Enrollment Periods. Our proposal addresses this and other barriers to pricing stability as follows.

- Our proposal sets the penalties for those who do not purchase an Insured Plan equal to the annual cost of the lowest plan available. Not enrolling or enrolling late has no benefit since the penalty is the same as the cost to purchase a plan. This should greatly reduce the movement in and out of the market and increase the size of the risk pool, resulting in greater stability.

- As premiums are automatically charged to the universal Medical ID Card and issuers automatically receive premium payments monthly, the ability of a person to drop coverage is eliminated. The need to recoup claim payments made after coverage was dropped will be reduced and limited to those who change coverage due to one of the few qualifying events.

- Requiring members to remain insured for the entire year will reduce the need for issuers to track movement in and out of the market throughout the year. This will allow for more accurate pricing and reduce the rate fluctuations from year to year.

- Issuers will regain responsibility for the enrollment process. This eliminates the data transfer process between the Exchange and the issuers, reducing issuers' administrative burden and reconciliation of errors that may have otherwise occurred.

- Annual production of ID cards will be eliminated once all consumers have their lifetime universal Medical ID Cards. Issuers will merely have to upload enrollment information to the administrator of the universal Medical ID Card, allowing immediate access to enrollment information.

- As each family member will be able to select their own plan, the need for issuers to verify many of the qualifying events will be eliminated, reducing the issuers' administrative burden. This further reduces the number of mid-year changes to premiums as well as dependent member tracking.

- Since the ACA provision of charging for only three dependents is eliminated, issuers will no longer have to track the number of dependents covered as each member enrolls separately and all dependents are charged a premium.

- Issuers will realize a simplification in the administration of accumulating family deductibles and out-of-pocket maximum totals for medical and prescription drug claims.

- Penalties for late enrollment will be easily administered as the issuer merely has to charge the member's universal Medical ID Cards for the premium of the plan selected as if the member had been covered since the beginning of the year. Penalties for not purchasing coverage at all during the year will be administered by the IRS/state.

Affordability

Our proposal brings predictability to the issuers' claim liability calculation through the implementation of the Adverse Risk Mitigation program. Many of the costs associated with the reduction in the administrative burden described above will also reduce the premiums.

- Removing the cost of the Preventive Plan services, family planning and prenatal care immediately reduces the premium level.
- Through the ARM program, issuers will be able to more easily estimate the amount of their own liability. As ARM payments to the issuers will be paid within 30 days of submitting an invoice to the government, cash flow will be more predictable and stable.
- Allowing the purchase of mail order prescription drugs internationally via the internet, the premiums will be reduced by the amount of savings realized.
- As hospital reimbursement rates will be set at Medicare reimbursement levels or negotiated by the state, premiums will be reduced by the difference between the current negotiated rates and the Medicare reimbursement rates.
- The calculation and payment of the premium subsidy to the issuer will be greatly simplified and payments will be made in a timelier manner. Collection of overpayments and additional fund transfers for underpayments will not be as prevalent since premium subsidies will be based on known versus estimated income. Exceptions will still be allowed under certain circumstances.
- As the Cost Share Reduction Program (CSR) is not included in our proposal, the time consuming and costly administration of this program will be eliminated. A reduction of the administrative burdens translates to a reduction in the administrative costs built into the premiums.
- Additionally, premiums can be developed in a timelier manner as waiting for the determination of the CSR payment amount (or if there will be a payment) will not be necessary. Issuers will not need to include an amount in the rates to recoup under-payment or non-payment of CSR amounts.
- As the Transitional Reinsurance Program has expired and is not included in our proposal, the federal reinsurance premiums which were included in the premium calculation will be eliminated. The issuers will not be charged for the administration of the replacement ARM program.
- The elimination of the costly and time consuming administration of the Risk Adjustment Program will reduce administrative costs. Also, issuers will no longer have to include an estimate of the payment or receipt of a risk adjustment transfer which can cause great fluctuations and misstatements of premium.

- The administrative burden of contracting the services of collection agencies for nonpayment of premiums as payments will come predictably every month from the universal Medical ID Card administrator. Grace periods and the tracking of late payments will no longer be necessary. This brings additional predictability and stability to cash flow and potentially a reduction in administrative costs.

- The ACA issuer tax which directly adds to the premium will be eliminated. Issuers will no longer have to perform a rather complex calculation to estimate this amount in advance.

- The administrative burden of tracking, collecting and remitting the multitude of various ACA taxes will be eliminated as they will no longer be required.

