District of Columbia Health Benefits Exchange
Insurance Subcommittee

Essential Health Benefits Bulletin

August 29, 2012

Public Comment period ends: September 28, 2012

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SECTION 1:

EHB Bulletin and Recommendation

Part 1: Regulatory Overview

Section 1302(b)(2) of the ACA requires that all health insurance plans offered in the individual and small group markets cover the following ten areas of service:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services including behavioral health
6. Prescription drugs
7. Rehabilitative and habilitative services and devices[1]
8. Laboratory services
9. Preventative, wellness, and chronic disease management services
10. Pediatric services including dental and vision care

Under the ACA, self-insured group health plans, large group market health plans, and grandfathered plans[2] are not required to offer EHB.

On December 16, 2011, CCIIO released guidance to States for selection of an EHB package. The four benchmarks that a State can choose from include:

- The three largest plans, by enrollment, in the Federal Employees Health Benefits Program (FEHBP);
- The three largest plans, by enrollment, of District employee plans;
- The three largest plans, by enrollment, in the District small group market; or
- The largest HMO, by enrollment, offered in the District.

On February 17, 2012, CCIIO released an FAQ on their EHB guidance that provided clarity in several areas. The following points made in the FAQ are especially important to bear in mind as the District continues to develop an EHB recommendation:

- Due to the benchmark approach taken by HHS and CCIIO, which allowed the District to select a plan that includes District mandates, the District is not liable to defray the cost for those mandates included in any EHB selection.
    - This is temporary, however. CCIIO anticipates revisiting EHB selections in 2016 when the issue of defraying mandates could resurface if a different approach/policy is adopted.

- If the District selects a benchmark plan that does not include services in all 10 EHB categories, it must supplement that coverage from another plan within that benchmark. If the service is not included in the second or third largest plans within a particular benchmark, the District must look to the FEHBP benchmark plan with the highest enrollment to supplement its plan.

[1] Habilitation services involve a combination of treatment and education services which are designed to either increase or maintain the physical, intellectual, emotional, and social functioning of individuals who have not reached age-appropriate developmental milestones.
[2] Plans that were in effect prior to March 23, 2010 (signing of ACA).

- CCIIO research revealed that three categories of benefits- pediatric oral services, pediatric vision services, and habilitative services- are not included in many health insurance plans. For this reason, CCIIO describes in their February 2012 FAQ special rules to ensure meaningful benefits in those categories.

    - Habilitative services
        - A plan could have to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity, OR
        - A plan could decide which habilitative services to cover and report the coverage to HHS, which would then evaluate and further define habilitative services in the future.

    - Pediatric oral care
        - The District could supplement the potentially missing benefit with either the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment, OR
        - The District's pediatric Medicaid program.

    - Pediatric vision care
        - The District would supplement the potentially missing benefit from the FEDVIP vision plan with highest national enrollment.

Part 2: Actions Taken

In response to the December CCIIO bulletin, DISB created a template for District carriers to provide benefit and cost sharing information for plans in the prescribed benchmarks for each of the ten EHB categories.

Staff struggled with what appeared to be conflicting guidance in regards to "plan" versus "product." As referenced in the CCIIO bulletin,

> *"Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options.*
>
> *A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer.*
>
> *For example, multiple plans with different cost-sharing structures and rider options may derive from a single product."*

The guidance provided by CCIIO to States identifying small group carriers in the benchmark was conducted on a product level, not the plan level. Staff determined that the plan level detail is what is needed to make an appropriate selection, which was reflected in the District's data call.

After completed templates were received back from carriers, DISB staff developed a comprehensive workbook, made available to the public via healthreform.dc.gov to properly analyze the options. Findings are summarized below[3].

- *Top three largest plans, by enrollment, in the District small group market;*
    1. BlueCross Blue Shield CareFirst Preferred Option 1 (PPO)
    2. Kaiser Foundation of the Mid-Atlantic States HMO Plan 5 (HMO)
    3. BlueCross Blue Shield CareFirst Preferred Option 6 (PPO)

- *Largest HMO, by enrollment, in the District;*
    1. Kaiser Foundation of the Mid-Atlantic States HMO Plan 5

- *Top three largest, by enrollment, District employee plans;*
    - Aetna Open Access HMO
    - Aetna Open Access PPO
    - United HealthCare Choice Plan (PPO w/national provider network)

In addition to the above information, DISB also requested information from the two Managed Care Plan (MCO) administrators in the District on their Medicaid plan packages. This information was used purely for comparison purposes since nearly 1/3 of the District population is enrolled in one of these two plans.

[3] Excel workbook carrier call data available on healthreform.dc.gov.

Part 3: Frequently Asked Questions (FAQ)

Q: To what benchmark options do state mandates apply?

A: Benefits mandated by District law apply to all options EXCEPT Federal Employee Health Benefit Plan (FEHBP) benchmarks.

Q: What happens if the District mandates a coverage that falls outside the EHB benchmark plan?

A: This could occur if the District selects an FEHBP benchmark or adds mandates after the selection of a benchmark plan. In these cases, the District would be required to pay the subsidy for cost of the mandate to any District policyholder who is eligible for a premium subsidy through the DC HBX.

Q: What happens if the District does not make a decision about an EHB benchmark plan?

A: If the District neglects to make a decision and submit it to HHS before October 1, 2012, HHS will impose a "default" EHB benchmark option. This default option would be the largest small group plan by enrollment. For the District, that is BlueCross Blue Shield CareFirst Preferred Option 1 (PPO).

Q: Who is responsible for making the decision on which benchmark plan the District selects?

A: The Insurance Subcommittee will present a recommendation to both the Mayor and the DC HBX Authority Executive Board that has been vetted by stakeholders both publically and inter-agency. The responsibility of submission and regulation of the EHB selection falls under the Insurance Commissioner and DISB. The Commissioner intends to submit the selection, with incorporated stakeholder and HBX Executive Board feedback, to HHS/CCIIO no later than October 1, 2012.

Q: What if one of the ten required categories in the ACA is not covered in our selected benchmark?

A: If the District's selected benchmark is missing a category of benefits required by the ACA (typically pediatric oral and vision), HHS has a substitution method that allows us to plug in whole benefits from one of the other benchmark options. For example, if the District were to choose the Aetna HMO (top plan, by enrollment, for District employees) and it did not cover habilitative care, we would have to look to the next benchmark plan in that area to supplement (Aetna PPO, and United HealthCare Choice Plan) the missing benefit. If neither of those plans had that particular benefit, we would then look to the Small group benchmarks and FEHBP plans.

Part 4: Analysis

Compass Solutions (Compass) was retained by the District to research EHBs primarily in terms of richness of plans. Compass provided this analysis in a report titled *Essential Health Benefits (EHB) Benchmark Plans For the District of Columbia Health Exchange* (Report)[4].

Among the ten plans analyzed, Compass reported broad coverage for medical services such as physician, hospital, emergency services, skilled nursing facility, laboratory, durable medical equipment, and routine preventive and wellness care. They also found that all plans covered most conditions and illnesses, including maternity and newborn care, and mental health and nervous disorders. Compass, conceding that, in some cases, it did not have enough information to determine coverage, reportedly focused on services where variations between plans were identified.

The final report also provided guidance on inclusion of pediatric dental and vision benefits in the EHB package. In the Report, Compass estimated the cost of pediatric dental services to be around 1%, or $4 PMPM of the costs of the average plan. Further, the Report estimated the cost of pediatric vision services to be around 0.5%, or $2 PMPM of costs of the average plan. They found these figures to be reasonable based on the average PMPM of $437 cited by the Mercer Report. The report concludes that the District should look to the FEDVIP dental and vision programs to supplement pediatric benefits as necessary.

Along with the recommendations provided by Compass, the Insurance Subcommittee staff reviewed the data provided by carriers earlier this year and analyzed the work of other states that are further along in their process of selecting an EHB. The work of Colorado and Oregon was of particular interest due to the clarity in which they illustrated their decision making process for both stakeholders and the public as a whole.

The key factor in selecting an EHB package is each plan's benefits and how they fit into the ACA's ten EHB categories. While cost-sharing details can be instructive, today's cost-sharing structures will likely change within the District's HBX marketplace. This will occur because of the "metal level" structure within the HBX insurance marketplace that organizes plans by four cost-sharing structures: Bronze (60% of costs covered by plan premiums), Silver (70% of costs covered by plan premiums), Gold (80% of costs covered by plan premiums), and Platinum (90% of costs covered by plan premiums).

Research provided by Mercer in the Insurance Marketplace Report also provided the District with guidance in the selection process of potential premium costs. It is necessary to note that this analysis was done prior to CCIIO/HHS guidance on the EHB package. The assumption at the time of analysis was that the Secretary would issue a nation-wide package of benefits in which individual states would be financially liable for specific mandates. This is important because Mercer notes in their baseline scenario that the "average premium…in the individual market, prior to application of premium subsidies, are projected to increase 45% from 2013 to 2013. The (EHB) package accounts for roughly 25% of increase.[5]"

The average annual premium for all enrollees in consolidated market with a merged risk pool and small business defined as 100 or fewer would be $5,090 in 2014 ($4,840 in the small group market, $5,200 in

[4] See Section 5, *Compass EHB Deliverable*
[5] See Section 6, *Mercer Insurance Marketplace Report*, p.7

the individual market). Based on the Compass analysis of pediatric vision and dental benefit additions to the package (1% of total premium and 0.5% of total premium, respectively), the following estimates can be made:

- 2014 Average Small Group market Premium: $4,912
- 2014 Average Individual Market Premium: $5,278

Part 5: Conclusion and Stakeholder Comment

Comparing plans within the HHS/CCIIO benchmarks illustrates that there is little difference in benefit offerings among the three District-specific benchmarks. The guiding principles for the selection of the EHB were that it included District mandates, provided benefits in the ten required EHB benefit categories, and provided consumers with baseline benefit package to meet the most universal health care needs.

The District's analysis confirms Compass' finding that the benchmark plan most consistent with the EHB requirements with the richest benefit offerings is the BlueCross BlueShield CareFirst BluePreferred Option 1[6]. Therefore we recommend this plan as the District of Columbia EHB package.

DISB will be accepting public comment on the above recommendation until 5:00pm EST on Friday, September 28, 2012.

All comments will be incorporated into a final report that will be shared with the DC HBX Executive Board. DISB is targeting October 1, 2012 as the date we will notify HHS/CCIIO of the District's EHB plan selection.

To facilitate a better understanding of the recommendation and to discuss any issues stakeholders may have, the HBX Working Group meeting on Tuesday, September 4 will focus exclusively on the EHB selection.

We encourage you to comment on any aspect of the EHB selection, including the following questions:

- Do you support BlueCross BlueShield CareFirst BluePreferred Option 1 being selected as the EHB benchmark plan? Please provide detail in support or opposition.
- Are the level of benefits included for pediatric dental and vision appropriate or exorbitant?
- Among the benchmark plans, is there a plan that better suits the EHB selection?
- What omissions have been made in constructing the recommended DC EHB selection?

Please submit all comments electronically to Brendan.Rose@dc.gov. You can also mail comments to:

Brendan Rose
D.C. Department of Insurance, Securities, and Banking
810 First Street, NE
Suite 701
Washington, DC 20002

[6] EHB benefit illustration, by category, in Section 2.

SECTION 2:

Illustration of Total Essential Health Benefits

District of Columbia
Illustration of Total Essential Health Benefits
Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Coverage Details	Source Plan
1. Ambulatory Patient Services		
a. Outpatient hospital facility services	Covered	Small Group- CareFirst BluePreferred Option 1
b. Ambulatory surgical facility services	Covered	Small Group- CareFirst BluePreferred Option 1
c. Professional medical services provided at care facility	Covered	Small Group- CareFirst BluePreferred Option 1
d. Professional surgical services provided at care facility	Covered	Small Group- CareFirst BluePreferred Option 1
e. Home health services	Limited to 90 visits up to 4 hours per episode of care	Small Group- CareFirst BluePreferred Option 1
2. Emergency Coverage		
a. Emergency room services (including voluntary HIV test performed while receiving emergency medical services at a hospital ER).	Covered	Small Group- CareFirst BluePreferred Option 1
b. Ambulance service	Covered	Small Group- CareFirst BluePreferred Option 1
3. Hospitalization		
a. Inpatient facility services (medical or surgical condition)	Covered	Small Group- CareFirst BluePreferred Option 1
b. Hospitalization for rehabilitation	Covered	Small Group- CareFirst BluePreferred Option 1
c. Inpatient professional medical services	Covered	Small Group- CareFirst BluePreferred Option 1
d. Inpatient professional surgical services	Covered	Small Group- CareFirst BluePreferred Option 1
e. Anesthesia services	Covered	Small Group- CareFirst BluePreferred Option 1
f. Hospice services	Limited to max 180 day hospice eligibility period	Small Group- CareFirst BluePreferred Option 1
4. Maternity/Newborn Care		
a. Pre-natal care	Covered	Small Group- CareFirst BluePreferred Option 1

Benefit	Coverage Details	Source Plan
b. Post-natal care	Covered	Small Group- CareFirst BluePreferred Option 1
c. Labor and Delivery	Covered	Small Group- CareFirst BluePreferred Option 1
d. Inpatient Facility Services	Covered (48 hours following a vaginal delivery, 96 hours following a Cesarean section).	Small Group- CareFirst BluePreferred Option 1
e. Routine newborn care	Covered	Small Group- CareFirst BluePreferred Option 1
f. Postpartum home visits	Covered	Small Group- CareFirst BluePreferred Option 1
5. Mental Health, Substance Use Disorders, Behavioral Health Treatment		
a. Mental health outpatient services	Visits 1-40: 25% of allowed benefit. Visits 40+: 40% of allowed benefit.	Small Group- CareFirst BluePreferred Option 1
b. Substance abuse outpatient services	Visits 1-40: 25% of allowed benefit. Visits 40+: 40% of allowed benefit.	Small Group- CareFirst BluePreferred Option 1
c. Medication management office visits	Covered	Small Group- CareFirst BluePreferred Option 1
d. Inpatient mental health facility services	Limited to 60 days per benefit period	Small Group- CareFirst BluePreferred Option 1
e. Inpatient substance abuse facility services	Limited to 60 days per benefit period	Small Group- CareFirst BluePreferred Option 1
f. Detoxification	Limited to 12 visits (inpatient or outpatient) per benefit period	Small Group- CareFirst BluePreferred Option 1
g. Partial hospitalization	Covered	Small Group- CareFirst BluePreferred Option 1
6. Prescription Drugs		
a. Preferred preventative drugs	Covered	Small Group- CareFirst BluePreferred Option 1
b. Generic Drug	Covered	Small Group- CareFirst BluePreferred Option 1
c. Preferred brand name drug	Covered	Small Group- CareFirst BluePreferred Option 1
d. Non-preferred brand name drug	Covered	Small Group- CareFirst BluePreferred Option 1
e. Diabetic supplies	Covered	Small Group- CareFirst BluePreferred Option 1

Benefit	Coverage Details	Source Plan
f. Oral chemotherapy drugs	Covered	Small Group- CareFirst BluePreferred Option 1
g. Injectable, self-administered medications	For each (34) day supply of covered injectable meds that are self-administered, except for insulin, the Member will be required to pay 50e% of Allowed Benefit up to a Member maximum Copay of $75 per covered injectable medication. For up to (90) day supply of self-administered, injectable Maintenance Drugs, except for insulin, the Member will be required to pay 50% of the Allowed Benefit up to a Member maximum payment of $150.	Small Group- CareFirst BluePreferred Option 1
h. Prescription drugs (general)	For Prescription Drugs purchased in a Pharmacy or purchased through the mail order program, there is one Copayment due for each thirty-four (34) day supply.	Small Group- CareFirst BluePreferred Option 1
i. Maintenance drugs (general)	For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.	Small Group- CareFirst BluePreferred Option 1
j. Contraception	Covered	Small Group- CareFirst BluePreferred Option 1
7. Rehabilitative & Habilitative Services and Devices		
a. Rehabilitation Services	Occupational therapy, physical therapy, speech therapy	Small Group- CareFirst BluePreferred Option 1
b. Spinal manipulation services	Limited to Members who are twelve years or age older	Small Group- CareFirst BluePreferred Option 1
c. Habilitative services for children	Limited to members under the age of 21	Small Group- CareFirst BluePreferred Option 1
d. Cardiac rehabilitation	Limited to members under the age of 21	Small Group- CareFirst BluePreferred Option 1
e. Pulmonary rehabilitation	Limited to 1 pulmonary rehabilitation program per lifetime	Small Group- CareFirst BluePreferred Option 1

Benefit	Coverage Details	Source Plan
f. Skilled nursing facility services	Limited to 60 days per benefit period	Small Group- CareFirst BluePreferred Option 1
g. Medical devices and supplies	Covered	Small Group- CareFirst BluePreferred Option 1
8. Laboratory Services		
a. Laboratory tests	Covered	Small Group- CareFirst BluePreferred Option 1
b. X-rays and other diagnostic procedures	Covered	Small Group- CareFirst BluePreferred Option 1
9. Preventative and Wellness Services		
a. Adult routine physical exam	Covered	Small Group- CareFirst BluePreferred Option 1
b. Routine gynecological exam	Covered	Small Group- CareFirst BluePreferred Option 1
c. Prostate cancer screening	Covered	Small Group- CareFirst BluePreferred Option 1
d. Pap smear	Covered	Small Group- CareFirst BluePreferred Option 1
e. Mammography	Covered	Small Group- CareFirst BluePreferred Option 1
f. Colorectal cancer screening	Covered	Small Group- CareFirst BluePreferred Option 1
g. Immunizations	Covered	Small Group- CareFirst BluePreferred Option 1
h. Medical nutrition therapy	Covered	Small Group- CareFirst BluePreferred Option 1
i. Professional nutritional counseling	Covered	Small Group- CareFirst BluePreferred Option 1
j. Allergy testing, treatment, and shots	Covered	Small Group- CareFirst BluePreferred Option 1
k. Diabetes treatment	Covered	Small Group- CareFirst BluePreferred Option 1
10. Pediatric Services, including Oral and Vision		
a. Well-child care	Covered	Small Group- CareFirst BluePreferred Option 1
b. Preventative services for obesity	Covered	Small Group- CareFirst BluePreferred Option 1
c. Vision- eye exam (separate visit)	1 per year	FEDVIP- BlueVision High Plan
d. Vision- lenses	1 pair per year	FEDVIP- BlueVision High Plan
e. Vision- frames	1 per year ($150 allowance)	FEDVIP- BlueVision High Plan
f. Vision- contact lenses	1 per year ($150 allowance, $600 for medical necessity)	FEDVIP- BlueVision High Plan

Benefit	Coverage Details	Source Plan
g. Dental class A- diagnostic and treatment services	1 oral evaluation per 6 months	FEDVIP-MetLife High Option
h. Dental class A- preventative services.	Sealants (1 per tooth every 36 months), prophylaxis (1 every 6 months), space maintainers (limited to children under 19).	FEDVIP-MetLife High Option
i. Dental class B-minor restorative service	Covered	FEDVIP-MetLife High Option
j. Dental class B- oral surgery	Covered	FEDVIP-MetLife High Option
k. Dental class C- major restorative services	Covered	FEDVIP-MetLife High Option
l. Dental class C- endodontic services	Covered	FEDVIP-MetLife High Option
m. Dental class C- periodontal services	Covered	FEDVIP- MetLife High Option
n. Dental class C- prosthodontics services	Covered	FEDVIP-MetLife High Option
o. Anesthesia services	Covered	FEDVIP-MetLife High Option
p. Intravenous sedation	Covered	FEDVIP-MetLife High Option

SECTION 3:

HHS/CCIIO EHB Guidance

ESSENTIAL HEALTH BENEFITS BULLETIN

Center for Consumer Information and Insurance Oversight

December 16, 2011

Contents

ESSENTIAL HEALTH BENEFITS BULLETIN

Purpose

The purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services (HHS) plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act. This bulletin begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This bulletin only relates to covered services. Plan cost sharing and the calculation of actuarial value are not addressed in this bulletin. We plan to release guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage in the near future. In addition, we plan to issue future guidance on essential health benefit implementation in the Medicaid program.

The intended regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. In developing this intended approach, HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date.

Public input is welcome on this intended approach. Please send comments on the bulletin by January 31, 2012 to: EssentialHealthBenefits@cms.hhs.gov.

Defining Essential Health Benefits

A. Introduction and Background

Statutory Provisions

Section 1302(b) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to define essential health benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.[1] Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

[1] Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

Section 1302(b)(2) of the Affordable Care Act instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs the Secretary to establish an appropriate balance among the benefit categories. Further, under this provision, the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs. Benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population. The Secretary must submit a report to the appropriate committees of Congress along with a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

In addition, section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB.

The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.[2]

Public and Other Input

To inform the Department's understanding of the benefits provided by employer plans, HHS has considered a report on employer plans submitted by the Department of Labor (DOL), recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM), and input from the public and other interested stakeholders during a series of public listening sessions detailed below.

Section 1302(b)(2)(A) requires the Secretary of Labor to inform the determination of EHB with a survey of employer-sponsored plans. On April 15, 2011, the DOL issued its report, in satisfaction of section 1302(b)(2)(A) of the Affordable Care Act, providing results on the scope of benefits offered under employer-sponsored insurance to HHS.[3] The DOL survey provided a broad overview of benefits available to employees enrolled in employer sponsored plans. The report drew on data from the 2008 and 2009 National Compensation Survey (which includes large and small employers), as well as DOL's supplemental review of health plan Summary Plan Documents, and provided information on the extent to which employees have coverage for approximately 25 services within the 10 categories of EHB outlined in the Affordable Care Act (e.g., a certain percentage of plan participants have coverage for a certain benefit).

In order to receive independent guidance, HHS also commissioned the IOM to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access,

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[2] As noted, these will be the subject of forthcoming guidance.

[3] Available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf

and the effect of any benefit changes on cost. The IOM submitted its consensus recommendations in a report entitled "Essential Health Benefits: Balancing Coverage and Cost" on October 7, 2011.[4] In order to balance the cost and comprehensiveness of EHB, the IOM recommended that EHB reflect plans in the small employer market and that the establishment of an EHB package should be guided by a national premium target. The IOM also recommended the development of a framework for updating EHB that would take into account new evidence about effective interventions and changes in provider and consumer preferences while ensuring that the cost of the revised package of benefits remains within predetermined limits as the benefit standards become more specific. The IOM recommended flexibility across States and suggested that States operating their own Exchanges be allowed to substitute a plan that is actuarially equivalent to the national EHB package. The IOM also recommended continued public input throughout the process.

Following the release of the IOM's recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives, in both Washington, D.C. and around the nation to gather public input. Several key themes emerged. Consumer groups and some provider groups expressed concern at the IOM's emphasis on cost over the comprehensiveness of benefits. Some consumer groups expressed a belief that small group plans may not represent the typical employer plan envisioned by the statute, while employers and health insurance issuers generally supported the IOM conclusion that EHB should be based on small employer plans. Consumer and provider groups commented that specific benefits should be spelled out by the Secretary, while health insurance issuers and employers commented that they prefer more general guidance, allowing for greater flexibility. Both provider and consumer groups expressed concern about discrimination against individuals with particular conditions. Employers and health insurance issuers stressed concern about resources and urged the Secretary to adopt a more moderate benefit package. Consumers generally favored a uniform benefits package, and many consumers requested that State mandates be included in the benefits package. Some requested a uniform benefit package so that consumer choice of plan could focus on other plan features such as premium, provider network, and quality improvement. Some employer, health insurance issuer, and State representatives focused on the need for flexibility across the country to reflect local preferences and practices. States, health insurance issuers, and employers emphasized the need for timely guidance in preparing for implementation around EHB.

B. Summary of Research on Employer Sponsored Plan Benefits and State Benefit Mandates

While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of "typical." Therefore, HHS gathered benefit information on large employer plans (which account for

[4] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

the majority of employer plan enrollees), small employer products (which account for the majority of employer plans), and plans offered to public employees.[5]

There is not yet a national standard for plan reporting of benefits.[6] While the DOL collects information on benefits offered by employer plans, no single data set includes comprehensive data on coverage of each of the 10 statutory essential health benefit categories. Consequently, to supplement information available from the DOL, Mercer,[7] and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET)[8] surveys of employer plans, HHS gathered information on employer plan benefits from the IOM's survey of three small group issuers and supplemented this information with an internal analysis of publicly available information on State employee plans and Federal employee plans,[9] and information on benefits submitted to HealthCare.gov by small group health insurance issuers. To inform our understanding of the category of pediatric oral and vision care, HHS staff also analyzed dental and vision plans in the Federal Employees Dental/Vision Insurance Program (FEDVIP).[10] The FEDVIP program is a standalone vision and dental program where eligible Federal enrollees pay the full cost of their coverage.

Similarities and Differences in Benefit Coverage Across Markets

Generally, according to this analysis, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB. Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories.

For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and

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[5] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

[6] Section 2715 of the Public Health Service Act (PHS Act) requires group health plans and health insurance issuers in the group and individual markets to provide a Summary of Benefits and Coverage in a uniform format to consumers. HHS, DOL, and the Department of the Treasury issued proposed rules for PHS Act section 2715 at 76 FR 52442 (August 22, 2011). Further information is available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf and http://www.dol.gov/ebsa/faqs/faq-aca7.html.

[7] Available at http://www.mercer.com/survey-reports/2009-US-national-health-plan-survey

[8] Available at http://ehbs.kff.org

[9] HHS staff analyzed the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association Benefit plan booklets.

[10] Further information is available at https://www.benefeds.com/Portal/jsp/LoginPage.jsp

outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services.[11]

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States. However, in some cases, small group products cover some benefits that are not included in the FEHBP plans examined and may not be included in State employee plans, especially in States for which benefits such as in-vitro fertilization or applied behavior analysis (ABA) for children with autism are mandated by State law.[12] Finally, there is a subset of benefits including mental health and substance use disorder services, pediatric oral and vision services, and habilitative services – where there is variation in coverage among plans, products, and markets. These service categories are examined in more detail below.

Mental Health and Substance Use Disorder Services

In general, the plans and products studied appear to cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits. As discussed later in this document, coverage will have to be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA).[13]

The extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear. In general, plans do not mention behavioral health treatment as a category of services in summary

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[11] ASPE Research Brief, "Actuarial Value and Employer Sponsored Insurance," November 2011. Available at: http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf.

[12] In addition to mandated benefits, it appears that the small group issuers the IOM surveyed also generally cover residential treatment centers, which the FEHBP BCBS Standard Option plan excludes. However, as this analysis compares three small group issuers to one FEHBP plan, it is unclear if this finding can be generalized to other plans.

[13] See Affordable Care Act § 1311(j); see also PHS Act § 2726, ERISA § 712, Internal Revenue Code § 9812. See also interim final regulations at 75 FR 5410 (February 2, 2010) and guidance published on June 30, 2010 (http://www.dol.gov/ebsa/faqs/faq-mhpaea.html), December 22, 2010 (http://www.dol.gov/ebsa/faqs/faq-aca5.html), and November 17, 2011 (http://www.dol.gov/ebsa/faqs/faq-aca7.html).

plan documents. The exception is behavioral treatment for autism, which small group issuers in the IOM survey indicated is usually covered only when mandated by States.

Pediatric Oral and Vision Care

Coverage of dental and vision care services are provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage, which may be excepted benefits under PHS Act section 2722.[14] The FEDVIP vision plan with the highest enrollment in 2010 covers routine eye examinations with refraction, corrective lenses and contact lenses, and the FEDVIP dental plan covers preventive and basic dental services such as cleanings and fillings, as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. In some cases, dental or vision services may be covered by a medical plan. For example, the FEHBP BCBS Standard Option plan covers basic and preventive dental services.

Habilitative Services

There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions, or defining "habilitative services" as the term is used in the Medicaid program.[15,16,17] An example of habilitative services is speech therapy for a child who is not talking at the expected age .

Two of the three small group issuers surveyed by the IOM indicated that they do not cover habilitative services. However, data submitted by small group issuers for display on HealthCare.gov indicates that about 70 percent of small group products offer at least limited coverage of habilitative services.[18] Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans, which often includes visit limits. All three issuers reporting to the IOM covered PT, OT, and ST, though one issuer did not cover these services for patients with an autism diagnosis. The FEHBP BCBS Standard Option plan also covers PT, OT, and ST. State employee plans examined appear to generally cover PT, OT, and ST.

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[14] When dental or vision coverage is provided in plan that is separate from or otherwise not an integral part of a major medical plan, that separate coverage is not subject to the insurance market reforms in title XXVII of the PHS Act. See PHS Act §§ 2722(c)(1), 2791(c)(2).

[15] For State definitions, see Md. Code Ins. § 15-835(a)(3); D.C. Code § 31-3271(3); 215 Ill. Comp. Stat. 5/356z.14(i).

[16] See 76 Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[17] For Medicaid definition, see Social Security Act, § 1915(c)(5)(A).

[18] Data submitted in October 2011.

Comparison to Other Employer Plan Surveys

These findings are generally consistent with other surveys of employer sponsored health coverage conducted by DOL, Mercer, and KFF/HRET. The Department of Labor survey found that employees had widespread coverage for medical services such as inpatient hospital services, hospital room and board, emergency room visits, ambulance service, maternity, durable medical equipment, and physical therapy. Similarly, Mercer found employers provided widespread coverage for medical services such as durable medical equipment, outpatient facility charges, and physical, occupational, and speech therapy. The KFF/HRET survey also found widespread coverage of prescription drugs among employees with employer-sponsored coverage.

State Benefit Mandates

State laws regarding required coverage of benefits vary widely in number, scope, and topic, so that generalizing about mandates and their impact on typical employer plans is difficult. All States have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the 50 States and the District of Columbia.[19]

Almost all State mandated services are typically included in benefit packages in States without the mandate – such as immunizations and emergency services. In order to better understand the variation in State mandates, their impact on the benefits covered by plans, and their cost, HHS analyzed 150 categories of benefit and provider mandates across all 50 States and the District of Columbia. The FEHBP BCBS Standard and Basic Options are not subject to any State mandates, but our analysis indicates that they cover nearly all of the benefit and provider mandate categories required under State mandates. The FEHBP BCBS Standard Option is not subject to any State mandates, but our analysis indicates that it covers about 95 percent of the benefit and provider mandate categories required under State mandates. The primary exceptions are mandates requiring coverage of in-vitro fertilization and ABA therapy for autism, which are not covered by the FEHBP BCBS Standard Option plan but are required in 8 and 29 States, respectively.

These two mandates commonly permit annual dollar limits, annual lifetime or frequency limits, and/or age limits. Research by States with these two mandates indicates that the cost of covering in-vitro fertilization benefits raises average premiums by about one percent[20,21] and the cost of covering ABA therapy for autism raises average premiums by approximately 0.3 percent.[22] Approximately 10 percent of people covered by small

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[19] Of these 1,600 mandates, about 1,150 are benefit mandates and 450 are provider mandates.

[20] Maryland Health Care Commission. Study of Mandated Health Insurance Services: A Comparative Evaluation. January 1, 2008. Available at: http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

[21] University of Connecticut Center for Public Health and Health Policy. Connecticut Mandated Health Insurance Benefit Reviews. January, 2011. Available at: http://www.ct.gov/cid/lib/cid/2010_CT_Mandated_Health_Insurance_Benefits_Reviews_-_General_Overview.pdf

[22] California Health Benefits Review Program. Analysis of Senate Bill TBD 1: Autism. March 20, 2011. Available at: http://www.chbrp.org/docs/index.php?action=read&bill_id=113&doc_type=3.

group policies live in a State requiring coverage of in-vitro fertilization, and approximately 50 percent live in a State requiring coverage of ABA.

The small group issuers surveyed by the IOM indicated they cover ABA only when required by State benefit mandates. The FEHBP BCBS Standard Option does not cover ABA. The extent to which these services are covered by State employee plans is unclear, as there is variation between States in whether benefit mandates apply (either by statute or voluntarily) to State employee plans.

C. Intended Regulatory Approach

As noted in the introduction, the Affordable Care Act authorizes the Secretary to define EHB. In response to the research and recommendations described above, as a general matter, our goal is to pursue an approach that will:

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide States a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage.

As recommended by the IOM, HHS aims to balance comprehensiveness, affordability, and State flexibility while taking into account public input throughout the process of establishing and implementing EHB.[23] Our intended approach to EHB incorporates plans typically offered by small employers and benefits that are covered across the current employer marketplace.

We intend to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that State as required by section 1302(b)(2)(A) of the Affordable Care Act. This approach is based on the approach established by Congress for the Children's Health Insurance Program (CHIP), created in 1997, and for certain Medicaid populations.[24,25] A major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers' needs for comprehensiveness and affordability. As described below, health insurance

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[23] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

[24] Balanced Budget Act of 1997; Public Law 105-33

[25] Section 42 CFR 457.410 and 457.420

issuers could adopt the scope of services and limits of the State benchmark, or vary it within the parameters described below.

Four Benchmark Plan Types

Our analysis of offerings that exist today suggests that the following four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB in the Affordable Care Act:

(1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;[26]
(2) any of the largest three State employee health benefit plans by enrollment;
(3) any of the largest three national FEHBP plan options by enrollment; or
(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

To reflect the State flexibility recommended by the IOM, under our intended approach, States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their State and plans offered in the individual and small group markets in their State. To determine enrollment in plans for specifying the benchmark options, we intend to propose to use enrollment data from the first quarter two years prior to the coverage year and that States select a benchmark in the third quarter two years prior to the coverage year. For example, enrollment data from HealthCare.gov for the first quarter of calendar year 2012 could be used to determine which plans would be potential benchmarks for State selection and the benchmark plan specified during the third quarter of 2012 for coverage year 2014. If a State does not exercise the option to select a benchmark health plan, we intend to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State's small group market.

