WHY NOT BE HIP?

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Actuarial Challenge

The BE HIP workgroup appreciates the opportunity to contribute to the Actuarial Challenge, and is grateful to the Robert Wood Johnson Foundation, Milliman and the American Academy of Actuaries. Our primary focus in this project was to search for a way to meet two goals not attained by the ACA exchanges to this point: standardization of benefits and affordability. If these two can be reached, we believe that a more stable individual health insurance market in the US will result. It is no coincidence that we have entitled our solution BE HIP, as the inclusion of younger individuals is essential to the system's success.

WHY NOT BE HIP?

Our workgroup spent multiple sessions discussing how to develop a response to the Actuarial Challenge. The presidential election changed our approach from modification of the Affordable Care Act (ACA) to the more likely replacement option. Despite coming from different backgrounds and career paths, we agreed that the US health system would benefit from increased standardization, as opposed to the infinite variations that exist today. We believe that a **BE HIP**, or **Basic Essential Health Insurance Plan**, should be established nationwide, with supplemental coverage options built around it.

EXECUTIVE SUMMARY

This workgroup proposes that a **Basic Essential Health Insurance Plan** be established for the American individual market. The **BE HIP** plan would have the following features:

- Establishment of a comprehensive plan of benefits, but not as broad as the Essential Health Benefits created by the ACA;
- Single national standardized core plan, upon which would be built standardized supplements to offset enrollee cost-sharing;
- Inclusion of some first-dollar preventive care benefits, but the services selected must satisfy both a societal good and generate positive cost-effectiveness;
- Base plan premiums and cost-sharing tied to family income in the second year prior to the coverage effective date;
- Use of a 5:1 age slope in ratemaking instead of the ACA's 3:1 ratio;
- Administration of base and supplement plans by the private insurance marketplace;
- Federal regulation of the base BE HIP plan;
- State regulation of the BE HIP supplemental plans;
- No health underwriting or penalties for pre-existing conditions;
- Automatic enrollment in the lowest-cost plan, or a guaranteed insurability premium equal to that of the lowest-cost plan, for those who fail to enroll promptly; and
- Continuation of a risk adjustment program similar to that of the ACA, a reinsurance program to protect insurers against catastrophic claims, and a premium equalization process to account for socioeconomic variations between carriers in a given market.

If this solution is implemented, we believe that the US individual health insurance market will be improved in these ways:

- A leaner benefit plan will reduce the overall cost of the program;
- Standardized benefit options will cut the administrative expenses of both insurers and regulators, and provide much-needed simplicity for potential enrollees;
- More focused first-dollar preventive care will optimize spending on services proven to save money and lives;
- Premiums and cost-sharing tied to family income will improve the health system's equity;
- Appropriate age rates will reduce subsidization of one generation by another, and greatly improve affordability of the plan to younger individuals;

- Additional transparency tools will assist consumers in making wise decisions;
- Full enrollment will provide carriers with a more stable risk pool, enabling lower provision for adverse deviations from expected results; and
- Mandatory enrollment will also improve the ability of providers to manage their business, by reducing medical debt and uncompensated care issues.

Milliman provided a report on their modeling of the BE HIP proposal. The workgroup believes that most of the goals of our proposal are met as reflected in the model output, and that the individual health insurance market is vastly improved by its implementation. However, some important caveats about our reliance on Milliman can be found in the Conclusion to this paper.

The calculated impacts of the enactment of BE HIP, both included in Milliman's report and some that we feel were not fully credited in it, are included in commentary throughout this document. Additionally, the entire Milliman report is included as the Appendix.

Two Milliman, Inc. consulting actuaries, Stacey Muller and Jim O'Connor, were responsible for operating the underlying actuarial model that produced the numbers in this report. Both are consulting actuaries for Milliman, Inc. and members of the American Academy of Actuaries, and they meet the Qualification Standards of the American Academy of Actuaries to render the actuarial analysis contained in our report. The BE HIP team makes no warrantees or assumes any responsibilities about the accuracy of their analysis.

We have acted as a "creative force" or "idea factory" for this project. Milliman has stated to us that they did ". . . not intend for this work product to create any obligation or legal duty to you, your team, or any other party, as you and they are not considered to be a principal in our engagement with the Robert Wood Johnson Foundation (RWJF)."

WHY NOT BE HIP?

THE BE HIP SOLUTION:

The BE HIP proposal addresses the five (5) factors that are fundamental to improving the stability and ensuring the sustainability of an individual health insurance market:

1. Full participation by all eligible persons:
    a. Without full participation the system will continue to experience anti or adverse selection, require substantial and regular premium increases, and become unstable; and
    b. Full participation is accomplished by making the current "penalty" the same as the cost for insurance coverage.
2. Guaranteed issue:
    a. To ensure full participation all eligible persons must be accepted regardless of pre-existing conditions; and
    b. The public overwhelmingly accepts the Affordable Care Act (ACA) provision that provides coverage without regard to health status.
3. Affordability:
    a. Coverage under the ACA is or is perceived to be expensive — particularly younger people elect not to participate because the "value proposition" of coverage is low;
    b. Premium increases that exceed normal inflation and wage increases must be restrained or the individual health insurance market will be eliminated by public demand; and
    c. The BE HIP proposal aims to produce an environment where benefits and premiums are coordinated so as to provide some level of basic coverage for all eligible persons.
4. Simplicity:
    a. The present ACA environment is or is perceived to be complex by most people and, as a result, is often misunderstood by eligible persons;
    b. The BE HIP proposal greatly simplifies the individual health insurance market by offering a standardized national benefit plan that will have very limited benefit changes from year-to-year and be common to all health insurers; and
    c. For the most part, Medicare has been understood by its participants. Medicare offers a uniform base plan and provides several optional standardized supplements to fill in gaps of coverage. The BE HIP proposal has been designed to follow the successful approach used by Medicare.
5. Equity:
    a. Equity among participants can never be perfect but unless it is seen as being reasonable, it will engender misunderstanding and hostility from the participating insureds;
    b. For example, the 3:1 current exchange premium age slope creates a built-in subsidy of older insureds by younger insureds. Premium subsidies also have to be equitable for insured categories. BE HIP proposes that a more realistic actuarial premium slope be offered. We also propose income-based premiums, with a cap of

100% of the area- and age-adjusted premium rates for those with very high incomes.

c. From a tax perspective, some people feel that individual health insurance coverage penalizes people who are not provided health insurance through employment. For tax purposes health insurance must be treated equally, whether it is provided through work (largely group insurance) or purchased by individuals (regardless of their employment status). The specifics of this recommendation are beyond the scope of the Actuarial Challenge but income tax equity is an important factor in order to operate a sustainable individual health insurance market.

Based on the above fundamental concepts and principles, the BE HIP workgroup proposes a **Basic Essential Health Insurance Plan**, abbreviated as "**BE HIP**". We believe it should be a comprehensive plan of benefits, but not as broad as the current package of Essential Health Benefits (EHBs) with the ACA. Our consensus is that this should represent more of a "basic" program, upon which would be built standardized supplemental benefit packages available for purchase by those desiring additional protection. If the BE HIP sounds reminiscent of the US Medicare program, that is no coincidence. It is our view that a **single national standardized program** by income level stands the best chance of long-term success as the fundamental building block for an individual health insurance market.

The BE HIP would include **some first-dollar benefits**, but not to the extent that preventive care services are "free" today. We recommend that research be conducted to determine which services on the current US Preventive Services Task Force list meet each of two criteria: (1) value to society and (2) cost-effectiveness. The Robert Wood Johnson Foundation's own report from September 2009 revealed that only a few preventive services "are widely regarded as cost-saving". Those that meet both of the above criteria would be covered in full in the BE HIP; all others would require some level of cost-sharing. The purpose of this is to encourage utilization of those tests and procedures demonstrated to provide value to the overall system, and secondly to reduce the cost of the base medical plan.

We realize that a single basic benefit plan may have a low premium, but would include significant cost-sharing, making it nearly impossible for a low-income enrollee to afford. As a result, we are proposing that, in addition to premiums tied to the second prior year's family income, the BE HIP plans themselves are built on a multi-tier basis, with benefits directly correlated with the same income measure. This would maximize the potential for full participation and affordability to be met, while also limiting opportunities for adverse selection in plan design.