- Additional savings can be built into the premium determination as the administrator of the universal Medical ID Cards will have an extensive claim database to run fraud, waste and abuse detection programs . Comprehensive physician practice patterns will be available to detect potential issues as data from all issuers will be warehoused in a single database.

- Since members are required to remain in the plan for a full year, the administrative burden of tracking movement into and out of the plans will be reduced and fewer members will have partial year data. Both the reduction in administration and the enhanced claim data should contribute to lowering the premiums and improving their accuracy.

Quality of Care

- The de-identified claims from the universal Medical ID Card administrator's database can be used by issuers or health care research companies to develop best practices for the treatment of various medical conditions. Comprehensive historical data will be available for each member even if the member obtains health care coverage from a different issuer each year.

- As a central source will report quality measures for all hospitals, issuers will no longer be responsible for tracking this information.

Actuarial Soundness

- In developing Insured Plan rates, the requirement that issuers follow the rate setting methodology found in the Unified Rate Review instructions will be eliminated. It was found that this process was not followed by many issuers resulting in calculations that were backed into in order to fit the model. Our proposal recommends the NAIC or the state develops a list of pertinent information issuers should provide for rate review.

- Our proposal includes the use of a standardized, more actuarially sound age curve reducing the risk of age anti-selection.

- As MLR rebates will be eliminated under our proposal, allowing issuers to retain funds should allow a reduction in premiums. States may modify the ARM payment to issuers with unreasonably low MLRs.

- As the permanent Risk Adjustment Program will be eliminated, the wide swings in premiums to account for the unknown health of a future unknown membership compared to an unknown statewide average at the time rates are required to be set will likewise be eliminated. Reserves will be released from the financials of the issuers and the risk of financial hardship or insolvency resulting from large Risk Adjustment payment transfers will be eliminated. Hence, issuers will re-enter the market as many of the financial barriers will be eliminated.

- As Cost Share Reduction subsidies will be eliminated, issuers will not have the risk of large losses due to under-payment of these subsidies. Issuers will not need to decide whether to exit the market or increase premiums to recoup losses. This will bring stability to the market and will eliminate wide fluctuations in premium.

HEALTHCARE PROVIDER IMPACT

The various aspects of our proposal reduce the administrative burden on providers, allowing more time to focus on care.

Coverage and Access to Care

Our proposal includes comprehensive coverage and continued choice of plan options; however, choice of provider has been expanded.

- As there are no restrictions to access to preventive care, providers will see an increase in patient load for the Preventive Plan services.
- Hospitals may see increased utilization as they will be part of every issuer's network.
- Members' comprehensive plan coverage information will be easily accessible at the point of service through the members' universal Medical ID Cards once the member enters their PIN or thumbprint.

Enrollment and Participation

As providers do not participate in the enrollment process, they are mainly impacted by changes in patient load as the insured population is expected to increase.

- Through the universal Medical ID Card, coverage information will be available January 1. Patients will not need to wait for the receipt of their current annual ID card in order to seek health care early in the year. Providers may see an increase in the patient load at the beginning of January.
- Increased penalties will also increase the insured population, therefore increasing patient loads.
- As those eligible for Medicaid during the open enrollment window will be able to elect coverage through the Insured Plan, providers may also see a shift in patients from Medicaid to insurance, therefore increasing patient load.
- Individuals who seek Preventive Plan services who do not have a universal Medical ID Card will have their pertinent information entered into the ID card system by the provider. The universal Medical ID Card administrator will then have enough information to issue an ID card so that the individual's Preventive Plan services can be tracked.

Affordability

Our proposal aims to reduce the administrative burden on providers.

- As patient load is expected to increase, provider revenue will also increase.

- As services provided to uninsured patients are expected to decrease, uncompensated care will decrease, therefore increasing profitability.
- As member cost sharing will be paid through the universal Medical ID Card, provider cash flow will become more predictable and stable and bad debt will be reduced.
- Providers' cash flow will be more predictable as payments for the services covered under the Preventive Plan will be sent regularly from the government and the fee schedule will not fluctuate by issuer as it does today.
- Retail pharmacies may see a decrease in business due to allowing the purchase of drugs via the internet from certain qualified international locations.
- In the United States, increased price competition among domestic pharmaceutical companies will result by allowing the purchase of prescription drugs through certain qualified international locations.
- Durable medical equipment costs will decrease with the elimination of the ACA tax on medical devices.
- Preventive Plan and hospital facility services will be paid at no less than Medicare reimbursement levels (or more at the states discretion). Medicare reimbursement amounts, in general, should be set to cover the cost of care so cost shifting to other payors should not result.
- Billing will be greatly simplified as the member cost sharing amount will automatically be charged to the universal Medical ID Card. Providers will no longer need to submit multiple bills or engage the services of collection agencies. Cash flow will become more predictable and steady.