Defraying the Cost of Additional Benefits

Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of State-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market. Similar to other Exchange decisions, the State may select the benchmark plan. The approach for 2014 and 2015 would provide a transition period for States to coordinate their benefit mandates while minimizing the likelihood the State would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively,

[26] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

under our intended approach a State could also select a benchmark such as an FEHBP plan that may not include some or all of the State's benefit mandates, and therefore under Section 1311(d)(3)(B), the State would be required to cover the cost of those mandates outside the State EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.

Benchmark Plan Approach and the 10 Benefit Categories

One of the challenges with the described benchmark plan approach to defining EHB is meeting both the test of a "typical employer plan" and ensuring coverage of all 10 categories of services set forth in section 1302(b)(1) of the Affordable Care Act. Not every benchmark plan includes coverage of all 10 categories of benefits identified in the Affordable Care Act (e.g., some of the benchmark plans do not routinely cover habilitative services or pediatric oral or vision services). The Affordable Care Act requires all issuers subject to the EHB standard in section 1302(a) to cover each of the 10 benefit categories.[27] If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB. In selecting a benchmark plan, a State may need to supplement the benchmark plan to cover each of the 10 categories. We are considering policy options for how a State supplements its benchmark benefits if the selected benchmark is missing a category of benefits. The most commonly non-covered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.

Below, we discuss several specific options for habilitative services, pediatric oral care and pediatric vision care. Generally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option. In a State with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type (e.g. small group plans or State employee plans or FEHBP) by enrollment offering the benefit. If none of the benchmark options in that benchmark type offer the benefit, the benefit will be supplemented using the FEHBP plan with the largest enrollment. For example, in a State where the default benchmark is in place but that default plan did not offer prescription drug benefits, the benchmark would be supplemented using the prescription drug benefits offered in the largest small group benchmark plan option with coverage for prescription drugs. If none of the three small group market benchmark options offer prescription drug benefits, that category would be based on the largest plan offering prescription drug benefits in FEHBP. We are continuing to consider options for supplementing missing categories such as habilitative care, pediatric oral care and pediatric vision care if States do not select one of the options discussed below.

[27] A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covers pediatric oral services as defined by EHB is offered through the same Exchange.

Habilitation

Because habilitative services are a less well defined area of care, there is uncertainty on what is included in it. The NAIC has proposed a definition of habilitation in materials transmitted to the Department as required under Section 2715 of the PHSA, and Medicaid has also adopted a definition of habilitative services.[28,29] These definitions include the concept of "keeping" or "maintaining" function, but this concept is virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation). Private insurance and Medicare may use different definitions when relating to coverage of these services.[30] We seek comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. We are considering two options if a benchmark plan does not include coverage for habilitative services:

1) Habilitative services would be offered at parity with rehabilitative services -- a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
2) As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

Pediatric Oral and Vision

For pediatric oral services, we are considering two options for supplementing benchmarks that do not include these categories. The State may select supplemental benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2) The State's separate CHIP program.[31]

We intend to propose the EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision services we intend to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment. The rationale for a different treatment of this category is that CHIP does not require vision services. As with habilitative services, we also seek comment on an approach that lets plans define the pediatric oral and vision services with required reporting as a transition policy.

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[28] See 76Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[29] For Medicaid definition, see Social Security Act, Section 1915(c)(5)(A).

[30] See section 220.2(c) and (d) in the Medicare Benefits Policy Manual available here: http://www.cms.gov/manuals/Downloads/bp102c15.pdf

[31] If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards. http://www.cms.gov/SMDL/downloads/CHIPRA%20Dental%20SHO%20Final%20100709revised.pdf

Mental Health and Substance Use Disorder Services and Parity

The MHPAEA expanded on previous Federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits. However, although parity was applied for covered mental health and substance use disorder benefits, there was no requirement to offer such a benefit in the first instance. Also, prior to the Affordable Care Act, MHPAEA parity requirements did not apply to the individual market or group health coverage sponsored by employers with 50 or fewer employees.

The Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 categories and therefore as an EHB in both the individual and small group markets. The Affordable Care Act also specifically extends MHPAEA to the individual market. Because the Affordable Care Act requires any issuer that must meet the coverage standard set in section 1302(a) to cover each of the 10 categories, all such plans must include coverage for mental health and substance use disorder services, including behavioral health treatment. Consistent with Congressional intent, we intend to propose that parity applies in the context of EHB.

Benefit Design Flexibility

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benefits of the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories. This is the same equivalency standard that applies to plans under CHIP.[32] Similar to CHIP, we intend to propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories. Any flexibility provided would be subject to a baseline set of relevant benefits, reflected in the benchmark plan as modified. Permitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits. We are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However, we are also considering whether to allow substitution across the benefit categories. If such flexibility is permitted, we seek input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories. In addition, we intend to require that the substitution be actuarially equivalent, using the same measures defined in CHIP.[33]

To ensure competition within pharmacy benefits, we intend to propose a standard that reflects the flexibility permitted in Medicare Part D in which plans must cover the

[32] 42 CFR 457.420.

[33] 42 CFR 457.431

categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes.[34] If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.

The Affordable Care Act also directs the Secretary to consider balance in defining benefits and to ensure that health insurance issuers do not discriminate against enrollees or applicants with health conditions. Providing guidelines for substitution will ensure that health insurance issuers meet these standards.

Updating Essential Health Benefits

Section 1302(b)(4)(G) and (H) direct the Secretary to periodically review and update EHB. As required by the Affordable Care Act, we will assess whether enrollees have difficulties with access for reasons of coverage or cost, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks and the affordability of coverage as it relates to EHB. We invite comment on approaches to gathering information and making this assessment. Under the benchmark framework, we note that the provision of a "substantially equal" standard would allow health insurance issuers to update their benefits on an annual basis and they would be expected on an ongoing basis to reflect improvements in the quality and practice of medicine. We also intend to propose a process to evaluate the benchmark approach.

[34] Drug category and class lists would be provided by the U.S. Pharmacopoeia, AHMS, or through a similar standard. Note: we do not intend to adopt the protected class of drug policy in Part D.

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Frequently Asked Questions on Essential Health Benefits Bulletin

On December 16, 2011, the Department of Health and Human Services (HHS) released a Bulletin[i] describing the approach it intends to take in future rulemaking to define the essential health benefits (EHB) under the Affordable Care Act. This document is intended to provide additional guidance on HHS's intended approach to defining EHB.

1. Under the approach described in the Bulletin, would the Secretary permit the State to adopt different benchmark plans for its individual and small group markets?

   A: No. A State would select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets both inside and outside of the Exchange. HHS believes that selecting one benchmark for these markets in a State would result in a more consistent and consumer-oriented set of options that would also serve to minimize administrative complexity. HHS seeks to provide flexibility to issuers by permitting actuarially equivalent substitution of benefits within the ten categories of benefits required by the Affordable Care Act.

2. When a State chooses an EHB benchmark plan, would the benefits be frozen in time, or as the benchmark plan updates benefits each year, would the benchmark plan reflect these updates?

   A: As indicated in the Bulletin, we intend to propose a process for updating EHB in future rulemaking. Under the intended approach, the specific set of benchmark benefits selected in 2012 would apply for plan years 2014 and 2015. For 2014 and 2015, the EHB benchmark plan selection would take place in the third quarter of 2012. A consistent set of benefits across these two years would limit market disruption during this transition period. As indicated in the Bulletin, HHS intends to revisit this approach for plan years starting in 2016.

3. Would States be required to defray the cost of any State-mandated benefit?

   A: The Affordable Care Act requires States to defray the costs of State-mandated benefits in qualified health plans (QHPs) that are in excess of the EHB. If a State were to choose a benchmark plan that does not include all State-mandated benefits, the Affordable Care Act would require the State to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark.

   States have several benchmark options from which to choose, including the largest small group market plan in the State, which is the default benchmark plan for each State. Generally, insured plans sold in the small group market must comply with State mandates to cover benefits. Thus, if a small group market benchmark plan was selected, these mandated benefits would be part of the State-selected EHB. However, if there are State mandates that do not apply to the small group market,

such as mandates that apply only to the individual market or to HMOs, the State would need to defray the costs of those mandates if the mandated benefits were not covered by the selected benchmark.

As indicated in the Bulletin, the treatment of State benefit mandates is intended as a two-year transitional policy that HHS intends to revisit for plan years starting in 2016.

4. Could a State add State-mandated benefits to the State-selected EHB benchmark plan today without having to defray the costs of those mandated benefits?

   A: No. We intend to clarify that under the proposed approach any State-mandated benefits enacted after December 31, 2011 could not be part of EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate. Note that any State-mandated benefits enacted by December 31, 2011 would be part of EHB if applicable to the State-selected EHB benchmark plan. As mentioned above, HHS intends to revisit this approach for plan years starting in 2016.

5. How must a State supplement a benchmark plan if it is missing coverage in one or more of the ten statutory categories?

   A: We intend to propose that if a benchmark plan is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category, as described in the Bulletin. For example, if a benchmark plan covers newborn care but not maternity services, the State must supplement the benchmark to ensure coverage for maternity services. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

   Our research found that three categories of benefits - pediatric oral services, pediatric vision services, and habilitative services - are not included in many health insurance plans. Thus, the Bulletin describes special rules to ensure meaningful benefits in those categories:

   - **As a transitional approach for habilitative services, the Bulletin discusses two alternative options that we are considering proposing:**
     - **A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.**
     - **A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future. Under either approach, a plan would be required to offer at least some habilitative benefit.**
   - **For pediatric oral care, we are considering proposing that the State would supplement the benchmark plan with benefits from either:**

- **The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or**
- **The State's separate Children's Health Insurance Program (CHIP).**

- **For pediatric vision care, we are considering proposing that the State would supplement the benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment.**

6. One of the currently intended benchmark plans is *the largest plan by enrollment in any of the three largest products in the small group market.* What is the difference between a plan and a product?

   A: For the purpose of administering the health plan finder on HealthCare.gov, HHS has defined "health insurance product" (product) as a package of benefits an issuer offers that is reported to State regulators in an insurance filing. Generally, this filing describes a set of benefits and often a provider network, but does not describe the manner in which benefits may be tailored, such as through the addition of riders. For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all riders. HHS intends to propose that if benefits in a statutory category are offered only through the purchase of riders in a benchmark plan, that required EHB category would need to be supplemented by reference to another benchmark as described in question 5.

7. What is the minimum set of benefits a plan must offer in a statutory category to be considered to offer coverage within the category consistent with the benchmark plan?

   A: Under the approach described in the Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431, and provided that substitutions would not violate other statutory provisions. For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met. The benchmark plan would provide States and issuers with a frame of reference for the EHB categories.

8. Can scope and duration limitations be included in the EHB?

   A: Yes. Under the intended approach, a plan must be substantially equal to the benchmark plan, in both the scope of benefits offered and any limitations on those benefits such as visit limits. However, any scope and duration limitations in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. In addition, the Public Health Service Act (PHS Act) section 2711, as added by the Affordable Care Act, prohibits imposing annual and lifetime dollar limits on EHB. Note that for annual dollar limits, the prohibition generally applies in full starting in 2014, with certain restricted annual limits permitted until that time. The prohibition on annual dollar limits does not apply to grandfathered individual market policies.

9. State-mandated benefits sometimes have dollar limits. How does the intended EHB policy interact with the annual and lifetime dollar limit provisions of the Affordable Care Act?

   A: PHS Act section 2711, as added by the Affordable Care Act, does not permit annual or lifetime dollar limits on EHB. Therefore, if a benefit, including a State-mandated benefit, included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition without the dollar limit.

   However, based on the Bulletin describing our intended approach, plans would be permitted to make actuarially equivalent substitutions within statutory categories. Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

10. How would the intended EHB policy affect self-insured group health plans, grandfathered group health plans, and the large group market health plans? How would employers sponsoring such plans determine which benefits are EHB when they offer coverage to employees residing in more than one State?

    A: Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB. However, the prohibition in PHS Act section 2711 on imposing annual and lifetime dollar limits on EHB does apply to self-insured group health plans, large group market health plans, and grandfathered group market health plans. These plans are permitted to impose non-dollar limits, consistent with other guidance, on EHB as long as they comply with other applicable statutory provisions. In addition, these plans can continue to impose annual and lifetime dollar limits on benefits that do not fall within the definition of EHB.

    To determine which benefits are EHB for purposes of complying with PHS Act section 2711, the Departments of Labor, Treasury, and HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.

11. In the case of a non-grandfathered insured small group market plan that offers coverage to employees residing in more than one State, which State-selected EHB benchmark plan would apply?

    A: Generally, the current practice in the group health insurance market is for the health insurance policy to be issued where the employer's primary place of business is located. As such, the employer's health insurance policy must conform to the benefits required in the employer's State, given that the employer is the policyholder. Nothing in the Bulletin or our proposed approach seeks to change this

current practice. Therefore, the applicable EHB benchmark for the State in which the insurance policy is issued would determine the EHB for all participants, regardless of the employee's State of residence. Health insurance coverage not required to offer EHB, including grandfathered health plans and large group market coverage, would comply with the applicable annual and lifetime limits rule, as described in the answer to the previous question.

12. How do the requirements regarding coverage of certain preventive health services under section 2713 of the PHS Act interact with the intended EHB policy?

    A: The preventive services described in section 2713 of the PHS Act, as added by section 1001 of the Affordable Care Act, will be a part of EHB.

13. Under the intended EHB approach, would the parity requirements in MHPAEA be required in EHB?

    A: Yes. Consistent with Congressional intent, we intend to propose that the parity requirements apply in the context of EHB.

14. Could a State legislature require that issuers offer a unique set of "EHB" the way Medicaid and CHIP benchmarks have options for Secretary-approved benefits, or benchmark equivalent benefits, if the State benefits are actuarially equivalent to one of the choices that HHS defines to be EHB?

    A: No. Under the approach we intend to propose, States would be required to adhere to the guidelines for selecting a benchmark plan outlined in the Bulletin. Otherwise, EHB in that State would be defined by the default benchmark plan.

15. Would States need to identify the benchmark options themselves?

    A: HHS plans to report the top three FEHBP benchmark plans to States based on information from the Office of Personal Management. HHS also plans to provide States with a list of the top three small group market products in each State based on data from HealthCare.gov from the first quarter of the 2012 calendar year. We intend to continue working with States to reconcile discrepancies in small group market product enrollment data. If a State chooses to consider State employee plans and/or the largest commercial HMO benchmark plans, the State would be required to identify benchmark options for those benchmark plans, as is done today in Medicaid and CHIP.

16. When would States be required to select a benchmark plan?

    A: As noted in the Bulletin, we intend to propose that States must select an EHB benchmark plan in the third quarter two years prior to the coverage year, based on enrollment from the first quarter of that year. Thus, HHS anticipates that selection of the benchmark plan for 2014 and 2015 would need to take place in the third quarter of 2012 in order to provide each State's EHB package, which includes the benchmark plan, any State-supplemented benefits to ensure coverage in all statutory categories, and any adjustments to include coverage for applicable State

mandates enacted before December 31, 2011. This schedule would ensure plans have time to determine benefit offerings before QHP applications are due. Separate guidance on the selection of Medicaid benchmark plans is forthcoming.

17. How would a State officially designate and communicate its choice of benchmark plan and the corresponding benefits to HHS?

A: HHS is currently evaluating options for collecting a State's benchmark plan selection and benefit information. A State's EHB package would include the benefits offered in the benchmark plan, any supplemental benefits required to ensure coverage within all ten statutory categories of benefits, and any adjustments to include coverage for applicable State mandates enacted before December 31, 2011. HHS anticipates that submissions will be collected from States in a standardized format that includes the name of the benchmark plan along with benefit information and, if necessary, the benefits used to ensure coverage within a missing statutory category.

18. How can my State find benefit information with respect to the default benchmark plan?

A: As indicated in the Bulletin, we intend to propose that the default benchmark plan in each State would be the largest small group market product in the State's small group market. HHS anticipates that it will identify and provide benefit information with respect to State-specific default benchmark plans in the Fall of 2012.

19. By empowering the State to select an EHB benchmark plan, does HHS intend that the State executive branch (i.e., State Insurance Department) or the legislative branch must make the selection?

A: Each State would be permitted to select a benchmark plan from the options provided by HHS by whatever process and through whatever State entity is appropriate under State law. In general, we expect that the State executive branch would have the authority to select the benchmark plan. It is also possible that, in some States, legislation would be necessary for benchmark plan selection. It is important to note that, regardless of the entity making these State selections, it is the State Medicaid Agency that will be held responsible for the implementation of EHB through the Medicaid benchmark coverage option.

EHB Applicability to Medicaid:

20. How would EHB be defined for Medicaid benchmark or benchmark-equivalent plans?

A: Since 2006, State Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as "benchmark" or "benchmark-equivalent" coverage, based on one of three commercial insurance products, or a fourth, "Secretary-approved" coverage option. Beginning January 1, 2014, all Medicaid benchmark and benchmark equivalent plans must include at least the ten statutory categories of EHBs. Under the Affordable Care Act, the medical assistance provided to the expansion population of

adults who become eligible for Medicaid as of January 1, 2014, will be a benefit package consistent with section 1937[ii] benchmark authority.

For Medicaid benchmark and benchmark equivalent plans, three of the benchmark plans described in section 1937 (the State's largest non-Medicaid HMO, the State's employee health plan, and the FEHBP BCBS plan) may be designated by the Secretary as EHB benchmark plans, as described in the EHB Bulletin. A State Medicaid Agency could select any of these section 1937 benchmark plans as its EHB benchmark reference plan for Medicaid. There would be no default EHB benchmark reference plan for purposes of Medicaid; each State Medicaid Agency would be required to identify an EHB benchmark reference plan for purposes of Medicaid as part of its 2014-related Medicaid State Plan changes.

If the EHB benchmark plan selected for Medicaid were to lack coverage within one or more of the ten statutorily-required categories of benefits, the EHB benchmark plan (and therefore the section 1937 benchmark plan) would need to be supplemented to ensure that it provides coverage in each of the ten statutory benefit categories. This would be in addition to any other requirements for Section 1937 plan, including Mental Health Parity and Addition Equity Act compliance.

21. Could a State select a different EHB benchmark reference plan for its Medicaid section 1937 benchmark and benchmark equivalent plans than the EHB reference plan it selects for the individual and small group market?

    A: Yes. Under our intended proposal, a State would not be required to select the same EHB benchmark reference plan for Medicaid section 1937 plans that it selects for the individual and small group market, and it could have more than one EHB benchmark reference plan for Medicaid, for example, if the State were to develop more than one benefit plan under section 1937.

22. Could a State select its regular Medicaid benefit plan as its Section 1937 benchmark coverage package?

    A: Yes. A State could propose its traditional Medicaid benefit package as a section 1937 benchmark plan under the Secretary-approved option available under section 1937 of the Social Security Act. The State would have to ensure, either through that benefit plan or as a supplement to that plan, that the ten statutory categories of EHB are covered.

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[i] You can access the Bulletin at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[ii] You can access section 1937 at http://www.ssa.gov/OP_Home/ssact/title19/1937.htm

SECTION 4:

Compass EHB Deliverable

Essential Health Benefits (EHB) Benchmark Plans

For the District of Columbia Health Exchange

I. Introduction

The purpose of this report is to review those plans that are representative of the benchmark plans described in the "Essential Health Benefits Bulletin" issued December 16, 2011.

II. Executive Summary

Most of the ten essential benefits are covered by under the ten benchmark plans, with the exception of pediatric dental and vision. We recommend considering those plans offered in the District of Columbia, rather than those offered at the federal level, in order to make sure that all mandates are included.

We suggest that the Benchmark Plan that is chosen be supplemented by pediatric vision and dental provided in the Federal Employees Benefit Program.

III. The Ten Essential Benefits

Section 1302(b)(2) of the Affordable Care Act (ACA) requires that any health insurance plan that is offered to an individual or small business must cover the ten broad categories of services that are listed below. This list applies to plans offered inside and outside of the Exchange and represents the minimum services that must be covered. Plans may cover additional services at their own discretion.

The ten essential benefits that must be offered are as follows:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care

The ACA required HHS to provide more details on the ten service categories in order to create a comprehensive EHB package. According to the ACA, the EHB package is intended to represent "the scope of benefits provided under a typical employer plan."

IV. The Ten Benchmark Plans

The ten plans that were analyzed are as follows:

- THE 3 LARGEST FEDERAL PLANS
    - GEHA Federal Plan
    - BCBS Federal Plan - Basic
    - BCBS Federal Plan – Standard
- THE 3 LARGEST PLANS OFFERED TO DISTRICT OF COLUMBIA EMPLOYEES
    - Aetna HMO Open Access - Washington DC
    - Aetna PPO Open Choice (PPO) District of Columbia
    - United HealthCare Choice Plan
- THE 3 LARGEST SMALL GROUP PLANS OFFERED IN THE DISTRICT
    - BCBS/Carefirst BluePreferred Option 1
    - Kaiser Foundation Health Plan of the Mid-Atlantic States HMO Plan 5
    - Kaiser Foundation Health Plan of the Mid-Atlantic States HMO Plan 6
- THE LARGEST HMO OFFERED IN THE DISTRICT
    - Kaiser Foundation Health Plan of Mid-Atlantic States HMO

V. Findings

We found broad coverage for medical services such as physician, hospital, emergency services, skilled nursing facility, laboratory, durable medical equipment, and routine preventive and wellness care. We also found all plans covered most conditions and illnesses, including maternity and newborn care, and mental health and nervous disorders.

Our summary does not describe all services covered by each plan. For example, we did not include services that are generally covered by most comprehensive health plans. Instead, we focused on services where we found variations between plans.

The attached Table 1 summarizes our results. We list the health services where we anticipated there may be variation between the plans, and summarize whether the service was covered by each plan. In some cases, we did not have enough information to determine coverage.

We recommend considering those plans offered in the District of Columbia, rather than those offered at the federal level, in order to make sure that all mandates are included. Specifically, we suggest you choose a plan with the following characteristics:

1. DC mandates are included.
2. Rehabilitation benefits are limited, such as 60 per year combined PT, OT and ST.
3. Routine eye and hearing exams are covered.

VI. Mandates

Section 1311(d)(3)(B) of the ACA indicates that states and DC may be required to defray the cost of mandated benefits in excess of the ten benefit categories. The District of Columbia's mandated benefits that might be considered in excess of the EHB package are:

Autism
Habilitative Services for Congenital/Genetic Defects
Hormone Replacement Therapy
Speech and Hearing Therapy

We have estimated the cost of each of these four mandates as follows:

Autism: .23% ($1.00 PMPM)
Habilitative Services for Congenital/Genetic Defects: .05% ($.20 PMPM)
Hormone Replacement Therapy: .03% ($.14 PMPM)
Speech and Hearing Therapy: .01% ($.03 PMPM)

In total, we estimate the overall impact of these four mandates at .32% (about one third of one percent) or $1.37 PMPM.

The above PMPM cost estimates for the mandates are derived from the Mercer "Marketplace Report", page 12, with the percentages derived assuming an average PMPM premium of $437 (page 8 of the Mercer report, showing Total Exchange Average Annual Premium of $5,240 divided by 12). We believe that these cost estimates are reasonable.

The ACA may require states and DC to pay for the portion of Exchange premiums that are attributable to state insurance mandates not included in the EHB package. This provision was intended to ensure that federal dollars would not be used to subsidize coverage of state and DC mandates in the Exchange. However, any plan that is currently offered within the District of Columbia includes all current District of Columbia insurance mandates. By choosing a DC plan, the District of Columbia will essentially guarantee that no insurance mandates fall outside of the EHB package. HHS added that, while a DC plan will likely remain a benchmark option through 2015, future updates to the benchmark may eliminate that possibility. Thus, states and DC are encouraged to continually monitor the necessity and effectiveness of their current mandates.

VII. Habilitative Services and Pediatric Dental and Vision

If the District of Columbia defines a benchmark plan that excludes any of the ten categories of benefits required by the ACA, then the District of Columbia must supplement the service based on another benchmark plan. We believe that habilitative services and pediatric dental and vision care may require supplementation.

A. Habilitative Services

ACA requires habilitative services to be covered, but the scope of those services has not been defined for the EHB set of benefits.

Here is what the Bulletin on EHB says about this:

Habilitative Services

There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions, or defining "habilitative services" as the term is used in the Medicaid program. An example of habilitative services is speech therapy for a child who is not talking at the expected age.

Two of the three small group issuers surveyed by the IOM indicated that they do not cover habilitative services. However, data submitted by small group issuers for display on HealthCare.gov indicates that about 70 percent of small group products offer at least limited coverage of habilitative services. Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans, which often includes visit limits. All three issuers reporting to the IOM covered PT, OT, and ST, though one issuer did not cover these services for patients with an autism diagnosis. The FEHBP BCBS Standard Option plan also covers PT, OT, and ST. State employee plans examined appear to generally cover PT, OT, and ST.

However, it is our understanding that habilitative services can be provided in parity with rehabilitation services.

Here is the specific language from the FAQ on EHB:

As a transitional approach for habilitative services, the Bulletin discusses two alternative options that we are considering proposing:

- *A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.*

- *A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future.*

Under either approach, a plan would be required to offer at least some habilitative benefit.

Here is the definition in the DC code:

"Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

We recommend that the definition be limited, subject to further guidance and clarification, and that habilitative services be provided in parity with rehabilitation services.

B. Pediatric Dental and Vision

We estimate the cost of pediatric dental services at 1% ($4 PMPM) of costs of the average plan. We estimate the cost of pediatric vision services at .5% ($2 PMPM) of costs of the average plan. These estimates were derived based on comparison with estimates provided for various states, including those offered by Milliman in California (page 4 of report dated 2/21/2012). We have assumed the benefits are similar to standard dental plans offered by employers. In some cases, the benchmark plans cover some of these benefits, but most do not. We believe that the estimates are reasonable for pediatric dental and vision, based on the average PMPM of $437 derived from the previously cited Mercer report.

Here is the specific language from the FAQ on EHB:

For pediatric oral care, we are considering proposing that the State would supplement the benchmark plan with benefits from either:

- *The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or*
- *The State's separate Children's Health Insurance Program (CHIP).*

For pediatric vision care, we are considering proposing that the State would supplement the benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment.

We recommend that the Federal Employees Dental and Vision Program be utilized to supplement the Benchmark Plan for pediatric dental and vision services. It is our understanding that this would mean the MetLife Standard Dental Plan and the BlueVision Benefit Plan would be used as the supplements. Outlines of those plans are attached.

VIII. Data Sources

Data sources we used include:

1. **GEHA Federal Plan:** US Office of Personnel Management
2. **BCBS Federal Plan-Basic:** US Office of Personnel Management
3. **BCBS Federal Plan-Standard:** US Office of Personnel Management
4. **Aetna HMO:** http://dchr.dc.gov
5. **Aetna PPO:** http://dchr.dc.gov
6. **Kaiser HMO:** http://dchr.dc.gov
7. **BCBS/Carefirst BluePreferred Option 1:** DC Government Survey
8. **Kaiser Foundation Health Plan of the Mid-Atlantic States HMO Plan 5:** DC Government Survey
9. **Kaiser Foundation Health Plan of the Mid-Atlantic States HMO Plan 6:** DC Government Survey
10. **Kaiser Foundation Health Plan of Mid-Atlantic States:** HMO DC Government Survey

IX. Additional Comments

This report does not represent a comprehensive list of all services covered. We utilized summary plan descriptions from the various websites or from the DC Government Survey. The Evidence of Coverage of each plan serves as the ultimate source of the services that are covered.

Whether a plan covers a certain service is determined by factors besides the language in the Evidence of Coverage. This would include the definition and application of medical necessity, evolving clinical practice, agreements between a carrier and its regulatory agency, and overriding decisions made by the regulatory agencies. This analysis is intended to identify and compare services described in the various documents for the ten benchmark plans. To the extent we were not aware of other factors that may modify the language in the Evidence of Coverage documents, the results of our analysis may likewise by inaccurate or incomplete.

This report was produced for the internal use of the District of Columbia Health Benefits Exchange. No portion of this report may be provided to any other party without prior written consent. In the event this report is provided to other parties, it must be provided in its entirety.

SECTION 5:

Mercer Insurance Marketplace Report

MERCER

CONSULTING. OUTSOURCING. INVESTMENTS.

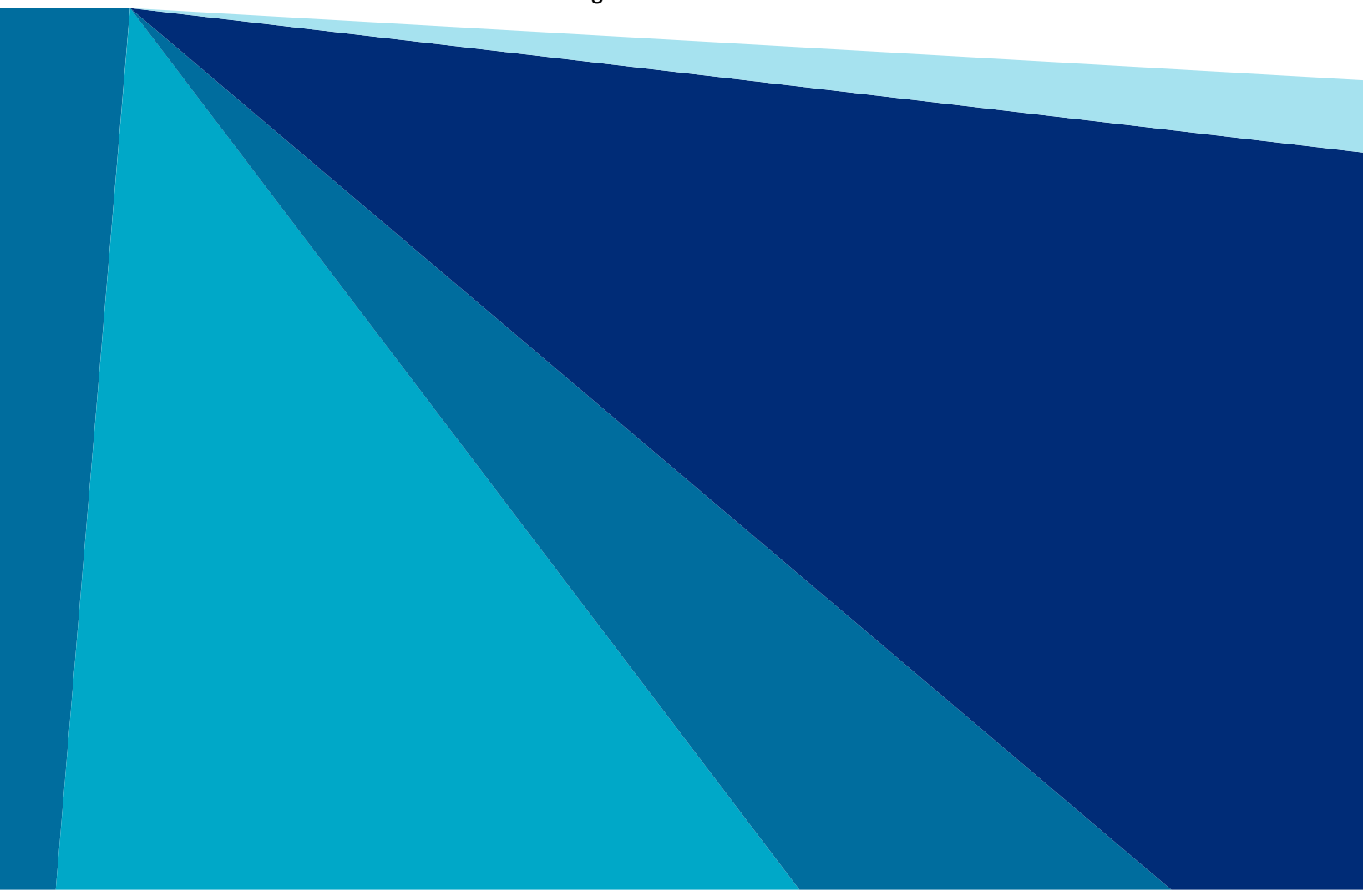
DISTRICT OF COLUMBIA HEALTH INSURANCE EXCHANGE

MARKETPLACE REPORT

DEPARTMENT OF HEALTH CARE FINANCE

NOVEMBER 23, 2011

Government Human Services Consulting



MARSH & McLENNAN COMPANIES

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1

Executive Summary

The Affordable Care Act of 2010 (ACA) provides funding assistance for the planning and establishment of the American Health Benefit Exchanges (Exchanges). Under the ACA, each state may elect to set up an exchange that will create a new marketplace for heath insurance. Mercer Government Human Services Consulting (Mercer), along with its sister company Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) as a subcontractor, was engaged by the District of Columbia (District) Department of Health Care Finance (DHCF) to assist in conducting planning tasks related to the development of the District's Health Insurance Exchange (DC HIX). The Exchanges would include the individual Exchange and Small Business Health Options Program (SHOP) Exchange.