The BE HIP would be **sold and administered by private health insurers**. Similar to today's Qualified Health Plan (QHP) filing process, there would be an organized system of application and rate submission. Rating areas within states would be established, and insurers must comply with those guidelines, as they do today. However, with a standardized plan or set of plans, the review and approval of the base plans would be vastly streamlined and reduce insurance company expenses. There would be no variation in benefits from one carrier to another, so the immense time and effort required to complete the ACA Plans and Benefits and Pharmacy templates

(among others) could be eliminated. Network adequacy and the use of Essential Community Providers would still be part of the filing.

Simplification of the filing process necessarily involves a rethinking of the relationship between federal and state regulation of health insurance. Our proposal is that the **BE HIP is regulated at the federal level**, so that a single uniform national standard is promulgated. Premiums for the s**tandardized supplemental products would be regulated by the states**, as is done today with Medicare Supplement. It is part of our proposal that a "national filing compact", as in the life insurance industry, be created to streamline administration.

By reducing the number of variables and increasing the user friendliness of online tools, it will make it possible for the BE HIP proposal to conduct the vast majority of enrollments through a **single national website**. If such a website is effective, we expect that insurance brokers and agents would not have a major role in the BE HIP enrollment process. On the other hand, we recommend continuing having navigators to assist individuals because this service will be needed. In total, we expect that the new delivery process would reduce acquisition costs and improve understanding of the program.

Our workgroup is sensitive to the fact that many people have elected not to participate in the ACA health exchanges. We believe that the concept of a "penalty" for failure to have health insurance has not succeeded. Instead, we would support some form of **automatic enrollment** in the appropriate lowest-cost plan in the person's geographic area. If this is not possible, then a **guaranteed insurability premium**, equal to the lowest-cost plan rate, would be charged, as both an incentive to participate and to ensure sufficient revenue for the system. The process for charging these premiums outside standard payroll deduction would have to be determined for non-traditional wage earners.

A **risk adjustment** process would still be in order with the BE HIP. In addition, because of the change to an income-based premium schedule, a form of **revenue equalization would be required** to reconcile enrollment variations in socioeconomic status among carriers.

CONSUMER IMPACT

Access to Health Insurance
Our solution provides insurance to all individuals who are not covered by employer group plans, Medicaid, or Medicare. Everyone will have health insurance under our plan. Similar to the ACA, in BE HIP there is no health underwriting or penalties for pre-existing conditions. Under the ACA, if an individual does not have health insurance they are subject to a penalty. However, for many the penalty is significantly less than the cost of coverage. In our solution, if an individual does not elect coverage they are automatically enrolled in the lowest cost plan. Alternately, the premium for the lowest-cost plan is described as a guaranteed insurability premium and is charged to all non-enrolled eligible people. Since these individuals are paying an amount equal to the premium, they are deemed to be covered under this plan.

Simplicity

Unlike the ACA, BE HIP is designed such that the benefits and cost sharing are standardized across the country with variation only based on second prior year's income. We believe that the BE HIP proposal will make it easier for individuals to acquire and maintain health insurance coverage. With no variation in benefits and coverage levels among insurers, comparisons would be on more of an apples-to-apples basis. Provider networks and rates would be the primary distinguishing characteristics between options. Improvements in simplicity and affordability should make the process more inviting to a large share of the eligible population.

To the extent that transitions to and from Medicaid and group coverage can be made smoother, acceptance of the plan would rise. In addition to BE HIP, we envision a market of supplemental plans that individuals could purchase if they would like to reduce some cost-sharing before the out-of-pocket maximum is reached. Since our plan design is based on income, those with a low income would not need to purchase the supplemental plans since the plan design would already capture it. High income individuals would have the option to purchase the additional coverage to make their costs more predictable.

Under the ACA, those who earn less than 400% of the Federal Poverty Level (FPL) receive tax credits, and those under 250% of the FPL receive cost sharing subsidies on the silver plans. The BE HIP premium is equal to a percentage of salary, up to actual premium for the individual. The ACA advance premium tax credits are problematic to many, as some may need to repay the government in the following year, if they underestimated their income when they initially enrolled. To simplify the process, there will no longer be tax credits; however, the Federal government will be responsible for paying the difference between the actual premium and the percentage of salary limit. The actual premium varies by age, up to a 5:1 cap.

The cost-sharing is based on the income an individual had in the second prior year which is analogous to the subsidies those under 250% of the FPL receive in silver plans. The chart below outlines the cost sharing of in-network (lowest tier) self-only benefits for those in the 100-150% FPL range and those earning over 400% of the FPL. A number of benefit plans would be established between these two endpoints, in order to promote affordability at all levels and provide smooth coverage transitions as income changes. The family deductible and out-of-pocket maximum amounts are capped at two times the self-only level. We envision that there could be multiple network tiers to help carriers direct members to the most efficient and effective providers.

**ILLUSTRATIVE BE HIP COST-SHARING
FOR LOWEST AND HIGHEST INCOME TIERS**

Income Range	100-150% FPL	Tiers in between	> 400% FPL
Single Deductible	$0		$6,550
Coinsurance	20%		100%
Out-of-Pocket Maximum	$1,000		$6,550
Essential preventive care	$0		$0
Secondary preventive care	$5		25%
Clinic visit	$5		Deductible
Primary care visit	$10		Deductible
All other medical	20%		Deductible
Generic drugs	$5		Deductible
Preferred brand drugs	$10		Deductible
Non-preferred brand drugs	$20		Deductible
Maximum HSA contribution	$0		$3,400

Affordability
ACA premiums vary only by geographic area, age and tobacco use. BE HIP would follow the same rating approach, with an important adjustment. The age slope will be increased from 3:1 to 5:1. BE HIP premiums will be capped at a percent of the second prior year's income (2016 income is known in late 2017 for January 2018 enrollment). This prior year income also allows individuals to better budget their health costs ahead of time. Our plan will be affordable because the out-of-pocket maximum plus the premium will be tied to an individual's income. The BE HIP premiums will also be lower because we remove anti-selection by covering everyone eligible and reduce the costs of product administration. The BE HIP benefits are less generous than the ACA benefits, further reducing cost. Even though the base BE HIP benefits are less generous, the catastrophic protection is stronger, providing more coverage when people really need it. Supplemental premiums are not subsidized.

Access to Providers
Similar to the ACA, insurers will maintain networks to steer enrollees to lower cost providers. There will be requirements the insurers need to follow to make sure the provider network is large enough to cover all of the enrollees and cover all provided services. To the extent that the net-

work cannot provide appropriate care, the insurer would be required to cover the costs if the enrollee is required to go out-of-network due to the inability to get the care in-network.

Transparency
While our proposal would encourage the use of provider networks, we also advocate an investment in additional transparency tools, in order to provide the maximum amount of information to potential enrollees about provider panels and fee schedules. While we do not envision a major role for brokers and agents in the BE HIP enrollment process, we recommend continuing having navigators to assist individuals because this service will be needed.

Consumer Responsibility
Consumers will be required to select a plan. If no plan is selected, they will default into the lowest cost plan. Absent a supplemental plan, because of the high deductible health plan (HDHP) nature of BE HIP, higher-income consumers will have greater responsibility to budget for care up to the out-of-pocket maximum, as well as to make sure they receive appropriate care at the best price possible. We hope insurers and providers will provide more cost information to consumers to make this easier than it currently is today. We also advocate research into the most effective long-term wellness programs for inclusion in the basic BE HIP plan.

RESULTS OF MODELING ON CONSUMER IMPACT

Milliman's output confirmed many of the impacts we believed enactment of the BE HIP program would create. Access to coverage would be guaranteed with this proposal, and indeed the uninsured count in 2018 and beyond is zero (see Appendix Table 1). By contrast, the ACA market is expected to have over 24 million still uninsured. Table 1 also shows that the average net premiums paid by individual enrollees over the three-year period 2018-2020 are 7% lower than corresponding costs in the status quo, thus assisting in the goal of overall affordability. For individuals eligible for subsidies, the BE HIP program produces lower year-over-year net premium increases (see Attachment A). The average net premium actually declines by 0.3% in 2019, and then grows by a modest 3.2% in 2020. In contrast, net premiums increase by 11% in 2019 and 5% in 2020 in the status quo ACA market, and the number of uninsured increases by 28 thousand in 2019. For those not subsidy-eligible, the BE HIP program also results in lower year-over-year increases in the full premiums. BE HIP premiums increase by 0.9% in 2019, and 5.4% in 2020, as compared with 17% (2019) and 7% (2020) in the status quo ACA market.

