Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange

August 31, 2011

Prepared for:

Ohio Department of Insurance

Prepared by:

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

Jill S. Herbold, FSA, MAAA
Consulting Actuary

Paul R. Houchens, FSA, MAAA
Consulting Actuary

Milliman, Inc.

Chase Center/Circle
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639 1000
Fax +1 317 639 1001

milliman.com

TABLE OF CONTENTS

1. INTRODUCTION

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Insurance (ODI) to assist in the first-year planning of a federally mandated American Health Benefit Exchange (exchange). This report is a direct response to Sections 1-3 of the scope of work included in request for proposal (RFP) number CSP904311. The components of Sections 1-3 are briefly described below:

Section 1: Study of the uninsured and underinsured.

- Determination of how the Ohio uninsured population will utilize the exchange
- Determination of the likely impact of an exchange on health insurance premium rates
- Determination of how frequently individuals might move between market segments
- Consideration of state estimates of the population of uninsured individuals who will be newly eligible for Medicaid
- Consideration of state analysis of who is already eligible for Medicaid, but not enrolled
- Consideration of analysis of other states' experiences with health coverage expansions and impact on other human services resources to identify appropriate options for an exchange and to plan for increases in demand
- Consideration of state estimates of the uninsured population in Ohio, as well as their socioeconomic status (i.e., their income as a percentage of federal poverty level) to predict who will likely access coverage through Medicaid or other publicly funded plans or through commercial plans with the assistance of subsidies;
- Impacts of creating a Basic Health Program for people between 133% and 200% of the federal poverty level, including costs and analysis of doing so
- Updated data about the number of insured and uninsured Ohioans and their characteristics, including income level, age, work status, health status, household characteristics, and place of residence

Section 2: Study of the current Ohio insurance market and employer programs.

- Anticipated characteristics of Ohio's health insurance markets, including current laws, benefits, premium rates and competitiveness of the markets
- The number and characteristics of health insurance carriers offering coverage in the individual, small group, large group, and self-insured markets
- The anticipated number and characteristics of employers in Ohio and the health insurance programs they offer to employees
- The impact of including public employee plans in the exchange
- The impacts if the Small Business Health Option Program (SHOP) exchange is available to businesses with 50-100 employees prior to 2016 and the number of businesses and employees that would potentially fall into this range
- Recommendations on whether the SHOP exchange should be separate or integrated with the primary exchange and the projected impacts of either scenario
- Strategies for integrating a defined contribution "choice model" for small employers in the exchange with conventional underwriting methods in Ohio's broader small group market
- The current number of brokers and agents interfacing with Ohio consumers and recommendations on how brokers and agents can be incorporated within the exchange
- The current status of the limited medical benefit plan market and anticipated characteristics within an exchange environment
- The impact associated with a catastrophic health plan

Section 3: Actuarial services and economic modeling in support of exchange planning.

- Projected take-up rates for public programs, private plans, and subsidy programs, including take-up both inside and outside the exchange in each market segment
- Projected impacts of an exchange and related market reforms on Ohio's individual, small group, large group, and self-insured markets, including impacts on plan design and premium rates
- Potential impacts of adverse selection caused by the market reforms and alternative exchange structures, including analysis of the effects of coverage offered outside an exchange, the ability of employers to self-insure, and an evaluation of approaches to mitigate adverse selection
- Strategies within an exchange environment to ensure competition within Ohio's health insurance markets, and to encourage carriers, employers, and individuals to participate in an exchange
- Projected prevalence and impact of grandfathered plans in Ohio
- Impact of risk adjustment, risk corridors, and transitional reinsurance with analysis of alternative approaches to address adverse selection, promote competition, and create fairness in the market
- Analyze risk adjustment methodologies and recommend best approaches to comply with the Affordable Care Act (ACA)
- Assess and recommend available reinsurance options
- Examine open enrollment strategies and modeling the impact such strategies could have on the insurance market both inside and outside the exchange
- Model the impact of merging employer-sponsored (ESI)-small group and non-group markets
- Impact of expanding the ESI-small group market from 2-50 employees to 1-100 employees
- Review the current mandated benefits in Ohio as compared to essential benefits packages to be offered in exchanges, with associated impacts and costs

We have modified the order of the RFP tasks and sections to suit our report flow and analysis. The section numbers and specific tasks do not follow the RFP numbering above. Additionally, we have prepared a separate report for Section 4 of the RFP scope of work that analyzes the financing options and sustainability of an exchange.

2. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), introduces significant changes in covered benefits, premium rating and underwriting, carrier regulation, and the overall issuance of health insurance coverage in the U.S. Certain changes have already occurred, while the majority of the impacts will begin on January 1, 2014. This is the date when all states must have both an individual market exchange and a Small Business Health Options Program (SHOP) exchange in operation, or default to a federally run exchange. This includes significant changes in the benefit offerings and underwriting of insurance policies both inside and outside these required exchanges.

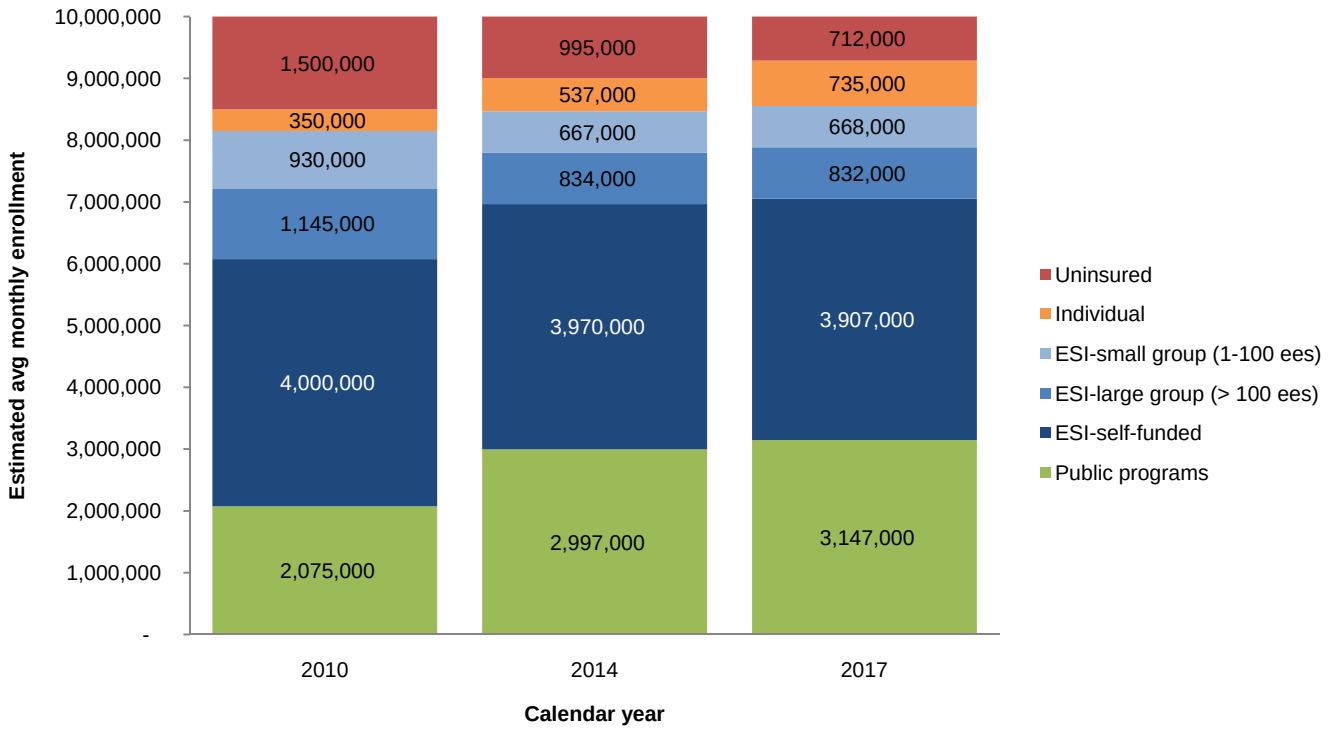
The primary ACA requirements for the commercial employer-sponsored (ESI)-small group and individual health insurance markets, both inside and outside the exchanges, include:

- Guaranteed issue of insurance coverage regardless of pre-existing medical conditions or health status
- Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1)
- Premium rate consistency inside and outside the exchanges
- Ability of states to merge the ESI-small group and individual health insurance markets
- Ability of states to define small group up to 100 employees (mandatory by January 1, 2016)
- Definition and requirements for essential health benefits
- Individual tax penalty if not covered by minimum essential insurance coverage
- Employer tax penalty if not offering qualified insurance coverage (groups under 50 employees exempt)