As part of our work, one of the first tasks was to conduct background research required to assess the District's current population and health insurance marketplace. The results of our work in this area were presented in a report titled "Current Status of Insurance Coverage in the District of Columbia". We provided the final copy of this report to the District on September 28, 2011. The goal of that work was to develop a current picture of the District's population by insurance mode, prior to the impact of major reforms scheduled to begin in 2014. This report focuses on changes that will occur in the District's insurance marketplace in 2014 and later.

For this report, we have relied on many of the same data sources that provided the foundation for our Background Research Report, as well as regulations issued by The United States (US) Department of Health and Human Services (HHS) as of October 26, 2011, the date this report was initially released in draft format. In this report, we relied on information from the US Census Bureau, the American Community Survey, the Medical Expenditure Panel Survey (MEPS), Dun & Bradstreet (D&B), annual statutory financial statements of insurers issuing policies in the District and other sources. Most critically, we also relied on data provided by insurance carriers that participate in the District's current insurance marketplace. This allowed us to calibrate our actuarial models at a granular level, using very detailed, District-specific information on premium rates, benefits, demographics and group composition.

Oliver Wyman's Healthcare Reform Micro-simulation Model (Oliver Wyman's HRM Model) was used to project potential enrollment in a District-run Exchange under four scenarios. The model is comprised of three primary modules. The first module generates a synthetic population made up of individuals, families, employer groups and government programs using the data described above. In addition, a synthetic insurance market is developed. The second module uses the synthetic population to calibrate the model by solving for various model parameters such that the model reproduces the District's current insurance marketplace. The calibration occurs at eight different sub-population levels. Using the simulated population, the solved-for model parameters

and many other economic variables, the third module introduces the changes to the marketplace that will come about as a result of the ACA. In particular, the third module projects the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace.

Similar to the Congressional Budget Office's (CBO's) Health Insurance Simulation model, a key underlying assumption of Oliver Wyman's HRM Model is that it assumes decisions related to the purchase of health insurance are made at the Health Insurance Unit (HIU)[1] level, and that the decisions made by these HIUs follow rational choice theory.[2] All options available to the HIU for obtaining health insurance are evaluated (i.e., they select among various insurance options with various premiums and out-of-pocket (OOP) cost sharing, public programs, or chose to remain uninsured), and the option with the highest economic utility is selected. For the group purchasing decision, the model uses a demand elasticity curve. In selecting the elasticity curve, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica[3] and the CBO's assumptions employed in its own micro-simulation model. Employers are assumed to respond to subsequent increases in premiums by reducing benefits until a Bronze level benefit plan has been reached. Once coverage has been reduced to Bronze level, the model assumes that additional decreases in benefits the employer would like to make are instead shifted to the employee through higher premium contributions. We have assumed that employers drop coverage once they have shifted an additional 10% of the contribution requirements to their employees.

There are several key underlying assumptions of the model that are important for the reader to understand. These include:

- A steady state population is assumed. While the population ages and grows, and incomes increase over time, the underlying mix of the population does not change with respect to most other variables. The distribution of the District's overall population by income, gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period.
- All major carriers participating in the District's individual and small group markets during the base period continue to participate in 2014 and beyond.
- No new carriers enter the market and obtain significant market share.
- All carriers participate in both the inside and outside Exchange markets.

[1] A Health Insurance Unit (HIU) is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy.

[2] Rational choice theory is based on the assumption that individuals act as if comparing the costs against the benefits of various choices to arrive at the action that maximizes their personal satisfaction.

[3] "Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature." Mathematica. http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf

- Products offered inside the Individual and SHOP Exchanges are similar to products offered outside the Individual and SHOP Exchanges, and premium rates are the same inside and outside the Exchanges for the same benefit package.
- Individuals currently enrolled in Medicaid, Children's Health Insurance Program (CHIP) and the DC Health Care Alliance Program (Alliance) will remain in those programs.
- Large employers with 101 or more employees are assumed to continue to offer coverage at the same rate they did in 2010.
- Small employers not offering coverage in 2010 will not begin offering coverage in 2014.
- Individuals and families receiving employer sponsored insurance (ESI) coverage through a government employer will not enroll in the Exchange, with the exception of members of Congress and their staff.
- The will be no individuals or small groups with grandfathered policies in 2014.
- Small groups will not self insure. (We note that with the rate shock that will occur in 2014, some groups are likely to self insure.)
- The model does not consider the impact that private exchanges may have on enrollment in the District's Individual and SHOP Exchanges.
- The model assumes undocumented workers are not included in the underlying American Community Survey (AC Survey)[4] data.
- Based on discussion with the District, 50% of all non-subsidy residents enrolling in individual coverage will do so through the Individual Exchange.
- 10% of all District small employers offering coverage will do so through the SHOP Exchange.
- The District will extend its 138% up to 200% of the Federal Poverty Level (FPL) Waiver program (if approved) or establish a Basic Health Program (BHP). As a result, individuals with incomes between 138% up to 200% FPL were not modeled as being eligible to enroll in the Individual Exchange.

Baseline Reform Scenario

To understand how certain design scenarios could impact enrollment and premiums in the District's Individual and SHOP Exchanges, four scenarios identified by the District were modeled. The focus of the modeling is on exchange design scenarios and the sensitivity of results to those scenarios. Our Baseline Reform Scenario assumes separate individual and small group markets are maintained; it also assumes the definition of small group remains at 50 until 2016, at which point it increases to 100. The following table summarizes the modeled enrollment and premium in the Exchange in this Baseline Scenario.

[4] In the Background Research Report, we referred to the American Community Survey as the ACS data. In order to avoid potential confusion with Information Technology vendors with the same acronym that were also reviewed in this project, we are referring to the American Community Survey as the AC Survey going forward.

	Baseline Scenario								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	14,500	$4,710	$68,341,000	37,500	$5,440	$204,143,000	52,000	$5,240	$272,484,000
2015	14,000	$4,900	$68,559,000	38,000	$5,620	$213,457,000	52,000	$5,420	$282,016,000
2016	17,500	$5,320	$93,117,000	39,000	$5,980	$233,135,000	56,500	$5,770	$326,252,000
2017	17,000	$5,620	$95,540,000	41,000	$6,470	$265,429,000	58,000	$6,220	$360,969,000
2018	16,750	$5,870	$98,301,000	42,500	$6,880	$292,508,000	59,250	$6,600	$390,809,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

Key observations for calendar year 2014 (as compared to 2010) when employing the assumptions previously described include:

- Enrollment in the District's total individual market is projected to more than triple, from roughly 20,000 members in 2010 to 61,250 members in 2014 (not shown), with 61% of covered individuals enrolled in the Individual Exchange.
- Of the individuals that enroll in the Individual Exchange, 22% will receive premium subsidies.
- Average premium on a per capita basis in the individual market, prior to application of premium subsidies, are projected to increase by 45% from 2013 to 2014. The Essential Health Benefits (EHB) package (i.e., required coverage for EHB and the required increase to an actuarial value of at least 0.60) accounts for roughly 25% of the increase.
- Individual premiums are projected to be 15% higher than small group premiums in 2014. This compares to premiums in the individual market today that are 25% lower than in the small group market.
- Enrollment in the District's small group market is projected to decline by approximately 13% in 2014, with roughly 18% of individuals receiving coverage through their small group employer enrolled in the SHOP Exchange.
- Enrollment in the SHOP Exchange increases by roughly 3,500 members in 2016 when the definition of small group expands to include businesses with up to 100 employees.
- Average premiums on a per capita basis in the small group market are projected to increase by only 6% from 2010 to 2014. This reflects significant rate decreases (averaging 12.2%), which results from carriers' efforts to comply with minimum loss ratio requirements starting in 2011. It also reflects a recent significant rate decrease by one major carrier.
- Enrollment in Medicaid/CHIP (based on coverage up to 200% FPL) is projected to increase by roughly 9,500 lives from 2010 to 2014.
- The uninsured population in 2014 is projected to be roughly half of the 2009 level,[5] decreasing to roughly 21,000 individuals, or approximately 3.5% of the District's population.

[5] The current uninsured rate is based on the 2009 American Community Survey data that was used for the background research. As of the time this analysis was completed, 2010 American Community Survey data was not available to update this statistic.

Underlying this estimate is an underlying assumption that 20% of those currently eligible for Medicaid, but uninsured would enroll by 2014.[6]

Alternate Reform Scenario 1

This scenario assumes that the District elects to define a small group as employers with 50 or fewer eligible employees until 2016, but decides to merge the individual and small group pools into one. Merging these markets would mean that the rates for the individual and small group markets would be based on the combined morbidity of the two pools, which would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all. Based on information from the Census Bureau, the average morbidity of the two pools is not assumed to be significantly different today (the average morbidity of the current individual pool is roughly 2% lower than the average morbidity of the current small group pool).

Alternate Reform Scenario 1

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	13,750	$4,760	$65,447,000	38,500	$5,210	$200,690,000	52,250	$5,090	$266,137,000
2015	12,750	$5,100	$64,981,000	39,500	$5,410	$213,686,000	52,250	$5,330	$278,667,000
2016	17,250	$5,250	$90,548,000	39,750	$5,780	$229,676,000	57,000	$5,620	$320,224,000
2017	16,750	$5,550	$92,907,000	41,750	$6,250	$260,863,000	58,500	$6,050	$353,770,000
2018	16,250	$5,910	$96,040,000	43,250	$6,650	$287,798,000	59,500	$6,450	$383,838,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

Without a merger, the average morbidity of the individual pool would be roughly 7.3% higher than the average morbidity of the small group pool, after the influx of uninsured into the individual market. Therefore, a merger would provide moderate premium relief to the individual market at a small cost to the small group market. Other key observations from this scenario, relative to the Baseline Scenario, include:

- Premium levels do differ as a result of the market merger; however, the variance is not so extreme that take-up patterns are markedly different.
- Premiums in the individual market are 3.5% lower in 2014 in a merged market, relative to the Baseline Scenario.
- Premiums in the small group markets are 3.6% higher in 2014 in a merged market, relative to the Baseline Scenario.
- Individual market consumers react to the somewhat lower premiums with slightly higher take-up rates than in the Baseline Scenario. Small employers and their employees react to higher premiums with somewhat lower take-up rates.

[6] Note, not all individuals eligible for Medicaid but not currently enrolled are uninsured; many of these individuals currently have ESI coverage.

- The average enrollment in the combined Individual and SHOP Exchanges is not significantly different than under the Baseline Scenario.
- Most of the difference in the results in this scenario relative to the Baseline Scenario is migration from the small group market to the individual market, such that the size of the overall insurance market in the District is relatively the same.

In addition to the direct financial impact that merging the individual and small group pools may have on the rates for each market, there are other considerations when making the decision of whether or not to merge the pools, which are discussed in the report.

Alternate Reform Scenario 2

This scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible employees immediately in 2014, but decides not to merge the individual and small group pools into one. Groups with 51-100 employees are less likely to participate in the SHOP Exchange unless significant administrative savings exist. Without concerted effort to provide either value-added services for larger small employers or significantly lower premiums, the Exchange may not be able to attract those consumers.

Defining small group in the District to include employers with up to 100 employees in 2014 and 2015 may enlarge and strengthen the small group risk pool in the near term, but it does not produce significantly higher levels of Exchange enrollment in the long term. This is because the current 51-100 market is roughly half the size of the current small group market and groups size 51-100 will not be eligible for small business tax credits, which are projected to attract a fair number of small groups.

Projected enrollment and premium in the Exchange under this scenario are presented in the following table. We have assumed that carriers with under 100 employees would not self insure. This is a key assumption that could have a significant impact on the results.

Alternate Reform Scenario 2

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,750	$4,810	$90,095,000	37,500	$5,450	$204,550,000	56,250	$5,240	$294,645,000
2015	18,250	$5,000	$91,309,000	38,000	$5,630	$213,883,000	56,250	$5,430	$305,192,000
2016	18,000	$5,260	$94,769,000	38,500	$6,010	$231,453,000	56,500	$5,770	$326,222,000
2017	17,500	$5,600	$98,018,000	40,500	$6,480	$262,436,000	58,000	$6,210	$360,454,000
2018	17,250	$5,870	$101,316,000	42,000	$6,900	$289,919,000	59,250	$6,600	$391,235,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

Key observations for this scenario, relative to the Baseline Scenario, include:

- An additional 4,250 members are projected to enroll in the SHOP Exchange in 2014 due to inclusion of the 51-100 population in the small group pool.
- The early entrance of the 51-100 life groups into the small group pool slightly increases premiums in the expanded small group market. This increase is due to differences in demographics and benefits of these two sub-populations (the under 50 population and the 51-100 population).
- The early expansion of the small group market has almost no impact on either premiums or enrollment in the individual market.

Given the fact that the District will be required to ultimately change its current definition of small group to 1-100, it may be easier to make the change along with the host of other changes that will occur in 2014. On the other hand, if carriers are allowed to continue rating groups size 51-100 using current methods until 2016, postponing the market merger may limit the number of groups that decide to self insure or drop coverage.

Alternate Reform Scenario 3

This final scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible employees immediately in 2014 and also decides to merge the individual and small group pools into one. Projected enrollment and premiums in the Exchange under this scenario are as follows:

Alternate Reform Scenario 3

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,250	$4,840	$88,313,000	38,500	$5,200	$200,288,500	56,750	$5,090	$288,601,500
2015	17,250	$5,160	$88,941,000	39,500	$5,390	$212,748,500	56,750	$5,320	$301,689,500
2016	17,250	$5,380	$92,728,000	39,750	$5,790	$230,197,500	57,000	$5,670	$322,925,500
2017	16,750	$5,680	$95,205,500	41,750	$6,260	$261,517,000	58,500	$6,100	$356,722,500
2018	16,250	$6,060	$98,467,500	43,250	$6,660	$287,971,500	59,500	$6,490	$386,439,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

The results for this scenario are similar to those of Alternate Scenario 1, because the early expansion of the definition of small group to 100 had little impact on the projected results. However, given the merger in Alternate Scenario 1 had the effect of lowering premiums for the individual market in 2014, merging with a larger small group pool will result in larger decreases for the individual market. Other key observations for this scenario include:

- Premiums in the individual market are expected to be 4.2% lower than under the Baseline Scenario. This compares with only a 3.5% reduction when the individual market is merged with a small group market defined as 2-50 employees.

- Premiums in the expanded small market are expected to be 2.8% higher than for the small group market under the Baseline Scenario or Alternate Scenario 2. This compares with a 3.6% increase when the individual market is merged with a small group market defined as 2-50 employees.
- Total enrollment in the Exchange is relatively the same as under the Baseline Scenario.

Increased Participation in the Exchange

In order to ensure a viable Exchange, sufficient enrollment must be obtained. It will be important that an adequate mix of affordable plan choices be made available within the Exchange in order to incentivize individuals and small groups who are not eligible for subsidies to participate. If broad choices at affordable rates cannot be found, these individuals and small groups will look to additional options made available in the outside market. Premium and cost sharing subsidies will draw many into the Individual Exchange; however, there are no comparable financial incentives to draw small groups into the SHOP Exchange with the exception of small business tax credits, which are temporary and only apply to a small number of groups.

There are several key items we recommend the District consider in planning its Exchange to try to maximize enrollment. These items, which are discussed further in the report, include:

- Attract a sufficient number of carriers
- Ensure a broad selection of product choices
- Ensure easy access to Information
- Engage brokers and agents
- Consider offering value-added services and benefits inside the Exchange

Benefit Levels Permissible Under the ACA

Starting in 2010, all plans sold in the individual and small group markets must meet prescribed actuarial values. The higher the actuarial value, generally the lower point-of-service cost sharing required of the enrollee. There are four levels at which coverage will be permissible. These levels and their corresponding actuarial values are: Platinum (0.90), Gold (0.80), Silver (0.70) and Bronze (0.60). The ACA requires the HHS develop guidelines that provide for a de minimis variation in the actuarial values used in determining the level of coverage of a plan.[7] In addition, carriers will be able to offer a catastrophic plan to individuals under age 30; however, the details of that plan have not yet been released.

Starting with the underlying 2010 cost of coverage in the District, we projected these costs forward to 2014. We then calibrated Oliver Wyman's Benefit Rating Model to this cost and developed benefit design and cost sharing options that would meet each of the actuarial levels permissible under the ACA. A wide range of deductibles, coinsurance, copayments and OOP limit combinations are offered in the market today leading to almost an endless number of

[7] Section 1302(d)(3) of the ACA.

possible benefit combinations. Even with the restricted actuarial values in the future, we anticipate variation in benefit design within each metallic level.

For simplicity and ease of comparison, we developed plans where all services are subject to an overall deductible, coinsurance and OOP maximum. In reality, plans offered will likely include copayment for various services as they do in many cases today. We restricted the deductible and OOP maximum to meet the requirements of the EHB package. The following table presents various benefit offerings anticipated at each metallic level in 2014:

Coverage Level	Deductible	Coinsurance	OOP Max
Platinum	$200	90%	$1,000
	$50	100%	$1,000
Gold	$250	70%	$2,500
	$500	80%	$2,500
	$750	90%	$2,500
Silver	$500	65%	$5,500
	$750	70%	$5,000
	$1,000	80%	$5,950
	$1,500	85%	$3,500
Bronze	$1,500	60%	$6,000
	$2,000	70%	$6,000
	$2,500*	80%	$5,000
	$3,000*	90%	$5,000

*Not available in the Small Group market

Services Beyond Federally Mandated Benefits

According to the ACA, states will be required to cover the cost of any benefits provided by a qualified health plan (QHP) inside the Individual and SHOP Exchanges that are not included in the EHB package. So, for those policies sold inside the Exchange, the District will bear the cost for those benefits mandated by the District that are not included in the EHB package.

The long awaited (and recently released) report from the Institute of Medicine (IOM) did not include recommendations for specific services in the EHB package. Further, the report suggests that HHS should establish its initial draft of the EHB package by May 2012. With this uncertainty around the EHB package, it is not clear which services mandated by the District will be excluded from the EHB. Ultimately, we cannot perform a complete analysis of the potential cost to the District to cover these benefits.

However, we did perform a high level analysis, relying on information from the IOM Report, services explicitly included through the ACA and the frequency of certain mandated benefits

from a report published by the Council for Affordable Health Insurance. Based on this information, there are four current District mandates that have a reasonable chance of not being included in the EHB package. Those mandates, and our estimate of the costs, are:

- Autism: $0.70 per member per month (PMPM) to $1.00 PMPM
- Habilitative services for congenital/genetic defects: $0.20 PMPM
- Hormone replacement therapy: $0.14 PMPM
- Speech and hearing therapy: $0.03 PMPM

These costs total $1.07 PMPM to $1.37 PMPM. In total, these estimates suggest that under the Baseline Scenario the District would have to pay approximately $650,000 to $850,000 in 2014, increasing to $750,000 to $950,000 in 2018, to cover these benefits. This range assumes that the District's other mandated benefits are included in the EHB package. It also assumes that the scope of the District's coverage (e.g., age limits, annual visits, etc.) is consistent between the District and those states for which the estimates were prepared.

Adverse Selection and Options for Mitigation

There are three primary types of adverse selection that have the potential to influence the District's individual and small group health insurance marketplace in the reformed environment that will exist beginning in 2014:

- Adverse selection against the market — If healthier individuals and groups choose not to participate in the fully insured market, either by going uninsured or self insuring.
- Adverse selection against the Exchange — If its design causes the Exchange to be more attractive to higher risk populations while healthier populations stay in the outside market.
- Selection among carriers and products offered inside the Exchange.

Adverse selection against the market is likely to occur as a result of guarantee issue and adjusted community rating (ACR) rules. This could cause groups and individuals to delay purchase of insurance until they need it. Without enough healthy individuals in the risk pool, premiums will be higher. Another potential source of selection against the small group market is self insurance.

Adverse selection against the Exchange could result if the Exchange disproportionately attracts less healthy enrollees than the outside market. This type of environment could discourage carriers from offering coverage through the Exchange, which would reduce consumer choice and threaten the ongoing viability of the Exchange. There are a number of ACA provisions designed to discourage this type of selection, but there remain a number of areas that could contribute to it. Adverse selection against the Exchange can occur as a result of:

- Product offerings designed to attract healthy individuals and offered only outside the Exchanges
- Narrow networks designed to attract healthy individuals outside the Exchanges

- Grandfathered plans outside the Exchanges, which will typically be comprised of healthier individuals, as they will benefit most from pre-ACA rating rules
- Self funded Multiple Employer Welfare Arrangements (MEWAs) outside the Exchange enrolling health groups willing to self insure
- Exchange fees assessed only inside the Exchange
- Employee contributions set at levels such that they will be deemed unaffordable for low-income employees in poor health

Adverse selection can also occur within the Exchange. Greater choice afforded to employees of small groups and individuals will likely result in healthy individuals selecting low-cost Bronze plans and less healthy individuals selecting higher cost Gold and Platinum plans. Given that plans must be priced based on the entire pool of individual or small group business, this type of selection will lead to Bronze plans being over priced for the healthy individuals, but by less than the Gold and Platinum plans are underpriced for the less health individuals.

As noted earlier, the ACA includes a number of provisions designed to discourage adverse selection, but many sources of selection remain. Possible actions the District could take to mitigate these sources of adverse selection include:

- Eliminate the outside market
- Extend some or all QHP requirements to the outside market
- Require carriers to participate in the Exchange
- Require carriers participating only in the outside market to offer Gold and Silver products
- Require carriers participating in the Exchange to offer Bronze products
- Prohibit carriers from establishing affiliates which offer lean plans only outside the Exchange
- Restrict products with narrow networks from being offered only outside the Exchange
- Control the minimum level for specific and aggregate stop-loss
- Take actions to increase enrollment in the Exchange
- Place restrictions on plan designs offered outside the Exchange
- Do not allow employees in the SHOP Exchange to select from all products

The District must decide whether its Exchange will follow an active purchaser model, a passive model of a market organizer/aggregator or a hybrid model, combining some features of each model. An active purchaser model would allow the Exchange to selectively contract with QHPs and potentially impact health care costs, access and quality. As an active purchaser the Exchange may be in a better position to control adverse selection by limiting the products offered and standardizing cost sharing. However, this type of model is very resource intensive and additional costs would be incurred. A passive market organizer model would function more like a clearing house, setting minimum standards for the Exchange. This type of model would likely provide for more consumer choice and less market disruption than the active purchaser model; however, it would not leverage the purchasing power of the Exchange. A hybrid model would allow the Exchange to impose stricter requirements in areas most effective for controlling adverse selection while allowing flexibility and product innovation that could be attractive to new

carriers considering the market, which would be beneficial in markets such as the District which are dominated by only a few carriers.

2

Introduction

The ACA provides funding assistance for the planning and establishment of the Exchanges. Under the ACA, each state may elect to set up an Exchange that will create a new marketplace for heath insurance. The Exchanges will offer consumers a choice of health plan options, oversee the pricing and certification of health plans offering coverage within the Exchanges, calculate premium subsidies and provide information to assist consumers in their purchasing decisions.

Mercer, along with its sister company Oliver Wyman as a subcontractor, were engaged by the the DHCF to assist them in conducting planning tasks related to the development of the District's Exchange, which includes the Individual Exchange and the SHOP Exchange. As part of our work, one of the first tasks was to conduct background research required to assess the District's current population and health insurance marketplace. The results of that research, which were presented in a report dated July 26, 2011, serve as the basis for many of the inputs into our actuarial modeling that is the focus of this report.

Oliver Wyman's HRM Model was used to project potential enrollment in a District-run Exchange under four scenarios. A considerable amount of data from various sources was gathered and synthesized to populate the model, which was then calibrated to reproduce the 2010 District population and insurance marketplace, prior to projecting estimated enrollment and premium from 2014 through 2018.

In the remaining sections of this report, we first describe the various data sources that were used in our analysis. We then provide a discussion of key aspects of the ACA that will cause individual and employer behavior changes in the post-2014 market, which are reflected in our modeling. These changes are the result of many aspects of the ACA which will impact access to coverage, benefits covered, and the associated premiums. Next, we describe the methodology upon which our model is based. We describe how the various data sources were synthesized and discuss key underlying assumptions of the model. In the next section we present our results for each of the following four scenarios:

- Baseline Scenario: Small group up to 50 until 2016; separate individual and small group pools
- Alternate Scenario 1: Small group up to 50 until 2016; merged individual and small group pool
- Alternate Scenario 2: Small group up to 100 in 2014; separate individual and small group pools
- Alternate Scenario 3: Small group up to 100 in 2014; merged individual and small group pool

After the presentation of our model, modeling methodology and modeling results, we include two additional sections. The first of these is a discussion of the financial impact to the District of maintaining mandated benefits beyond the EHB. Since the list of EHB has not yet been defined, a detailed analysis of the financial impact of mandated benefits cannot be completed at this time. In our discussions with the District, it was agreed that our analysis would include high level estimates based on assumptions as to which of the current District mandates might be considered EHB. Next, we provide a discussion of potential sources of adverse selection and discuss methods for mitigating these risks. Finally, we discuss various Exchange models and various insurance standards that could be applied to the market outside of the Exchange.

Mercer has prepared these projections exclusively for the District, to estimate the range of the impact of federal Health Care Reform. These estimates were based on draft regulations issued by HHS as of October 26, 2011. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time, and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. (For example, some Health Care Reform provisions will likely involve calculations at the individual employee level.) The District is responsible for all financial and design decisions regarding the ACA. Such decisions should be made only after the District's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Lastly, the District understands that Mercer is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it, a substitute for legal advice. Accordingly, Mercer recommends that the District secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

The information contained in this document and in any of the attachments is not intended by Mercer to be used, nor can it be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

3

Data and Reliance

For this report, we have relied on many of the same data sources that provided the foundation for our Background Research Report, "Current Status of Insurance Coverage in the District of Columbia." We provided the final copy of this report to the District on September 28, 2011. In this report, we relied on information from the Census Bureau, the MEPS, D&B, annual statutory financial statements of insurers issuing policies in the District and other sources. Most critically, we also relied on data provided by insurance carriers that participate in the District's current insurance marketplace. We discuss these data sources below.

Population Data

We relied on various data sources from the United States Census Bureau in estimating both the overall size of the population in the District as well as in segmenting the market by characteristics such as type of insurance coverage, age, gender, and income. Our primary source for these data was the AC Survey.

Consistent with the Background Research Report, we felt it important that we have one primary data source to provide a demographic characterization of the District's population. Had we instead relied on data from various different sources as the basis for various aspects of our analysis, we would have faced potential inconsistencies in definitions, time periods, and data collection techniques among these various sources.

Ultimately, we chose to rely on the AC Survey data (e.g., instead of the Current Population Survey) for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. The AC Survey applies logical edits to the data to adjust for this 'Medicaid undercount.'[8] Second, the AC Survey questionnaire includes the question: "Is this person CURRENTLY covered by any…health insurance or health coverage plans?"[9] (Emphasis is from the survey). In contrast, the Current Population Survey assesses insured status over an entire year. The first presentation of the question is more consistent with our approach to the model we present in this report, as it examines a population at a point in time. Third, enrollees are legally obligated to respond to the AC Survey, so the response rate is quite high (i.e., 98% in 2009).[10] Fourth, and finally, the AC Survey includes measures that permit the calculation of standard errors from the sample.

[8] http://www.census.gov/hhes/www/hlthins/publications/coverage_edits_final.pdf

[9] http://www.census.gov/acs/www/Downloads/questionnaires/2009/Quest09.pdf

[10] http://www.census.gov/acs/www/methodology/response_rates_data/

As discussed in the Background Research Report, there were inconsistencies between the AC Survey and two external sources. First, the DHCF identified Medicaid enrollment that was higher than the AC Survey. Second, statutory financial statements filed by insurers in the District's market suggest that the AC Survey overstated those residents with individual coverage by approximately 20,000. In the Background Research Report, we identify a number of possible reasons for these inconsistencies.

Although we were unable to fully reconcile these Medicaid enrollment inconsistencies, we did reclassify a number of people in the AC Survey data into Medicaid. Specifically, we moved approximately 19,000 persons identified with individual coverage and household earnings below 200% FPL (or whose income was not identified) into Medicaid.

Medical Expenditure Panel Survey and Dun & Bradstreet

We also used the Agency for Health Care Research and Quality's MEPS Insurance/Employer Component data from 2009 and 2010 to develop characteristics of the District's small employer market. MEPS identifies key statistics for the small employer market by state, including employer offer rates, employee take-up rates and premiums by tier. All statistics in the MEPS data were available by various employer group sizes. We used the average of the 2009 and 2010 survey results to enhance the credibility.

We also used the D&B employer data to establish distributions of group sizes by major industry classification. These distributions were critical for accurately classifying employees in the District in appropriate pools of groups. In preparing the D&B data, we removed any groups that reflected government employers (either domestic or foreign).

Carrier Data Call

The primary data source for calibrating premium, benefits and other rating factors was provided by carriers, as part of the carrier data call.

With the assistance of the Department of Insurance, Securities and Banking (DISB), we submitted a request for data and received responses from four small group carriers and five individual carriers. Together these carriers provide coverage to approximately 83% of the small group market and 95% of the individual market.

Our request for data focused on those rating elements that the ACA was most likely to affect. Specifically, we requested that carriers provide distributions by enrollment, premium, and claims by the following factors from the 2009 and 2010 experience periods:

- Age/gender/family composition
- Morbidity load
- Group size factor (for small group carriers)
- Industry load (for small group carriers)

Of the carriers that responded, we ultimately received enough information to reconcile the responses to their corresponding financial statements. (We were provided the full collection of information necessary for our reconciliation on September 15, 2011.)

The information provided by the carriers suggested a general consistency of rating practices, with some exceptions. For example, some carriers apply age/gender factors based on the average age of the group, while others calculate a rate for each contract, which they then composite for each group. Similarly, some carriers charge different rates to small groups based on the group's size, while others do not vary their rates by group size.

Finally, some carriers currently apply industry loads based on Standard Industrial Classification factors. In preparing the AC Survey data, we relied on North American Industry Classification System identifiers. In assessing the rate shock from the elimination of industry as a rating factor, we employed a weighted average factor based on the D&B data.

The reader can find additional discussion of adjustments we made to the carrier data in the technical appendix to this report.

Annual Financial Statement Data

Annual financial statements were used to identify total enrollment, premium, claims, and other data for the District's individual and small group insurance markets. Although prior years' data were also reviewed, the primary source for this work was the 2010 Annual Statutory Financial Statements filed on the Health blank or the Life, Accident and Health blank. To support new insurer reporting requirements, 2010 Annual Statements include a new schedule, the Supplemental Health Care Exhibit. Insurers are required to report this schedule separately for each state in which they write comprehensive major medical business.[11] The Supplemental Exhibit reports detailed income statement data based on individual, small group employer, large group employer, government business, other business, other health and uninsured plans. Small group employer is defined as groups with up to 100 employees, except in states exercising an option under ACA to define small groups up to 50 employees until 2016.[12] The large group employer category includes the Federal Employees Health Benefit Program (FEHBP) and state and local fully insured government programs. Access to the Annual Statutory Financial Statement data was obtained through a subscription service.

[11] Experience for individual plans sold through an association or trust is allocated to the issue state of the certificate of coverage. Experience for employer business issued through an association or trust is allocated based on the location of the employer. Experience for group plans with employees in more than one state is allocated to state based on situs of contract.

[12] District carriers appear to have used a 50 employee threshold for reporting small employer group in the 2010 Supplemental Exhibit.

In comparing various sources of data and following up with insurers regarding discrepancies, it was determined appropriate to make one significant adjustment to the financially reported data for use in this project, relative to that which was reported in the Background Research Report. Roughly 30,000 small group members for Kaiser which were reported in the financial statement as small group reflected a block of trust business that should have been reported as large group, and as a result was not included in the small group modeling.

Carrier Rate Filing Data

In addition to the annual financial statements, we also relied on rate filings to validate the information from the carrier data call. As part of the Background Research, we obtained copies of the most recent rate filings for individual and small group products filed with DISB for the six carriers with the largest market share in the District. These rate filings provided an independent source for the product offerings, premiums and rating structures employed by carriers offering coverage in the individual and small group markets.

While we have reviewed each of these data sources for reasonableness (and where discrepancies arose we performed further investigation to reconcile any differences), we have not independently audited any of these data.

4

Key Reform Issues

With the passage of the ACA, there are many changes scheduled to occur within the insurance marketplace in 2014 and beyond, including changes that will impact eligibility criteria, covered benefits, patient cost sharing, premium rates and more. At any point in time, there will be individuals moving in and out of the Exchange and between various coverage statuses (e.g., between small group and uninsured) for a variety of different reasons. This movement will be driven not only by changes in individuals' characteristics (e.g., health status or employment status) and eligibility status for various types of coverage (e.g., Medicaid, Medicare), but also changes in employers' behavior regarding their decision to offer coverage to their employees.

In addition to these traditional drivers, there are many new provisions in the ACA that will impact the demand for health insurance. These include the expansion of Medicaid eligibility, federal premium and cost sharing subsidies inside the Individual Exchange, individual penalties for not taking coverage, employer penalties for not offering coverage, and guarantee issue of coverage in the individual and small group markets, among other things. It is worth noting that the impact of the expansion of Medicaid eligibility will have minimal impact on enrollment in the District given that it has already expanded Medicaid eligibility to 138% FPL through a state plan amendment. In addition, it is important to keep in mind that the employer penalty for not offering coverage does not apply to groups with fewer than 50 employees.