We also believe that increased enrollment, rate and product stability of BE HIP will lead to a decreased need for risk margins in premium rates, but this is not factored into the analysis. Although our comments on insurers and providers appear later in this document, it is our view that this market stability will create a more robust and competitive market, which will further help consumers retain carriers and caregivers for the long term.

While it is not quantified in the model, the standardized BE HIP plan options greatly simplify the shopping experience for individuals. Furthermore, increased transparency in benefits and prices will raise customer satisfaction with the process, and reduce the demand for assistance from

agents, brokers and navigators. With premium and cost-sharing limits based on prior year income, out-of-pocket costs can be more easily anticipated and budgeted. As mentioned above, many of these impacts could not be evaluated in numerical terms in the model, but serve to further distance the BE HIP plan from the ACA.

INSURANCE IMPACT

The BE HIP workgroup believes that insurers will participate in providing the basic and supplemental benefit plans. Insurers will have the opportunity to compete by means of administrative efficiency, building and managing networks, marketing, and rating accuracy. Having a national standard basic plan will reduce the administrative burden and cost of developing, pricing, and administering multiple plans and eliminate adverse selection. Federal regulation of the underlying plan will further reduce the administrative burden of complying with multiple state filing rules for these plans.

With lower costs of administration and more predictability of claim costs, we are confident that carriers can provide the necessary levels of service and still earn a modest and fair operating gain. If the opportunity to make a profit is not achieved, it is likely that for-profit insurers will continue to abandon the market and lead to the development of special entities regulated in much the same manner as public utilities are today. A competitive marketplace, however, would give consumers more choices and carriers more flexibility, resulting in lower prices and better customer service.

Regardless of who administers the base medical plans, an active supplemental market would be an opportunity for commercial health insurers similar to the Medicare Supplement market today. Standardized supplemental plans will lead to streamlined state filings and clearer pricing options for carriers that choose to enter that market.

Insurers will get the enrollment of young, healthy individuals they had been expecting under the Affordable Care Act when everyone not already eligible for employer group plans, Medicare, or Medicaid is automatically enrolled in the BE HIP base plan. While this will better spread the risk among a larger pool of insureds, some carriers may not be equipped to manage a large influx of new members. This will be particularly acute among smaller carriers and in smaller markets. Allowing competition across state lines may also result in unexpected distributions of members among carriers and may overburden a carrier who will attract members from areas they had not previously served. However, cross-state competition will benefit consumers and will minimize situations where only a single carrier is available to members in a particular geographic area.

Large carriers with networks throughout the country will have an advantage when selling to members in various states. However, local or regional carriers who know the local market better and/or have existing relationships with providers will still find niches in which they can be competitive. A key goal of this plan is for better transparency of pricing, both by insurers and providers. Providing such transparency will facilitate the availability of the pricing information that the marketplace will need to function efficiently.

The implementation of risk adjustment, reinsurance, and risk pooling will help carriers to keep risk capital requirements lower and keep small carriers from being overwhelmed by jumbo claims. Where available, private reinsurance can also be used, and may be needed if public reinsurance is temporary.

Marketing of the basic plan will be through the exchange, with little to no involvement by agents and brokers. Supplemental plans may be sponsored through national organizations, similar to the way AARP now markets its Medicare Supplement plan. Variations in the availability of supplemental plans will give carriers the opportunity to price for a target market, depending on how competitive their networks of hospitals, doctors, and/or pharmacies are in the areas they are operating. For example, a carrier with a better pharmacy network in terms of price point will be able to have a lower price on a supplemental plan with more comprehensive drug coverage than a competitor without that network advantage. That same carrier may be less competitive for a supplemental plan with little to no pharmacy coverage.

Finally, carriers will need to have the data and expertise to properly price these plans. There will be opportunities for staff and consulting actuaries to come up with affordable yet adequate price points for both the basic and supplemental plans, similar to the way that the Affordable Care Act's plans and current Medicare Supplement plans have been priced.

RESULTS OF MODELING ON INSURANCE IMPACT

The Milliman model results supported our confidence that establishment of a more stable individual market would benefit insurance carriers, both currently in the market and potential entrants, who provide competitive networks and prices. With the assumption that an 80% medical loss ratio will be maintained by all issuers, Appendix Table 1 of the Milliman model shows BE HIP total market revenue of $45 billion, compared to just $24 billion under the ACA. The increases in revenue will improve carriers' margins, as many operating costs are fixed, and are now being spread across more enrollees.

The modeling shows that the three-year average per-member retention increases by 4% with BE HIP over the status quo ACA. However, we believe that insurers' operating gains in the individual market will increase by more than 4%, since their fixed costs should be significantly reduced. Standardization of benefit plans should result in vastly lower administrative costs for product development and contract/compliance work. In addition, the issuer's administrative burden will further be reduced by elimination of federal Cost-Sharing Subsidies with BE HIP plans. Federal regulation of rate review on the base plans will save costs for carriers operating in multiple jurisdictions. These areas of administrative cost reductions are not included in the global modeling done by Milliman. We believe that some carriers may be able to generate reasonable operating gains at loss ratios higher than 80%, further putting downward pressure on prices and enhancing the level of competition. Even so, the stable and predictable nature of the BE HIP exchange could prove inviting to issuers looking for a niche market, such as Medicare Supplement carriers have today.

HEALTHCARE PROVIDER IMPACT

No significant steps can be taken to improve the overall affordability of health care in this country without provider impacts and reforms. There is much to be learned from the way other countries deliver health care, including countries such as Canada where Universal Healthcare exists. The United States has free enterprise and privatized medicine, and the BE HIP proposal will maintain the free enterprise system.

The BE HIP plan proposal does not impose regulation and rules directly on healthcare providers. However, BE HIP will impact hospitals, doctors, and clinicians in several ways.

Mandatory enrollment in BE HIP will eliminate the uninsured and uncompensated care. Providers will benefit from more predictable income streams and eliminate most medical debt and its associated collection costs. In turn, the reduction in medical debt expenses will reduce rates for commercial insurers, as those cost burdens will no longer be shifted onto commercially insured plans. Since BE HIP is a standard benefit plan, providers will better be able to determine copays and coinsurance owed by members at time of service. This will also benefit providers by shortening their billing cycle for amounts not owed by insurers.

As the number of people covered increases, insurers will have more negotiation strength with providers and hospitals. This will likely lead to mergers and acquisitions in the provider community, as they will need to join together strengthen their position. Provider consolidation will result in further efficiencies in providing medical care by sharing of administrative resources, facilities, equipment, investment in technology, and other resources. These efficiencies should result in lower delivery costs, more standardization in quality of care, and a leveling of the cost of services, without discouraging physicians from practicing medicine.

By eliminating the uninsured, BE HIP encourages more primary care and OB/GYNs to practice in impoverished urban and underserved rural communities by reducing their risk of practice failure due to uncompensated care.

US health care delivery should continue to modernize and change how services are provided. The Plan structure of BE HIP includes tiered benefits to steer insured to seek care in the most cost-effective setting. In addition, BE HIP will cover more young “invincibles”, i.e., healthy people with the occasional ailment or minor injury that needs care. Therefore, we predict that the number and role of retail health clinics may provide an increasingly important source of health care services. These would not only include pharmacy-based clinics, but large retailers as well. We predict that many providers will find practicing in a retail environment to be refreshing, as they can focus on their profession, without the additional practice management responsibilities.

We also believe that BE HIP will encourage the continued evolution of accountable care organizations (ACOs), as insurers will work with their provider networks to control costs for those with chronic and more severe health issues. Since BE HIP relies on private insurance contracting with provider groups, BE HIP will encourage high quality, efficient coordinated care. These types of organizations typically organize to deliver the appropriate level of care to best manage costs, in

return for a performance bonus. We believe these types of partnerships between insurers and medical communities encourage best practices and improve healthcare outcomes.

RESULTS OF MODELING ON HEALTHCARE PROVIDER IMPACT

The BE HIP plan delivers over $71 billion more allowed charges to healthcare providers than the ACA, as can be seen in Table 1 of the Appendix. Even when viewed on a per-member basis, the increase in charges is 42%. Along with higher revenue, the BE HIP group is confident that this proposal delivers other important benefits to the provider community. Although Milliman concludes that the impact of this plan is minimal to them, it does admit that providers would better be able to manage their business with a reduced risk of uncompensated care. However, these reduced costs are not accounted for in the model. By replacing uninsured customers with insured ones, providers gain both additional revenue and leverage with insurers. Providers must still be willing to participate in managed care networks in order to obtain their share of these new enrollees. Having a national standard plan design should help all providers reduce costs, particularly rural providers without the capital to invest in complicated systems.