Quality of Care

Providers (as well as their patients) will greatly benefit from access to a patient's complete medical history.

- The family medical history will be accessed through the universal Medical ID Card enabling providers to better manage their patients' health.
- All procedures, lab results, immunizations, prescription drug usage, and so forth, will be accessible through the universal Medical ID Card allowing more targeted care and the elimination of repetitive and/or unnecessary procedures.
- Errors in the delivery of care will be reduced due to access to complete medical histories including drug allergies.
- Excessive care will be reduced as records will be maintained through the last date of service.

- Medical history will be accessible anywhere so if a patient is in an accident in a different state, drug allergies and all other pertinent information can be pulled up immediately. Again, errors and unnecessary procedures should be reduced.

GOVERNMENT RESPONSIBILITIES

The provisions presented in our proposal can be adopted at the federal level, state level or combination of the two. Our proposal will appeal to states that prefer to retain control of their insurance markets and prefer minimal federal oversight.

Coverage and Access to Care

The government will determine the funding of the programs outlined in our proposal. Many decisions will be made by the government as to the level of coverage, affordability, and administration of the programs as outlined below.

- Each state will determine the minimum required coverage under the Insured Plan. The minimum coverage includes all benefits covered by Medicare Parts A and B and prescription drugs plus any additional benefits determined by the state. The states will no longer have to select EHBs which is a more complex process than consideration of adding to well known Medicare benefits. Compliance with the standards will continue to be reviewed during the form filing review process.

- The government will contract with vendors to develop or modify existing technology to create the universal Medical ID Cards that will allow providers to access plan coverage and health history information.

- States will determine if the number of plans an issuer can offer will be limited and, if so, define the limit. Compliance with the limits will be enforced during the form filing review process.

- The states will determine minimum loss ratio requirements and will no longer need to monitor premium rebates. Compliance with the loss ratio standards will be enforced during the rate filing review process.

Enrollment

The actual enrollment in the Insured Plan will be completed by the issuers; however, the government will be responsible for the maintenance of the shopping website. Although this can be done at either the state or federal level, the recommendation is to allow states to continue using their own Exchange or outsource the function to a contractor or the federal government.

- The government will control the shopping website which will link to the issuer's website to complete the enrollment process.

- The government will be responsible for certifying the income on which the premium subsidy will be based. This information will be provided to the issuer and/or Medical ID administrator so they can properly charge the premiums.

- The government will be responsible for handling any subsidy appeals.

Affordability

Again, references to the government below can be the state, federal or combination of the two.

- As those eligible for Medicaid during the open enrollment window will be able to elect coverage through the Insured Plan, states may see a reduction in Medicaid cost if people shift to an Insured Plan.
- As today, the states may recommend a more actuarially sound age table or elect to use one developed by the NAIC.
- The IRS will be responsible for collecting and remitting to the appropriate government entity the penalties for residents who do not enroll in an insured plan.
- Funding needs will be reduced by penalties paid by those who do not purchase an insured plan.

Administration and Financial Accounting

This section outlines various administrative responsibilities the government will undertake.

- The government will be responsible for all financial aspects of the administration of the programs outlined in our proposal, including ensuring the use of the funds is restricted to the administration of the plan and adequate reserves are maintained.
- The government will no longer need to administer the ACA taxes that will be eliminated.
- The government will be responsible for ensuring funding is adequate over time, as well as the collection, investment, and distribution of these funds.
- The government will be responsible for setting the fee schedules for the Preventive Plan and licensed hospital facility services if Medicare reimbursement rates are modified.
- The government will contract with a vendor to pay the claims for the Preventive Plan benefits. If contracting with a vendor is completed at the federal level, redundancies will be reduced and perhaps better administrative fees could be negotiated with increased volume.
- The government will contract with various vendors to administer the universal Medical ID Card program as mentioned above. In addition to providing access to the members' coverage information, the universal Medical ID Card will also act as a low-interest credit card for payment of premiums, late enrollment penalties and plan cost sharing. The government will be responsible for monitoring and auditing the vendor.
- In the selection of the vendors to administer the universal Medical ID Card, the government will be responsible for ensuring their ability to develop a secure database to house not only plan coverage information but all billing and Electronic Health Records in

a standard format that are accessible through a standard universal Medical ID Card reader. This system will be most effective on many fronts if run at the federal level.