The option for states to establish a BHP for individuals with incomes between 138% and 200% FPL also impacts the potential enrollment in the Individual Exchange. If a BHP is established, individuals in this income range would not be eligible to enroll in the Individual Exchange and receive subsidized insurance coverage. The District currently has in place a 138%-200% FPL Waiver program that will be effective through 2013. We have been directed by the District to assume in our modeling that individuals in this income range would continue to receive this highly subsidized level of coverage in 2014 and beyond, either through a continuation of the Waiver program or through the establishment of a BHP. Therefore, regardless of which of these two options are ultimately elected by the District, in our modeling we have not allowed these individuals to enter the subsidized Exchange population.

Key ACA Provisions

New provisions under the ACA will redesign the landscape of the individual and small group insurance markets in the District. Requirements regarding minimum covered benefits and the standardization of coverage and rating rules will mean significant changes for insurance purchasers and companies issuing health insurance coverage. This section will describe key

provisions of the ACA, almost all of which are directly incorporated into the Oliver Wyman HRM Model, that are likely to impact the District's insurance market, including:

- Rating and issue rules
- Essential benefits package
- Individual mandate
- Employer mandate
- Premium and cost sharing subsidies
- Temporary small business tax credits
- Minimum medical loss ratio (MLR)
- Grandfathering of plans
- Inclusion of high risk pool insureds in the individual market
- Mandated benefits
- Risk adjustment, reinsurance and risk corridors
- New taxes and assessments impacting premiums
- Other key benefit changes required prior to 2014
  - Guarantee issue without pre-existing condition exclusions for children
  - Other changes that were effective September 23, 2010
  - Coverage of women's preventive benefits without cost sharing

Rating and Issue Rules

Currently, each state establishes its own rules regarding how insurance products are issued and rated within the state, subject to some broad federal requirements, such as the guarantee issuance of coverage in the small group market. Beginning in 2014, the ACA establishes a consistent framework of minimum standards for rating and issue rules throughout the country for the individual and small group markets. The ACA defines a "small group employer" as one with up to 100 employees, but provides an option for states to maintain their current definition of a small employer until 2016.

In general, the ACA issue and rating requirements that apply to these markets are designed to encourage access to health insurance for all Americans by removing barriers associated with poor health status. These changes are paired with an individual coverage mandate, which is hoped to prevent healthy risks from fleeing the market in response to the changes, with the intent of ensuring a balanced risk pool. An employer penalty for not offering coverage is also designed to maintain this channel for providing access to coverage.

To start, the ACA requires individual and small group markets to issue insurance products on a "guarantee issue and renewal" basis, which means that applicants cannot be denied coverage due to their health status. For example, individuals without access to ESI coverage, and who currently are unable to purchase insurance in the private market due to their health status, will be able to purchase coverage in 2014 under the new rules. The premiums they will be charged will not reflect the relative level of their own risk, but the overall pool risk. Although small group coverage already meets this standard in all 50 states, as mandated by the Health Insurance

Portability and Accountability Act of 1996 (HIPAA), many states (including the District) currently allow insurers to deny coverage in the individual market. In addition, small groups may be denied coverage today if they do not meet minimum participation or employer contribution requirements.

Second, under the ACA, premium costs may only be determined using ACR rules. ACR limits the number of factors that can be used to set the premium to recognize the expected cost of providing coverage for a particular individual or group. This process, as outlined in the ACA, allows premiums to be adjusted based only on the following risk factors:

- Geographic rating area (based on state requirements)
- Age (no more than a 3:1 ratio across adult age bands within a coverage tier)
- Family composition (single, couple, single parent, family)
- Tobacco use (no more than a 1.5:1 ratio)

The experience of all individual policies, both inside and outside the Individual Exchange, must be pooled together for the purpose of determining premium rates. Likewise, the experience of all small groups inside and outside the SHOP Exchange must be pooled. Premiums will no longer be allowed to vary based on health status or gender. Further, in the small group market premiums will no longer be allowed to vary based on group size or industry. The effect of these changes will be more cross-subsidization in premium levels — younger insureds and those in better health will pay relatively more, so that older insureds, and those in poor health, can pay less. We note that the District's recently passed "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010" resulted in the early adoption of some of these rating requirements. For example, effective July 1, 2011, carriers were no longer allowed to rate by gender, and carriers must use one-year age bands where the standard rate for any age may not be more than 104% of the standard rate for the previous age and the highest standard rate may not be more than 300% of the lowest standard rate.

These changes to rating and issue rules under the ACA will occur in conjunction with many other reform-related marketplace changes that will occur in 2014, including a shift to minimum required benefits, benefit packages with standardized actuarial values, an individual coverage mandate, and significant premium subsidies for low-income populations. It is possible that new market entrants will introduce fundamental changes in the covered population demographics and risk levels on which premiums are based. Any particular consumer's change in premium will likely reflect the interaction of a host of changes, and will depend on his or her current product choice, age and health status, among other things.

All else being equal, healthier market participants will pay higher premiums than they do today with medical underwriting. Older purchasers in the individual market will continue to pay higher premiums than younger people, but the difference will not be as great as it is today. In the small employer market, the smallest employers will no longer be levied extra charges related to their

size. Marked premium changes such as those expected in 2014 have a high potential to produce short-term churn in the marketplace.

Essential Health Benefits Package

Effective January 1, 2014, all individual and small group policies sold both inside and outside the exchanges must include the EHB package. According to §1302 of the ACA the EHB package is defined to include three components:

- Coverage for all EHB, as defined by the Secretary
- Limits placed on certain cost sharing amounts
- Defined actuarial coverage values

Coverage for Essential Benefits

All policies must include a minimum set of covered services, referred to as EHB. The Secretary of HHS has yet to specify the benefits that will be considered EHB that insurers will be required to cover beginning in 2014. Per federal law, this package must be based on offerings in a "typical employer plan" and include at least the following service categories:

- Ambulatory patient services
- Emergency services
- Hospitalizations
- Laboratory services
- Maternity and newborn care
- Mental health and substance abuse (MHSA) services, including behavioral health treatment
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

On October 6, 2011 the IOM released its report on EHB.[13] The report does not define the EHB, but rather recommends a process to help HHS select the benefits that would be included. The report indicates that the package of benefits ultimately selected must strike a balance between enabling access to essential services while at the same time allowing coverage to remain affordable.

Since several of the services included in the list above are not included in many individual policies today (e.g., maternity coverage or prescription drug coverage), the impact of the requirement to include the essential benefits in all individual policies starting in 2014 will be greater to premiums in the individual market than it will be in the small group market.

[13] "Essential Health Benefits: Balancing Coverage and Cost." Institute of Medicine. October 6, 2011.

Cost Sharing Limits

Annual maximums for OOP cost sharing will be subject to thresholds applicable for qualified high deductible health plans (HDHPs).[14] In 2014, small group plans will be prohibited from imposing a deductible greater than $2,000 for self only coverage and $4,000 for any other coverage; this amount will be adjusted annually thereafter. This requirement will likely require some employers to change their plans. Employers that maintain their grandfathered plan status will not be subject to these ACA deductible thresholds.

Actuarial Values

The ACA establishes various "tiers" of health insurance coverage, labeled as Bronze, Silver, Gold and Platinum. These coverage tiers will apply to all products offered in the individual and small group insured markets starting in 2014.[15] They allow for a level of standardization and comparison across products, without imposing a particular cost sharing structure.

The ACA's levels of coverage are defined using the concept of actuarial value. The higher the actuarial value, generally the lower point-of-service cost sharing required of the enrollee. For example, a Gold plan with an actuarial value of 80% would be expected to pay approximately 80% of covered benefits for a standard population. In a Platinum product, the insurer would be expected to pay 90% of covered benefits for that population. Silver and Bronze coverage levels correspond to actuarial values of 70% and 60%, respectively. The actual cost sharing paid by any particular individual enrolled in one of those plans will differ based on his or her specific service usage. Insurers may design a variety of cost sharing structures that produce a particular actuarial value. The ACA requires HHS to develop guidelines that provide for a de minimis variation in the actuarial values used in determining the level of coverage of a plan.[16]

The Congressional Research Service (CRS) characterizes actuarial value as a summary measure of a health plan's benefit generosity.[17] All else being equal, a higher actuarial value is associated with a higher premium, and a lower actuarial value is associated with a lower premium. Given a choice, healthier individuals may choose a lower actuarial value plan with higher OOP cost sharing, reasoning that this choice is cost effective for them and provides the greatest economic utility. Conversely, individuals with greater health needs may be willing to pay a higher monthly premium to have lower direct service costs when they receive care.

[14] The 2011 levels are $5,950 for single coverage and $11,900 for family coverage.

[15] The ACA also allows insurers to sell catastrophic plans with a lower actuarial value to persons in the individual market who are under the age of 30 or would otherwise be exempt from maintaining coverage because the coverage is unaffordable or enrollment in the available coverage would be a financial hardship.

[16] Section 1302(d)(3) of the ACA.

[17] Hinda Chaiking, Bernadette Fernandez, Mark Newsome, and Chris Peterson. Congressional Research Service. "Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)." May 4, 2010.

At this time, there is no federal guidance on the technical details for how the actuarial value should be determined. There are outstanding questions, such as:

- If plans offer benefits beyond the essential benefits, does the extra coverage get reflected in the actuarial value?
- Should network pricing variation factor into the actuarial value calculation?

In addition, as noted in the recent Kaiser Family Foundation report on ACA actuarial values, the results of an actuarial value calculation are quite sensitive to underlying assumptions regarding health care trends, individual claims distribution and enrollee utilization changes associated with cost sharing levels.[18]

Currently, carriers are not yet generally marketing products targeted to these specific actuarial values, as they will in the reformed market. Therefore, in 2014 when only products with these actuarial values will be allowed to be sold in the individual and small group markets, those with non-grandfathered plans will be required to change their benefits. This will mean, for example, that individuals and small groups with a plan having an actuarial value of 0.75 (i.e., 75%) in 2013 will need to, at a minimum, chose between increasing their benefits to a Gold plan with an actuarial value of 0.80 or decreasing their benefits to a Silver plan with an actuarial value of 0.70. As a result, additional premium shock will be introduced into the market. We note again that a de minimis variation around these actuarial values will likely be allowed so the required benefit change may be slightly less than implied by this example.

Individual Mandate

The ACA imposes an individual mandate to encourage healthy populations to stay in the market and balance the risk pool. If the individual mandate is successful in achieving its goal, the impact of the new rating and issue rules will be to further cross-subsidize risk between lower cost and higher cost populations. Beginning in 2014, all non-incarcerated US citizens must maintain minimum essential coverage.[19] Minimum essential coverage is defined as coverage that meets one of the following:

- Coverage under a government sponsored program (e.g., Medicaid, Medicare)
- Coverage under an ESI plan offered in the small or large group market
- Coverage under a plan offered in the individual market
- Coverage under a grandfathered plan
- Coverage under a state risk pool as recognized by HHS

[18] The Henry J. Kaiser Family Foundation, Focus on Health Reform. "*What the Actuarial Values in the Affordable Care Act Mean*." April 2011.

[19] Section 5000A of the ACA.

The ACA imposes a penalty for those individuals who do not maintain minimum essential coverage. The mandate is not universal and provides a penalty exemption for certain low-income individuals who cannot afford coverage (those where the cost of coverage is more than 8% of their income), individuals with a tribal affiliation or exemption due to religious beliefs. Among those who are not exempt, individuals not maintaining coverage will be subject to the following penalties, as outlined in the ACA:

Year	Flat Annual Penalty	Percent of Income Penalty
2014	$95	1.0%
2015	$325	2.0%
2016	$695	2.5%

The penalty is the larger of the flat annual penalty or the percent of income penalty shown in the table above. Children are assessed one half of the annual penalty shown in the table and the flat annual penalty for a family is capped at 300% of the amount shown in the table.

The presence of the mandate is expected to bring more individuals into the market, particularly young, healthy individuals who have not found great economic utility in purchasing health insurance coverage up to this point. The addition of healthier individuals to the risk pool would have a favorable effect on rates and reduce adverse selection. The individual mandate penalty is low in 2014 and will increase until fully implemented in 2016. This may cause take-up rates to be lower during the first few years after 2014.

Employer Mandate

The ACA does not directly require that employers offer health insurance coverage to their employees. However, if they do not offer minimum essential coverage, they will be subject to annual penalties.[20] Employers with less than 50 employees are exempt from the penalty. Employers with 50 or more full-time employees that do not offer minimum essential coverage will pay an annual penalty of $2,000 for every employee, beyond the first thirty, given at least one employee is eligible for and enrolls in subsidized coverage within the Individual Exchange.

Employers with 50 or more full-time employees that do offer coverage will pay a penalty equal to the lesser of $3,000 a year for each employee who is offered coverage but instead enrolls in the Individual Exchange and receives a premium subsidy, and $2,000 per full-time employee. Employees offered coverage by their employer will not be eligible to enroll in the Individual Exchange and receive subsidies as long as coverage offered by the employer has at least a 0.60 actuarial value and the employee is not required to pay more than 9.5% of household income for single coverage.

[20] Section 1513 of the ACA.

Premium and Cost Sharing Subsidies

Beginning in 2014, premium subsidies in the form of advance tax credits will be available to individuals and families with household incomes between 138% and 400% FPL[21, 22] who are eligible to enroll in the Individual Exchange. Those with incomes below 250% FPL will also be eligible for cost sharing subsidies. Individuals with incomes between 138% and 200% will not be eligible for subsidized coverage in the Individual Exchange if the District establishes a BHP. Individual premium and cost sharing subsidies will only be available to individuals that enroll for coverage within the Individual Exchange.

The amount of the premium subsidy will be tied to both the household income and the premium associated with the second lowest cost Silver plan available within the Individual Exchange. The following table shows the maximum premium that an individual or family will be required to pay.

Household Income as a % of FPL	Maximum Premium as a % of Household Income
138% up to 150%	3.00%-4.00%
150% up to 200%	4.00%-6.30%
200% up to 250%	6.30%-8.05%
250% up to 300%	8.05%-9.50%
300% up to 400%	9.50%

After the maximum premium is calculated from the table above, it will be subtracted from the cost of the second lowest Silver plan to determine the subsidy the individual or family is eligible to receive. The individual or family may then "go shopping" with this subsidy and select from any plan available within the Individual Exchange, with the exception of those who are also eligible for cost sharing subsidies and must enroll in a Silver plan to receive them. The net premium paid will be equal to the premium for the plan selected, less the subsidy amount.

Individuals who do not have qualified ESI coverage available to them may enter the Individual Exchange. In order for an employer's plan to meet the definition of qualified coverage for a given individual it must:

- Provide coverage that has an actuarial value of at least 0.60
- Require employee contributions for single coverage that are not more than 9.5% of household income

[21] The lower FPL limit is 133% in the ACA, however after application of a 5% disregard, this limit essentially becomes 138%.

[22] Modified Adjusted Gross Income (MAGI) will be used to determine the percentage of FPL that a household's income represents.

If either of the two conditions outlined above are not met, and the employee's household income is less than 400% FPL, the employee may opt out of the employer's plan and is eligible for premium subsidies within the Exchange.

Cost sharing subsidies will also be made available to individuals and families with household incomes below 250% FPL.[23] The purpose of the cost sharing subsidies is to protect lower-income individuals by reducing the total OOP costs required at the point of service. To receive cost sharing subsidies, individuals must enroll in the second lowest cost Silver plan. The reduction in OOP costs essentially increases the actuarial value of the benefits they receive to levels above a Silver plan. The following table shows the enhanced actuarial value of benefits these individual will receive, after the impact of cost sharing subsidies:

Household Income as a % of FPL	Enhanced Actuarial Value of Benefits
138% up to 150%	0.94
150% up to 200%	0.87
200% up to 250%	0.73

The table above shows that after application of the cost sharing subsidies, individuals with incomes between 138% and 150% FPL would essentially receive coverage greater than that provided by a Platinum plan. Those with incomes between 150% and 200% FPL will receive coverage slightly below Platinum benefits, while those with incomes between 200% and 250% will receive coverage that is only slightly enhanced over the standard Silver level. The lower cost sharing levels at the lowest income levels will help smooth the transition as individuals move between Medicaid eligibility and subsidized coverage in the Individual Exchange.

How these cost sharing subsidy reductions would actually filter through the system is complex and somewhat unclear. The ACA entitles low-income exchange enrollees to coverage with the enhanced actuarial values shown above, and it requires QHPs to provide that coverage. The Federal Government will pay insurers directly for the difference between cost sharing under a Silver plan and the lower cost sharing eligible individuals will pay. It is anticipated that an advance payment may be made to insurers based on the population enrolled in their plans that are receiving cost sharing subsidies, with an end of year reconciliation, similar to the process used with the Medicare Part D program. Therefore, these low-income individuals will see the effects of the lower cost sharing up front at the time services are received.

The CBO estimates that 57% of people purchasing coverage in the individual market in 2016 will receive subsidized coverage through the Individual Exchange, and that the average subsidy would result in premiums for these individuals that are 56% to 59% lower than premiums they

[23] Section 1401 of the ACA.

would have paid in the absence of the ACA.[24] This assumption is based on individuals 138% up to 200% FPL enrolling in the Exchange.

Temporary Small Business Tax Credits

The ACA made temporary tax credits available to small employers beginning in 2010. These credits will continue through 2013 at the current levels. The amount of the credit will increase in 2014; however, they may only be claimed for two years after 2014. The credits are designed to encourage small employers to offer coverage for the first time or maintain coverage already in place. In general, the credit is available to small employers that offer qualified coverage and pay at least 50% of the cost for single premiums for their employees.

In order to receive the credit today, an employer must have fewer than 25 full-time workers and an average annual payroll below $50,000. The maximum credit is equal to 35% of the small employer's premium costs (25% for tax-exempt organizations) and available to employers with 10 or fewer full-time employees and an average payroll of $25,000 or less. The amount of the credit phases out gradually as the number of full-time employees increases to 25 and the average annual payroll increases to $50,000.

In 2014, the amount of the credit increases to 50% of the small employer's premium costs (35% for tax-exempt employers). Small employers must enroll in the SHOP Exchange in order to receive these tax credits.

While these credits will undoubtedly reduce the cost of providing coverage for those employers that qualify and apply for the credit, the effect that they will have on small employers offering coverage beyond 2016 is questioned by some. First, as described above, the credits are temporary and may only be claimed for two years after 2014. Second, the employers that are eligible to receive the credits will not be subjected to a financial penalty if they do not offer coverage. Therefore, the incentive to offer coverage in order to avoid a penalty does not exist.

Minimum Medical Loss Ratio

In the individual and small group insurance markets, the ACA requires insurers to spend at least 80% of the premium received on providing health care services or improving those services. Insurers that do not meet that standard must pay rebates to their customers. These requirements became effective January 1, 2011, and are expected to change many insurers' pricing arrangements. A review of 2010 Annual Statutory Financial Statements filed by the primary insurers in the District's individual and small group markets confirms that these new requirements are likely to have premium implications for District consumers in the small group market, in or out of the Exchange, relative to premium levels in the absence of the minimum MLR requirement.

[24] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf

While individual carriers achieved an aggregate MLR in 2010 that is likely to meet the federal requirement, after making allowable adjustments for taxes, quality improvement programs and credibility, small group carriers did not. A few of the District's largest small group carriers experienced loss ratios significantly below 80%. This means some carriers would have been required to issue premium refunds in 2010, had the MLR requirement been in effect. We reviewed recent rate filings for these carriers and found that the largest of these small group carriers has recently implemented significant rate decreases. Given 2010 experience was utilized as a basis for our modeling, we needed to ensure this impact of the MLR was reflected.

Grandfathered Plans

The ACA allows health plans that existed on March 23, 2010 to maintain "grandfathered" status. This status means that these plans are exempt from several of the requirements of the ACA and can only make minor changes to their coverage without being subject to all of the ACA requirements. Specifically, with respect to ACA provisions related to the individual and small group markets, grandfathered plans:

- Are not subject to the new rating rules
- Are not subject to essential health benefit package coverage standards
- Are not included in risk pooling for the purposes of premium development
- Are not included in risk adjustment arrangements
- Cannot be offered through the Exchange

To the extent that grandfathered plans represent healthier than average risk, high rates of grandfathering will tend to cause remaining market premiums to be higher than they would be otherwise. This is due to the fact that grandfathered status is most beneficial to young, healthy groups and individuals as it exempts them from many of the ACA changes that would result in premium increases — in many cases significant premium increases. Should extremely high grandfathering rates develop and persist into 2014 and beyond, the size and stability of the market risk pools could be affected. To retain "grandfathered" status, plans cannot:

- Significantly cut or reduce benefits
- Raise coinsurance charges/percentages
- Significantly raise copayment charges (no more than $5, adjusted annually for medical inflation or by a percentage equal to medical inflation plus 15%)
- Significantly raise deductibles (no more than a percentage equal to medical inflation plus 15%)
- Significantly lower employer contributions (no more than 5%)
- Add or tighten an annual limit on what an insurer pays

By 2014, there will likely be fewer grandfathered plans than observed in this first year after ACA passage, but the precise number cannot be known. It is expected that small employers and individuals will be more likely than large employers to make changes in the next few years that cause them to lose grandfathered status. Shortly after ACA passage, the Federal Government

estimated that 70% of small employers might maintain grandfathered status in the first year, dropping to approximately 33% over several years. Individual grandfathered rates were expected to be lower.[25] However, more recent surveys of insurers and employers suggest that this conclusion may not hold. A Hewitt survey found that out of 466 companies — representing 6.9 million employees — almost all (90%) expect to lose grandfathered status by 2014 because of health plan design changes (72%) and/or changes to company premium contribution levels (39%).[26]

Inclusion of High Risk Pool Insureds in the Individual Market

The Pre-existing Condition Insurance Plan (PCIP) is a new temporary high-risk pool that is offered under the ACA. The program was designed to provide coverage to individuals who, due to their health, were denied coverage in the private individual insurance market or are unable to purchase affordable coverage, and are not eligible for coverage through public programs such as Medicaid and Medicare. Applicants may qualify for the PCIP if they have been uninsured for at least six months and have a pre-existing condition or have been denied coverage or excluded coverage for the pre-existing condition by a private insurance company. The PCIP must provide coverage with an actuarial value of at least 0.65 and rates must be 100% of the standard risk rates.

States could elect to run their own program or elect to have HHS operate the program in their states; HHS administers the PCIP in the District. The program will continue until 2014 when these individuals will be eligible to purchase coverage through the Exchange. At that point, it is expected that individuals in the PCIP will enter the individual market. Given these individuals have higher morbidity than those currently covered through the individual market, upward pressure will placed on rates in the individual market as a result.

Mandated Benefits

A health insurance benefit mandate is a state requirement that an insurer cover certain benefits, health care providers, or patient populations on fully insured products in a particular market. Section 1311(d)(3)(b) of the ACA requires states to reimburse enrollees (or health plans on behalf of enrollees) for the cost of any mandates that exceed benefits included in the EHB package. Thus, an important policy consideration for states will include evaluation of their existing mandates as compared to the EHB and estimation of costs associated with any mandates that exceed the EHB. This issue is explored in detail further in Section 7.

[25] See analysis and projections available at http://www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html. Note that these projections were made prior to a rule revision allowing group grandfathered status to be retained despite a change in insurer.

[26] http://www.aon.com/attachments/Employer_Reaction_HC_Reform_GF_SC.pdf

Risk Adjustment, Reinsurance and Risk Corridors

The ACA introduces three new programs for addressing risk that will be introduced into the commercial market in 2014: risk adjustment, reinsurance and risk corridors. The first is a permanent program and the other two are temporary until 2016. These risk-spreading mechanisms are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets.

Risk Adjustment[27]

The risk adjustment program will effectively require plans with healthier participants to make payments to plans with less healthy participants. Risk adjustment will occur among non-grandfathered plans, separately within the individual and small group markets, but across plans sold inside and outside the Exchanges.

Risk adjustment can reduce the incentives for competing plans to avoid issuing policies to individuals with higher health care needs, and may also help stabilize the experience among carriers which can reduce disruption for policyholders. Risk adjustment can help to reduce adverse selection between carriers; however, it cannot reduce adverse selection against the market as a whole. It is important to understand that while risk adjustment can help adjust for differences in spending across carriers, no risk adjustment mechanism can perfectly adjust for the effects of adverse selection and some level of adverse selection against specific carriers will remain.

Temporary Reinsurance Program[28]

For the years 2014 through 2016, states will be required to establish a temporary reinsurance program. The intent of the program is to help stabilize premiums in the individual market for coverage during the first three years after significant reforms take effect, by protecting carriers from very high-cost members entering the market. Initial costs may be higher in the individual market if more high-risk individuals enroll (those that were previously covered under the PCIP or were uninsured) than individuals with average or low risks.

Health insurance issuers and third party administrators of self insured health plans will be required to make payments to the program for each of these three years. Total contributions will total $25 billion over the three years with $10 billion redistributed for 2014, $8 billion redistributed for 2015 and $4 billion redistributed for 2016. The reinsurance program will make payments to issuers that cover high-risk beneficiaries in the individual market (excluding grandfathered plans). The details as to how carriers in the individual Exchange market will be reimbursed for high-risk individuals are still undefined.

[27] Section 1343 of the ACA.

[28] Section 1341 of the ACA.

Temporary Risk Corridors[29]

A temporary, federally administered and funded risk corridor program will be established for the first three years of implementation of the Exchanges (2014-2016). The risk corridor program will protect carriers participating in the Exchanges against the uncertainty of setting rates during the first three years of operation. It will also prevent carriers from receiving significant financial gain. The program will apply to individual and small group plans sold within the Exchange. Payments will be provided to carriers if their cost of benefits (net of payments under the risk adjustment and reinsurance programs) exceed premium collected less administrative costs by more than 3%. If a carrier's cost of benefits is less than premium less administrative costs by more than 3% a carrier will have to make a payment to the program. The payment will be equal to 50% of the amount between 3% and 8% plus 80% of the amount over 8%.

Of these three ACA programs only the temporary reinsurance program is explicitly reflected in the Oliver Wyman HRM model. Theoretically, risk adjustment and risk corridors do not impact aggregate average gross premium rates and would possibly result in a slightly lower risk charge incorporated into the rates. This is because there are no new funds coming into the individual and small group markets from external sources under these programs (either from the Federal Government or from assessments to large employers).[30] Therefore, they involve exchanging premium dollars among the carriers in the individual and small group markets, and we have assumed that this will have no overall impact on premium rates.

New Taxes and Assessments Affecting Premiums

The ACA will impose new taxes and fees on health insurers, brand name pharmaceuticals and medical device manufacturers. Given these new fees will increase the cost of providing coverage, it is more than likely that they will be passed along to consumers in the form of higher premiums, to the extent possible.

Insurer Tax[31]

A non-tax deductible assessment of $8.0 billion will be allocated across the health insurance industry based on net premium written in 2014. This amount will gradually increase to $14.3 billion in 2018, with the amount increasing by at the rate of premium growth thereafter. In May 2011 the Joint Committee on Taxation recognized the likely pass through of this tax to

[29] Section 1342 of the ACA.

[30] The ACA does not specify a specific funding source for any short fall that may occur if the losses for health plans participating in the Exchanges are greater than the gains. General discussions seem to imply that HHS does not anticipate this situation to occur, based upon the experience of Medicare Part D, which also incorporated risk corridors. For Medicare Part D, the gains were materially greater than the losses. Since there is no specific funding source and no specific authorization to provide additional funds if necessary, we are assuming that the only sources for funding the health plans sustaining losses are from the shared gains from the health plans with positive financial results. Therefore, while there may be monies distributed among the health plans within the Exchanges, the average premium will not change.

[31] Section 9010 of the ACA and Section 1406 of the HCERA of 2010.

consumers, estimating premiums would increase between 2.0% and 2.5% as a result of the insurer tax.[32]

Tax on Pharmaceutical Manufacturers[33]

A new fee was imposed on manufacturers and importers of brand name prescriptions beginning in 2011. The cost will be allocated among manufacturers in proportion to drug sales to government programs. Because these fees would not be imposed on prescriptions sold in the private market, the CBO estimates that it would not result in measurably higher premiums in the commercial market.[34] However, it is likely that at least a portion of these tax assessments will be transferred to the private market through higher drug costs.

Tax on Medical Devices[35]

Starting in 2013, the ACA places a 2.9% excise tax on most medical devices (certain devices such as eyeglasses, contact lenses and hearing aids are exempt). In order to avoid this new tax, companies may begin to manufacture more of these devices overseas. The extent to which this happens will impact the increased costs that consumers will see as the net effect of these taxes are passed along to them in the form of higher premiums.

Other Key Benefit Changes Required Prior to 2014

In addition to the changes described above, there are several other aspects of the ACA that that will affect premium rates which go into effect prior to 2014, many of which have already become effective, but are not fully reflected in the 2010 base period experience used for our modeling.

Guarantee Issue Without Pre-existing Conditions Exclusions for Children

Starting September 23, 2010, insurers were no longer able to deny claims for children under 19 years of age related to a pre-existing condition. With the issuance of interim final regulations,[36] the waiver of the pre-existing condition exclusion was expanded to require guarantee issue of coverage for all children younger than age 19. The addition of the guarantee issue requirement materially increases the cost of a policy over the cost of a policy with only a prohibition on the application of exclusions for pre-existing conditions. Given this additional cost will not be mitigated by the individual mandate until 2014, the additional cost associated with covering these children will put immediate upward pressure on premiums, while at the same time expanding coverage opportunities for children with pre-existing conditions.

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[32] Joint Committee on Taxation, letter the Honorable Jon Kyl. May 12, 2011.

[33] Section 9008 of the ACA and Section 1404 of the HCERA of 2010.

[34] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf

[35] Section 9009 of the ACA and Section 1405 of the HCERA of 2010.

[36] "Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule." Issued by HHS on June 28, 2010.

Other Changes Effective September 23, 2010

In addition to requiring health insurers to guarantee issue coverage to children under age 19, there are several other changes that became effective on September 23, 2010. The primary changes that impact premiums in the individual and small group markets are:

- Coverage for preventive services without cost sharing[37]
- Prohibition of lifetime limits on EHB[38]
- Mandatory coverage of adult children up to age 26 (only required for grandfathered groups/policies if the dependent child does not have access to coverage through his/her own employer until 2014)[39]
- Limited annual dollar limits on EHB until 2014 when annual limits are prohibited[40, 41]
- Cost sharing for emergency services out-of-network may not be higher than for services provided in-network[42]

Given the EHB package is not yet defined, insurers were required to make good faith efforts in determining from which services annual and lifetime limits were excluded. All of the items included in the list above increased the cost of providing insurance coverage under a given policy; however, the impact will vary by benefit plan. For example, some plans previously covered preventive services without cost sharing and the cost for this aspect of the ACA would not increase premiums for these policies. In addition, plans with lower actuarial values, and therefore lower premiums, that previously covered preventive services subject to cost sharing saw higher increases in premium as a result of the requirement to remove cost sharing from preventive services than did plans with higher actuarial values.

Coverage of Women's Preventive Benefits Without Cost Sharing

Beginning August 1, 2012, individual and group health plans will be required to cover certain benefits related to women's health and well being, in accordance with HHS guidelines. Specifically, the following services must be covered without cost sharing:

- Annual well-women visits to obtain recommended preventive services, including preconception and prenatal care
- Screening for gestational diabetes
- Human papillomavirus DNA testing every three years for women age 30 and older
- Annual screening for HIV and other sexually transmitted infections

[37] Section 1001 of the ACA amending Section 2713 of the PHSA.

[38] Section 1001 of the ACA amending Section 2711 of the PHSA and Section 2301 of the HCERA of 2010.

[39] Section 1001 of the ACA amending Section 2714 of the PHSA and Section 2301 of the HCERA of 2010.

[40] Section 1001 of the ACA amending Section 2711 of the PHSA and Section 2301 of the HCERA of 2010.

[41] Grandfathered policies in the individual market are exempt from this restriction.

[42] Section 10101 of the ACA amending Section 2719A(b) of the PHSA.

- Coverage for contraceptives and contraceptive counseling for FDA approved contraceptive methods and sterilization procedures
- Comprehensive lactation support and counseling, and costs of renting breastfeeding equipment
- Screening and counseling for domestic violence

Many of the services in the list above are covered today by most plans, but in many cases are subject to cost sharing. One notable exception is the fact that it is common for policies in the individual market today to exclude coverage for contraceptives. Therefore, the impact of these changes will have greater upward pressure on premiums in the individual market than they will in the group market.

It is also important to consider the fact that in some cases the lack of cost sharing for these services may increase costs by more than the value of any deductibles, coinsurance or copayments that are waived. In addition to increases in utilization that occurs when cost sharing is removed, services may be substituted for other lower cost services that have cost sharing. For example, if tubal ligation is required to be covered with no cost sharing, these services in some cases may be substituted for much lower cost vasectomies. The net effect is a much larger increase on costs.

5

Model Design, Methodology and Assumptions

In this section, we describe the design, methodology and basic assumptions underlying the reform modeling performed for the District. We present a general overview of the model, describing the basic methodology employed. For the interested reader, we have included a technical discussion with additional detail in Appendix A. The modeling was performed using Oliver Wyman's HRM Model. Many aspects of the model are similar to the CBO's and/or The RAND Corporation's simulation models. As will be shown in the next section, the results of our modeling are generally consistent with those from these other models. However, in this work, our model was calibrated to a much more granular level using very detailed, District-specific information on premium rates, benefits, demographics and group composition and not to the higher level, nationwide average information generally used in these other models. As a result, the model captures the many unique characteristics specific to the District.