GOVERNMENT RESPONSIBILITIES

Fiscal Responsibility: Under the BE HIP proposal the Federal government, as today, would continue to raise revenue to fund cost-sharing and subsidize costs for those with income levels less than 400% of the FPL. We advocate the expansion of the provider fee to include self-insured entities and an adjustment in the calculation of the Excise tax to be based on actuarial value rather than premiums charged in order to fund the subsidy programs.

The Federal government would also retain its role in overseeing and adjudicating the risk adjustment program. Although not perfect, the workgroup believes this program would continue to provide valuable protection for insurers against adverse selection. Additionally, the Federal government would now be responsible for overseeing and administering a reinsurance fund to protect insurers against extremely high cost cases that risk adjustment cannot fully account for. This pool would be funded through pooling charges in carriers' premium rates for the basic plan offering.

Assessments for non-enrollment, which we have called the guaranteed insurability premium, or non-payment of base plan premiums would continue to be handled by the Federal government.

Regulatory Roles: The BE HIP plan offering of a carrier would be regulated at the Federal level to ensure a single national standard is promulgated. This is in contrast to today where the Federal or state governments are responsible, depending on the type of marketplace that exists in the state. With a standardized plan or set of plans, the review and approval of the BE HIP plans would be vastly streamlined. There would be no variation in benefits from one carrier to another.

Network adequacy and the use of Essential Community Providers would still be part of the filing. We envision state involvement in developing state-based network adequacy standards, as

state governments have more knowledge of their particular circumstances. Rating areas within states would be established and approved by state governments, and insurers must comply with those guidelines, as they do today. Premium rates for the BE HIP base plan would be reviewed and approved by the Federal government.

We envision the MLR program for the individual market to continue to be overseen and administered by the Federal government.

The BE HIP proposal includes standardized supplemental products as a way for those who wish to have additional coverage and do not qualify for enhanced cost-sharing to purchase a product that will wrap around the basic plan. Premiums for standardized supplemental products would be regulated by the states, as is done today with Medicare Supplement. The standardization of the plan design, however, would be handled at the Federal level.

Other Roles: As today, the BE HIP proposal would assign the Federal government the responsibility of determining the set of benefits to be covered under the basic plan.

We advocate a change from the current list of preventive services covered with no cost-sharing to be limited to those that are proven to be cost-effective or those that provide added value to society. The Federal government would be appointed to develop a non-partisan group to make recommendations on those services to be included with no cost-sharing requirements.

RESULTS OF MODELING ON GOVERNMENT RESPONSIBILITIES

Milliman's model of the BE HIP results in additional outlays over the period 2018-2020 of almost $54 billion, an increase of 93%. This is shown in Table 1 of the Appendix. The individual market would have grown by 80% in that same period. The primary expenditure would be premium subsidies, as all persons would potentially be eligible for them. Cost-sharing subsidies under the ACA would be unnecessary, as low-income persons are guaranteed a low out-of-pocket benefit plan, and thus, the government would eliminate that administrative burden.

Medicaid and Medicare enrollments would also climb, as more eligible persons would sign up for those programs as alternatives to the BE HIP market. These costs are not included in the model, and the share of patients covered by these government programs would decline. The BE HIP reinsurance program would be zero-sum across the market, so the federal government would only incur the cost of reinsurance administration.

The core standardized BE HIP benefit plan would be administered from Washington, so a uniform regulatory approach can be assured. Carriers with business in multiple states can streamline their benefit and rate filings.

PRESCRIPTION DRUGS

Our team spent considerable time discussing the role of pharmaceutical companies in the drive to reduce costs. While drugs have made dramatic improvements in the quality of life in recent dec-

ades, additional steps must be taken to achieve lower costs for pharmaceutical products. Drug companies cannot be allowed to charge US customers many times higher prices for their products than are paid by consumers in other countries. Research and development must continue, but controls on prices must be part of any significant overhaul of this country's health system. While the US does have controls for Medicare, Department of Defense, the Veterans Administration, and Medicaid, more needs to done to control costs and limit pharmaceutical company profits, and to eliminate cost-shifting to the commercial insured populations.

Our proposal would be for drug makers to disclose the actual research and production costs of developing and manufacturing each drug, and the projected sales for each drug, and to propose a profit limit on any drug. Of course, the limit would have to consider capping salaries and bonuses for drug makers and their sales force. In addition, pharmaceutical advertising in magazines, newspapers, and television has proliferated the induced demand for drugs. Advertising must be limited to professional medical journals to reduce the sales and marketing component of pharmacy costs.

The BE HIP workgroup also extensively discussed drug formularies. While it is appealing to allow the federal government to establish a single national formulary for all BE HIP basic plans, we realize that the decisions made in arriving at one are bound to be contentious and subject to intense lobbying. Private insurer formularies are often a leading determinant of network discounts, and removing this advantage might be difficult. We recommend study of the feasibility of a single national drug formulary.

CONCLUSION AND LIMITATIONS

The BE HIP program has met most objectives of the Actuarial Challenge. BE HIP increases the enrollment in the individual market by 80%. As a result over the three-year period 2018-2020: (1) premium rate increases stabilize at a relatively low level; (2) insurers' revenues increase and profitability is likely to return due to streamlined administration and less selection risk; and (3) providers benefit from more revenue. Over the long term, costs might also decrease due to benefits of care management for the previously uninsured and as additional revenues for providers are invested into healthcare infrastructure improvements.

The BE HIP proposal includes standardized supplemental products as a way for those who do not qualify for enhanced cost sharing to purchase a product that will wrap around the basic plan. Standardized supplemental products would be regulated by the states, as is done today with Medicare Supplement. The standardization of the plan design, however, would be handled at the Federal level. We do not anticipate that these supplemental plans would add benefits not covered by the basic plan, but would fill in the cost-sharing gaps of the basic plan, as determined by the income level of the enrollee.

To repeat, the opinions and ideas expressed in this proposal are those of the participants. They represent a consensus approach agreed to by the members of the workgroup, but not the views of their employers or the actuarial organizations of which they are members. None of us has a direct

conflict of interest with respect to the sponsorship of this project by the Robert Wood Johnson Foundation, Milliman or the American Academy of Actuaries.

Regarding the model documented in the following Appendix, the BE HIP workgroup has relied on Milliman for all calculations and has not audited any of its work. We did not have adequate time to review and question the assumptions and formulas used by Milliman, nor were we permitted access to the software. Per §3.3.3 of ASOP No. 41, we are unable to express any opinion about the assumptions chosen for the model. Some areas in which we disagree with the results produced by the model have been noted in the text of this report. However, a more thorough review of the underlying figures by the workgroup could have identified many more areas for discussion and improvement. We acknowledge that, on the whole, Milliman effectively translated the basic ideas of the BE HIP program into its model.

The BE HIP participants remain available to continue to be engaged in this project should there be an opportunity to refine our concepts, or if further discussion and exploration of our proposal is requested by the Robert Wood Johnson Foundation or any other party.

APPENDIX

Milliman's report is attached in its entirety.

I. FINANCIAL MODELING

Modeling results for the Why Not BE HIP? (BE HIP) health care reform proposal is 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 BE HIP 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 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 plus 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 BE HIP 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 judgement. 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, insurers, providers, and regulators strongly influences the choices made in the individual market. Results may also differ from other analyses Milliman may perform due to differences in the timing of model updates, assumptions, and additional information that may be gathered and learned since these analyses were performed.