- The government will be responsible for, or contract out, the management of the ARM program that will handle collection, distribution, investing and accounting for all ARM funds.

- The government will transmit payment to issuers under the Premium Subsidy Program.

Oversight

Our proposal eliminates the Effective Rate Review requirements and allows states to reinstitute their own rate review process. States are anticipated to react favorably to a reduction in federal oversight.

- Our proposal includes a recommendation that the NAIC develop guidelines on information that issuers should submit for regulators to determine the adequacy of the rates and solvency of the issuers. States can modify or develop their own review process or implement some or all of the NAIC recommendations.

CONCLUSION

There are many challenges to overcome in implementing any change to the individual health insurance market where there will be winners and losers. From a consumer perspective, the goals to provide basic medical services to all individuals in the interest of public health, make care affordable, accessible and consistently high in quality can be achieved. Getting issuers to re-enter the individual market can be achieved by implementing programs that are logical and predictable while easing voluminous administrative burdens. We encourage continued exploration of programs to reimburse providers so they can continue to provide high quality care. The unsustainable escalation of costs in the individual market will be mitigated by setting reasonable but not excessive fee schedules for preventive and hospital services. Lastly regulators will also realize a reduction in administrative burden by allowing states, if they choose, to control their own markets with less oversight.

The overall cost and enrollment impact of our proposal recommendations has been modeled by Milliman. The estimated sales tax percentage can subsequently be determined by an organization such as the Urban Institute and Brookings Institution Tax Policy Center.

Great strides have been made to promote innovation in the delivery of care, in the development of provider reimbursement models, in removing financial barriers to preventive medical services and so forth. We appreciate the opportunity to present ideas to further enhance the delivery and financing of health care in the individual insurance market.

APPENDIX

Financial Modeling Results

The Simplifiers Team Proposal
Financial Modeling Results

I. FINANCIAL MODELING

Modeling results for the Simplifiers 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 Simplifiers 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 Simplifiers scenario results reflect Milliman's understanding of the authors' proposal.

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

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

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

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

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

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

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

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

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

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

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

IV. FINANCIAL MODELING RESULTS

Table 1 summarizes key results compared to the baseline status quo scenario for various affected parties. The table addresses each of the four major stakeholder areas connected with the individual insurance market: issuers, members, health care providers, and sources for funding. These are averages over the 3-year period of 2018 – 2020. Attachment A provides year-by-year detail of the results.

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

	Status Quo Scenario	The Simplifiers Scenario	Difference	Percentage Change
Enrollment Results				
Uninsured Count *(thousands)*	24,296	0	-24,296	-100%
Individual Market Enrollment *(thousands)*	17,885	34,165	16,281	91%
Individual Market Issuer Health Plan Results				
Average Premium PMPY	$6,736	$2,221	-$4,515	-67%
Avg. Prem. Subsidy PMPY	$2,848	$821	-$2,027	-71%
Net Member Premium PMPY	$3,888	$1,400	-$2,488	-64%
Average Plan A/V*	71%	62%	-9%	-13%
Loss Ratio after Risk Transfers	80%	64%	-16%	-20%
Average Plan A/V including Preventive Plan Benefits**	71%	63%	-8%	-11%
Loss Ratio after Risk Transfers including Preventive Plan	80%	72%	-8%	-9%
Issuer Retention				
Total Dollars ($ millions)	$24,103	$27,028	$2,925	12%
Retention Dollars PMPY	$1,348	$791	-$557	-41%
Retention as a Percentage of Premium	20%	36%	16%	78%
Member Obligations PMPY***				
Member Out-of-Pocket Net Premium	$3,888	$1,400	-$2,488	-64%
Member Benefit Cost Share Obligation	$1,821	$1,758	-$63	-3%
Total Member Out-of-Pocket Obligations	$5,710	$3,158	-$2,551	-45%
Health Care Provider Impact				
Total Allowed Charges Received ($ millions)****	$168,577	$163,925	-$4,652	-3%
Allowed Charges PMPY	$5,180	$4,798	-$382	-7%
Funding Outlays from Government and / or Other Sources				
Total Dollars of Funding Outlays *($ millions)*	$57,909	$83,663	$25,754	44%
Funding Outlays per Indiv. Market Member per year (PMPY)	$3,238	$2,449	-$789	-24%