Model Design and Methodology

The Oliver Wyman HRM Model is comprised of three primary modules. The first module generates a synthetic population made up of individuals, families, employer groups and government programs. The second module uses the synthetic population to calibrate the model by solving for various model parameters, such that the model reproduces the District's current insurance marketplace. Using the simulated population, the solved-for model parameters and many other economic variables, the third module introduces the changes to the marketplace that will come about as a result of the ACA, which are described in the previous section, and projects the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace.

Similar to the CBO's model, a key underlying assumption of our model is that it assumes decisions related to the purchase of health insurance are made at the HIU[43] level, and that the decisions made by these HIUs follow rational choice theory.[44] In reality, consumers will not always behave in an economically rational manner, and for this and other reasons, actual results will vary from those produced by our model. All options available to the HIU for obtaining health insurance are evaluated (i.e., they select among various insurance options with various premiums and OOP cost sharing, public programs or chose to remain uninsured), and the option with the highest economic utility is selected. We have chosen to use a utility function consistent

[43] A Health Insurance Unit (HIU) is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy.

[44] Rational choice theory is based on the assumption that individuals act as if comparing the costs against the benefits of various choices to arrive at the action that maximizes their personal satisfaction.

with that used by The RAND Corporation in its model,[45] but have calibrated it to reproduce the District's current insurance marketplace. We chose a utility function over an elasticity function (which postulates that behavior can be modeled on changes to historical prices) given the choices consumers will face in the reformed market are in many cases significantly different from those they have faced in the past.

While the individual purchasing decision will change significantly with the introduction of the Individual Exchange, premium and cost sharing subsidies, ACR, and the individual mandate, the decision from the employer perspective will remain essentially the same. That is, the employer will choose between offering their employees health insurance benefits or higher wages based on price. Therefore, we have based the employer's decision of whether to offer ESI coverage to their employees, and if so at what level, on demand price elasticity theory. In an effort to obtain the strongest assumptions available, we reviewed numerous published sources. In particular, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica.[46] In addition, we also relied on the CBO's assumptions employed in its micro-simulation model.

A significant portion of the cost of operating any business is related to employee payroll. Therefore, we assume employers view projected increases in payroll as budgeted costs of doing business, and base the elasticity of any insurance purchasing decision on the excess of rate increases they are being asked to pay over the increase in per capita payroll. For example, if the employer is faced with a 7% increase in insurance premiums and per capita payroll is projected to increase at 3%, the impact that the 4% excess cost will have on employer behavior is evaluated using the selected elasticity curve. For each year modeled, the elasticity curve is applied to this excess amount, if any, and the employer chooses to adjust the actuarial value of benefits offered in a manner consistent with the demand elasticity curve. In our modeling, we assume that employers continue to "buy down" benefits until the point at which the actuarial value falls below the minimum level of 0.60 that may be offered in the small group market in 2014 and later, at which point the employer elects to drop coverage. As the results in the following section show, many employers reach this minimum actuarial value in 2014 due to significant rate shock that is introduced by the many changes under the ACA.

Steady State Population

A key underlying assumption of the model is a steady state population. By this we mean that the underlying mix of the population does not change with respect to most variables. Annual increases in income and population growth are included, which also include anticipated changes in the distribution of the population by age to reflect the increasing age of the population as the baby boomers age. However, the distribution of the District's overall population by income,

[45] The utility function utilized by The RAND Corporation was previously justified by research performed by Goldman, Buchanan and Keeler (2000).

[46] "Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature." Mathematica. http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf

gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period. For example, we have not attempted to project rates of employment in 2014, but have assumed that rates of employment in 2014 will be the same as in 2010. This steady state assumption does not mean that the health status or specific individuals will not change over time, only that the overall relative health status by specific subsets of the population (e.g., by FPL and age) do not change. However, as will be described below, as people move between various insured statuses (e.g., small group, individual and uninsured), changes in the average morbidity of those markets will change. Similarly, the family composition of a given household may change, however it is assumed that the overall distribution of the District's population by family composition does not change.

Market Simulation Module

As mentioned above, the first module in the Oliver Wyman HRM Model creates a synthetic population and a synthetic insurance marketplace using a simulation process. The process of simulating this marketplace utilizes a substantial amount of information, including but not limited to information on demographics, income, employment status, health status, availability of ESI, health insurance premiums and eligibility to participate in public programs.

District Residents and Employees

Information from the AC Survey[47] was used as the basis for assigning many of the characteristics to each simulated District resident and employee. Because not all of the individual characteristics needed for the model were included on the AC Survey records, other sources were relied upon for this additional information. For example, while the AC Survey contains information on age, gender, income and current health insurance coverage, it does not capture information on health status. We relied on self-reported data from the Census Bureau's Current Population Survey (CPS) for this information. Through a simulation process, the additional information that was not included on the AC Survey data were synthesized onto the AC Survey records.

Synthetic Employer Groups

In addition to creating the individual District resident and employee population, this module creates synthetic employer groups in order to model the impact that the ACA reforms will have on the rate and level at which employers offer ESI coverage to their employees. By creating synthetic employer groups and placing individual District employees in them, the model more accurately reflects the fact that an individual's access to ESI coverage, and the associated premiums, is dependent upon all members of the group. Further, it recognizes that the employer's decision to offer coverage is based on the characteristics of the entire group.

[47] In the Background Research Report, we referred to the American Community Survey as the ACS data. In order to avoid potential confusion with Information Technology vendors with the same acronym that were also reviewed in this project, we are referring to the American Community Survey as the AC Survey going forward.

Information from D&B was used to determine the current make up of the District's employer market by size and industry. Individuals from the AC Survey were assigned to groups based on their reported state of employment and occupation, and the industry of the employer. This information was blended with employer offering rates, employee eligibility rates and employee take-up rates from the MEPS to determine which groups would be populated with employees that had current ESI coverage. MEPS data reflects variations in these offering and coverage statistics by group size and this variation is reflected in the assignments we make in the model.

The assignment was further controlled to ensure that the number of individuals with ESI coverage through small employers was, in aggregate, consistent with the number of individuals known to have ESI coverage through small employers in 2010 based on an examination of financial statement information for all carriers that wrote small group business in the District. Likewise, the model controls the assignment of individuals within large employers.

Synthetic Health Insurers

Synthetic health insurers are also created within the market simulation module. With the assistance of the DISB, we were able to obtain a significant amount of detailed information related to the groups and individuals covered by private health insurance in the District. As described in Section 3, a data call was issued to the carriers with the largest market share. Enrollment for the subset of carriers providing responses represented 95% of the individual market and 83% of the small group market.

The information gathered included premium, claims, membership and distributions of the amounts by various rating factors including age, gender, underwriting load, group size and industry. In addition, the small group information included a detailed listing with a record for each group insured in 2010. This information, along with information obtained from rate filings, allowed us to create a synthetic rating manual for each carrier. Separate rating manuals were developed for the individual and small group markets. Using this information we were also able to model the changes to the rating manual that are anticipated to occur in 2014 as a result of the change to an ACR methodology, and the corresponding rate shock that each group and individual would observe.

The synthetic rating manuals were then used to develop premiums for each HIU with current coverage in the small group market. Groups were randomly assigned a carrier based on each carrier's market share, and further assigned a benefit plan based on the distribution of benefit plans in force with that carrier in 2010. Base period premiums were then developed using the assigned carrier's rating manual and the demographics and health status of the individuals within the group. Since the model evaluates the option of enrolling in individual coverage for all individuals, regardless of current coverage status (though we considered only non-Medicaid-eligible individuals would be allowed to enroll in individual coverage in 2014 and later), an individual premium was developed for each HIU in a similar manner. As with group coverage, individuals were randomly assigned a carrier based on each carrier's market share, and further assigned a benefit plan based on the distribution of benefit plans in force with that

carrier in 2010. The assigned carrier's rating manual was then used to develop a premium based on the age, gender and health status of the members of the HIU.

Calibration Module

The second module in the Oliver Wyman HRM Model is a calibration module. The purpose of the calibration module is to adjust the underlying parameters of the simulation module and the migration module until they replicate the status quo at various sub-population levels. In calibrating the market simulation module, model parameters are adjusted so that across multiple iterations the results are representative of the 2010 District insurance marketplace. Results are examined to ensure that the simulation produces:

- The appropriate number of individuals with each type of coverage (e.g., Medicaid, small group, individual and uninsured)
- The correct average premiums that were present in the individual and small group markets in 2010
- A distribution of rate shock anticipated to occur in 2014 which is consistent with that anticipated based on the raw carrier data received

If the simulation repeated for several iterations did not produce the desired results, the model parameters were adjusted until the desired results were achieved.

The market migration module will be described in detail in the next section, but in brief it predicts the market into which individuals will enroll, based on an evaluation of the options available to them. To calibrate the market migration module, output from the calibrated market simulation module are input into the market migration module; however, the actual market into which the HIU was enrolled in the base period is temporarily ignored as the goal of the calibration is to have the model reproduce the enrollment choices actually made during the base period. Premiums for ESI coverage (where applicable) and individual coverage are passed from the calibrated market simulation module to the market migration module for each HIU. This process is repeated for each simulated market created by successive iterations of the market simulation module, and the results are aggregated across all simulations. The underlying parameters of the individual utility function employed in the market migration module are adjusted until the current market distribution is replicated across several key sub-populations. The following table lists the sub populations to which the model was calibrated and demonstrates that parameters for the utility function were found such that the market migration module produced base period results consistent with the calibrated simulation module.

	Known Distribution	Migration Module
Uninsured (District Residents) <=200% FPL	17.3%	18.4%
Uninsured (District Residents) 201%-400% FPL	4.6%	4.8%
Uninsured (District Residents) >400% FPL	4.4%	4.6%
Individual (District Residents)	8.8%	9.2%

	Known Distribution	Migration Module
Small Group (District Residents; Work in District)	10.7%	10.5%
Small Group (Non-District Residents; Work In District)	32.8%	32.2%
Mid-group (District Residents; Work in District)	5.8%	5.6%
Mid-group (Non-District Residents; Work in District)	15.5%	14.8%
Total	**100.0%**	**100.0%**

Market Migration Module

The final module in Oliver Wyman's HRM Model is the market migration module. The purpose of the calibrated market migration module is to use the simulated marketplace, along with many other medical and economic input variables and the introduction of the changes that will occur in 2014 and beyond as a result of the ACA, and project the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace. Population growth, household incomes for each HIU, and personal claims cost (PCC) for each member of the HIU, are projected forward for each year.

Projected incomes are used to determine the household's Modified Adjusted Gross Income (MAGI), which in turn is used to determine their income as a percentage of projected FPL levels. Once the HIU's income as a percent of FPL is determined, it is used to further determine the HIU's eligibility for Medicaid, CHIP, premium subsidies, cost sharing subsidies and exemption from penalties under the individual mandate.

Using the employer elasticity curve, the small employer decision to offer coverage, and if so at what level, is made. As described above, the employer elasticity curve is applied to the excess of the requested rate increase over the increase in per capita employee wages. In our model, we have characterized an employer's response to increasing premiums by decreasing the benefits that the employer offers in their health plan. For example, an increase in premium might cause an employer to offer a Silver plan instead of a Gold plan.

The employer responds to subsequent increases in premiums this way until the actuarial value of coverage the employer is willing to offer falls below the minimum allowable level in the post reform market of 0.60 (i.e., Bronze level coverage). Once coverage has been reduced to the Bronze level, the model assumes that additional decreases in employer costs are instead shifted to the employee through higher premium contributions. The employer maintains Bronze level coverage and shifts additional costs until the point at which the employee has been asked to contribute an additional 10% of premium beyond the baseline level developed from the MEPS data. As the actuarial value of coverage that the employer is willing to offer falls below this level (i.e., employee contributions would have to increase by more than 10%), the employer makes the decision to no longer offer coverage.

As will be seen in the following section, the shock that is introduced as a result of the change to an ACR methodology in 2014 will be significant. In the first year of implementation, it will increase costs substantially for some employers (beyond our threshold) compelling many of them to drop coverage.

Individual purchasing decisions in the modeled years are based on the calibrated utility function resulting from the calibration module. The utility function is used to evaluate many different purchasing options available to consumers in the reformed market. The model only considers options for which HIUs are eligible. For example, the model does not consider Medicaid as an option for HIUs with high household incomes. Nor does it consider ESI for an HIU where the AC Survey respondent in the HIU is not simulated to work for an employer that currently offers ESI.

The District is unique in that roughly two-thirds of those insured through its private insurance markets are not residents of the District. If these non-resident employees do not have ESI coverage offered to them, or work for an employer that decides to no longer offer ESI coverage, they are essentially dropped from the model. This is because they are not eligible to enroll in public programs or the Individual Exchange within the District, but rather their eligibility for coverage is through their state of residence.

This is important to understand in interpreting the results that are presented in the next section. Nationwide, 94% of workers live in the same state where they work. Therefore, in most states, when an employer with 50 employees drops coverage, almost all of these 50 employees and their dependents will evaluate the option of enrolling in that state's Individual Exchange. However, in the District when an employer with 50 employees decides to no longer offer coverage, only about 17 of these employees and their dependents will be potential candidates for enrollment in the District's Individual Exchange. This means that as District employers drop coverage, the size of the District's total private insurance market will decrease, all else equal. In reality, there is the possibility these workers have a spouse that also works in the District for an employer that offers ESI coverage into which these employees could enroll, which would cause them to remain within the District's insurance marketplace, however the complexity of this scenario is not included in the model.

Key Underlying Assumptions

The previous discussion focused on the underlying framework upon which the model was built. We now turn to a discussion of the key underlying assumptions on which the model was built. We follow this with a discussion of the assumptions that are direct inputs to the model and can be changed to test the sensitivity of the results to the change.

Carrier Participation and Product Offerings in the District's Individual and Small Group Markets

We made the following assumptions regarding carrier participation:

- All major carriers participating in the District's individual and small group markets during the base period continue to participate in 2014 and beyond
- No new carriers enter the market and obtain significant market share
- All carriers participate in both the inside and outside Exchange markets
- Products offered inside the Individual and SHOP Exchanges are similar to products offered outside the Individual and SHOP Exchanges, and premium rates are the same inside and outside the Exchanges for the same benefit package

Individuals Currently Enrolled in Medicaid/CHIP/Alliance

Individuals currently enrolled in the District's Medicaid, CHIP or Alliance programs are not specifically included in our model and are assumed to remain enrolled in these programs in 2014 and beyond. Factors are applied to this set of individuals to reflect general population growth. Individuals who are currently eligible for these programs but are not enrolled are addressed later in this section.

Large Employers Continue to Offer ESI

We have assumed that large employers (defined as those with 101+ employees) continue to offer ESI coverage at the same rate they did in 2010, and we have assumed that employees who are eligible and enroll in this coverage do so at the same rate they do today. Employees who are not eligible to enroll, or those who are eligible to enroll but choose to remain uninsured, are reflected in our modeling. It is assumed that the combination of the employer penalty for not offering qualified coverage, along with the fact that benefits are many times a significant factor for large groups when attracting and retaining employees, will cause large employers to continue to offer coverage through the period over which we have modeled.

Small Employers Not Offering Coverage During the Base Period Do Not Offer Coverage in 2014 and Beyond

The model assumes that small employers that did not offer coverage in 2010 will not begin to offer coverage in 2014. We note that the small employer tax credits were introduced in 2010 and it is assumed that any small employers electing to offer coverage as a result of these credits would have done so in 2010, and as a result are reflected in the base experience used for our modeling. It is true that some employers may have elected not to offer coverage today due to high premiums presented to them, resulting from an employee or dependent with significant health needs, and they will see premiums in the post reform market decrease under the ACR methodology. However, the employees of these employers will also be able to access the Individual Exchange and see these same reductions in premium, in addition to any subsidies for which they may qualify.

To the extent that coverage is newly offered by small employers in 2014 and beyond, the projected enrollment figures we develop in this report may be understated.

Government Workers

If either the primary AC Survey respondent or the spouse is identified as working for the government, and the HIU is identified as currently having ESI coverage, we have assumed that the ESI coverage is provided through a government employer. Our model assumes that these individuals, with the exception of Congressional staff described below, will continue to receive this coverage and will not enroll in the Individual Exchange.

Congressional Staff

Section 1312(d)(3)(D) of the ACA requires that beginning January 1, 2014, Members of Congress and their personal staff may no longer receive coverage through the FEHBP and that these individuals must purchase coverage through a health plan created or offered through an exchange established under the ACA. While for most states the impact of the inflow of these individuals into the state based exchange will be negligible, this may not be the case for the District. First, many of these roughly 5,000 Congressional staffers may live in the District and be eligible to enroll in the District's Individual Exchange. Second, the District's population is much smaller than most states', so the addition of these individuals into the Exchange may represent a measurable impact.

We attempted to identify these individuals, or at a minimum a distribution by state of residency. After an exhaustive Internet search did not provide this information, we contacted the US Office of Personnel Management (OPM). While OPM was ultimately able to provide information on the number of non-postal federal employees who are District residents and enrolled in the FEHBP program, they were not able to provide information for the subset of individuals we were interested in. As a result, these individuals are not included in the modeling results we present and our results are understated by the number of these individuals that ultimately enroll in the District's Individual Exchange.

Grandfathered Policies

As described in Section 4, a recent survey found that out of 466 companies — representing 6.9 million employees — almost all (90%) expect to lose grandfathered status by 2014 because of health plan design changes (72%) and/or changes to company premium contribution levels (39%).[48] Given the limitations on benefit changes that can be made and still maintain grandfathered status and the pressure that the current economic conditions are putting on employers and individuals to limit premium increases, our model assumes that there will be no individual or small group policies with grandfathered status in 2014.

[48] http://www.aon.com/attachments/Employer_Reaction_HC_Reform_GF_SC.pdf

Self Insurance

As previously described, an ACR methodology will have the impact of increasing rates for young, healthy groups and individuals. In some cases these groups will have a financial incentive to self insure their benefits rather than purchase coverage through the fully insured risk pool. The exit of these healthier than average groups from the fully insured small group market could increase the average morbidity of those that remain, and put upward pressure on rates. The impact of this phenomenon is not reflected in the baseline modeling that is the subject of this report.

Private Exchanges

Recently, there has been much discussion about the development of private health exchanges. Wellpoint recently purchased an exchange vendor and Aon Hewitt launched an exchange in April 2011. It is unclear how these private exchanges will compete against the state and federal run ACA exchanges. It is also unclear whether more private exchanges will develop. While a lot is not known about them, we do know that individuals who are subsidy eligible will not be able to enroll in a private exchange and receive Federal premium and cost sharing subsidies. Our model does not consider the impact that these private exchanges may have on the enrollment in the District's Individual or SHOP Exchanges.

Undocumented Individuals

With the introduction of the District's current 138%-200% FPL Waiver programs, all documented individuals in this income range were migrated from the Alliance program to the new Waiver program. Therefore, it is likely that many of those that remain in the Alliance program are undocumented individuals. Undocumented individuals will not be eligible to enroll in the District's Individual Exchange. Our model does not specifically handle these undocumented individuals, as they are not separately identifiable in the AC Survey data. Rather, our modeling assumes that these individuals are not likely to respond to the AC Survey and are therefore not included in the AC Survey data used as a basis to develop the simulated marketplace.

Model Input Assumptions

In addition to the underlying assumptions upon which the model is built, there are numerous inputs and variables that can be adjusted in Oliver Wyman's HRM Model. Changing multiple assumptions at once does not allow one to observe the sensitivity to changes from any one variable. Therefore, in each of the four scenarios presented in the next section the assumptions described below remain constant. This allows the District to understand the sensitivity to changes in only the assumptions that are varied in each scenario (i.e., definition of small group, merging of individual and small group pools). While sensitivity to changes in many of the baseline assumptions listed above and any of the variables listed below may be modeled, additional modeling to test the sensitivity to these other assumptions is outside the scope of this project.

Guarantee Issue

Under ACA, coverage must be offered on a guarantee basis. In our modeling, we do not evaluate certain coverage options for individuals unless they meet eligibility requirements (e.g., meet Medicaid eligibility requirements or work for an employer that offers coverage). However, due to the guarantee issue provision in the ACA, our model does not restrict individuals from evaluating coverage options due to their own health status, nor do the calculated premium rates vary based on their individual health status.

Medical Trend

Based on our own independent analysis, research of analyses performed by other consulting firms, results from the Society of Actuaries' Long Term Healthcare Cost Trends Resource Model,[49] and analysis performed by the CBO, we have selected and employed in our model an annual medical trend rate of 7%.

Targeted Medical Loss Ratios

As discussed in Section 4, health insurers will be required to meet new loss ratio requirements of 80% beginning in 2011 in the individual and small group markets and 85% in the large group market. Our model assumes that insurers will prospectively develop their 2014 premiums based on loss ratio targets consistent with these loss ratios to which they will be held to on a retrospective basis.

ACA Changes Effective September 23, 2010

As described in Section 4, the ACA required several changes to eligibility, coverage and benefits effective on the first policy anniversary date on or after September 23, 2010. Given the base period experience used for our modeling reflects calendar year 2010, only a very small portion these changes are reflected in the experience. We increased the base period experience premiums by 5% in the individual market and 3% in the small group market to reflect the following changes:

- Coverage of dependents up to age 26
- Elimination of cost sharing on preventive services
- Removal of lifetime limits on EHB
- Restriction of annual limits on EHB
- Increase in cost sharing for out-of-network emergency services to in-network levels
- Guarantee issue with no pre-existing condition exclusions for children up to age 19

Benefits and Actuarial Values

In order to model benefits and premiums in 2014 and beyond, we first needed to understand how current District insurance products compare to the ACA coverage tiers. Oliver Wyman actuaries obtained information from the largest carriers in the District. For small group business,

[49] "Modeling Long Term Healthcare Cost Trends." Society of Actuaries. December 2007.

this information contained premium, claims, membership and the various rating factors (e.g., age/gender, group size, industry and underwriting load) assigned to each group in 2010. The actuarial value of the benefit plan underlying each small group's premium was not provided. Using the information obtained, each group's premium was normalized for all rating factors provided, which in effect resulted in normalized premiums that reflected only benefit differences.

In 2010, carriers were not yet designing products targeted to specific actuarial values (as they will in the reformed market); the observed benefit differences did not cluster around specific actuarial value levels. After removing outliers at both extremes, estimates of actuarial values were assigned to the various groups. By examining rate filing information for the carriers included in the data call, we were able to discern the level and approximate actuarial value of the richest plans offered in the market in 2010. We assigned the richest normalized premiums an actuarial value consistent with the actuarial value of the richest plans offered in 2010. Small groups were then pooled into ranges based on their normalized premium, where the average actuarial value of each range was approximately 10% lower than the average actuarial value of the previous range. The following table shows the estimated average actuarial value for each range and the distribution of groups by these actuarial value ranges.

Actuarial Value	Distribution of Groups
0.953	11%
0.854	16%
0.756	22%
0.656	25%
0.547	25%
0.716	**100%**

**Totals do not sum due to rounding*

The table above shows that current product offerings in the small group market appear to be distributed fairly evenly over coverage levels that are comparable to Silver and Bronze coverage, with the average actuarial value of 0.716 being close to Silver coverage. The table also shows that a significant percentage of small groups have coverage today that is likely to fall below Bronze coverage.

We performed a similar analysis for the current individual market. The following table shows that the average actuarial value in the individual market is approximately 12% lower than in the small group market. The average actuarial value of 0.629 is in line with the CBO's estimate that the average actuarial value of individual policies is 0.60 under current law.[50]

[50] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

Actuarial Value	Distribution of Groups
0.950	3%
0.853	5%
0.753	13%
0.653	37%
0.523	43%
0.629	**100%**

**Totals do not sum due to rounding*

The impact of the EHB package will have a significant impact on premiums in the District's individual market. The table above shows that roughly half of the individual plans offered today have an actuarial value below Bronze level coverage. In addition, the average package of services covered in the current individual market is on average leaner than in the small group market. In many cases, the coverage excludes maternity and/or prescription drugs. The CBO estimates that average premiums in the individual market in 2014 will be 27% to 30% higher because of greater coverage requirements. These increases result from the average insurance policy covering a substantially larger share of an enrollee's costs for health care and a wider range of covered benefits as a result of the EHB package.[51] Our modeling indicates that the average impact in the District will result in individual premiums that are roughly 25% higher for these items. We suspect this figure for the District is below the low end of the CBO's range because the District already mandates coverage for MHSA services in the individual market, where as 32 other states do not.[52]

Actuarial values associated with a particular product option can change over time, especially for product options with fixed dollar cost sharing elements such as deductibles or service specific copayments. For example, as the general level of health care expense increases, a given deductible (or copayment) value represents a lower proportion of expected service cost, and thus it will produce a higher actuarial value. The presence of coinsurance can mitigate that leveraging effect, because it moves proportionately with health care expense levels until an OOP maximum is reached. Thus, between 2010 and 2014 when the coverage tiers become effective, a particular product option that is now modeled as Bronze may require cost sharing changes to remain at the Bronze level.

Starting with the underlying 2010 cost of coverage in the District, we projected these costs forward to 2014. We then calibrated Oliver Wyman's Benefit Rating Model to this 2014 cost and developed benefit design and cost sharing options that would meet each of the actuarial levels permissible under the ACA. A wide range of deductibles, coinsurance, copayments and OOP limit combinations are offered in the market today, leading to almost an endless number of

[51] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

[52] http://www.statehealthfacts.org/comparereport.jsp?rep=1&cat=7

possible benefit combinations. Even with the restricted actuarial values in the future, we anticipate variation in benefit design within each metallic level.

For simplicity and ease of comparison, we developed plans where all services are subject to an overall deductible, coinsurance and OOP maximum. In reality, plans offered will likely include copayment for various services as they do in many cases today. We restricted the deductible and OOP maximum to meet the requirements of the EHB package. The following table presents various benefit offerings anticipated at each metallic level in 2014.

Coverage Level	Deductible	Coinsurance	OOP Max
Platinum	$200	90%	$1,000
	$50	100%	$1,000
Gold	$250	70%	$2,500
	$500	80%	$2,500
	$750	90%	$2,500
Silver	$500	65%	$5,500
	$750	70%	$5,000
	$1,000	80%	$5,950
	$1,500	85%	$3,500
Bronze	$1,500	60%	$6,000
	$2,000	70%	$6,000
	$2,500*	80%	$5,000
	$3,000*	90%	$5,000

*Not available in the Small Group market

Coverage for Individuals with Incomes Between 138% and 200% FPL

Based on guidance from the District, we were directed to assume that the District will either continue the current 138% up to 200% FPL Waiver program beyond 2013 or establish a BHP. Therefore, our modeling does not allow individuals with household incomes in this range to enroll in the Individual Exchange and receive premium and cost sharing subsidies.

Coverage for Women's Preventive Services

A 1.5% increase to premiums was applied to reflect the coverage of women's preventive services without cost sharing effective August 1, 2012.

Uninsured Utilization and Pent-up Demand

Individuals without current health insurance do not seek medical services at the same level as those with insurance. The CBO estimates that the uninsured currently use about 60% as much medical care as insured individuals, after taking into consideration differences in age and

morbidity.[53] We have used this assumption in our model and therefore multiply an individual's expected PCC by a factor of 0.60 when evaluating the utility associated with becoming or remaining uninsured.

Because of the fact that individuals who are currently uninsured do not utilize services at the same level as those with insurance, they will have pent-up demand and utilize services at a higher rate during their first year that they are insured. We estimate the impact of pent-up demand will cause the expected claims costs for a newly insured individual, relative to an individual of the same age, gender and health status that has insurance, to be 10% higher in the first year. Therefore, when calculating the utility associated with various purchasing options for an individual that is currently uninsured, the individual's PCC is multiplied by a factor of 1.10 for each health insurance option evaluated. The pent-up demand factor is not included in calculating the utility associated with the person remaining uninsured. If the individual elects to take-up coverage, their expected claims cost in subsequent years is assumed to be the same as the average insured individual of the same age, gender and health status. In other words, the pent-up demand adjustment is removed after the first year of insurance.

Adverse Selection Due to Risk Pool Composition Changes

A critical consideration in premium development is the relative morbidity associated with individuals and small group enrollees that depart the market, as well as new market entrants. To the extent that the risk pool composition changes, those changes will influence premium levels. Some of the factors impacting the average morbidity level of the pools are discussed below.

Residents with Current Individual Insurance Leaving the Pool

Residents currently covered by policies through the District's individual market that experience significant rate shock resulting from the ACR methodology may find it economically beneficial to become uninsured. Given young and healthy individuals will experience the most upward pressure on rates resulting from a shift to an ACR methodology, the exit of these healthy individuals can lead to an increase in the average morbidity of the individual pool.

Residents Currently Uninsured Entering the Pool

Residents who are currently uninsured and were previously denied coverage in the individual market due to their health status will increase the average morbidity of the pool as they enter the individual market under guarantee issue rules. In addition, these individuals will have pent-up demand, as described above, which will put further upward pressure on the anticipated utilization rates of the individual pool.

Participants in the PCIP High Risk Pool

Residents currently enrolled in the PCIP high risk pool will be allowed to enter the District's Individual Exchange in 2014. Given these individuals have average morbidity that is higher than

[53] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf

those currently enrolled in the individual market, their entrance will put additional upward pressure on rates. However, as of August 31, 2011, there were only 36 District residents enrolled in the PCIP.[54] As a result, the impact of transitioning these individuals to the Individual Exchange will likely have minimal impact on rates. Therefore, we did not specifically model the migration of these individuals to the District's Individual Exchange and the results presented in the following section do not include these individuals.

Those with Current Employer Sponsored Coverage that Lose Coverage

Individuals with current ESI coverage will have the option to enter the Individual Exchange if their employer terminates coverage. Employers with low-income employees may be more likely to terminate coverage as a result of premium and cost sharing subsidies that will be available to their employees in the Individual Exchange.

Our model assumes that health insurance carriers will anticipate adverse selection associated with the four items discussed above and prospectively price for it, to the extent they are allowed (with the exception that we have not included the PCIP participants as described above). Assumptions for these relative morbidity levels were derived based on iterative testing by applying adverse selection loads to premiums and observing the resulting changes in morbidity of the pool due the new market entrants and exits. As significant enrollment of new market entrants who were previously uninsured bring a pent-up demand for services, as previously described, and the impact of that phenomenon was also included in premium development. We found that the upward pressure on rates in the individual market resulting from this migration was 9.6% in the Baseline Scenario.[55] Therefore, rates in the individual market in 2014 were increased 9.6% in anticipation of this shift in average morbidity. We found no significant change in the risk pool composition of the small group pool in 2014 under the Baseline Scenario.

Increases in the Consumer Price Index

We have used increases in the Consumer Price Index (CPI) consistent with the middle estimate as reported in the 2011 Social Security Trustees Report, Table V.B.1.[56] The following table shows the estimates employed in our modeling for the District.

Year	CPI Estimate
2010	1.6%
2011	1.2%
2012	1.7%
2013	1.9%

[54] http://www.healthcare.gov/news/factsheets/2011/10/pcip10142011a.html

[55] The baseline scenario assumes separate individual and small group risk pools, and a small group definition of 50 employees until 2016.

[56] http://www.ssa.gov/oact/tr/2011/lr5b1.html

Year	CPI Estimate
2014	2.0%
2015	2.0%
2016	2.0%
2017	2.2%
2018	2.6%

Penalties under the Individual Mandate

Penalties for 2014 through 2016 are prescribed in the ACA. The ACA specifies that after 2016, the flat dollar penalty is increased based on the cost of living, with any increase that is not a multiple of $50 rounded to the next lowest multiple of $50. Therefore, using this formula and the increases in CPI outlined above, we project that the penalties under the individual mandate will be as follows and have used these values in our model.

Year	Dollar Penalty	Percentage Penalty
2014	$95	1.00%
2015	$325	2.00%
2016	$695	2.50%
2017	$700	2.50%
2018	$700	2.50%

Increases in Annual Average Wages

We have used increases in the average annual wage from the middle estimate as reported in the 2011 Social Security Trustees Report, Table V.B.1, "Annual Percentage Change in Average Annual Wage in Covered Employment."[57] The following table shows the estimates employed in our modeling for the District.

Year	Salary Inflation
2010	4.0%
2011	4.1%
2012	4.5%
2013	4.6%
2014	4.2%
2015	3.9%
2016	4.0%

[57] http://www.ssa.gov/oact/tr/2011/lr5b1.html

Year	Salary Inflation
2017	4.0%
2018	4.4%

Premium Subsidies

Premium subsidies consistent with those outlined in the ACA were employed. Our model places individuals into income ranges and applies the same subsidy to all individuals within a given range. This is slightly different from the ACA, in that subsidies at specified income levels are prescribed and subsidies for HIUs are interpolated between these points based on the HIU's actual income. Therefore, we translated the subsidies included in the ACA into an average premium subsidy for each income range used in our model. The income ranges used were selected to coincide with thresholds for eligibility for various public programs, premium subsidies and cost sharing subsidies, and are narrow enough so as not to introduce bias or lack significant specificity. The following table compares the subsidy levels included in the ACA with the income range subsidies employed in our model.