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

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

IV. FINANCIAL MODELING RESULTS

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

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

	Status Quo Scenario	BE HIP Scenario	Difference	Percentage Change
Enrollment Results				
Uninsured Count *(thousands)*	24,296	0	-24,296	-100%
Individual Market Enrollment *(thousands)*	17,885	32,252	14,367	80%
Individual Market Issuer Health Plan Results				
Average Premium PMPY	$6,736	$7,062	$325	5%
Avg. Prem. Subsidy PMPY	$2,848	$3,461	$614	22%
Net Member Premium PMPY	$3,888	$3,600	-$288	-7%
Average Plan A/V*	71%	76%	5%	7%
Loss Ratio after Risk Transfers	80%	80%	0%	0%
Issuer Retention				
Total Dollars ($ millions)	$24,103	$45,412	$21,310	88%
Retention Dollars PMPY	$1,348	$1,408	$60	4%
Retention as a Percentage of Premium	20%	20%	0%	0%
Member Obligations PMPY*				
Member Out-of-Pocket Net Premium	$3,888	$3,600	-$288	-7%
Member Benefit Cost Share Obligation	$1,821	$1,788	-$33	-2%
Total Member Out-of-Pocket Obligations	$5,710	$5,388	-$322	-6%
Health Care Provider Impact				
Total Allowed Charges Received ($ millions)***	$168,575	$240,006	$71,431	42%
Allowed Charges PMPY	$5,180	$7,442	$2,261	44%
Funding Outlays from Government and / or Other Sources				
Total Dollars of Funding Outlays *($ millions)*	$57,909	$111,636	$53,727	93%
Funding Outlays per Indiv. Market Member per year (PMPY)	$3,238	$3,461	$223	7%

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

** This represents the cost-share obligation for the member. Under the status quo, this value includes any reduction for CSR subsidies (which do not apply under BE HIP).

*** *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 an 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 BE HIP 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 BE HIP proposed reforms yield higher premium rates in 2018 and 2019, but ultimately achieve the goal of stabilizing premium rates in the longer-term. This is primarily due to the following:

1. *Migration of the Uninsured to the Individual Market:* The migration of uninsured into the insured markets has the initial effect of increasing the average risk score in the Individual Market. However, by 2020, the BE HIP marketplace is expected to have an overall risk score that is lower than the projected Individual Market under the status quo scenario. This impact is consistent with the proposal's goal of establishing stability in the individual marketplace.

2. *BE HIP Reinsurance Program*: this plan is described as covering 50% of costs between $100k and $250k of annual expenses per individual. Under the federal reinsurance program in existence from 2014-2016 under the ACA, all commercial issuers contributed to the reinsurance pool. In contrast, the BE HIP reinsurance program is funded solely through contributions made by Individual Market issuers who sell the BE HIP basic plan. As such, the program is zero-sum across the entire individual market, and therefore does not produce an impact at the market-wide level. However, in practice, this risk mitigation program would provide additional protections to individual issuers, and would therefore encourage participation, possibly reduce premium risk loads, and contribute to the stability of the overall individual market.

3. *Plan Selection*: under BE HIP, default plan selections will be tied to income, with members bearing the full cost sharing (i.e., there are no CSR-type benefit subsidies from government).

    a. The BE HIP proposal assumes all individuals will be enrolled in a basic plan design which varies by income level. Individuals with incomes up to 150% of FPL, 150-250% of FPL, 250%-400% of FPL, and >400% of FPL qualify for basic plan designs with actuarial values of 95%, 85%, 70%, and 55%,

respectively. For enrollees with income below 150% of FPL, this structure mirrors the cost-sharing level offered by 94% CSR plans under the ACA. For enrollees in the next income bracket (150%-250% of FPL), the BE HIP coverage falls between the 87% and 73% CSR plans offered under the ACA, but is richer on average.

b. Individuals falling in other FPL ranges will have a guaranteed issue opportunity to buy-up into 70%, 85%, and 95% AV plans, but would not receive additional subsidy support for the portion of premium attributable to supplemental coverage. In other words, any additional premium resulting from a decision to enhance one's coverage through the supplemental market would not be subsidized. The model assumes the likelihood of buying up through supplemental coverage is positively correlated with an individual's income and health status, meaning the wealthiest and sickest people are the most likely to purchase supplemental coverage. This creates adverse selection against the supplemental plans. The supplemental market's initial enrollment in 2018 is targeted to be 10% of the total individual market. For 2019 and later, the model considers the characteristics and choices available as individuals select coverage. The enrollment in the basic plus supplemental plans decreases in total volume, but stabilizes at about 5% of the market in 2020. Please note that it was assumed that all issuers offering the basic levels of coverage will also offer supplemental coverage options in the BE HIP scenario. This requirement will ensure that issuers will actually participate in the supplemental market. If issuers were unable to pool the supplemental plan risk with the basic plans in a single risk pool, or if participation was optional, issuers might choose not to offer these plans in light of the adverse selection present in the supplemental market.

c. Attachment B provides year-to-year summaries for each plan design and the overall BE HIP marketplace. Please note Attachment B-1 represents enrollment-weighted averages across all plan designs available in the marketplace and reconciles with Attachment A.

d. Attachment C illustrates insured plan selections by income level and plan design to provide an understanding of the implications of the model assumptions surrounding supplemental buy-ups. Please note the supplemental plans in the model represent the combination of the member's basic plan coverage and the supplement coverage chosen. As such, the supplemental plans shown represent basic coverage supplemented to actuarial values of 70%, 85%, and 95%. However, to reiterate, member subsidies are determined only for the basic levels of coverage applicable to their income level (i.e., the coverage levels described in (a) above).

These impacts combine to increase gross premium by 16% in 2018 relative to the status quo. However, as the market stabilizes in subsequent years, gross premium in 2019 is projected to be just 0.3% higher than the status quo, and 1% lower than the status quo in 2020.

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 BE HIP proposal is projected to produce gross premiums, PMPY, at a similar level as the status quo by 2020, the minimum MLR assumption of 80% was maintained. Although aggregate issuer retention is expected to increase dramatically given the large influx of uninsured under this scenario, the per member per year issuer retention under BE HIP is actually lower than the status quo in 2019 and 2020.

A key consideration in making these reforms is whether total retention 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 states will tolerate. As noted above, the ACA minimum is 80%. The pre-ACA minimum in most states was 55%. The BE HIP scenario maintains a target loss ratio of 80%.

MEMBER OUT-OF-POCKET OBLIGATIONS

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

- *Premium Out-of-Pocket Costs*: This is the gross premium charged by the health plan less any premium subsidy or premium tax credit that is paid to the health plan from outside sources like the government. Both the current ACA program and the BE HIP proposal offer 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 BE HIP proposed subsidy is a 10% of income contribution cap offered to all income levels. Table 3 summarizes the factors used in the model for the current status baseline scenario (ACA) and The BE HIP scenario.

Table 3
Premium Subsidy Structure: ACA vs. BE HIP

Household Income Range	ACA Cap on Premium as % of Income	BE HIP Cap on Premium as % of Income
<139%	2.0%	10%
139%-150%	3.0% - 4.0%	10%
150%-200%	4.0% - 6.3%	10%
200%-250%	6.3% - 8.05%	10%
250%-300%	8.05% - 9.5%	10%
300%-400%	9.5%	10%
400%+	No Limit	10%

  Premium subsidies average about 48% to 50% of gross premium under BE HIP basic plans compared to 40% to 44% under the status quo scenario. On a per member per year basis, premium subsidies are projected to be 22% higher than that of the status quo scenario on average.

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

  Member cost sharing obligations are expected to decrease slightly (2%) on a PMPY basis primarily due to the shift in plan designs. Note that the member cost sharing obligation under the status quo model is offset by expected cost sharing reduction (CSR) subsidies.

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 BE HIP 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	BE HP Scenar-io	Difference	Percentage Change
Average Gross Premium PMPY	$6,736	$7,062	$325	5%
Avg. Prem. Subsidy PMPY	$2,848	$3,461	$614	22%
Member Out-of-Pocket Net Premium PMPY	$3,888	$3,600	-$288	-7%
Provider Charges for Services PMPY	$7,600	$7,442	-$158	-2%
less Health Plan Benefits PMPY	$5,389	$5,654	$265	5%
less Government Benefit Subsidies	$390	$0	-$390	-100%
Member Benefit Cost Share Obligation PMPY	$1,821	$1,788	-$33	-2%
Total Member Out-of-Pocket Obligations PMPY	$5,710	$5,388	-$321	-6%

IMPACT TO HEALTHCARE PROVIDERS

The effect of BE HIP reforms on healthcare providers is likely to be minimal.

Similar to the status quo, provider networks under the BE HIP reform proposal will remain a primary distinguishing factor between different health plan options. Issuers will continue to negotiate with providers and develop plan designs that effectively steer enrollees to lower cost providers. The paper proposes network adequacy standards be carried forward to ensure sufficient access to coverage for the large influx of additional insureds proposed by the BE HIP reform.

The paper concludes full enrollment would improve the ability of providers to manage their business given the reduced risks of uncompensated care and encourage higher quality, efficient care.