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

*** A/V as defined above, but also including the Preventive Plan benefits along with the insured plan benefits.*

**** 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".*

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

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 the penalty for non-coverage being 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 purchase a health insurance plan in 2018 and later**. Most uninsured 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 Simplifiers 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 Simplifiers proposed reforms achieves the goal of significantly lowering average premium rates, making coverage much more affordable. This is primarily due to the following:

1. *Provider reimbursement rate change*: the proposal calls for all hospital facility care to be reimbursed at Medicare fee schedule levels or at a higher rate negotiated by the state. Professional medical services would continue to be reimbursed at fee levels negotiated between the health plans and providers. Prescription drugs are also assumed to be priced 35% lower than current billed charge levels. The assumption is made that the Medicare reimbursement scale will be used for facilities. This results in a significant reduction in claim cost levels from the current Individual Market environment (about a 35% to 40% reduction in allowed costs). These reductions get even more leveraged for benefit calculations.

   The reader should note that the impact of moving to Medicare fee schedule reimbursement levels for hospital facilities is not fully considered herein since potential ramifications of reimbursement changes such as provider cost-shifting to other markets (e.g., commercial large employer group plans) and manufactured increased utilization to compensate for unit cost reductions have not been modeled. The analysis also does not model the potential reduction of health care provider availability to the Individual Market due to non-acceptance of Medicare fee schedule reimbursement by facility providers, or other potential unintended consequences. The reduction in pharmacy reimbursement does not consider the pricing adjustments that might be enacted by pharmaceutical companies and pharmacy benefit managers (PBMs) in response to allowing the importation of prescription drugs. These are important caveats when assessing the validity of the reform impacts indicated in this report.

2. *Exclusion of preventive benefits from insured plans*: because the government separately creates and funds a preventive services plan for all documented and undocumented residents, these services do not need to be included in any insured plan. This further reduces the cost of claims for the plan.

3. *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 plans with less than a 60% actuarial value. 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 a fairly level distribution among the plan tiers.

    b. There is no longer a cost-sharing reduction program (CSR) requiring eligible people to enroll in a Silver plan. The Simplifiers scenario shows a sharp reduction in the number of people enrolled in Silver plans. 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.

4. *The ARM reinsurance program*: The creation of the ARM reinsurance program, funded through government revenues, is modeled to reduce the premium for the insurance plans by a target of approximately 50% (after incorporation of other reforms like the Preventive Program and moving to Medicare fee schedule reimbursement levels for facilities).

5. *Issuer Retention*: there is an increase in total dollars, but a significant decrease in per member cost for Issuer retention. The reforms proposed in this paper help reduce certain administrative and operating expenses for issuers, which in turn get reflected in the premium rates. This is discussed below in more detail.

These combine to lower gross premium rates by 67% on average over the three years. Premium subsidies, while not as generous as those under the ACA, lower the consumer's out-of-pocket premiums 37% from gross levels, such that total out-of-pocket premiums for insured members are 64% of average net member out-of-pocket premium calculated in the status quo baseline model.

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 Simplifiers proposal is reduced significantly, while the reforms should result in administrative expense reductions in some areas on a per member basis (e.g., less claim settlement activity due to the government processing claims for preventive benefits instead of the issuer, more streamlined regulatory requirements), the model targeted a retention percentage to result in a 65% MLR. Table 1 illustrates that this results in an overall increase of $2.9 billion in retention dollars, but retention per member per year is 41% lower than under the status quo scenario.

A key consideration in making these reforms is whether such a significant 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 Simplifier proposal states, "We do believe however that loss ratio standards are relevant and should be set by the states and considered during the rate review process." 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 low premium rates. The model has targeted a loss ratio of 65%.

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.

- *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 Simplifiers 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 Simplifiers' proposed subsidy is a discount from gross premium varying by household income. Table 3 summarizes the factors used in the model for the current status quo baseline scenario (ACA) and The Simplifiers scenario.

Table 3
Premium Subsidy Structure: ACA vs. The Simplifiers

Household Income Range	ACA Cap on Premium as % of Income	The Simplifiers Subsidy as a % of Premium
<139%	2.0%	75%
139%-150%	3.0% - 4.0%	75%
150%-200%	4.0% - 6.3%	75%
200%-250%	6.3% - 8.05%	50%
250%-300%	8.05% - 9.5%	50%
300%-400%	9.5%	25%
400%+	No Limit	0%

- *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 (note though that preventive benefits under The Simplifiers proposal are covered under the government plan at 100% and therefore not included in the insured plans).