ACA Subsity		Modeled Subsidy	
Federal FPL Percentage	**Maximum Premium Contribution**	**Modeled FPL Range**	**Maximum Premium Contribution**
100%	2.00%	100%-138%	2.50%
133%	3.00%	139%-150%	3.50%
150%	4.00%	151%-200%	5.15%
200%	6.30%	201%-250%	7.18%
250%	8.05%	251%-300%	8.78%
300%	9.50%	301%-350%	9.50%
400%	9.50%	351%-400%	9.50%

Tax Considerations

An employee's premium contributions under an ESI health plan may be purchased with pre-tax dollars. Our model takes this into consideration when applying the utility function for individual purchasing decisions. We estimated District and federal tax rates for various MAGI ranges. We used current tax rates as reported by the Office of the Chief Financial Officer to estimate District tax rates for various MAGI levels.[58] Federal tax rates were modeled using an analysis conducted by the CBO which examined federal tax rates by pre-tax income quintile.[59] We considered Federal Insurance Contributions Act (FICA) taxes at 2010 levels and assume the temporary reduction in the employee's portion of the rate from 6.2% to 4.2% for 2011 will not continue, and

[58] http://www.cfo.dc.gov/cfo/cwp/view,a,1324,q,610984,cfoNav,|33210|.asp

[59] http://www.cbo.gov/publications/collections/tax/2010/AverageFedTaxRates2007.pdf

that 2014 rates will correspond with 2010 rates.[60] We have also considered Medicare taxes at the current 1.45% rate for both employees and employers.

In factoring FICA and Medicare taxes in, we have used both the employee and employer portion, recognizing that the employer paid portion is effectively in the employee's wages. We have also reflected the income cap on which individuals and employers are required to pay FICA taxes, which results in a lower effective rate as income increases. Using this information we developed the following tax rates for various MAGI ranges and employed these estimates in our model.

MAGI	DC Tax Rate	Federal Tax Rate	FICA Tax Rate	Medicare Tax Rate	Total Tax Rate
$0-$10,000	4.00%	1.00%	12.40%	2.90%	20.30%
$10,001-$20,000	4.25%	2.00%	12.40%	2.90%	21.55%
$20,001-$30,000	4.50%	4.00%	12.40%	2.90%	23.80%
$30,001-$40,000	5.00%	6.00%	12.40%	2.90%	26.30%
$40,001-$50,000	5.50%	8.00%	12.40%	2.90%	28.80%
$50,001-$75,000	6.00%	11.00%	12.40%	2.90%	32.30%
$75,001-$100,000	6.25%	14.00%	12.40%	2.90%	35.55%
$100,001-$200,000	6.50%	17.00%	8.83%	2.90%	35.23%
$200,001-$300,000	7.00%	21.00%	5.30%	2.90%	36.20%
$300,001-$350,000	7.50%	25.00%	4.07%	2.90%	39.47%
$350,001-$400,000	8.00%	25.00%	3.53%	2.90%	39.43%
$400,001-$500,000	8.50%	25.00%	2.94%	2.90%	39.34%
$500,001+	8.50%	25.00%	2.65%	2.90%	39.05%

Temporary Reinsurance Program

As described in the previous section, a temporary reinsurance pool will be established for three years (2014 through 2016) to transition into rates the impact of the adverse selection that will occur due to changes in the risk of the population insured in the individual market. The reinsurance program is anticipated to allocate $10 billion to carriers in the individual market in 2014, $6 billion in 2015 and $4 billion in 2016. These payments to carriers in the individual market are anticipated to be roughly 10% of premium in 2014, all else equal, and this reduction will be phased out over the next three years as the level of payments in each subsequent year is reduced. These payments to the individual market will result in assessments against all markets, including the individual market, of about 1% of premium in 2014. The following table shows the annual impact of the reinsurance program on premiums in the individual and small group markets that are built into our model. The 9.1% reduction in the individual market in 2014 is the

[60] http://ssa.gov/pubs/10003.pdf

net of the 10% reduction due to reinsurance payments to the market and a 1% of premium assessment against the individual market.

Year	Individual Market	Small Group Market
2014	-9.1%	1.0%
2015	4.1%	-0.3%
2016	1.9%	-0.2%
2017	3.7%	-0.4%

Take-up of Medicaid Coverage among Those Eligible but Not Enrolled

As with most states, there are residents of the District that are eligible for Medicaid but not enrolled today. However, the Background Research Report demonstrated that the percent of the District's population that falls into this category is lower than nationwide. There are many possible reasons why these individuals may choose not to enroll in Medicaid. Some may make this election based on the fact that they are healthy and do not currently need services, knowing they can enroll when they do. A US Government Accountability Office study found that many do not enroll because of the perceived stigma associated with filing for public assistance.[61] The same study reported that some individuals found completing the application and gathering the required documentation to be burdensome.

With a "single front door" integrated approach to the exchanges and Medicaid, some of the stigma associated with enrolling in Medicaid today may be reduced. In addition, the navigators and their mission to educate consumers, raise awareness of the exchanges, and facilitate enrollment may also increase the number of these individuals that enroll in Medicaid. The District has also informed us that additional outreach to this segment of the population is already underway. For these reasons, we have included in our modeling the assumption that 20% of the individuals currently eligible for Medicaid, but not enrolled, will enroll by 2014. An additional 5% are assumed to enroll by 2015 and another 5% by 2016.

Participation in the Individual Exchange

Premium and cost sharing subsidies will only be made available within the Individual Exchange. Therefore, individuals qualifying for subsidies will have strong financial incentives to purchase coverage through the exchange rather than in the outside market. Our model assumes that individuals eligible for premium and cost sharing subsidies will not enroll in the outside market.

Lower participation in the Individual Exchange is assumed among HIUs with incomes in excess of 400% FPL. A recent Kaiser survey of people with individual insurance found that 36% purchased their coverage with the use of an insurance broker.[62] Roughly three-quarters of the

[61] http://archive.gao.gov/t2pbat4/150626.pdf

[62] http:/www.kff.org/kaiserpolls/upload/8077-R.pdf

remaining individuals purchased coverage directly from the insurance company while only one-quarter, or 13%, purchased coverage through the Internet. We note that the survey did not report these statistics separately by income range. A recent Pew Research study found that those with incomes over $40,000 are twice as likely to consider themselves high-access Internet users as compared to those with incomes under $40,000.[63] Therefore, we estimate that the rate at which individuals with incomes over 400% FPL purchase coverage over the Internet today is at least twice the average 13% figure reflected in the Kaiser survey.

Once the Individual Exchange is up and running in 2014, there will be even more exposure to on-line purchasing of insurance than there is today. National attention given to exchanges as an alternate vehicle for purchasing insurance is sure to increase the rate at which this method of purchase is used today. In addition, the navigator's role in conducting public education and raising awareness of the availability of QHPs will also increase awareness. Additional advertising and outreach by the District can work to increase the awareness even more. Based on the research above and our discussions with the District about planned efforts to make the public aware of the Individual Exchange, we have assumed in our modeling that 50% of the individuals with incomes over 400% FPL that purchase coverage in the individual market will do so through the District's Individual Exchange.

Participation in the SHOP Exchange

Small groups that are eligible for the temporary small business tax credits must enroll in the SHOP Exchange in order to receive those credits beginning in 2014. Therefore, our model assumes that for any small employer that is both eligible for the tax credits and is modeled as offering coverage will enroll in the SHOP Exchange. Once the temporary tax credit program expires, these small employers will need to decide whether they can afford to continue to offer coverage. Given that premium rates must be the same inside and outside the SHOP Exchange for the same benefits, we think it is unlikely that employers will not have access to plans with significantly lower benefits or premiums in the outside market. Therefore, our model assumes that if these employers continue to offer coverage beyond 2016, they will continue to do so within the SHOP Exchange.

Among employers that do not qualify for the tax credits, enrollment in the SHOP Exchange is projected to be much lower. Given the exchanges created under the ACA are new, there is no empirical evidence upon which to base an assumption related to employer participation. An examination of enrollment by small employers in the Massachusetts Connector, the Utah Health Exchange, and HealthPass New York reveal that significantly less than 10% of the small groups are enrolled.[64] While these "exchanges" are different from the District's planned SHOP Exchange that will be established under the ACA, they do provide a starting point for setting enrollment estimates.

[63] http://www.pewinternet.org/~/media//Files/Reports/2007/Pew_UI_LibrariesReport.pdf.pdf

[64] http://www.smallbusinessmajority.org/reports/shop_exchange.pdf

One feature of the District's SHOP Exchange that could lead to higher enrollment is the fact that employers must be offered the option of selecting a metallic level, and then allowing employees to select among the various plan choices available at that level. This option is not required in the outside market and may result in attracting employers into the SHOP Exchange. We have assumed in our modeling that 10% of small employers that offer coverage and do not qualify for the small business tax credit will enroll in the District's SHOP Exchange. This assumption is higher than the enrollment levels observed by existing exchanges and reflects the fact that the employee choice option is expected to draw in some employers. We note this assumption is consistent with those employed by other states in similar modeling that we have reviewed. At the same time, these other states recognize the need to explore options to increase enrollment, such as strong outreach to insurers and employers, broker engagement, and the value-added benefits and services that can be offered through the SHOP Exchange.

Insurer Tax

As described in Section 4, a new insurer tax equal to $8 billion in 2014 and increasing to $14 billion in 2018 will be allocated across all insurers based on net premiums written. Our analysis indicates that the value of this new tax as a percent of premium will be as follows, and we have incorporated these increases into the projected premiums in both the individual and small group markets:

Year	Insurer Tax as a % of Premium
2014	2.10%
2015	2.70%
2016	2.70%
2017	3.30%
2018	3.30%

Inertia Factor

A 10% inertia factor was used in the model. This factor requires that the utility associated with any source of coverage evaluated be at least 10% greater than the utility associated with the HIU's current source of coverage, in order for them to make a change to the new coverage status.

6

Modeling Results

To understand how certain design scenarios could impact enrollment and premiums in the Individual and SHOP Exchanges, we used the Oliver Wyman HRM Model to test potential results for four scenarios identified by the District. The focus of the following modeling results is on Exchange design scenarios and the sensitivity of results to those scenarios.

As previously described, the model is based upon the assumption that consumers will select the option that maximizes the utility for the HIU. Employers' decisions to offer or continue offering coverage is based on a demand elasticity curve. Significant rate shock for some small groups and individuals in the District will result in dropped coverage or movement among coverage levels in the new market, as healthier consumers react to premium increases associated with the new rating rules. Other consumers who are currently not covered may be attracted to the marketplace as premiums become more affordable for them, or as financial penalties associated with the individual mandate reduces the utility associated with remaining uninsured. Finally, other consumers, many of whom will be newly eligible for Medicaid, will leave the insurance market to participate in that program.

The District requested scenarios that test the impact of merging the small group and individual markets, as well as the definition of small group. A merger of the small group and individual markets would require carriers to blend the experience in the two markets for the purposes of premium development and to apply a consistent set of rating rules. Carriers doing business in one market would by default be required to participate in both. The ACA defines small group as employers with up to 100 employees, but it offers the option to use the District's current definition of up to 50 employees for plan years beginning in 2014 and 2015. The first scenario that follows presents the results in the case where separate pools are maintained for the individual and small group markets, and the small group definition remains at 50. We refer to this as our Baseline Reform Scenario. We then present three alternate scenarios, one where the small group definition is increased to 100 in 2014, one where the individual and small group markets are merged, and one where both of these changes occur.

Baseline Reform Scenario

In the Baseline Reform Scenario separate individual and small group markets are maintained, and the definition of small group remains at 50 until 2016. The following table presents the modeled enrollment and premiums in the individual and small group markets, both inside and outside the Exchange. While premium subsidies are considered in the model, the premiums shown in the table below are prior to reduction for any subsidies, and therefore reflect total premium dollars flowing to insurers.

It should be noted that a variety of factors and influences will affect how District enrollment and premiums develop between 2011 and 2014, and beyond. The results shown here will be different from actual results to the extent that experience emerges differently than the assumptions used. These results should be considered point estimates within a wide range of possible outcomes. In particular, longer projection timeframes introduce greater uncertainty so the projections for later years are even more uncertain than those for the earlier years in the projections.

Baseline Scenario

Exchanges

	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	14,500	$4,710	$68,341,000	37,500	$5,440	$204,143,000	52,000	$5,240	$272,484,000
2015	14,000	$4,900	$68,559,000	38,000	$5,620	$213,457,000	52,000	$5,420	$282,016,000
2016	17,500	$5,320	$93,117,000	39,000	$5,980	$233,135,000	56,500	$5,770	$326,252,000
2017	17,000	$5,620	$95,540,000	41,000	$6,470	$265,429,000	58,000	$6,220	$360,969,000
2018	16,750	$5,870	$98,301,000	42,500	$6,880	$292,508,000	59,250	$6,600	$390,809,000

Baseline Scenario

External Markets

	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	65,750	$4,510	$296,722,000	23,750	$5,230	$124,159,000	89,500	$4,700	$420,881,000
2015	64,250	$4,740	$304,481,000	24,250	$5,210	$126,421,000	88,500	$4,870	$430,902,000
2016	101,500	$5,160	$523,387,000	25,000	$5,620	$140,578,000	126,500	$5,250	$663,965,000
2017	99,250	$5,460	$541,818,000	25,000	$6,140	$153,424,000	124,250	$5,600	$695,242,000
2018	98,000	$5,770	$565,073,000	26,000	$6,480	$168,524,000	124,000	$5,920	$733,597,000

Baseline Scenario

District Total Individual and Small Group Insurance Markets

	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	80,250	$4,550	$365,063,000	61,250	$5,360	$328,302,000	141,500	$4,900	$693,365,000
2015	78,250	$4,770	$373,040,000	62,250	$5,460	$339,878,000	140,500	$5,070	$712,918,000
2016	119,000	$5,180	$616,504,000	64,000	$5,840	$373,713,000	183,000	$5,410	$990,217,000
2017	116,250	$5,480	$637,358,000	66,000	$6,350	$418,853,000	182,250	$5,800	$1,056,211,000
2018	114,750	$5,780	$663,374,000	68,500	$6,730	$461,032,000	183,250	$6,140	$1,124,406,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations for calendar year 2014 (as compared to 2010) when employing the assumptions previously described include:

- Enrollment in the District's individual market is projected to more than triple, from roughly 20,000 members in 2010 to 61,250 members in 2014, with 61% of covered individuals

enrolled in the Individual Exchange, and 22% of those with individual coverage receiving subsidies. (We note the percentage of people receiving subsidies is much lower than the estimate by the CBO that 57% of people with individual coverage would.) First, the CBO's estimate includes individuals between 138% up to 200% FPL; in our model those individuals were assumed to remain in a 138%-200% FPL Waiver program or enroll in a BHP, which ever the District decides to pursue. Second, the background research showed that 72% of individuals currently purchasing coverage in the District's individual market are above 400% FPL.

- Enrollment in the District's small group market is projected to decline by approximately 13% in 2014, to 80,250 members, with roughly 18% of covered individuals enrolled in the SHOP Exchange. Roughly one half of the members projected to enroll in the SHOP Exchange are employed by small employers eligible for the temporary small business tax credit.
- The small group market will increase by almost 40,000 members in 2016 when the definition of small group is increased to 100, however, the enrollment in the SHOP Exchange will only increase by roughly 3,500 members.
- Enrollment in Medicaid/CHIP (based on coverage up to 200% FPL) is projected to increase by roughly 9,500 lives by 2014, over 2010 levels.
- The uninsured population in 2014 is projected to be roughly half of the 2009 level,[65] decreasing to roughly 21,000 individuals, or approximately 3.5% of the District's population, keeping in mind the underlying assumption that 20% of those currently eligible for Medicaid but uninsured would enroll by 2014.[66] By 2018, the uninsured rate is projected to be 3.0% if the District achieves the assumption of enrolling 30% of those eligible for Medicaid but not enrolled today.

Premiums are projected to change in 2014 for several reasons. In addition to increases for medical trend, required increases in benefits, and new taxes and assessment, premiums for each market will adjust based on the individuals that enroll in the market. As members change markets, their claims morbidity moves with them and impacts premiums in the market to which they migrate.

- Average premiums on a per capita basis in the small group market are projected to increase by only 6% from 2010 to 2014. In addition to increases due to medical trend, required increases in benefits covered and new taxes and assessments, this change reflects changes in demographics, average morbidity of those enrolled, and benefit buydowns made by employers. It also reflects significant rate decreases (averaging 12.2%) resulting from carriers not meeting the minimum loss ratio requirement, and recently significant rate decreases by one major carrier.

[65] The current uninsured rate is based on the 2009 American Community Survey data that was used for the background research. As of the time this analysis was completed, 2010 American Community Survey data was not available to update this statistic.

[66] Note not all individuals eligible for Medicaid but not enrolled are currently uninsured; many of these individuals have current ESI coverage.

- Average premium on a per capita basis in the individual market, prior to application of premium subsidies, are projected to increase by 45% from 2013 to 2014. In addition to increases due to medical trend, additional mandated covered benefits as a result of the EHB package and new taxes and assessments, this change reflects changes in demographics, benefit plan changes, and changes in the average morbidity of those enrolled. Required increases due to the EHB package (i.e., required coverage for EHB and the required increase to an actuarial value of at least 0.60) account for roughly 25% of the increase in premiums. The average morbidity of the individual pool is projected to increase by roughly 10.3% in 2014, primarily due to the influx of individuals who were previously uninsured, however this increase is offset in 2014 by the temporary reinsurance program. The remaining difference is due to one year of trend, changes in demographics, and the fact that individuals receiving subsidies in the Individual Exchange are modeled to enroll in a Silver plan, which leads to a higher average benefit than is found in the individual market today.
- In the Exchange, individual premiums are projected to be 15% higher than small group premiums in 2014. This compares to premiums in the individual market today that are approximately 25% lower than in the small group market. This difference can be reconciled as follows:
  - The EHB package and the requirement to bring benefits up to at least a 0.60 actuarial value increases individual rates by approximately 22% more than it increases small group rates.
  - The impact of recent and projected decreases in small group rates to comply with the minimum loss ratio requirement results in small group rate decreases of 12% with no change to individual rates.
  - The impact of higher morbidity from the uninsured entering the individual market increases rates 10.3%, however this is offset by the 10% reduction in rates in 2014 due to the temporary reinsurance program.
  - The ACA benefit changes required in 2010 (i.e., no cost sharing for preventive services, no lifetime limits, etc.) are projected to have increased individual premiums by 2% more than small group premiums.
  - The remaining difference is due to changes in average demographics and benefits between the two markets.

Alternate Reform Scenario 1

This scenario assumes that the District elects to define a small group as employers with 50 or fewer eligible employees until 2016, but decides to merge the individual and small group pools into one. Merging these markets would mean that the rates for the individual and small group markets would be based on the combined morbidity of the two pools.

Merging the individual and small group insurance markets would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all. The District's current individual insurance market is significantly smaller than the small employer market in terms of covered lives. However, based on information from the Census Bureau, we have assumed the average morbidity of the two pools is not significantly different today (the

average morbidity of the current individual pool is roughly 2% lower than the average morbidity of the current small group pool) and a market merger of the District's current individual and small group pools would appear more of a merger of equals.

However, the entrance of those who are currently uninsured into the individual pool, as was seen in the results from the Baseline Scenario, has the effect of increasing the average morbidity of the individual market to levels above that of the current small group pool. Without a merger, the average morbidity of the individual pool would be roughly 7.3% higher than the average morbidity of the small group pool, after the uninsured enter the pool. Therefore, a merger would provide a moderate amount of premium relief to the individual market at a small cost to the small group market.

This result is very different than was experienced by the only state to merge its markets to date, Massachusetts. In Massachusetts, a small individual market with high premiums was merged with a much larger small group market that had more moderate premiums. Significant premium relief was provided to individual enrollees at the cost of only a small increase in small group premiums.

The tables below present the results from this scenario.

Alternate Reform Scenario 1

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	13,750	$4,760	$65,447,000	38,500	$5,210	$200,690,000	52,250	$5,090	$266,137,000
2015	12,750	$5,100	$64,981,000	39,500	$5,410	$213,686,000	52,250	$5,330	$278,667,000
2016	17,250	$5,250	$90,548,000	39,750	$5,780	$229,676,000	57,000	$5,620	$320,224,000
2017	16,750	$5,550	$92,907,000	41,750	$6,250	$260,863,000	58,500	$6,050	$353,770,000
2018	16,250	$5,910	$96,040,000	43,250	$6,650	$287,798,000	59,500	$6,450	$383,838,000

Alternate Reform Scenario 1

	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	62,500	$4,560	$284,964,000	25,250	$4,970	$125,601,000	87,750	$4,680	$410,565,000
2015	59,000	$4,880	$287,942,000	25,750	$5,000	$128,846,000	84,750	$4,920	$416,788,000
2016	99,250	$5,130	$509,286,000	26,250	$5,380	$141,224,000	125,500	$5,180	$650,510,000
2017	97,250	$5,420	$527,188,000	26,250	$5,860	$153,696,000	123,500	$5,510	$680,884,000
2018	96,250	$5,740	$552,120,000	27,000	$6,250	$168,721,000	123,250	$5,850	$720,841,000

	Alternate Reform Scenario 1								
	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	76,250	$4,600	$350,411,000	63,750	$5,120	$326,291,000	140,000	$4,830	$676,702,000
2015	71,750	$4,920	$352,923,000	65,250	$5,250	$342,532,000	137,000	$5,080	$695,455,000
2016	116,500	$5,150	$599,834,000	66,000	$5,620	$370,900,000	182,500	$5,320	$970,734,000
2017	114,000	$5,440	$620,095,000	68,000	$6,100	$414,559,000	182,000	$5,680	$1,034,654,000
2018	112,500	$5,760	$648,160,000	70,250	$6,500	$456,519,000	182,750	$6,040	$1,104,679,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations relative to the Baseline Scenario include:

- Premium levels do differ as a result of the market merger; however, the variance is not so extreme that take-up patterns are markedly different.
- Premiums in the individual market are 3.5% lower in 2014 in a merged market, relative to the Baseline Scenario.
- Premiums in the small group markets are 3.6% higher in 2014 in a merged market, relative to the Baseline Scenario.
- Individual market consumers react to the somewhat lower premiums with slightly higher take-up rates than in the Baseline Scenario. Small employers and their employees react to higher premiums with somewhat lower take-up rates.
- The average enrollment in the combined Individual and SHOP Exchanges is not significantly different than under the Baseline Scenario.
- Most of the difference in the results in this scenario relative to the Baseline Scenario is migration from the small group market to the individual market, such that the size of the overall insurance market in the District is relatively the same.

Additional Considerations for Merging the Individual and Small Group Pools in 2014

In addition to the direct financial impact that merging the individual and small group pools may have on the rates for each market, there are other considerations when making the decision of whether or not to merge the pools.

Advantages to Merging the Pools

- Merging of the two markets would result in a larger risk pool, and perhaps more rate stability.
- If the markets are kept separate, individual and small group rates may be materially different for identically suited people.
- Carriers' administrative expenses may be lower in a merged market due to consistent product portfolios, a reduced number of rate flings, etc. These savings should theoretically be passed along to District residents and businesses.

- Individuals leaving groups or in groups that no longer offer coverage would be able to continue their coverage at their current level of benefits.
- Theoretically, a single pool could prompt the highest number of carrier options, since it could conceivably require carriers operating only in the existing individual market — as well as carriers operating only in the existing small group market — to participate in both markets, resulting in more competition and choice for consumers. The dominance of one carrier in each of these markets today may make this particular consideration for the District less important than it would in some other states.
- If more employers move toward a defined contribution approach, the small employer market would function more like the individual market. Even if employers do not adopt a defined contribution approach, the fact that the SHOP Exchange must allow individual choice among a given metallic level of coverage means that a merged market that is based on an individual rather than group rating structure may be more conducive to these arrangements.
- Some managed care entities that, until now have focused only on those markets that did not require underwriting expertise, (e.g., Medicaid or Medicare Advantage markets) may perceive a combined market as a greater business opportunity than separate markets, and may be more willing to assume the risk of expanding into the commercial sector.

Disadvantages to Merging the Pools

- Merging the markets could lead to even more market disruption than that which will occur from the rate shock resulting from the required changes under the ACA (e.g., ACR, guarantee issue), and the markets can always be merged at a later date.
- A single pool could result in fewer total carriers and less competition if those carriers that specialize in only one of the existing separate markets choose not to participate in the new combined market.
- A merged market might limit the Exchange's flexibility to address the differing needs of individuals and small groups.
- Products in the individual market could potentially look very different from those in the small group market, unless restricted by the District. This could require benefit changes for these individuals migrating from small group coverage to individual coverage.
- In the District, we expect that merging the markets will raise premiums for small groups and reduce premiums for individuals. Higher small group rates in a merged market could lead to more groups dropping coverage. If more small employers drop coverage, the costs to taxpayers will increase as more individuals become eligible for subsidies.
- Upward pressure on small group rates resulting from merging the markets could cause more small groups to consider self insuring, which could in turn result in healthier risks leaving the market.
- Merging the markets could complicate the Exchange's operations. As an example, the Exchange would have to enforce one set of open enrollment rules for individuals and another set for small groups.
- While our modeling results do not show tremendous disruption from merging the markets, we would note that there is more uncertainty surrounding premiums in the small group

market after 2014 due to the difficulty in estimating the costs associated with covering those who were previously uninsured.
- For these reasons, the District may want to keep the markets separate initially.

Alternate Reform Scenario 2

This scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible immediately in 2014, but decides not to merge the individual and small group pools into one. Disruption for groups size 51-100 is likely to occur as these groups must be rated on an ACR basis. Today, many of these groups are, in part, rated on their own experience. Groups with 51-100 employees are less likely to participate in the SHOP Exchange unless significant administrative savings exist. Groups with good experience may see a significant increase in rates as a result of community rating and these groups will be more likely to self insure. Without concerted effort to provide either value-added services for larger small employers or significantly lower premiums, the Exchange may not be able to attract those consumers.

Defining small group in the District to include employers with up to 100 employees in 2014 and 2015 may enlarge and strengthen the small group risk pool in the near term, but it does not produce significantly higher levels of Exchange enrollment in the long term. This is because the current 51-100 market is roughly half the size of the current small group market, and groups size 51-100 will not be eligible for small business tax credits, which is projected to attract a fair number of small groups into the Exchange.

A key assumption that could have a significant impact on the results is the fact that one of the underlying baseline assumptions is that carriers with under 100 employees would not self insure.

Alternate Reform Scenario 2

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,750	$4,810	$90,095,000	37,500	$5,450	$204,550,000	56,250	$5,240	$294,645,000
2015	18,250	$5,000	$91,309,000	38,000	$5,630	$213,883,000	56,250	$5,430	$305,192,000
2016	18,000	$5,260	$94,769,000	38,500	$6,010	$231,453,000	56,500	$5,770	$326,222,000
2017	17,500	$5,600	$98,018,000	40,500	$6,480	$262,436,000	58,000	$6,210	$360,454,000
2018	17,250	$5,870	$101,316,000	42,000	$6,900	$289,919,000	59,250	$6,600	$391,235,000

Alternate Reform Scenario 2

	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	104,500	$4,750	$496,210,000	23,750	$5,240	$124,451,000	128,250	$4,840	$620,661,000
2015	103,500	$4,940	$511,186,000	24,500	$5,170	$126,752,000	128,000	$4,980	$637,938,000
2016	103,000	$5,200	$535,259,000	25,000	$5,590	$139,781,000	128,000	$5,270	$675,040,000
2017	101,500	$5,510	$559,390,000	24,750	$6,130	$151,833,000	126,250	$5,630	$711,223,000
2018	99,750	$5,820	$580,844,000	25,750	$6,490	$167,220,000	125,500	$5,960	$748,064,000

Alternate Reform Scenario 2

	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	123,250	$4,760	$586,305,000	61,250	$5,370	$329,001,000	184,500	$4,960	$915,306,000
2015	121,750	$4,950	$602,495,000	62,500	$5,450	$340,635,000	184,250	$5,120	$943,130,000
2016	121,000	$5,210	$630,028,000	63,500	$5,850	$371,234,000	184,500	$5,430	$1,001,262,000
2017	119,000	$5,520	$657,408,000	65,250	$6,350	$414,269,000	184,250	$5,820	$1,071,677,000
2018	117,000	$5,830	$682,160,000	67,750	$6,750	$457,139,000	184,750	$6,170	$1,139,299,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations for this scenario, relative to the Baseline Scenario, include:

- An additional 4,250 members are projected to enroll in the SHOP Exchange in 2014 due to inclusion of the 51-100 population in the small group pool.
- The early entrance of the 51-100 life groups into the small group pool has the impact of increasing premiums in the expanded small group market, slightly. This is due to differences in demographics and benefits of these two sub-populations (the under 50 population and the 51-100 population).
- The early expansion of the small group market has almost no impact on either premiums or enrollment in the individual market.

Given the fact that the District will be required to ultimately change its current definition of small group to 1-100, it may be easier to make the change along with the host of other changes that will occur in 2014. On the other hand, if carriers are allowed to continue rating groups size 51-100 using current methods until 2016, it may postpone the number of groups that decide to self insure or drop coverage. Much of the market disruption that will occur in 2014 will have worked through the system and postponing the small group expansion until 2016 will allow these groups time to understand the new system. Further, it will give the District more time to implement programs such as value-added benefits and services which could work to draw more groups into the SHOP Exchange; groups size 51-100 may see value in these benefits and services as well.

Alternate Reform Scenario 3

This final scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible employees immediately in 2014, and also decides to merge the individual and small group pools into one. As previously discussed, merging the individual and small group insurance markets would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all.

The results for this scenario are similar to those of Alternate Scenario 1, because the early expansion of small group to 100 employees had little impact on the projected results. However, given the merger in Alternate Scenario 1 had the effect of lowering premiums for the individual market in 2014, merging with a larger small group pool will result in larger decreases for the individual market. The results of this scenario are shown in the following tables.

Alternate Reform Scenario 3

Exchanges

	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,250	$4,840	$88,313,000	38,500	$5,200	$200,288,500	56,750	$5,090	$288,601,500
2015	17,250	$5,160	$88,941,000	39,500	$5,390	$212,748,500	56,750	$5,320	$301,689,500
2016	17,250	$5,380	$92,728,000	39,750	$5,790	$230,197,500	57,000	$5,670	$322,925,500
2017	16,750	$5,680	$95,205,500	41,750	$6,260	$261,517,000	58,500	$6,100	$356,722,500
2018	16,250	$6,060	$98,467,500	43,250	$6,660	$287,971,500	59,500	$6,490	$386,439,000

Alternate Reform Scenario 3

External Markets

	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	102,250	$4,780	$489,186,000	25,250	$4,970	$125,528,500	127,500	$4,820	$614,714,500
2015	99,250	$5,050	$501,661,500	25,750	$5,000	$128,803,000	125,000	$5,040	$630,464,500
2016	99,000	$5,330	$527,728,000	26,250	$5,400	$141,702,000	125,250	$5,340	$669,430,000
2017	97,000	$5,630	$546,288,000	26,250	$5,880	$154,239,500	123,250	$5,680	$700,527,500
2018	96,250	$5,950	$572,685,000	27,000	$6,260	$169,011,000	123,250	$6,020	$741,696,000

Alternate Reform Scenario 3

District Total Individual and Small Group Insurance Markets

	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	120,500	$4,790	$577,499,000	63,750	$5,110	$325,817,000	184,250	$4,900	$903,316,000
2015	116,500	$5,070	$590,602,500	65,250	$5,230	$341,551,500	181,750	$5,130	$932,154,000
2016	116,250	$5,340	$620,456,000	66,000	$5,630	$371,899,500	182,250	$5,450	$992,355,500
2017	113,750	$5,640	$641,493,500	68,000	$6,110	$415,756,500	181,750	$5,820	$1,057,250,000
2018	112,500	$5,970	$671,152,500	70,250	$6,510	$456,982,500	182,750	$6,170	$1,128,135,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations for this scenario include:

- Under this scenario, premiums in the individual market are expected to be 4.2% lower than under the Baseline Scenario. This compares with only a 3.5% reduction when the individual market is merged with a small group market defined as 2-50 employees.
- Under this scenario, premiums in the expanded small market are expected to be 2.8% higher than for the small group market under the Baseline Scenario or Alternate Scenario 2. This compares with a 3.6% increase when the individual market is merged with a small group market defined as 2-50 employees.
- Total enrollment in the Exchange is relatively the same as under the Baseline Scenario.

This scenario produces the largest decrease in rates for the individual market. This premium relief for the individual market comes at the cost of increased premiums to the small group market, however the cost is lower than in Alternate Scenario 1 where only groups size 2-50 were merged with the individual market. We remind the reader of the underlying assumption that small groups do not self insure. If small groups were to find it attractive to self insure, the premium relief projected for the individual market will not emerge at the levels presented in this report.

Increased Participation in the Exchange

As part of their planning, states are studying what actions they could take to maximize participation in their Exchange. It will be important that an adequate mix of affordable plan choices be made available within the Exchange in order to incentivize individuals and small groups who are not eligible for subsidies to participate. If broad choices at affordable rates cannot be found in the Exchange, these individuals and small groups will look to additional options made available in the outside market. Under the ACA, carriers are only required to offer coverage at the Silver and Gold level inside the Exchanges. To increase Exchange participation, the District may consider requiring health insurance carriers to offer coverage at the Bronze level inside the Exchanges as well. This will eliminate the scenario where carriers only sell Bronze level coverage in the outside market and individuals cannot find this low level of affordable coverage within the Exchanges.

While premium and cost sharing subsidies will draw many into the Individual Exchange, there are no comparable financial incentives to draw small groups into the SHOP Exchange with the exception of small business tax credits, which are temporary, and only apply to a small number of groups. In our modeling, we assumed 10% of all small groups offering coverage that are not eligible for a small business tax credit would enroll in the SHOP Exchange. This assumption is higher than the enrollment levels observed by existing exchanges to date, but it is reasonable because of the employee choice option that must be made available inside the Exchange. This flexibility is expected to draw some employers in. At the same time, states recognize the need to explore options to increase enrollment in order to have a financially sustainable SHOP Exchange, and they are beginning to study methods to do this.