All of the above items could have favorable impact on health care costs; however, the modeling assumes no explicit adjustments to provider reimbursement levels or overall utilization. It is anticipated that any changes in costs would be reflected in premiums as they occurred.

Table 5 illustrates a comparison between the status quo scenario and the BE HIP scenario.

Table 5
Comparison of BE HIP Proposal Model Results to Status Quo Baseline Model Results
Average Annual Impact to Health Care Providers over the 3-Year Period 2018 – 2020

Out-of-Pocket Component	Status Quo Scenario	BE HIP Scenar-io	Difference	Percentage Change
Insured Allowed Charges ($ millions)	$135,921	$240,006	$104,085	77%
Uninsured Allowed Charges ($ millions)*	$32,655	$0	-$32,655	-100%
Grand Total ($ millions)*	$168,575	$240,006	$71,431	42%
Amt per Indiv / Uninsured Mkt Members PMPY*	$5,180	$7,442	$2,261	44%

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

Despite including no explicit modeling adjustments related to provider reimbursement, Table 5 illustrates that healthcare providers can anticipate a significant increase in total revenue simply due to the increased volume of covered members under the BE HIP scenario. Additionally, beyond the significant increase in volume, individuals that were uninsured under the status quo are projected to have substantially more allowed charges PMPY under BE HIP relative to their allowed charges PMPY received under the status quo (when

these individuals were uninsured). This increase recognizes (among other items) induced utilization associated with having an insurance contract versus being uninsured.

FUNDING OUTLAYS

Required funding outlays increase under the BE HIP proposal compared to the status quo. These may be funded by the Government, be it state or federal, or a combination of broad public / private funding. This proposal treats the Government as the funding source. There are two areas of impact for these funding outlays:

1. *Premium Subsidies*: Annual premium subsidies for the 3-year period average about $112 billion under the BE HIP proposal compared to $51 billion expected under the current ACA for 2018-2020 (a 119% increase). The $61 billion increase is driven by setting the maximum income contribution at 10% for all income levels. Although this subsidy structure is less generous on a percentage basis for lower income levels than those offered under the ACA, the dollar values are much more significant given the lowest income members are enrolled in the highest cost plan designs under the BE HIP program. Additionally, since all members in the BE HIP program are eligible for subsidies, a larger portion of the insured marketplace will be receiving subsidies. Beyond these considerations with respect to plan and enrollee characteristics, the total amount of subsidies is significantly higher given the much larger insured population under the BE HIP proposal.

2. *Cost-Sharing Subsidies*: The BE HIP proposal eliminates CSR subsidies from the Government. However, low-income individuals are still protected from significant cost-sharing through income-based plan designs. Under the status quo scenario, the CSR payments to issuers are expected to average about $7 billion per year in 2018-2020.

Table 6 summarizes the estimated funding outlays for the BE HIP proposal and compares them to funding under the ACA program. The increased outlays in total dollars average $54 billion per year over the 2018-2020 period, and on a per member basis the increase is $223 per year.

Table 6
Comparison of The BE HIP Proposal Model Results
to Status Quo Baseline Model Results
Average Annual Funding Outlays

Program	Status Quo	BE HIP	Difference
Premium Subsidies (billions)	$51	$112	$61
CSR Subsidies (billions)	$7	$0	-$7
Grand Total (billions)	$58	$112	$54
Total per Member (PMPY)	$3,238	$3,461	$223

The Government costs shown do not include current outlays for Medicaid and other programs requiring funding under current law. Only costs associated with commercial business are reflected, as noted in Table 3. The modeling does not assume any changes to the taxes required under current law. Any change in government revenue would need to be considered in a comprehensive econometric analysis of the proposal. It is beyond the scope of the modeling to review items outside of the direct insurance aspects of the proposal. The Milliman model does not address government and non-insurance related revenue sources.

IMPACT TO EMPLOYERS

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. This impact is not reflected in the attached exhibits, as the scope of the modeling was limited to individual market costs.

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

Baseline Scenario
Individual Market
Individual Market Health Plan Results

Measure	2018	2019	2020	Avg. 2018-2020
Individual Market Enrollment (millions)	18.424	17.608	17.623	17.885
Uninsured Count (millions)	24.481	24.509	23.899	24.296
Average Premium PMPY	$5,920	$6,937	$7,389	$6,736
Average Premium Subsidies PMPY	$2,345	$2,987	$3,233	$2,848
Net Member Premium PMPY	$3,574	$3,950	$4,156	$3,888
Insurer Retention				
Total Dollars ($ 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%
Average Plan A/V*	69%	71%	72%	71%
Loss Ratio after Risk Transfers	81%	79%	80%	80%

BE HIP Scenario
Individual Market
Individual Market Health Plan Results

Measure	2018	2019	2020	Avg. 2018-2020
Individual Market Enrollment (millions)	32.584	32.284	31.887	32.252
Uninsured Count (millions)	0.000	0.000	0.000	0.000
Average Premium PMPY	$6,896	$6,960	$7,334	$7,062
Average Premium Subsidies PMPY	$3,326	$3,401	$3,661	$3,461
Net Member Premium PMPY	$3,570	$3,559	$3,673	$3,600
Insurer Retention				
Total Dollars ($ millions)	$44,580	$45,425	$46,232	$45,412
Retention Dollars PMPY	$1,368	$1,407	$1,450	$1,408
Retention as a Percentage of Premium	20%	20%	20%	20%
Average Plan A/V*	77%	76%	76%	76%
Loss Ratio after Risk Transfers	80%	80%	80%	80%

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

Baseline Scenario
Individual Market
Member Obligations

Measure	2018	2019	2020	Avg. 2018-2020
Member Premium 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 Obligations	$5,345	$5,755	$6,045	$5,710

BE HIP Scenario
Individual Market
Member Obligations

Measure	2018	2019	2020	Avg. 2018-2020
Member Premium PMPY	$3,570	$3,559	$3,673	$3,600
Benefit Cost-Share after Subsidies PMPY	$1,671	$1,790	$1,906	$1,788
Total Member Obligations	$5,241	$5,349	$5,579	$5,388

** This represents the cost-share obligation for the member. Under the status quo, this value includes any reduction for CSR subsidies.

Baseline Scenario
Individual and Uninsured Markets Only
Total Provider Reimbursement Under Base Scenario

Measure	2018	2019	2020	Avg. 2018-2020
Insured Allowed Charges ($ millions)	$127,742	$135,311	$144,709	$135,921
Uninsured Allowed Charges ($ millions)***	$31,335	$32,885	$33,744	$32,655
Grand Total ($ millions)***	$159,077	$168,196	$178,453	$168,575
Amt per Indiv / Uninsured Mkt Members***	$4,793	$5,192	$5,570	$5,180

BE HIP Scenario
Individual and Uninsured Markets Only
Total Provider Reimbursement Under BE HIP Scenario

Measure	2018	2019	2020	Avg. 2018-2020
Insured Allowed Charges ($ millions)	$234,563	$237,072	$248,383	$240,006
Uninsured Allowed Charges ($ millions)	$0	$0	$0	$0
Grand Total ($ millions)	$234,563	$237,072	$248,383	$240,006
Amt per Indiv / Uninsured Mkt Members	$7,199	$7,343	$7,790	$7,442

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

Baseline Scenario
Individual Market
Total Funding Outlays from Government or Other Sources Under Base Scenario

Program	2018	2019	2020	Avg. 2018-2020
Premium Subsidies (millions)	$43,212	$52,604	$56,975	$50,930
Benefit Subsidies (millions)	$6,388	$6,959	$7,590	$6,979
Grand Total (millions)	$49,600	$59,563	$64,565	$57,909
Total per Member	$2,692	$3,383	$3,664	$3,238

BE HIP Scenario
Individual Market
Total funding Outlays from Government or Other Sources Under BE HIP Scenario

Program	2018	2019	2020	Avg. 2018-2020
Premium Subsidies (millions)	$108,370	$109,804	$116,734	$111,636
Benefit Subsidies (millions)	$0	$0	$0	$0
Grand Total (millions)	$108,370	$109,804	$116,734	$111,636
Total per Member	$3,326	$3,401	$3,661	$3,461