Table 4 summarizes the average annual model results over the period of 2018 to 2020 for these two components of members out-of-pocket obligations on a per member per year basis.

Table 4
Comparison of The Simplifiers 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	The Simplifiers Scenario	Difference	Percentage Change
Average Gross Premium PMPY	$6,736	$2,221	-$4,515	-67%
Avg. Prem. Subsidy PMPY	$2,848	$821	-$2,027	-71%
Member Out-of-Pocket Net Premium PMPY	$3,888	$1,400	-$2,488	-64%
Provider Charges for Services PMPY*	$7,600	$4,798	-$2,802	-37%
less Health Plan Benefits PMPY*	$5,389	$3,040	-$2,348	-44%
less Government Benefit Subsidies	$390	$0	-$390	-100%
Member Benefit Cost Share Obligation PMPY	$1,821	$1,758	-$63	-3%
Total Member Out-of-Pocket Obligations PMPY	$5,710	$3,158	-$2,551	-45%

** Includes Preventive Plan and Health Plan charges and benefits.*

IMPACT TO HEALTH CARE PROVIDERS

Health care providers are significantly impacted by the Simplifiers reforms, particularly health care facilities.

The proposal requires that all hospital facilities be paid at Medicare reimbursement levels (or a higher rate negotiated by the state). Issuers would continue to negotiate rates with physicians and other non-facility providers in a similar fashion as they do today. The model assumes that all facility claims will be reimbursed at Medicare fee schedule levels, and that non-facility providers will be reimbursed at negotiated payment levels typical of the current market. As discussed earlier, this is a significant reduction in revenue for hospital providers if they do not balance bill.

On the plus side for providers is that having all previously uninsured people covered under a health plan increases both the utilization of their services as well as the fees that they will receive for many of those services. Physicians may fair better in this regard than facilities since they are being paid at fees greater than Medicare levels.

Table 5 illustrates a comparison between the status quo scenario and The Simplifiers scenario. It shows that moving to this fee level structure will require a loss of revenue to health care providers of $4.7 billion. Overall, this reduction represents less than ½% of nationwide health care expenses for all markets.

Table 5
Comparison of The Simplifiers Proposal Model Results to Status Quo Baseline Model Results
Average Annual Provider Revenue over the 3-Year Period 2018 – 2020

Out-of-Pocket Component	Status Quo Scenario	The Simplifiers Scenario	Difference	Percentage Change
Preventive Charges ($ millions)*	$0	$6,128	$6,128	n/a
Insured Allowed Charges ($ millions)	$135,921	$157,796	$21,876	16%
Uninsured Allowed Charges ($ millions)**	$32,656	$0	-$32,656	-100%
Grand Total ($ millions)*	$168,577	$163,925	-$4,652	-3%
Amt per Indiv / Uninsured Mkt Members PMPY*	$5,180	$4,798	-$382	-7%

** Includes only Individual Market members; excludes undocumented uninsured people and Group Market members.*

*** Includes only costs of the 14.8 million uninsured who move to the Individual Market under the Simplifier Scenario.*

While facility providers have almost universally accepted Medicare reimbursement levels as full payment for their Medicare patients, it is less certain that they would do so for those in the individual market, particularly given the sharp growth projected for this market. However, the projected Individual Market membership would account for about 10% of the total nationwide population, while Medicare represents about 20%. Perhaps more importantly, the Individual Market members are estimated to account for only about 4% to 7% of total health care costs, while Medicare members account for 35% to over 40%.

At the same time, those percentages also point out the Medicare members are much more important to many hospitals to keep as patients since they generate so much of their revenue, even if at Medicare reimbursement levels. The Individual Market member may not be as important to them. They may decide not to service the Individual Market patients at Medicare payment levels, resulting in less choice for these people.

Additionally, providers might likely push for increases in the Medicare reimbursement rates to help make them whole with current revenue. Alternatively, they might push for having the Individual Market priced at some multiple of the Medicare fee schedule (e.g., 110% or 120%), cost-shifting the rest to the employer markets, or manufacturing increased utilization. Such reactions by providers would increase the premium rates and subsidies shown in this report or those for the employer markets.