In order to have a viable SHOP Exchange, efforts beyond just attracting small employers will be required. Benefits and other options will also be needed to attract employees; the engagement of brokers will also be critical. Attracting carriers to participate in the Exchange will be a necessity for both the Individual and SHOP Exchanges. Below, we discuss several items we recommend the District consider when establishing its Exchange, all of which may help to increase participation in the Exchange.

Attract a Sufficient Number of Carriers

In order to have a viable Exchange and ensure affordable rates, participation in the Exchange must be attractive to carriers. Participation by a number of carriers will mean more choices for individuals and small groups and a greater chance that they will purchase coverage through the Exchange. Greater carrier participation will also likely mean more competition for a fixed pool of individuals, which may in turn help to keep rates affordable. In order to encourage carriers to participate though, the Exchange must be able to demonstrate that they have "rules" in place to control adverse selection; carriers who perceive they will be selected against inside the Exchange may choose not participate. At the extreme, the District could require that all carriers that wish to do business in the District participate in the Exchange; however, this option must be explored with caution, as it could lead carriers that planned to participate only in the outside market to exit the District altogether.

Ensure a Broad Selection of Product Choices

Having a number of carriers participate in the Exchange increases the chances that offerings inside the Exchange will provide a wide variety of deductibles, coinsurance and providers from which individuals and small employers may choose. A wide variety of products is needed to ensure enough choice to attract individuals and small groups; it is also needed to create robust competition among carriers. If the choices inside the Exchange are more limited than those available in the outside market, participation by non-subsidized individuals and small groups could be reduced. Options are available to the Exchange to limit or standardize the benefit offerings; however, if this same restriction is not applied to the outside market, these restrictions may also hinder enrollment. Therefore, if the District does decide to standardize benefits, a balance must be struck to ensure a variety of deductible and coinsurance options are available at each metallic level.

While choice will be important, the District should also take care to ensure the Exchange does not overwhelm individuals and small employers with so many options that the process of selecting a plan becomes overly complicated. The standardized benefit form that will be required for all products sold inside the Exchange will assist individuals and small groups when comparing plans. Different plans offered by the same carrier should be meaningfully different.

Ensure Easy Access to Information

Individuals and small group carriers must be able to access carrier and benefit information with relative ease. The process should be no more cumbersome than obtaining this same information from the market outside of the Exchange. Exchanges are required to contract with navigators to assist with providing information to consumers, which could lead to greater enrollment in the Exchange. One of the roles of the navigator is to facilitate the distribution of information about plans in a culturally and linguistically appropriate manner. Given the District's diverse population, the navigator's role will be particularly important. To the extent that the outside market does not meet these diverse needs at the same level, the Exchange may have an advantage.
Some of the functions related to facilitation of information might include:

- Information related to price and quality should be easily accessible through the navigator program in a single location.
- Provide small groups with a summary of each employee's benefit plan choice, coverage tier and premium to facilitate employee premium contribution calculations.
- Provide small employers with estimated small business tax credits.

Engage Brokers and Agents

Brokers and agents play a significant role in the current market. They advise individuals and small businesses of the most appropriate coverage for them, and they help them shop among different carriers. While the navigator will perform these functions, brokers and agents provide additional advisory services and many small businesses rely heavily on their brokers for this advice. The Exchange must recognize the need to rely on brokers and agents to help them build their market and ensure affordable rates. To protect against a scenario where agents and brokers are not as active within the Exchange as they are in the outside market, the Exchange should ensure that navigators are able to assist agents with their functions. At the same time, rules must be in place to ensure agents are not incentivized to steer small groups comprised of unhealthy individuals into the exchange while steering healthy groups only to the outside market.

Consider Offering Value-added Services and Benefits Inside the Exchange

Many small businesses do not have human resource departments, and the small business owner fills this role. This takes time that they could otherwise spend focusing on their business. An exchange that could provide business services might be especially appealing to a small group. Additional services the SHOP Exchange could consider providing include:

- New employee education and enrollment facilitation
- COBRA administration
- Flexible spending account administration
- HSA administration
- Payroll services

- Human resource reference desk
- Business counseling

A successful SHOP Exchange would not only draw small employers into the SHOP Exchange, but maintain them. While the initial "sale" is primarily targeted at the employer, employees play a role in retention. If the employees do not like the plan or service they receive from the Exchange, they will likely complain to their employer. In addition to value-added services, the District may want to explore the option of providing value-added benefits. Many of these benefits are directed more toward the employees than the employer, and they may work to increase employee satisfaction with the Exchange. Some examples of additional benefits that could be attractive to SHOP Exchange enrollees if they could be made available at little or not cost include:

- Discounts programs for employees (e.g., health club memberships, vision hardware)
- Discount programs for employers (e.g., printing and shipping services)
- Nurse advice lines
- Health appraisals and lifestyle coaching
- Employee assistance programs
- One stop shopping for ancillary insurance products (e.g., life, dental, vision, auto, homeowner's)
- Assistance helping employees understand explanation of benefits forms
- Negotiating with providers on employee's behalf to reduce OOP cost sharing

States are performing cost/benefit analysis to study these options, and we recommend the District do so as well.

7

Services Beyond Federally Mandated Benefits

According to the ACA, states will be required to cover the cost of any benefits provided by a QHP inside the Individual and SHOP Exchanges that are not included in the EHB package. So, for those policies sold inside the Exchanges, the District will bear the cost for those benefits mandated by the District that are not included in the EHB package.

The District's benefit mandates are found in Title 31 of the District of Columbia Official Code; we have summarized them in the following table.

Section	Benefit*
31-3103	Alcoholism/Substance Abuse Treatment
31-3272	Autism
31-3832	Breast Reconstruction
31-2902	Cervical Cancer/HPV Screening
31-2931	Colorectal Cancer Screening
31-3002	Diabetes Self Management
31-3002	Diabetic Supplies
31-2802	Emergency Room Services
31-3272	Habilitative Services for Congenital/Genetic Defects
31-3834	Hormone Replacement Therapy
31-2902	Mammography Screening
31-3161	Maternity Minimum Stay
31-3104	Mental Illness
31-2952	Prostate Cancer Screening
31-3272	Speech/Hearing Therapy

**No Long-term or Well Child Care*

(Please note that the Council for Affordable Health Insurance also identified Long-Term Care and Child Wellness visits as District mandated benefits; because we were unable to find those benefits in the Code, we have excluded them from our analysis.) The long awaited (and recently released) report from the IOM did not include recommendations for specific services in the EHB package. The report indicates that the committee was not tasked with recommending specific services for the EHB package; further, the report suggests that HHS should establish its initial draft of the EHB package by May 2012. With this uncertainty around the EHB package, it is not

clear what services that are mandated by District will be excluded from the EHB. Ultimately, we cannot perform a complete analysis of the potential cost to the District to cover these benefits. However, we can highlight some of the topics from the IOM's report and from those highlights suggest some services that are not likely to be included in the EHB package.

Before we begin a discussion of the EHB package and the services it might exclude, it is important that we first clarify that there are many services explicitly included through the ACA. For example, services related to emergencies, maternity, mental health/substance abuse treatment and preventive care (i.e., mammography screening, colorectal screening, etc.) are specifically included by the ACA in the EHB package. The remaining benefits that are either not yet implemented or not scheduled for implementation include services for the following: Autism, Breast Reconstruction, Habilitative Services, Hormone Replacement Therapy and Speech/Hearing Therapy.

According to the IOM's report, HHS has a number of considerations that they must balance in designing the EHB package. Among other things, these considerations include the following:

1. HHS should take into account the cost and efficacy of certain services
2. They should emphasize the services currently provided to a typical small group
3. HHS should design the EHB package so that the cost is generally consistent with current costs

We are unable to anticipate how HHS' interpretation of considerations 1 and 3 might interact with the District's mandated benefits. However, for consideration 2, we were able to infer the frequency of certain mandated benefits from a report published by the Council for Affordable Health Insurance (CAHI). Specifically, CAHI's report identifies those states with laws mandating certain services. For example, Breast Reconstruction is mandated in all 50 states; Hormone Replacement Therapy is mandated in only four states.

From CAHI's report, we found that the services included in the ACA are all mandated in over 50% of the states. Along with those services, Autism and Breast Reconstruction are also mandated in at least 50% of the states. Using small group employment in the nation's nine most populous states, we found similar results (i.e., of the states we reviewed, over 50% of small group employees were in states mandating those benefits). Speech/Hearing Therapy was also mandated for over 50% of employees when weighting the results by small group employment in those states. From CAHI's report, it would seem that Autism and Breast Reconstruction could satisfy the "typical" small group consideration put forth by the IOM. However, it is not clear that HHS will consider these services essential if they ultimately cause benefit costs to exceed their pre-ACA levels.

For the services that were not represented in over 50% of states, we estimated their costs by relying on other sources. Please note that, although a benefit may be mandated in more than one state, the scope of the benefit may be quite different from state to state. For example, some

states mandate chiropractic care, but impose limits on the number of visits that must be allowed; other states mandate chiropractic care and require that carriers cover it as they would any other physician. Our survey of available information did not account for these differences in mandates between states.

Our estimates of costs are the following:

- Autism: $0.70 PMPM to $1.00 PMPM
- Habilitative services for congenital/genetic defects: $0.20 PMPM
- Hormone replacement therapy: $0.14 PMPM
- Speech and hearing therapy: $0.03 PMPM

These costs total $1.07 PMPM to $1.37 PMPM. The estimated cost for covering Autism assumes a benefit maximum of approximately $35,000; they are taken from analysis Oliver Wyman has performed for Pennsylvania and Virginia. The estimates for Habilitative Services are taken from data that Oliver Wyman has purchased from MarketScan. Finally, the Hormone Replacement Therapy and Speech/Hearing Therapy estimates were both prepared by the Commonwealth of Massachusetts in an examination of their own mandated benefits.

In total, these estimates suggest that under the Baseline Scenario the District would have to pay approximately $650,000 to $850,000 in 2014, increasing to $750,000 to $950,000 in 2018, to cover these benefits. This range assumes that the District's other mandated benefits are included in the EHB package. It also assumes that the scope of the District's coverage (e.g., age limits, annual visits, etc.) is consistent between the District and those states for which the estimates were prepared. We recommend the District perform a more detailed analysis of these benefit costs once the official EHB packaged is released. In addition to estimating cost changes, the analysis should include a complete medical, financial and social impact analysis for any mandated benefits the District may consider eliminating.

8

Potential Adverse Selection and Options for Mitigation

Adverse selection can occur when the average risk profile of the individuals enrolled in a product is higher than the risk profile embedded (or assumed) in that product's rates. Whenever individuals and employers have choices among health insurance options (including the option to forgo insurance altogether), there is potential for this type of selection to occur. Unlike other types of insurance, such as automobile or homeowner's coverage, the upcoming year's health care expenditures are relatively predictable for most people. Unrestrained risk selection can produce an unstable marketplace; so, striking a balance between preserving choice and mitigating the potential for adverse selection is a key challenge for states implementing Exchanges.

There are three primary types of adverse selection that have the potential to influence the District's individual and small group health insurance marketplace in the reformed environment that will exist beginning in 2014:

- Adverse selection against the market, if healthier individuals and groups choose not to participate in the fully insured market, either by going uninsured or self insuring.
- Adverse selection against the Exchange, if its design causes the Exchange to be more attractive to higher risk populations while healthier populations stay in the outside market.
- Selection among carriers and products offered inside the Exchange.

The ACA includes a number of provisions designed to discourage adverse selection, but many sources of selection remain. This section of the report discusses each type of selection further, describes the ACA's provisions designed to address them, and identifies additional options we recommend the District evaluate to further mitigate potential selection.

Adverse Selection Against the Market

Guarantee issue and ACR rules, described earlier, could cause groups and individuals to delay purchase of insurance until they need it. Without enough healthy individuals in the risk pool, premiums will be higher. In the past, states that have adopted issue and rating rules similar to those specified by the ACA have experienced challenges in their individual markets related to the departure of healthy populations and resulting premium increases.

In a given health insurance marketplace, individuals with greater health needs are more likely to enroll in products with higher actuarial values than other individuals. Individuals purchasing insurance could be influenced in their coverage choice if they expect that their claims will be

higher than normal. The carriers typically do not have this information or are unable to price known information fully into rates due to restrictions imposed on them**.**

The ACA includes a “carrot and stick” approach to mitigating the potential for this type of selection against the insurance market. The premium and cost sharing subsidies are available to defray the cost of individual insurance, while the individual mandate will introduce a penalty for not having insurance. Both of these provisions are designed to draw more individuals into the market and provide a cross section of risks.

In combination, the subsidy and responsibility provisions included in the legislation could provide sufficient incentive to mitigate some of the potential for adverse selection against the market. However, some feel that the individual mandate is too weak to produce the incentive required to ensure a good cross section of risk. The penalty costs are lower than the cost of maintaining coverage, and it is possible that some healthy individuals will choose to pay the penalty rather than to enroll in coverage. In theory, states could establish a state individual insurance mandate and apply additional penalties for non-compliance, strengthening the financial incentive for individuals to purchase coverage. We are not aware of any states considering this type of action at this time.

Another potential source of selection against the small group market is self insurance. Rate shock introduced by an ACR methodology will cause large increases for groups comprised of healthy individuals, as these groups are likely receiving underwriting discounts today that will be prohibited under the ACA. Some small groups could choose to self insure if they are in good health and are able to obtain attractively priced reinsurance at relatively low attachment points. An incentive to self insure could result in more of the preferred risks staying out of the fully insured risk pool. In turn, it could reduce the size of the risk pool and lead to adverse selection and reduced rate stability. The availability of value-added services could be used to make the SHOP Exchange attractive to these small employers and keep them in the risk pool.

Adverse Selection Against the Exchange

One of the main concerns to states in the post-reform marketplace is the adverse selection that can occur against the Exchange. In states that maintain individual and/or small group markets outside the Exchange, it is possible that the Exchange could disproportionately attract less healthy enrollees than the outside market. This type of environment could discourage carriers from offering coverage through the Exchange, reducing consumer choice and threatening the ongoing viability of the Exchange. There are a number of ACA provisions designed to discourage this type of selection, but there remain a number of areas that could contribute to it.

The concept of a “level playing field” between products in the Exchange and products in the outside market is another critical component of minimizing selection against the Exchange. If carriers and products in both markets are subject to the same rules, the opportunity for selection is reduced. To this end, ACA provides a number of rules meant to put the Exchange and outside markets on a consistent basis:

- Reforms related to rating, issue and renewal in the individual and small group markets apply to both QHPs in the Exchange and the outside market.
- Plans inside and outside the Exchange must contain the EHB, must abide by the same cost sharing limitations and must standardize benefit packages into the Bronze, Silver, Gold and Platinum levels of coverage.
- Carriers must consider all enrollees in their individual products, inside or outside the Exchange, as a single risk pool, and they must establish their small group risk pool similarly.
- Carriers who offer a QHP on the Exchange must agree to charge the same premium rate for that product whether it is offered inside or outside the Exchange.
- States are required to administer a risk adjustment mechanism that applies across non-grandfathered individual health plans both inside and outside the Exchange; a similar risk adjustment must apply across non-grandfathered small groups both inside and outside the exchange.
- If a disproportionate share of high-risk individuals enrolls in plans in the Individual Exchange, the temporary reinsurance program will compensate these plans for the additional risk.

However, even with these leveling features, there are several possible sources of selection against the Exchange that remain.

Product Offerings

The ACA does not require that all products offered inside the Exchange also be offered outside the Exchange. Likewise, some products may be offered only outside the Exchange. While there is a requirement that carriers operating in the Exchange offer at least Silver and Gold product levels, no such requirement exists for carriers operating outside the Exchange. Therefore, carriers could choose to offer only Bronze plans in the outside market, which would be most attractive to relatively healthy populations.

Network Design

The ACA places requirements regarding provider network access standards on products sold within the Exchange. Lack of these same requirements outside the Exchange can drive adverse selection. Minimum standards of network adequacy and quality should also apply outside the Exchange to avoid wide disparities between networks inside and outside the Exchange. Network design could be used to avoid enrollment of members with certain chronic conditions. Therefore, minimum network requirements need to be established outside the Exchange.

Grandfathered Plans

The presence of grandfathered plans outside the Exchange also has the potential to cause adverse selection inside the Exchange. Maintaining grandfathered status will be most valuable to young, healthy individuals and groups since carriers will be allowed to continue using pre-ACA rating rules for these plans. This provision could allow lower age factors and underwriting discounts for these grandfathered groups and individuals; in turn, it could produce lower rates than are available inside the Exchange. The exclusion of these plans from the risk

pool will affect risk-sharing mechanisms, such as risk adjustment and risk corridors set by the ACA for addressing adverse selection.

Self Funded Multiple Employer Welfare Arrangements

MEWAs provide health and welfare benefits to employees of two or more unrelated employers who are not parties to bona fide collective bargaining agreements.[67] An example of a MEWA would be a plan sponsored by a trade association for its members. MEWAs can be fully insured, or self insured. Fully insured MEWAs covering small employers will be subject to the same rating rules that will govern the small employer market in general in 2014 and beyond, (e.g., 3:1 rate bands for age, and premiums based on experience pooled across the entire small group market). However, self insured MEWAs would be able to have the cost of their benefits be based on the experience of the MEWA. This would be attractive to those groups that expect their health claims to be lower than the small group pool as a whole. The ACA includes several provisions related to MEWAs, including giving the Secretary of Labor the authority to make a MEWA subject to state regulatory jurisdiction.[68] The District may want to consider a means for monitoring the extent to which MEWAs are selecting against in the Exchange or the small group market in general, and may want to begin developing options for addressing the situation should it begin to occur.

Exchange Fees

If Exchange fees are assessed only inside the Exchange and some carriers sell only outside the Exchange, this could lead to adverse selection. This adverse selection would occur when carriers outside the Exchange are able to avoid the fees and offer comparable products at a lower price. Carriers that sell inside and outside the Exchange would be assessed these fees against all of their products. Since these carriers are required to charge the same premium for a plan sold both inside and outside the Exchange, the fees assessed against their policies sold inside the Exchange would essentially be spread across their policies outside the Exchange as well.

Employee Contributions

Employers could set employee contributions at a level high enough so that the contribution for single coverage exceeds 9.5% of the employee's household income. At this point, the coverage would be deemed unaffordable, and if the employee's household income is less that 400% FPL, the employee would be eligible to enroll in the Exchange and receive premium subsidies. Employers could take this action in order to avoid covering low wage individuals with health conditions while still continuing coverage for other employees. This approach could lead to adverse selection against the Exchange.

[67] 29 U.S.C. 1002(40)

[68] ACA Sec. 6604.

Other ACA Provisions that Apply Only to Plans Inside the Exchange

In §1311(c)(1), the ACA includes certain requirements that apply only to plans sold inside the Exchange. Some of these requirements may influence risk attraction patterns, while others might lead to higher administrative costs. The list below summarizes the minimum requirements for QHPs. QHPs must:

- Not employ marketing practices or benefit packages that discourage enrollment of individuals with significant health needs
- Ensure a sufficient choice of providers and provide information to consumers regarding provider availability and network status
- Include essential community providers in their provider networks
- Maintain accreditation related to quality standards
- Implement a quality improvement strategy
- Use a uniform enrollment form and a standardized format for presenting benefit plan options.
- Provide information to the Secretary of HHS, the Exchange and consumers on certain quality measures

As a result of the factors outlined above, it is possible for carriers to choose to operate only outside the Exchange and in such a manner that they are able to attract the healthiest risk. Reallocation of premium through the risk adjustment mechanisms will address this type of risk selection to some extent, but current risk adjustment tools are imperfect predictors of risk.

There are two additional areas where careful evaluation and appropriate policy setting can assist in mitigating risk against the Exchange. First, health insurance brokers and agents play an important role in the current market; they help individuals and small groups to choose health insurance products. If Exchanges do not include a role for brokers and agents with comparable compensation inside and outside the Exchange, there is potential for steering patterns that produce disproportionate risk enrollment between the Exchange and the outside market. Second, the ACA provides states the option to allow large employers (over 100 employees) to purchase insurance on the Exchange beginning in 2017.[69] This option, if the District elects to enact it, would have distinct potential to produce adverse selection against the Exchange. It is much easier for larger groups to self insure. As a result, it is likely that the large employers that elect to purchase insurance through the Exchange will have higher than average risk profiles.

Selection Among Carriers and Products Inside the Exchange

The third type of selection is selection among plans and insurers offering products inside the Exchange. When provided a choice among health insurance products, individuals tend to choose the plans that provide the most value to them. Healthier individuals tend to favor products with low premiums, and they are not deterred by the narrow networks and higher cost sharing that may go along with those low premiums. Higher utilizing individuals will look for

[69] Section 1312(f)(2)(B) of the ACA

products with broader provider networks and low cost sharing; they are willing to accept the higher prices those products require. If high- and low-risk enrollees concentrate among different insurers on the Exchange, some of this selection may be reflected in the premiums. These premium differences could lead to lower affordability for some consumers and fewer insurers willing to participate in the Exchange.

Certain provisions in the ACA are expected to influence the risk distribution within the Exchange.

- Insurers that participate in the Exchange must offer at least one QHP in each of the Silver and Gold coverage levels.[70]
- Premium tax credits for qualified individuals are based on the cost of the second lowest cost Silver product available.[71] It is likely that this policy will cause many subsidized individuals to select coverage in the Bronze or Silver tiers to minimize the OOP premium cost they must pay.
- Cost sharing reductions for eligible individuals are available only if they are enrolled in Silver coverage level plans.[72]
- States may decide to offer a BHP to individuals with incomes below 200% FPL who are ineligible for Medicaid.[73] This policy decision is likely to reduce considerably the enrollment in the Silver plans that would otherwise be produced by the cost sharing reductions.

It seems likely that, because the premium subsidy and cost sharing reductions are tied to the Silver plan level, these incentives will cause significant enrollment in the individual market to concentrate at the Silver plan level. Healthier individuals, particularly those at higher income levels (e.g., above 250% FPL) may be attracted to Bronze level products as well. Without additional state action, there may be little incentive for insurers to offer robust Platinum level products. Those that do offer Platinum level products may experience significant selection in those products. Risk pooling across all individual market enrollees, combined with the risk adjustment mechanism may mitigate the premium effects of that selection somewhat. However, insurers that do not achieve sufficient enrollment of healthy individuals at lower coverage levels may still experience poor results on rich products.

Carriers could choose to be late market entrants to avoid the initial risks of adverse selection; they could also pull out and re-enter markets, which could cause adverse selection concerns for carriers offering products inside the Exchange. Not allowing late entrants inside the Exchange could help address this issue.

[70] Section 1301 of the ACA

[71] Section 1401 of the ACA

[72] Section 1402(b)(1) of the ACA

[73] Section 1331 of the ACA

Techniques for Mitigating Selection against the Exchange

There are several measures that the District could take to address the various sources of adverse selection against the Exchange. While each of the options presented below has the potential for mitigating adverse selection, they should be studied with care and considered alongside other design aspects of the Exchange; they may have unexpected ramifications on the broader insurance market in the District.

Eliminate the Outside Market

The District could decide to make the Exchange the sole distribution channel for individual and/or small group insurance coverage. Under this option, all products available to individuals and/or small groups would be required to be offered through the Exchange and meet the standards for QHPs. This policy option would eliminate the opportunity for adverse selection against the Exchange in a particular market, because the Exchange would be the only source of coverage available for that market. It would also potentially allow carriers to shift more administrative costs to the Exchange where economies of scale might produce overall administrative cost reductions and lower premiums.

Despite its effectiveness as a solution to the adverse selection issue, there are a number of disadvantages to this option. First, there could be distinct political challenges with this policy. Second, elimination of the outside market could constrain the District's ability to selectively certify plans offered in the Exchange if the Exchange decides to take an active role in selecting plans. Third, the additional requirements under §1311(c)(1) could ultimately raise administrative costs with no offsetting efficiencies. If that occurs, an unintended side effect might be increased costs and premiums across the entire market.

Extend Some or All QHP Requirements to the Outside Market

This policy would extend the concept of the "level playing field" further than the existing ACA provisions do. A common set of requirements would neutralize any selective or cost influences of the additional QHP requirements. The primary disadvantage associated with this policy option is the potential for increasing administrative costs in the outside market through the imposition of new requirements. An alternative is to extend some, but not all, of the additional requirements to the outside market.

Require Carriers to Participate in the Exchange

A third option the District could consider is to require carriers to offer products in the Exchange as a condition of offering small group and/or individual products in the District. This policy would protect against carriers targeting a particularly healthy risk outside the Exchange and benefiting from known imperfections in risk adjustment. It would also protect against carriers establishing a subsidiary to avoid the requirement that experience inside and outside the Exchange be pooled for pricing purposes. The ACA provision that carriers must pool their risk inside and outside the Exchange is effective in managing risk selection only to the extent that carriers participate in both marketplaces.

While requiring carriers to participate in the Exchange may have some intuitive appeal, there may be limitations to its effectiveness. Requiring carriers to participate in the Exchange does not necessarily ensure that they will design and offer attractive Exchange products at competitive prices. The rate review process may prevent premium levels that are excessive, but carriers determined to avoid risks that may be present in the Exchange could be creative in network or benefit design (i.e., they could produce products that are unattractive to Exchange populations).

Require Carriers Participating Only in the Outside Market to Offer Gold and Silver Products

Because healthier individuals tend to be attracted to lower cost insurance products (e.g., Bronze and Silver coverage levels rather than Gold and Platinum), there is a distinct opportunity for adverse selection if carriers have the opportunity to specialize solely in low-cost plans in the outside market. With this approach, they may be successful at attracting a lower than average risk, without being required to pool that risk with higher-cost consumers in other product levels. Premiums for the remainder of the market will be higher than they would be if these individuals were included in the risk pools. The risk adjustment mechanism is designed to address this kind of risk selection, but it will not produce a perfect reallocation of funds.

Require Carriers Participating in the Exchange to Offer Bronze Products

Absent this requirement, there is the potential for carriers to offer only rich plans inside the Exchange while offering leaner Bronze plans outside. This could allow carriers to enroll only the least healthy individuals inside the Exchange and draw healthier risks out. The District could require carriers participating in the Exchange to offer Bronze plans, in addition to Silver and Gold plans. This requirement would ensure that there will be more low-cost options offered inside the Exchange; these low-cost options typically attract a healthier population. The presence of these low-cost plans would improve the chances that healthier individuals would enroll in the Exchange.

Control the Minimum Level for Specific and Aggregate Stop Loss

As described earlier, another risk of selection against the market, and therefore against the Exchange, is adverse selection that might occur if small employers self insure. The District may wish to set minimum levels for stop loss coverage in an effort to control this selection. For example, if small groups are allowed to self insure and purchase specific stop loss with a $5,000 attachment point, the risk is not much different than that of a $5,000 deductible fully insured plan offered in the market today. However, the cost of self insuring could be much lower than the cost of a fully insured plan for certain employers with younger, healthier employees. This rate difference could occur for several reasons including:

- The ability to have the cost of coverage reflect the group’s actual experience rather than subsidizing older, sicker groups
- The ERISA exemption from the requirement to cover state mandates

- Elimination of the carrier's risk and profit charge on the self funded portion of costs
- Potential for lower administrative expenses

We find that some states are regulating this coverage in an effort to control this potential for selection. These states will require minimum specific stop loss attachment points of $10,000 to $15,000 and an attachment point for aggregate stop loss of at least 115% of expected claims.

Take Actions to Increase Enrollment in the Exchange

The risk of adverse selection is closely tied to overall enrollment in the Exchange. If the Exchange is large, it will be much less likely to have an imbalance of risk. Outreach and enrollment efforts will help the stability of the Exchange, however additional targeted efforts may be needed to reach and draw in healthier consumers, since consumers with health problems are the most receptive to information about new coverage options.

While the presence of premium and cost sharing subsidies will attract those eligible for them into the Individual Exchange, there are limited financial incentives to attract small employers into the SHOP Exchange. (There are small business tax credits which are temporarily available to only a limited subset of employers.) Therefore, additional efforts to engage brokers and offer value-added benefits and services to draw in small employers should be explored.

Place Restrictions on Plan Designs Offered Outside the Exchange

Plans with many different cost sharing combinations (e.g., deductibles, coinsurance, copayments) can be configured to achieve a specific actuarial value, and some cost sharing designs can be used to attract low-risk individuals. In addition, plans with narrow networks will also tend to attract healthier individuals, all else equal. The District may consider placing restrictions on the benefit plans that can be offered outside the Exchange. At the extreme, the District could consider requiring that only plans offered inside the Exchange can be offered outside the Exchange in order to prevent this type of selection from occurring. However, this could stifle innovation such as some of the value based benefit packages that are starting to emerge.

Do Not Allow Employees in the Shop Exchange to Select From All Products

The Exchange must make available the option for an employer that purchases coverage in the SHOP Exchange to select a metallic level from which their employees then have the option to select any plan (from all carriers). This flexibility inside the Exchange is required under the ACA, but it is unlikely to be available outside the Exchange, and as a result may draw employers in. However, this flexibility also comes with the risk of increased selection among carriers. The ACA also affords exchanges the option to decide whether or not to open up further this employee choice model. At the discretion of the states, the ACA allows employees to select from any available plan offered inside the SHOP Exchange. This option introduces selection at yet another level. Healthy employees could select low-cost Bronze coverage while unhealthy employees could select richer Gold and Platinum plans. Given plans will be priced based on the

average morbidity of the carriers' pool, the amount by which the Bronze plan is overpriced for a healthier than average individual is not likely to be enough to offset the amount by which the Gold or Platinum plan is underpriced for the less healthy individual. This premium shortfall will put upward pressure on rates, all else equal. Offering this additional choice may be attractive to employers, and therefore it could be helpful in raising the level of participation in the SHOP Exchange. However, we recommend the District study this potential for adverse selection carefully before deciding the level of choice offered inside the SHOP Exchange.

Several of the options discussed above could have material repercussions on the individual and small group markets in the District. It is important to balance the need to discourage adverse selection with the need to retain choice, flexibility and innovation in the marketplace. There are important provisions established by the ACA that may be successful at managing some selection, however many sources for selection remain. We recommend the District study these and similar options further.

9

Exchange Models and Insurance Standards Outside the Exchange

Exchanges can play various roles in developing a fair insurance market place for consumers depending on the philosophy, the insurance environment, and the goals of the Exchange. The ACA requires Exchanges to only offer QHPs that cover the EHB package, offer prescribed actuarial value plans and meet cost sharing standards. In addition to these requirements, QHPs also need to meet certification criteria such as marketing, network adequacy, accreditation, quality, standardization and transparency standards as described below.

Certification of QHPs is one of the important responsibilities of a Health Benefit Exchange. The comments here apply equally to a SHOP Exchange, Individual Exchange or an Exchange where the SHOP Exchange and the Individual Exchanges have been merged. The certification process has to be repeated periodically, and the Exchanges could also decertify plans based on plans or carriers' inability to meet the criteria set forth by the Exchange. Some of the criteria for certification of QHPs are established under the ACA but the Exchange has considerable latitude in setting and enforcing additional guidelines to manage adverse selection and to help ensure an optimal set of insurance options inside the Exchange.

Per the ACA, carriers offering QHPs should be licensed and in good standing to offer health insurance coverage in the District. Additional requirements include:

- QHPs must cover the EHB under Section 1302(b) and offer plans with an actuarial value (implies plan covers at least the stated percentage of covered benefits for a standard population) at one of four defined levels; Bronze (60%), Silver (70%), Gold (80%) or Platinum (90%), as required by 1302(a)(3). In addition, QHPs may also offer a catastrophic plan to individuals age 30 or younger.
- Carriers participating in the Exchange must offer at a minimum at least one Silver plan and one Gold plan.
- QHPs must abide by insurance market regulations relating to pre-existing condition exclusions, guaranteed issue, etc.
- Pediatric dental benefits should be covered by the QHPs unless one qualified dental plan in the Exchange can supplement coverage of other plans.
- The same rates must be charged for the same plan inside and outside the Exchange, regardless of the source of purchase being through an Exchange, or directly from a carrier or an agent.
- Premium rates and contract language need to be approved by the Exchange for the plans offered within the Exchange. This task could be coordinated with DISB's rate review responsibilities.

- The OOP cost sharing requirements should not exceed the limits for qualified HDHPs,[74] and for the SHOP Exchange the deductible must not exceed $2,000 for single coverage and $4,000 for other coverage tiers in 2014, indexed annually thereafter.[75]
- QHPs must comply with the risk adjustment program as outlined in 45 CFR Part 153.
- QHPs must provide to the Exchange on at least an annual basis rates, covered benefits, and cost sharing requirements for each plan offered within the Exchange.
- SHOP Exchange enrollment records must be reconciled with the Exchange data at least on a monthly basis.
- QHPs must implement a quality improvement program which should include improvement of health outcomes through care coordination, case management, improved patient safety, implementation of wellness and health improvement activities and reduction in health care disparities.
- Information on health care quality measures must be disclosed and reported to enrollees and prospective enrollees, as well as the results of an appropriate enrollee satisfaction survey.[76]
- Standardized formats for presenting health benefit coverage options (not to exceed four pages), uniform enrollment forms and quality measures must be used.
- QHPs must provide cost sharing and out-of-network coverage information.
- QHPs must be accredited as meeting quality measures during standard periods of time as defined by the Exchange.
- Networks offered by QHPs based on provider networks must be robust enough to include sufficient choice of providers, including those that serve predominantly low-income and medically needy individuals.
- QHPs must meet marketing standards and not discourage application of individuals with significant health care needs.
- Selective contracting with QHP issuers is allowed while some standards on exclusions of plans are provided. The Exchange cannot exclude a plan because it pays providers on a fee-for-service basis or because the plans provide treatments to prevent patients' deaths deemed costly by the Exchange.
- Additional benefits (including current state-mandated benefits) beyond the EHB are allowed, however, states are responsible for covering costs associated with these additional benefits through direct payment to individuals or carriers, for all members enrolled in the Exchange.
- Premium increase justification must be submitted by QHP issuers to the Exchange prior to implementation of a rate increase. The Exchange should take into consideration patterns of excessive or unjustified premium increases and excessive premium growth inside versus outside the Exchange before allowing plans to participate.