Attachment B
BE HIP Summary By Plan

Attachment B-1 BE HIP Scenario All Plan Designs Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$6,896	$6,960	$7,334
Subsidies PMPY	$3,326	$3,401	$3,661
Premium less Subsidies	$3,570	$3,559	$3,673
Allowed PMPY	$7,199	$7,343	$7,790
Paid PMPY	$5,528	$5,553	$5,884
Paid to Allowed	0.768	0.756	0.755
Risk Adjustment PMPY	$0	$0	$0
Net Reinsurance PMPY	$0	$0	$0
Total Population	32.584	32.284	31.887
Percent of Total Individual Market	100%	100%	100%
Raw Loss Ratio	80%	80%	80%
Loss Ratio Net of Reins	80%	80%	80%
Loss Ratio Net of Reins and RA	80%	80%	80%

Attachment B-2 BE HIP Scenario All BE HIP Plan Designs Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$6,761	$6,874	$7,261
Subsidies PMPY	$3,520	$3,528	$3,777
Premium less Subsidies	$3,241	$3,345	$3,484
Allowed PMPY	$6,576	$6,697	$7,062
Paid PMPY	$4,883	$4,913	$5,171
Paid to Allowed	0.743	0.734	0.732
Risk Adjustment PMPY	-$377	-$406	-$477
Net Reinsurance PMPY	$0	$0	$0
Total Population	29.170	30.248	30.191
Percent of Total Individual Market	90%	94%	95%
Raw Loss Ratio	72%	71%	71%
Loss Ratio Net of Reins	72%	71%	71%
Loss Ratio Net of Reins and RA	78%	77%	78%

Attachment B-3 BE HIP Scenario All Supplemental Plan Designs Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$8,043	$8,245	$8,633
Subsidies PMPY	$1,666	$1,510	$1,592
Premium less Subsidies	$6,377	$6,735	$7,041
Allowed PMPY	$12,515	$16,949	$20,752
Paid PMPY	$11,031	$15,058	$18,584
Paid to Allowed	0.881	0.888	0.896
Risk Adjustment PMPY	$3,217	$6,035	$8,491
Net Reinsurance PMPY	$0	$0	$0
Total Population	3.415	2.036	1.696
Percent of Total Individual Market	10%	6%	5%
Raw Loss Ratio	137%	183%	215%
Loss Ratio Net of Reins	137%	183%	215%
Loss Ratio Net of Reins and RA	97%	109%	117%

Attachment B-4 BE HIP Scenario 95% AV Plans (BE HIP and Supplemental) Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$8,358	$8,592	$9,158
Subsidies PMPY	$5,482	$6,017	$6,594
Premium less Subsidies	$2,876	$2,575	$2,564
Allowed PMPY	$8,865	$9,273	$10,072
Paid PMPY	$8,321	$8,704	$9,469
Paid to Allowed	0.939	0.939	0.940
Risk Adjustment PMPY	$1,409	$1,681	$1,927
Net Reinsurance PMPY	$0	$0	$0
Total Population	5.802	4.941	4.614
Percent of Total Individual Market	18%	15%	14%
Raw Loss Ratio	100%	101%	103%
Loss Ratio Net of Reins	100%	101%	103%
Loss Ratio Net of Reins and RA	83%	82%	82%

Attachment B-5 BE HIP Scenario BE HIP 95% Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$8,214	$8,471	$9,067
Subsidies PMPY	$6,479	$6,701	$7,254
Premium less Subsidies	$1,735	$1,770	$1,814
Allowed PMPY	$7,108	$7,205	$7,721
Paid PMPY	$6,624	$6,709	$7,197
Paid to Allowed	0.932	0.931	0.932
Risk Adjustment PMPY	$368	$336	$262
Net Reinsurance PMPY	$0	$0	$0
Total Population	4.422	4.212	4.014
Percent of Total Individual Market	14%	13%	13%
Raw Loss Ratio	81%	79%	79%
Loss Ratio Net of Reins	81%	79%	79%
Loss Ratio Net of Reins and RA	76%	75%	76%

Attachment B-6 BE HIP Scenario BE HIP Supplemented to 95% Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$8,822	$9,285	$9,764
Subsidies PMPY	$2,289	$2,063	$2,180
Premium less Subsidies	$6,533	$7,223	$7,584
Allowed PMPY	$14,494	$21,212	$25,812
Paid PMPY	$13,756	$20,226	$24,680
Paid to Allowed	0.949	0.954	0.956
Risk Adjustment PMPY	$4,744	$9,447	$13,068
Net Reinsurance PMPY	$0	$0	$0
Total Population	1.381	0.729	0.600
Percent of Total Individual Market	4%	2%	2%
Raw Loss Ratio	156%	218%	253%
Loss Ratio Net of Reins	156%	218%	253%
Loss Ratio Net of Reins and RA	102%	116%	119%

Attachment B-7 BE HIP Scenario 85% AV Plans (BE HIP and Supplemental) Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$7,461	$7,682	$8,165
Subsidies PMPY	$4,301	$4,577	$4,991
Premium less Subsidies	$3,160	$3,105	$3,174
Allowed PMPY	$7,559	$7,791	$8,423
Paid PMPY	$6,231	$6,419	$6,981
Paid to Allowed	0.824	0.824	0.829
Risk Adjustment PMPY	$389	$452	$505
Net Reinsurance PMPY	$0	$0	$0
Total Population	11.955	11.524	11.198
Percent of Total Individual Market	37%	36%	35%
Raw Loss Ratio	84%	84%	86%
Loss Ratio Net of Reins	84%	84%	86%
Loss Ratio Net of Reins and RA	78%	78%	79%

Attachment B-8 BE HIP Scenario BE HIP 85% Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$7,395	$7,640	$8,132
Subsidies PMPY	$4,611	$4,798	$5,203
Premium less Subsidies	$2,785	$2,842	$2,929
Allowed PMPY	$6,930	$7,087	$7,606
Paid PMPY	$5,652	$5,775	$6,230
Paid to Allowed	0.816	0.815	0.819
Risk Adjustment PMPY	$39	$39	$17
Net Reinsurance PMPY	$0	$0	$0
Total Population	10.736	10.752	10.543
Percent of Total Individual Market	33%	33%	33%
Raw Loss Ratio	76%	76%	77%
Loss Ratio Net of Reins	76%	76%	77%
Loss Ratio Net of Reins and RA	76%	75%	76%

Attachment B-9 BE HIP Scenario BE HIP Supplemented to 85% Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$8,042	$8,264	$8,690
Subsidies PMPY	$1,575	$1,506	$1,574
Premium less Subsidies	$6,467	$6,759	$7,115
Allowed PMPY	$13,100	$17,608	$21,584
Paid PMPY	$11,328	$15,390	$19,079
Paid to Allowed	0.865	0.874	0.884
Risk Adjustment PMPY	$3,467	$6,205	$8,357
Net Reinsurance PMPY	$0	$0	$0
Total Population	1.219	0.772	0.655
Percent of Total Individual Market	4%	2%	2%
Raw Loss Ratio	141%	186%	220%
Loss Ratio Net of Reins	141%	186%	220%
Loss Ratio Net of Reins and RA	98%	111%	123%

Attachment B
BE HIP Summary By Plan

Attachment B-10 BE HIP Scenario 70% AV Plans (BE HIP and Supplemental) Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$6,364	$6,489	$6,851
Subsidies PMPY	$2,472	$2,607	$2,853
Premium less Subsidies	$3,892	$3,882	$3,997
Allowed PMPY	$6,893	$7,089	$7,601
Paid PMPY	$4,697	$4,813	$5,193
Paid to Allowed	0.681	0.679	0.683
Risk Adjustment PMPY	-$532	-$532	-$491
Net Reinsurance PMPY	$0	$0	$0
Total Population	8.193	8.364	8.362
Percent of Total Individual Market	25%	26%	26%
Raw Loss Ratio	74%	74%	76%
Loss Ratio Net of Reins	74%	74%	76%
Loss Ratio Net of Reins and RA	82%	82%	83%

Attachment B-11 BE HIP Scenario BE HIP 70% Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$6,323	$6,468	$6,842
Subsidies PMPY	$2,662	$2,734	$2,967
Premium less Subsidies	$3,661	$3,734	$3,875
Allowed PMPY	$6,739	$6,877	$7,321
Paid PMPY	$4,556	$4,627	$4,949
Paid to Allowed	0.676	0.673	0.676
Risk Adjustment PMPY	-$619	-$646	-$656
Net Reinsurance PMPY	$0	$0	$0
Total Population	7.378	7.828	7.921
Percent of Total Individual Market	23%	24%	25%
Raw Loss Ratio	72%	72%	72%
Loss Ratio Net of Reins	72%	72%	72%
Loss Ratio Net of Reins and RA	82%	82%	82%