FUNDING OUTLAYS

Required funding outlays increase under the Simplifiers proposal 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 four areas of impact for these funding outlays:

1. *Preventive Plan*: the Preventive plan is fully funded by the government with no cost to consumers. This program includes coverage for all commercial members as well as undocumented uninsured people. So it goes beyond just benefiting the Individual Market. The total cost to the Government for this plan is an average of $36 billion per year over the 3-year period, of which less than $7 billion is for the Individual Market. This includes recognition of pent up demand for these services from those previously uninsured and the undocumented uninsured. The $36 billion price tag includes $28 billion on the group market and about $1 billion on an estimated 5 million undocumented uninsured immigrants.[1] By their nature of being undocumented, it is difficult to estimate the number of undocumented uninsured people. Table 6 below shows only the costs for the Individual Market members since that market is the focus of this paper.

   In addition to the amounts reimbursed to health care providers for this program, the model includes 10% in additional costs borne by the government to pay for the administration of the program, including claim processing, fraud and abuse prevention, and other required activities. The model results reflect provider reimbursement at Medicare fee schedule levels.

2. *Premium Subsidies*: Premium subsidies for the 3-year period average $28 billion under the Simplifiers proposal compared to a yearly average of $51 billion expected under the current ACA for 2018-2020. Achieving this $23 billion reduction is highly dependent on being able to secure Medicare reimbursement rates at hospital facilities for the entire Individual Market.

3. *Benefit Cost-Sharing Subsidies*: The Simplifiers proposal eliminates CSR subsidies from the Government. Under the status quo scenario, the CSR payments to issuers are expected to average about $7 billion per year.

[1] "Health Coverage and Care for Immigrants", S. Artiga et. al., The Kaiser Commission on Medicaid and the Uninsured, Issue Brief, The Henry Kaiser Family Foundation, January 2016

4. *The ARM Program*: The ARM reinsurance program is fully funded by the Government and is targeted to reduce premium rates in the Individual Market by 50% of what they would have otherwise been after making the all the other proposal changes (e.g., preventive program and moving to Medicare fee schedules). This program is expected to cost the Government an average of $49 billion per year over the period of 2018-2020. There is no current equivalent program in the ACA.

Table 6 summarizes the Government funding for the Simplifiers proposal and compares it to funding under the status quo scenario. While the increased outlays in total dollars average $26 billion per year over the 2018-2020 period, on a per Individual Market member basis, costs decrease by $789 per year. This should be viewed in light of whatever current government funding is for uncompensated care of the uninsured and underinsured.

Table 6
Comparison of The Simplifiers Proposal Model Results
to Status Quo Baseline Model Results
Individual Market Only
Average Annual Funding Outlays 2018-2020

Program	Status Quo ($billions)	The Simplifiers ($billions)	Difference ($billions)
Preventive Plan*	$ 0	$7*	$7*
Premium Subsidies	$51	$28	-$23
CSR Subsidies	$ 7	$ 0	-$7
ARM Program	$ 0	$49	$49
Grand Total	$58	$84	$26
Total per Member (PMPY)**	$3,238	$2,449	$-789

** Only includes Individual Market costs; excludes cost for group markets as well as for undocumented uninsured people. These add another $30 billion in government costs, for a total of $36 billion for the entire proposed Preventive Plan.*

*** Cost per Individual Market member. Does not Include cost of Preventive Plan for Group members or for the undocumented uninsured.*

The Government costs shown do not include current outlays for the Medicaid and other programs requiring funding under current law. Only costs associated with commercial business are reflected. Furthermore, it must be noted that the proposal eliminates most of the taxes that the current law requires. It is beyond the scope of the modeling to review items outside of the direct insurance aspects of the proposal. However, any such government revenue losses or gains 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. This proposal does call for a sales tax increase to pay for the ARM program.

IMPACT TO EMPLOYERS

Employers are affected by these reforms in the following ways:

1. Some of the uninsured may opt to enroll in the health plans offered by their employers. The model indicates a 3% increase in group membership. This will add cost to the employers since they usually contribute a significant share of the plan premium.

2. 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 ARM

payments it would need to pay. The model shows that the average out-of-pocket premium to 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.

3. 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 health care providers if the members in the Individual Market as a percentage of the total population increased significantly, since then the Medicare reimbursement levels at facilities would be much more impactful.

4. Employers will benefit from the free Preventive Plan sponsored by the Government. Not needing to cover these services will reduce benefits and premiums the employer will need to pay. This represents a $29 billion savings for group plans.

5. However, the employer group market may fall victim to cost-shifting by health care facility providers due to the reimbursement reduction forced upon them in the Individual Market.

None of these impacts on the 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 market costs.