[74] 1302(c)(1) of the ACA

[75] 1302(c)(2) of the ACA

[76] Sections 1311(c)(1)(H) and (I) of the ACA

- Carriers must post justification for premium increases on its website; price, benefit and provider network changes should be posted on a timely basis on a publicly accessible Internet website.
- Carriers should provide cost sharing information for a specific service that the individual would be responsible for paying upon request and in a timely manner. This information can be provided through the Internet or by other means for individuals without access to the Internet.
- Accurate and timely information on claims payment policy and procedures, data on enrollment and disenrollment and other data parameters, as required, should be submitted to the Exchange, the Secretary, the State Insurance Commissioner and the public in plain and clear language.

Even though the ACA sets minimum federal standards for QHPs and QHP issuers to be able to participate in the Exchange, the states have considerable flexibility to set state specific standards to meet public health, provider access, delivery system reform, quality and transparency needs.

Exchange models can vary from a passive model of market organizer/aggregator of QHPs to a more active purchaser or even a hybrid model combining some features of each model.

Active Purchaser Model

The Exchange as an active purchaser of health care could selectively contract with QHPs, set standards and have the ability to impact health care costs, access and quality. The Exchange could consider implementing a bidding process, recertify restrictively, be actively involved with setting standards, monitoring compliance with these standards and have the ability to negotiate with QHPs and providers. The Exchange could recruit new entrants into the Exchange if desired, limit the number of products offered, standardize cost sharing, encourage new delivery system strategies, require application of new health technology initiatives, and align with other District health purchasers such as District employee plans or Medicaid. An active purchasing strategy will be resource intensive and will need market research, infrastructure, outreach to stakeholders and expertise to monitor the impact of various actions and initiatives. Advantages of an active purchaser model would be the ability to impact different aspects of the health delivery system. It is a well known fact that Medicaid Programs have been able to impact health care trends nation wide, set up a bidding process for Medicaid, set provider fee schedules and require plans to meet key criteria including network standards imposed by these programs. Medicaid programs have also demonstrated selective contracting and negotiating with issuers/health plans and are a good example of an active purchaser model. The District could consider a similar strategy for their Exchange model but would face challenges since the small group and individual markets are dominated by a few carriers. As previously mentioned this is a resource intensive model, and additional expenses would be incurred to cover resources needed before adopting such a strategy. It is also important to include a cost benefit analysis and evaluate the impact of this strategy on the financial sustainability of the Exchange.

The Massachusetts Connector model is an active purchaser model and similar in many ways to the model under the ACA. The Massachusetts model has been able to limit the number of plan options inside the Exchange but has not been able to control costs or attract small group employers into the Exchange. The presence of subsidies, community rating, mandated benefits and guaranteed issue have increased health care costs.

Market Organizer/Aggregator Model

A passive Exchange would act more like a clearinghouse for QHPs and set minimum standards for participation in the Exchange. The Exchange would play the more facilitative role of a market organizer. While this would provide non-group and small group markets with more organized health care purchasing opportunities than they have had before, it would not leverage the collective power of the combined markets to negotiate better health care value. Advantages of a passive model are that it would likely reflect more consumer choice, less market disruption and encourage more carriers to participate. On the other hand, disadvantages are that it could result in confusion when faced with numerous choices for members making health care purchase decisions. It would also be challenging to implement any changes such as provider reform, quality improvement and other cost containment initiatives easily over a short-term period. Changes in the health care space would be gradual and over time depending on voluntary market based change and cooperation from many stakeholders. This model would definitely be less resource intensive and less expensive than the active purchaser approach. Given the market domination by a few carriers this would be easier to implement and could work easily with any type of administrative model selected by the District.

The Utah Health Exchange is an example of a market organizer which facilitates and aggregates health plan options in the Exchange. This model basically lets the market shape itself and facilitates insurance options for consumers by acting as a clearinghouse. This is a good example of a passive certification model which facilitates the development of an insurance marketplace but does not get involved on an active basis. The Utah Health Exchange has been successful in enabling small employers to provide more employee choice, defined contribution options for health care purchasing, good carrier participation and collective decision making on items such as risk adjustment and reinsurance. Some traditional risk mechanisms such as underwriting load have been retained and this model reflects many of the current risk management mechanisms which would definitely encourage carrier participation. In some ways the Utah model is successful in increasing consumer choice, encouraging greater dialog between carriers, etc. However, achievement of goals of cost containment, quality and health technology initiatives may take much longer and be achievable through gradual self reform by the marketplace.

Hybrid Model

A hybrid model would reflect a combination of the active purchaser and the passive market organizer models. The Exchange could selectively choose to impose stricter criteria on certain issues such as standardizing cost sharing and limiting the number of products offered. In markets dominated by a few carriers, it could encourage and assist new entrants into the Exchange. Depending on the needs or the environment in the District, it could choose to focus on delivery system reform, align with other District purchasers, or work to sponsor pilots on

ACOs, medical homes etc. Strategies under this type of a model could be phased in and could be worked on over time depending on the need and as the Exchange matures. Resources and infrastructure could also be added over time with increased evidence of financial sustainability. This is a good model for the District to consider given the market concentration in the District by a few carriers and less initial financial outlay compared to an active purchaser model. This would help the District select a more balanced approach and allow the Exchange to be able to enforce some standards while letting the market shape other considerations in the insurance markets.

The CBIA model in Connecticut is a hybrid between the passive market organizer to active purchaser of care, and plays a role in between the two models. While the CBIA does not perform some of the roles that a typical active purchaser would, such as negotiating with carriers regarding rates, it does take on active purchaser roles such as limiting the number of plans that can be offered in the Exchange to encourage competition etc.[77]

There are various factors that are unique to the District's insurance market that need to be considered in the selection of the model most appropriate for the District. The Background Research Report showed that about 32% of those insured through the private insurance marketplace reside in the District while 68% reside outside the District. Currently the 68% residing outside of the District purchase insurance in the District through their employer, and their participation in the SHOP Exchange could depend on the decisions made by their employer. Another characteristic of the District's insurance market is that roughly 30.5% of the market is covered by Medicaid and other low-income programs, and the District currently has a 7% uninsured rate. The low-income market coverage is higher than what we see nationwide and the percentage of uninsured is lower. These statistics are reasonable given the expanded Medicaid and low-income programs provided in the District. Given these characteristics, the Exchange would be better served in selecting a hybrid purchaser model since it will help balance the roles it would need to play inside and outside the Exchange while continuing to meet the needs of those enrolled in the low-income programs.

A hybrid model will allow phasing in of various standards depending on employer and carrier actions, impacts of neighboring state Exchange decisions, and actions needed to balance network and quality standards. The Exchange can use any early lessons learned to adjust standards or negotiate better options for the insurance marketplace. Currently a few carriers dominate the District insurance market place and it is possible that this would continue. The District will want to shape the Exchange standards it sets taking into consideration feedback from various stakeholders since the small group market is heavily dependent on their brokers (producers). The potential size of the Individual Exchange and the SHOP Exchanges are much smaller than those in most other states. This issue of scale would impact financial sustainability parameters and therefore insurance standards. Finally, the model adopted by the Exchange for administration and governance, the impact of the ACA rating parameters on a merged versus non merged Exchange will have an impact on the type of model that would be best for the

[77] http://www.rwjf.org/files/research/72457healthexchange201106.pdf

District to adopt. All of these issues suggest that the use of a hybrid model would be the most appropriate for the District, providing opportunities for change in the future as needed and a degree of active purchasing that can be adjusted and phased in over time as necessary. The application of this model will give the Exchange opportunities to balance the needs of carriers and consumers, which will help establish a healthy insurance marketplace in the District. The District first needs to decide whether to have separate SHOP and Individual Exchange or a merged Exchange and the appropriate administrative and governance model that would support this decision. A careful evaluation of costs and benefits of a hybrid model should then be conducted and decisions should be made based on long-term financial sustainability.

Appendix A

Technical Discussion of Oliver Wyman HRM Model

The Oliver Wyman HRM Model was used to assess potential enrollment in a District sponsored Exchange. The model has three primary modules which are discussed in this technical appendix. The first module attempts to characterize the current population, the second module calibrates the simulated population to the current market, and the third module projects the simulated population in future years given coverage options, choice and market reforms.

Market Simulation Module

The first module has its origins in the Background Research Report that Oliver Wyman prepared for the District and delivered in its final form on September 28, 2011. In that report, we discussed the rationale for characterizing the District's population with AC Survey[78] rather than other potential data sources. In particular, we addressed the AC Survey's approach to the Medicaid undercount phenomena. We also identified a consistency of basis between the AC Survey's coverage questions and our models (i.e., coverage at a particular point in time rather than over the course of a year). Finally, we also identified the AC Survey's high response rate as a strength. For each person from the AC Survey, we examined their age, gender, income, industry, insurance coverage type, geographic place of work, geographic place of residence, employment and many other characteristics.

When preparing the AC Survey data for the first module, we first adjusted the basis on which the data are reported. The AC Survey requests information about households; we have built our models to reflect decisions for HIUs. We define these HIUs as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. So for example, an AC Survey household might consist of only a brother and sister; they would likely not be eligible for coverage under the same policy. In this example, we have created identifiers to treat them as separate HIUs for purposes of our modeling.

We have excluded a number of individuals who we assumed would not be materially affected by the presence of a District sponsored exchange. In particular, we excluded HIUs where either the primary person or their spouse (if a spouse is present) is identified as a government worker. We also ultimately excluded anyone identified as an undergraduate student with ESI or individual coverage. Consistent with the Background Research Report, we revised the coverage classification for anyone identified as having individual coverage with an income below 200% FPL; for the model, we assumed that these people were covered by Medicaid. Finally, we identified a number of individuals who were identified both as having ESI and as being

[78] In the Background Research Report, we referred to the American Community Survey as the ACS data. In order to avoid potential confusion with Information Technology vendors with the same acronym that were also reviewed in this project, we are referring to the American Community Survey as the AC Survey going forward.

unemployed. We assumed that these persons would behave in our modeled market as if they were uninsured.

Module Design and Data Restrictions

Ultimately, the Oliver Wyman HRM model is designed to assess the economic incentives related to insurance coverage for each HIU. In this sense, the design is almost that of a seriatim model. However, we faced several challenges with this approach. First, there is no single data source with all the information necessary to create a seriatim model. Although the AC Survey contains information about demographics, current insurance coverage, and income, it does not include insurance characteristics of a person's employer (e.g., group size), that person's health status, the source of coverage in the HIU (e.g., the husband or wife), or premiums for coverage. Also, the person record from the AC Survey does not correspond with a single individual in the population. Rather, each record is assigned weights so that one survey respondent might represent 250 individuals in the population while another respondent might only represent 50 individuals.

To address the issue of varying weights, we duplicated AC Survey records so that they roughly corresponded to the weight assigned to an individual. For example, a person with a weight of 250 might translate to 20 duplicated records (all with the same characteristics), while a person with a weight of 50 might translate to four duplicate records. Because of computing limitations, we were not able to represent the entire District market in this fashion, but we were able to reflect a robust, stratified subset of it.

To address the issue of incorporating non-AC Survey data (e.g., health status, insurance premium), we built a micro-simulation model. This model assigns health status to each person; it also assigns people with ESI to groups. This assignment of variables is then repeated many times to ensure that we have an accurate estimate of the range of possible results.

For health status, we developed coverage-specific assumptions from self-reported data in the Census Bureau's Current Population Survey (CPS). Individuals are classified into one of five health status categories, ranging from excellent to poor. We noticed that, within a coverage type, individuals generally had similar distributions across income levels. However, there was one exception to this observation: those uninsured individuals with higher incomes reported themselves as being in better health than their uninsured, lower-income counterparts. This dynamic likely results because individuals with the means to purchase insurance are less likely to do so if they have better health; individuals without the means to purchase insurance will remain uninsured regardless of their health status.

We also noticed that the health status reported by those with individual coverage was generally less favorable than the health status reported by those with ESI coverage. (We have noticed this dynamic in similar exchange studies sponsored by other states.) Because individual coverage is underwritten and insurers have the option not to offer coverage in most states today, this observation of higher morbidity in not consistent with our expectations. We would expect that

insurers would only offer coverage to the healthiest subset of individuals; this option not to offer coverage is not available to insurers in the small group market. We have assumed that this higher-than-expected morbidity in the individual population is an inaccuracy (e.g., it might occur if individual insureds perceive their own health differently than those with group coverage). We adjusted the health status distribution for the individual insureds so that they were more consistent with the self-reported status of the ESI market. Each person was then assigned a personal claim cost relative-value based on their self-reported health status.

Synthetic Insurance Carriers

With the assistance of DISB, a data call was issued to those carriers writing business in the District with the largest market share in 2010. The information obtained through the data call, in combination with information gathered through a review of recent rate filings, was specific enough to allow us to develop theoretical, or synthetic insurance carriers.

The information obtained from each small group carrier participating in the data call included premium, claims, enrollment, and the associated rating characteristics and variables (i.e., group size factor, age/gender factor, industry factor and underwriting load factor) for each small group with coverage in 2010. The actuarial value of the benefit plan underlying each small group's premium was not provided. Using the information obtained, each group's premium was normalized for all rating factors provided, which in effect resulted in normalized premiums that reflected only benefit differences.

Because carriers are not yet designing products targeted to specific actuarial values, as they will in the reformed market, the observed benefit differences did not cluster around specific actuarial value levels. After removing outliers at both extremes, estimated actuarial values were assigned to the various groups. By examining rate filing information for the carriers included in the data call, we were able discern the level and approximate actuarial value of the richest plans offered in the market in 2010. We assigned the richest normalized premiums an actuarial value consistent with the actuarial value of the richest plans offered by the carrier in 2010. Small groups were then grouped into ranges based on their normalized premium, where the average actuarial value of each range was approximately 10% lower than the average actuarial value of the previous range. This analysis was performed independently for each carrier.

Using this information, we were then able to develop a synthetic rating manual for each carrier. The observed premiums were normalized for all rating variables to arrive at a manual rate representing a 1.00 level for all rating variables. The range of current values for each rating variable were developed from the carrier data and validated against information included in rate filings.

A set of revised rating manuals for 2014 and beyond that reflects the ACR methodology required under the ACA were also developed. The District has passed its own law[79] which reflects the

[79] "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010."

early adoption of certain aspects of the ACR methodology that will be required under the ACA in 2014 (e.g., elimination of gender rating and compression of range by which rates can vary by age). From these changes in the law, we were able in some cases to see how carriers' rates will be adjusted under the new ACR requirements.

For those carriers for which we did not have recent rate filings reflecting these changes, and for other changes that will be required in 2014, we developed new rating manual factors such that the average impact on rates across the carrier's entire block was premium neutral. Industry, group size and underwriting load factors were set to 1.0 to reflect the fact that rates will not be able to vary based on these characteristics in 2014 and the underlying manual base rate was adjusted based on the average in force factor under the current methodology. For example, if the average group size factor under the current rating methodology was 1.05, the base rate was increased by a factor of 1.05 to offset the fact that the average group size factor in 2014 will be required to be 1.00.

Synthetic Groups

In addition to assigning health status to each person, we also assigned each person with group coverage to a theoretical, or synthetic group. In describing their micro-simulation model, the CBO discusses their approach to creating these synthetic groups. As we understand it, the CBO pooled individuals with similar incomes to develop their synthetic groups;[80] in our model, we have pooled individuals in similar industries. The AC Survey data include industry classification for those persons that are employed. As we created synthetic groups, we ensured that health care providers were included in groups with other health care providers, we ensured that lawyers were included in groups with other lawyers, etc.

Our model also reflects the industries and corresponding group sizes in the District based on existing distributions of employers. For these distributions we relied on data prepared by D&B. The D&B data show each employer in the District, their industry, the number of employees at each establishment in the District, and the number of employees across the entire organization. As with the AC Survey data, we took care to remove any government employers (either based in the US or other countries) from the data. These D&B data do not provide any information related to employee health benefits; so, we used data from the MEPS to supplement the missing information. Specifically, we relied on the blended results from the 2009 and 2010 MEPS insurance/employer component data to establish the rates at which coverage was offered at various group sizes. We also used the MEPS data to examine rates of eligibility and enrollment at various group sizes.

Based on these assumptions, the micro-simulation model assigned employees from the AC Survey data to groups of similar industries (at various group sizes) until all covered employees in the AC Survey data were assigned. For example, a lawyer in one iteration might be assigned to a large law firm, and in the next iteration, that same lawyer would be assigned to a small

[80] http://www.cbo.gov/ftpdocs/87xx/doc8712/10-31-HealthInsurModel.pdf

practice. Employees in synthetic groups were then summarized, and assigned a carrier based on the carrier's market share. The groups were assigned a premium based on the groups' characteristics, their carriers' rating practices, and the synthetic rate manual of their assigned carriers. So, extending our example, the model might build a small group of lawyers, assign them a carrier, and then assign them rating factors from that carrier for health status, demographics (i.e., the age, gender, and family composition of each employee), group size and industry.

In addition to examining the premium based on the carriers' present rating practices, we also examined the rate change (called "rate shock") that each group would experience in 2014 as a result of new rating restriction imposed on carriers by the ACA. These restrictions will limit rating for age, while eliminating rating for gender, health status, group size, and industry. Consequently, groups that have benefited with lower premiums as a result of their characteristics (e.g., those who are younger and healthier) will potentially see very large rate increases, while groups that have paid higher premiums as a result of their characteristics (e.g., those who are older and more unhealthy) will see rate decreases. The original group premium and the group premium resulting from the rate shock are both carried with the employee into subsequent modules.

For each small group, we also estimate whether or not the group might be eligible for subsidies under the ACA. As discussed in the Background Research Report, small groups meeting certain size, average wage, and employer contribution requirements might be eligible for tax credits. Based on the simulated individuals in the synthetics groups, we have attempted to estimate eligibility for these credits.

Finally, we estimated the cost of individual coverage for every HIU in the model. This cost estimate is a key element in future modules. The cost of individual coverage is critical for estimating the behavior of those who currently have individual coverage, but it is equally important for those with ESI or even those who are uninsured. As employers choose to eliminate coverage and tax credits become eligible for certain individuals in the Exchange, many persons beyond the existing individual market will begin to examine coverage there.

As with our estimates for group costs, we assigned a carrier to each HIU based on the carrier's market share. We then built a premium for that HIU based on the carrier's rating practice and the rating characteristics of the HIU. Finally, we estimated a rate shock that the HIU would experience as a result of new rating restrictions under the ACA (e.g., elimination of rating based on health status, gender, etc.) The original individual premium and the individual premium resulting from the rate shock are both carried with the HIU in subsequent modules.

Market Calibration Module

The second module in the Oliver Wyman's HRM Model is a calibration module. The purpose of the calibration module is to solve for the model parameters that replicate the known insurance marketplace in 2010. The steps in the simulation module described above represent one

iteration. These steps are repeated multiple times until the average results across multiple iterations replicate the known current population. If the known results are not replicated, model parameters are adjusted and the simulations are repeated.

The results are calibrated at a number of different levels. First, results are examined to ensure the appropriate number of people were simulated to have each type of current coverage (e.g., individual, small group, Medicaid, etc.). Within the individual and small group markets, the average premiums developed through the application of the synthetic rating manuals were also reviewed to ensure they were consistent with known premiums of $263 PMPM in the individual market and $355 PMPM in the small group market.

Next, the distribution of rate shock anticipated in 2014 is reviewed. Using the carrier data obtained for small group business, a rate shock due to the shift to an ACR methodology is developed for each group by adjusting each of the rating variables for the group to the average for the carrier's small group block. This distribution of rate shock is then compared with the distribution of rate shock simulated through the application of the synthetic insurer rate manuals. Since the groups included in the simulations may posses different combinations of age, gender, group size, industry and morbidity characteristics, the calibration process ensures that the distribution of overall rate shock resulting from the aggregation these individual factors is consistent with the distribution of overall rate shock from the known carrier data. A similar process is employed for the individual market.

Ensuring consistency of carriers' morbidity loads was the critical test of the rating calibration. We calculated the cumulative probability distribution for the morbidity loads as assigned by each carrier. We then mapped these morbidity loads to each synthetic group. During this process, we were careful to map morbidity loads so that the probability distribution of health statuses matched probability distribution of morbidity loads.

Once the simulation module is calibrated, the results are used to calibrate the market migration module (discussed in detail next). The market migration module uses the results of the 2010 populations created by the calibrated simulation module and projects the market into which individuals will enroll, based on the options available to them. For those individuals that were enrolled in ESI coverage, the premium for that coverage is also passed from the calibrated market simulation module. Premiums in the individual market are calculated for each HIU and passed from the market simulation module. In order to ensure that an appropriate utility function is utilized in the market migration module, the model is calibrated to reproduce the status quo.

While a utility function can model people's desire for consumption of health care services, as well as their aversion to financial risk, it cannot predict certain behaviors, such as why people eligible to enroll in Medicaid do not enroll, or why individuals with sufficient financial means to purchase health insurance chose to be uninsured. It is because of these behaviors that the model calibration is necessary.

To perform this calibration, all of the information resulting from the simulation module is considered except the known market in which the individual was enrolled in 2010. Individuals with coverage through Medicaid, Medicare, military coverage and coverage through District or Federal government employee programs were excluded from the calibration, as individuals with these types of coverage are assumed to continue with those coverages throughout the projection. For each of the remaining HIUs, the various coverage options available to them in 2010 are examined and the utility associated with each option is calculated. HIUs with household MAGI greater than 200% FPL are not allowed to evaluate the option of enrolling in Medicaid, the Alliance program or the 138%-200% FPL Waiver program. Once a utility is calculated for each of the allowable options, the option with the greatest utility is selected and the HIU is assumed to enroll in that health insurance option.

For HIUs where the current coverage is not the same for all family members, these “split decisions” were also an option that was evaluated. For example, if the primary respondent to the AC Survey is reported to have ESI coverage, but the spouse is reported to have individual coverage, an option where the primary individual enrolls in single coverage under the simulated employer group plan is evaluated in combination with the spouse enrolling in any of the five coverage levels modeled to be available in the individual market.

For most of 2010, the reforms that became effective September 23, 2010 were not in effect, in particular the requirement that dependents be allowed to remain on their parent’s coverage up to age 26. Therefore, in performing this calibration, dependents under age 19 were handled separately from those ages 19-26. For the 19-26 population, we examined the actual coverage that the 19-26 year old had in 2010, relative to the rest of the HIU. If the primary respondent to the AC Survey had ESI or individual coverage, but the 19-26 year old dependent did not, we assumed it was because they were not eligible to enroll under the same coverage as the primary individuals. In this case, the 19-26 year old was evaluated as a separate HIU for purposes of the calibration. It is important to note that this rule was only used for the calibration, as these 19-26 year olds would be eligible to enroll on their parent’s coverage in 2014 and beyond.

The process of determining which coverage option(s) each HIU would enroll in based on application of the utility maximization methodology was repeated for each iteration of results from the simulation module. The projected enrollment in each market was aggregated across all simulations and compared to the known 2010 distribution (the distribution resulting from each iteration of the simulation model is referred to here as the known 2010 distribution) by market at several sub-population levels.

If the projected enrollment results did not replicate the known 2010 distribution, the various parameters in the utility function were revised until the projected enrollment was consistent with the known enrollment at several key sub-population levels. The following table compares the known 2010 distribution of District residents (excluding those enrolled in public programs and those covered as government employees) and employees (including their covered dependents) with the projected distribution resulting from the migration model, across all model iterations.

	Known Distribution	Migration Module
Uninsured (District Residents) <=200% FPL	17.3%	18.4%
Uninsured (District Residents) 201%-400% FPL	4.6%	4.8%
Uninsured (District Residents) >400% FPL	4.4%	4.6%
Individual (District Residents)	8.8%	9.2%
Small Group (District Residents; Work in District)	10.7%	10.5%
Small Group (Non-District Residents; Work In District)	32.8%	32.2%
Mid-group (District Residents; Work in District)	5.8%	5.6%
Mid-group (Non-District Residents; Work in District)	15.5%	14.8%
Total	**100.0%**	**100.0%**

The table above demonstrates that we were able to calibrate our model to reproduce the distribution of individual purchasing decisions that were made in 2010.

Market Migration Module

The final module in the Oliver Wyman's HRM Model is the market migration module. The purpose of the market migration module is to project the migration of individuals between the various coverage statuses that will be available to them in the post-reform insurance marketplace. We developed these projections based on the simulated population, along with many other medical and economic input variables, and also based on the introduction of the ACA changes that will occur in 2014 and beyond.

Limited aspects of the module were described previously when describing the model calibration; however, here we provide a more detailed overview.

For each iteration of the market simulation module, the resulting simulated population is input into the calibrated market migration module, and the purchasing decisions for each HIU are modeled for each of the years 2014 through 2018. Individuals currently enrolled in Medicaid, Medicare, those having coverage through the military and those receiving coverage as a result of being an employee or a dependent of an employee that works for the District or Federal government are assumed to retain that coverage. In addition, as described in the body of the report, large groups are assumed to continue offering coverage at the same rate at which they do today. As a result, all of these individuals are not run through the market migration module. These populations are projected to grow at the same population growth rate assumed in the model. Additional individuals with current individual or ESI coverage, and those currently uninsured, are allowed to enter the Medicaid population as will be described below.

As described in the body of the report, the model assumes a steady state population from the perspective that the underlying mix of the population does not change with respect to many variables. Annual increases in population growth and income are projected. In projecting

population growth each individual in 2010 receives a population growth weight based on their age in 2010. These population growth weights allow each person in the 2010 population to represent an additional fraction of a person in 2014 and beyond, with the weight increasing each year by the population growth for the age range to which they belong.

Incomes are increased by the assumed salary inflation factors, and FPL levels are projected based on the statutory formula for calculating FPL. Based on the income, family size and composition of each HIU, the MAGI is calculated for each projection year. Projected MAGI levels for each HIU are then compared with projected FPL levels to determine each HIU's income as a percentage of FPL for each projection year. These FPL percentages are then used for:

- Determining whether the HIU is eligible for Medicaid or children within the HIU are eligible for CHIP
- Determining whether the HIU is eligible for premium subsidies within the Individual Exchange
- Determining whether the HIU is eligible for cost sharing subsidies within the Individual Exchange
- Determining whether the HIU is eligible for exemption from the individual mandate penalty if they elect not to enroll in coverage
- Determining whether the ESI coverage made available to HIU is deemed "unaffordable" and as a result the HIU is eligible to enroll in the Individual Exchange and receive premium and cost sharing subsidies

The market migration module evaluates several different options in which the HIU is eligible to enroll. The model calculates the utility for each one of these options. HIUs are only allowed to evaluate ESI coverage if they are currently enrolled in this market as the model does not assume new offerings of ESI coverage. HIUs are only allowed to evaluate the option of enrolling in Medicaid or subsidized coverage inside the Individual Exchange if they meet the income eligibility requirements.

The potential options that are evaluated for each HIU (where eligible) include:

- All individuals in the HIU enroll in ESI coverage at the level made available by the employer for the year modeled
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Bronze level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Silver level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Gold level coverage in the individual market

- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Platinum level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI remain uninsured
- All individuals in the HIU enroll in Silver coverage within the Individual Exchange and receive premium subsidies, and cost sharing subsidies where applicable
- All individuals in the HIU enroll in non-subsidized Bronze level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Silver level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Gold level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Platinum level coverage in the individual market
- All individuals in the HIU elect to remain uninsured

Individual Utility

Individual HIUs are assumed to make insurance purchasing decisions by evaluating the various options above and making an economically rational decision to select the option that maximizes the utility for the HIU. In cases where different members of an HIU enroll in different markets (e.g., the primary AC Survey respondent enrolls in ESI coverage but the spouse enrolls in individual coverage), the utilities for all members of the HIU are aggregated to develop the corresponding utility for the HIU under that option.

In order to model this behavior, a utility function and associated parameters were selected. As described in the previous section, the utility function and parameters selected were those that resulted in replicating the status quo upon application of the market migration module to the simulated population, across several iterations. The underlying utility function that resulted in this optimal model calibration is as follows:

$$U_{i,j} = -E(OOP_{i,j}) - premium_{i,j} - \frac{1}{2} rVAR(OOP_{i,j}) + u(H_{i,j})$$

In the equation above, $OOP_{i,j}$ is the OOP health expenditures for HIU i under purchasing option j, r is the risk aversion coefficient and $U(H_{i,j})$ is the utility associated with consuming health services. $U(H_{i,j})$ is assumed to be proportional to the expected value of the total expenditures for health care services with the ratio a. In calibrating the model, we elected to vary the parameters r and a at three different ranges of incomes to reflect the fact that individuals with higher incomes are more risk averse. The parameters for r and a that resulted from the market calibration module are:

Income as a % of FPL	r	a
<200%	0.0000025	0.10
201%-400%	0.000012	0.15
>400%	0.000016	0.15

Personal Claims Cost

Within the model, a PCC is developed for each District resident and employee for the base calibration year, and each subsequent year modeled. This PCC, or some multiple of it, is used as an approximation for the expected value of total expenditures for health care services utilized in the utility function above.

The PCC for each individual is calculated as the base claims cost for the insured market for the year, multiplied times an adjustment to reflect the relative level of claims expected for someone of their age/gender relative to someone of the age/gender underlying the base claims cost, multiplied times an adjustment to reflect the relative level of claims expected for someone of their health status relative to someone with the health status underlying the vase claims cost.

In evaluating the utility associated with being uninsured, the PCC for the individual is reduced by a factor to account for the fact that those without current health insurance do not seek medical services at the same level as those with insurance. In evaluating the utility associated with a currently uninsured individual taking up insurance, the PCC is increased by a factor to account for pent-up demand.

Employer Demand Elasticity

The response from employers to changes in premiums and other financial incentives, is a critical element of the model. Because of new rating requirements in the ACA, many groups will see substantial rate changes (both up and down). In addition, there are provisions in the ACA that we assume will only increase the cost of coverage (e.g., fees collected by the Federal government from insurers). These additional costs will generally discourage employers from offering coverage at their existing benefit levels. When trying to model the specific response a group will have to a price change, we rely on elasticity assumptions.
Generally speaking, these elasticities measure changes in behavior in response to changes in price (e.g., an increase in the price of bread causes a decrease in the quantity demanded). In our model, we have characterized an employer's response to increasing premiums by decreasing the benefits that the employer offers in their health plan. For example, an increase in premium might cause an employer to offer a Silver plan instead of a Gold plan. The employer responds to increasing premiums this way until the benefit levels no longer justify offering coverage.

One significant challenge with this particular assumption is the uncertainty associated with it. Employer coverage decisions occur in an environment with numerous financial incentives as

well as qualitative considerations. (For example, a small group employer in today's market may absorb very high premium changes as long as it means that her employee's ill spouse is able to receive their required care.) Any attempt to model behavior of this sort is going to have shortcomings. In an effort to obtain the strongest assumptions available, we reviewed numerous published sources. In particular, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica. This report identifies ranges for price elasticity of employer offer from -0.14 to -5.80. In addition, we also relied on the CBO's assumptions employed in its own micro-simulation model. The final assumptions we employed varied by group size (identified as GS), were generally consistent with the results published in the Mathematica Report, and are characterized by the following equations:

GS 1 to 10:	-1.14
GS 11 to 50:	0.1722 * ln (GS) – 2.2273
GS 51 to 350:	0.1182 * ln (GS) – 0.8424

As we reviewed the results from the model, we found that the expected group behavior was generally consistent with other estimates we have seen from independent studies of the ACA's effect on small group coverage.

Inertia Factor

In many cases, the evaluation of two competing options using the selected utility function results in utility values that are very similar. For example, the utility associated with purchasing Bronze level coverage in the individual market may be only marginally different than the utility associated with being uninsured. From year to year, the impact of medical trend and the change in the penalty under the individual mandate for not taking coverage do not change at the same rate. This can result in individuals alternating back and forth between these two options in subsequent years under a pure utility maximization approach.

Several studies have documented the inertia related to individual decision making, where people elect the status quo even though utility theory indicates it is rational to elect an alternate option.[81, 82] Therefore, to reflect this behavior and add stability to the modeled results, we have built an inertia factor into the model such that if the utility associated with an option that has the maximum utility for a given year is not at least a stated percentage higher than the utility associated with the current option, the change in coverage is not made.

[81] Su, X. (2009). "A Model of Consumer Inertia with Applications to Dynamic Pricing. Production and Operations Management." 18: 365–380. doi: 10.1111/j.1937-5956.2009.01038.x

[82] "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." Brigitte Madrian and Dennis Shea.

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