Attachment B-12 BE HIP Scenario BE HIP Supplemented to 70% Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$6,727	$6,799	$7,011
Subsidies PMPY	$749	$763	$817
Premium less Subsidies	$5,978	$6,036	$6,195
Allowed PMPY	$8,288	$10,193	$12,640
Paid PMPY	$5,973	$7,538	$9,564
Paid to Allowed	0.721	0.740	0.757
Risk Adjustment PMPY	$256	$1,144	$2,469
Net Reinsurance PMPY	$0	$0	$0
Total Population	0.815	0.535	0.441
Percent of Total Individual Market	3%	2%	1%
Raw Loss Ratio	89%	111%	136%
Loss Ratio Net of Reins	89%	111%	136%
Loss Ratio Net of Reins and RA	85%	94%	101%

Attachment B-13 BE HIP Scenario 55% AV Plans (BE HIP Plan Only - No Supplemental Plan Exists) Individual Market			
Measure	**2018**	**2019**	**2020**
Premium PMPY	$5,255	$5,293	$5,559
Subsidies PMPY	$737	$740	$851
Premium less Subsidies	$4,518	$4,553	$4,709
Allowed PMPY	$5,469	$5,657	$5,708
Paid PMPY	$2,843	$2,957	$2,895
Paid to Allowed	0.520	0.523	0.507
Risk Adjustment PMPY	-$1,276	-$1,216	-$1,354
Net Reinsurance PMPY	$0	$0	$0
Total Population	6.635	7.456	7.712
Percent of Total Individual Market	20%	23%	24%
Raw Loss Ratio	54%	56%	52%
Loss Ratio Net of Reins	54%	56%	52%
Loss Ratio Net of Reins and RA	78%	79%	76%

Attachment C
BE HIP Scenario

Attachment C-1 BE HIP Scenario Population Counts by FPL and by Metal Level All Plans in BE HIP Marketplace								
Income as Percent of FPL	**BE HIP 95%**	**BE HIP 85%**	**BE HIP 70%**	**BE HIP 55%**	**BE HIP Supplemented to 95%**	**BE HIP Supplemented to 85%**	**BE HIP Supplemented to 70%**	**Overall**
2018								
<139%	3.122	0.000	0.000	0.000	0.000	0.000	0.000	3.123
139% - 150%	1.298	0.000	0.000	0.000	0.000	0.000	0.000	1.299
151% - 200%	0.000	5.369	0.000	0.000	0.139	0.000	0.000	5.508
201% - 250%	0.000	5.367	0.000	0.000	0.138	0.000	0.000	5.506
251% - 300%	0.000	0.000	3.002	0.000	0.180	0.190	0.000	3.373
301% - 350%	0.000	0.000	2.540	0.000	0.149	0.155	0.000	2.845
351% - 400%	0.000	0.000	1.835	0.000	0.106	0.123	0.000	2.063
401% - 500%	0.000	0.000	0.000	2.006	0.196	0.227	0.238	2.668
501%+	0.000	0.000	0.000	4.628	0.472	0.523	0.577	6.200
All Income Levels	4.422	10.736	7.378	6.635	1.381	1.219	0.815	32.584
2019								
<139%	2.933	0.000	0.000	0.000	0.000	0.000	0.000	2.933
139% - 150%	1.278	0.000	0.000	0.000	0.000	0.000	0.000	1.278
151% - 200%	0.000	5.365	0.000	0.000	0.040	0.000	0.000	5.405
201% - 250%	0.000	5.387	0.000	0.000	0.043	0.000	0.000	5.430
251% - 300%	0.000	0.000	3.167	0.000	0.095	0.106	0.000	3.368
301% - 350%	0.000	0.000	2.701	0.000	0.080	0.085	0.000	2.866
351% - 400%	0.000	0.000	1.960	0.000	0.055	0.064	0.000	2.078
401% - 500%	0.000	0.000	0.000	2.256	0.124	0.157	0.164	2.701
501%+	0.000	0.000	0.000	5.200	0.293	0.360	0.371	6.224
All Income Levels	4.212	10.752	7.828	7.456	0.729	0.772	0.535	32.284
2020								
<139%	2.757	0.000	0.000	0.000	0.000	0.000	0.000	2.757
139% - 150%	1.257	0.000	0.000	0.000	0.000	0.000	0.000	1.257
151% - 200%	0.000	5.259	0.000	0.000	0.034	0.000	0.000	5.292
201% - 250%	0.000	5.285	0.000	0.000	0.033	0.000	0.000	5.318
251% - 300%	0.000	0.000	3.201	0.000	0.077	0.084	0.000	3.362
301% - 350%	0.000	0.000	2.736	0.000	0.064	0.066	0.000	2.867
351% - 400%	0.000	0.000	1.983	0.000	0.042	0.051	0.000	2.077
401% - 500%	0.000	0.000	0.000	2.351	0.105	0.139	0.130	2.725
501%+	0.000	0.000	0.000	5.361	0.245	0.316	0.311	6.233
All Income Levels	4.014	10.543	7.921	7.712	0.600	0.655	0.441	31.887

Attachment C
BE HIP Scenario

Attachment C-2 BE HIP Scenario Plan Selection Distribution by FPL All Plans in BE HIP Marketplace								
Income as Percent of FPL	**BE HIP 95%**	**BE HIP 85%**	**BE HIP 70%**	**BE HIP 55%**	**BE HIP Supplemented to 95%**	**BE HIP Supplemented to 85%**	**BE HIP Supplemented to 70%**	**Overall**
2018								
<139%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
139% - 150%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
151% - 200%	0.0%	97.5%	0.0%	0.0%	2.5%	0.0%	0.0%	100.0%
201% - 250%	0.0%	97.5%	0.0%	0.0%	2.5%	0.0%	0.0%	100.0%
251% - 300%	0.0%	0.0%	89.0%	0.0%	5.3%	5.6%	0.0%	100.0%
301% - 350%	0.0%	0.0%	89.3%	0.0%	5.2%	5.5%	0.0%	100.0%
351% - 400%	0.0%	0.0%	88.9%	0.0%	5.1%	6.0%	0.0%	100.0%
401% - 500%	0.0%	0.0%	0.0%	75.2%	7.4%	8.5%	8.9%	100.0%
501%+	0.0%	0.0%	0.0%	74.6%	7.6%	8.4%	9.3%	100.0%
All Income Levels	13.6%	32.9%	22.6%	20.4%	4.2%	3.7%	2.5%	100.0%
2019								
<139%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
139% - 150%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
151% - 200%	0.0%	99.3%	0.0%	0.0%	0.7%	0.0%	0.0%	100.0%
201% - 250%	0.0%	99.2%	0.0%	0.0%	0.8%	0.0%	0.0%	100.0%
251% - 300%	0.0%	0.0%	94.0%	0.0%	2.8%	3.1%	0.0%	100.0%
301% - 350%	0.0%	0.0%	94.3%	0.0%	2.8%	3.0%	0.0%	100.0%
351% - 400%	0.0%	0.0%	94.3%	0.0%	2.6%	3.1%	0.0%	100.0%
401% - 500%	0.0%	0.0%	0.0%	83.5%	4.6%	5.8%	6.1%	100.0%
501%+	0.0%	0.0%	0.0%	83.5%	4.7%	5.8%	6.0%	100.0%
All Income Levels	13.0%	33.3%	24.2%	23.1%	2.3%	2.4%	1.7%	100.0%
2020								
<139%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
139% - 150%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
151% - 200%	0.0%	99.4%	0.0%	0.0%	0.6%	0.0%	0.0%	100.0%
201% - 250%	0.0%	99.4%	0.0%	0.0%	0.6%	0.0%	0.0%	100.0%
251% - 300%	0.0%	0.0%	95.2%	0.0%	2.3%	2.5%	0.0%	100.0%
301% - 350%	0.0%	0.0%	95.5%	0.0%	2.2%	2.3%	0.0%	100.0%
351% - 400%	0.0%	0.0%	95.5%	0.0%	2.0%	2.5%	0.0%	100.0%
401% - 500%	0.0%	0.0%	0.0%	86.3%	3.9%	5.1%	4.8%	100.0%
501%+	0.0%	0.0%	0.0%	86.0%	3.9%	5.1%	5.0%	100.0%
All Income Levels	12.6%	33.1%	24.8%	24.2%	1.9%	2.1%	1.4%	100.0%