Attachment A
Summary of Model Results for Years 2018 - 2020
Comparison of Simplifiers 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

Simplifiers 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)	32.575	34.257	35.664	34.165

Baseline Scenario Individual Market 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 PMPY	$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 Ratio	69%	71%	72%	71%
Paid to Allowed Ratio incl Preventive Plan	69%	71%	72%	71%
Risk Adjustment PMPY	$0	$0	$0	$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%
Net Loss Ratio including Preventive Plan	81%	79%	80%	80%

Simplifiers Scenario Individual Market Issuer Health Plan Results				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium PMPY	$1,886	$2,260	$2,491	$2,221
Subsidies PMPY	$714	$837	$905	$821
Premium less Subsidies PMPY	$1,173	$1,423	$1,586	$1,400
Allowed Costs PMPY	$4,338	$4,587	$4,905	$4,619
Paid Benefits PMPY	$2,473	$2,874	$3,202	$2,861
Paid to Allowed Ratio	57%	63%	65%	62%
Paid to Allowed Ratio incl Preventive Plan	59%	64%	67%	63%
Risk Adjustment PMPY	$0	$0	$0	$0
Net Reinsurance PMPY	$1,236	$1,437	$1,601	$1,430
Raw Loss Ratio	131%	127%	129%	129%
Loss Ratio Net of Reins	66%	64%	64%	64%
Loss Ratio Net of Reins and RA	66%	64%	64%	64%
Net Loss Ratio including Preventive Plan	75%	71%	72%	72%

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%

Simplifiers Scenario Individual Market Only Total Insurer Plan Retention				
Retention Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Total Dollars ($ millions)	$21,169	$28,196	$31,719	$27,028
Retention Dollars PMPY	$650	$823	$889	$791
Retention as a Percentage of Premium	34%	36%	36%	36%

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

Simplifiers Scenario Individual Market Member Cost Obligations				
Member Obligation Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Premium after Subsidies PMPY	$1,173	$1,423	$1,586	$1,400
Benefit Cost-Share after Subsidies PMPY	$1,866	$1,713	$1,703	$1,758
Total Member Out-of-Pocket PMPY	$3,038	$3,136	$3,289	$3,158

Baseline Scenario Individual and Uninsured Markets Only Total Provider Reimbursement				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Preventive Charges ($ millions)	$0	$0	$0	$0
Insured Allowed Charges ($ millions)	$127,742	$135,311	$144,709	$135,921
Uninsured Allowed Charges ($ millions)*	$31,336	$32,887	$33,745	$32,656
Grand Total ($ millions)*	$159,079	$168,197	$178,454	$168,577
Amt per Indiv / Uninsured Mkt Members*	$4,793	$5,192	$5,570	$5,180

* Includes only costs of the 14.8 million uninsured who move to the Individual Market under the Simplifier Scenario

Simplifiers Scenario Individual and Uninsured Markets Only Total Provider Reimbursement				
Measure	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Preventive Charges ($ millions)**	$5,800	$6,051	$6,534	$6,128
Insured Allowed Charges ($ millions)	$141,316	$157,137	$174,936	$157,796
Uninsured Allowed Charges ($ millions)	$0	$0	$0	$0
Grand Total ($ millions)**	$147,116	$163,189	$181,470	$163,925
Amt per Indiv / Uninsured Mkt Members**	$4,516	$4,764	$5,088	$4,798

** Includes only Individual Market members; excludes undocumented uninsured people and Group Market members

Baseline Scenario Individual Market Average Annual Costs to the Government				
Program	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Preventive ($ millions)	$0	$0	$0	$0
Premium Subsidies ($ 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	$0
Grand Total ($ millions)	$49,600	$59,563	$64,565	$57,909
Total per Individual Market Member	$2,692	$3,383	$3,664	$3,238

Simplifiers Scenario Individual Market Average Annual Costs to the Government				
Program	**2018**	**2019**	**2020**	**Avg. 2018-2020**
Preventive* ($ millions)	$6,380	$6,656	$7,187	$6,741
Premium Subsidies ($ millions)	$23,243	$28,660	$32,263	$28,055
Benefit Subsidies ($ millions)	$0	$0	$0	$0
ARM Program ($ millions)	$40,270	$49,230	$57,100	$48,867
Grand Total ($ millions)	$69,893	$84,546	$96,550	$83,663
Total per Individual Market Member	$2,146	$2,468	$2,707	$2,449

* Includes only Individual Market members; excludes undocumented uninsured people and Group Market members