The ACA also includes a significant expansion of the state Medicaid program to include all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

These changes are certain to impact the current source of health insurance coverage for a large number of Ohioans. The key question is, to what extent are the current markets going to be impacted? More specifically, what will the Ohio insurance market look like in 2014 and beyond? While the exact impacts are not known, this report used a model developed to illustrate the potential landscape of the Ohio insurance market in 2014 (initial year) and in 2017 (mature year). The estimates take into account the potential behavior of individuals and employers based on income level, age, and health status. Figure 2-1 illustrates the estimated changes in the source of coverage for 2010 to 2014 and 2017. It should be noted that these results assume that the state does not implement a Basic Health Program.

Figure 2-1: Ohio non-elderly covered lives by source of coverage – changes from 2010 to 2014 and 2017



The primary observations for calendar year 2017 (as compared to 2010) from the model results used to develop Figure 2-1 include:

- The individual health insurance market increases by approximately 110% or 390,000 lives
- The public programs increase by approximately 52% or 1,070,000 lives
- The ESI-small group market decreases by approximately (28%) or (260,000) lives
- The ESI-large group market decreases by approximately (27%) or (310,000) lives
- The ESI-self-funded market decreases by approximately (2%) or (90,000) lives
- The uninsured population decreases by approximately (53%) or (790,000) lives

The premium rates in the various markets are expected to react to the movement of individuals summarized above. This indicates that the model used to develop this report assumed that the healthcare cost of each individual is unique and that as they move to another market segment their associated costs go with them. The minimum benefit standards required in the ACA will also impact the premium rates to the extent they are higher standards than the current markets. Our analysis estimates that the premium rates may change as follows:

- Prior to the application of the premium tax credit subsidy, the individual health insurance market premiums are estimated to increase by 55% to 85% above current market average rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits. Current insured benefit expenses in the individual market are approximately 40% less than the ESI-small group market.[3] This is attributable to today's individual market having leaner covered benefits, such as the exclusion of maternity services, and a lower-cost population relative to the ESI markets.

It is estimated that the post-ACA individual market will have average benefit coverage levels more comparable to the small group market. It is also anticipated that this new individual market will be less healthy compared to the ESI market populations. For these reasons, premiums in the individual health insurance market post-ACA are estimated to be 8%-12% higher than the ESI-small group market, post ACA reforms.

- The ESI-small group market premiums are estimated to increase by 5% to 15% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the remaining ESI-small group market, ACA-imposed insurance carrier fees, and provider cost shifting from the public programs.

- The ESI-large group market premiums are estimated to increase by 3% to 5% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the ACA-imposed carrier fees and provider cost shifting from the public programs.

- It should be noted that these increases will be in addition to regular expected healthcare inflation. The 2011 Milliman Medical Index reported 7% to 8% annual trends for the fourth year in a row.[1]

The premium change estimates illustrated above represent the estimated **average** premium impact to each of the market segments. It is important to note that individual policyholders and ESI-group policy premiums will have significant variability as a result of the ACA requirement for adjusted community rating (ACR). Individuals and smaller employers will observe the greatest impacts since they are more likely to be at one extreme or the other of the total current premium range (i.e. health status tier, age band, and gender category).

- In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%. However, a 60 year old with chronic health conditions may experience a significant premium decrease.

- In the ESI-small group market, rating changes may result in a premium increase of 150% or a premium decrease of nearly 40% for groups at opposite ends of the current rating structure.

- Rate change variability attributable to ACR may result in healthier insured risks leaving the insured risk pool, while attracting a greater proportion of less healthy risks.

This estimated premium impact includes the combination of items impacting the entire market (such as minimum benefits and risk pool composition changes) as well as the items that mainly impact the lowest or highest extremes of the current premium range (such as restriction of age rating to a 3:1 ratio, removal of health status underwriting, and the elimination of gender rating). Similarly, individuals and ESI-small groups who consist of older ages, higher health risks, and higher female concentration will experience lower than average premium rate changes as a result of the subsidies created by ACR.

The changes which will result from to ACA will be significant. The task of implementing these regulations will require a significant amount of leadership and collaboration among the state, carriers, employers, consumers, brokers and agents, and providers. The key will be finding the issues that can be regulated by policy and using that authority to ensure as much market stability as possible through this period of change.

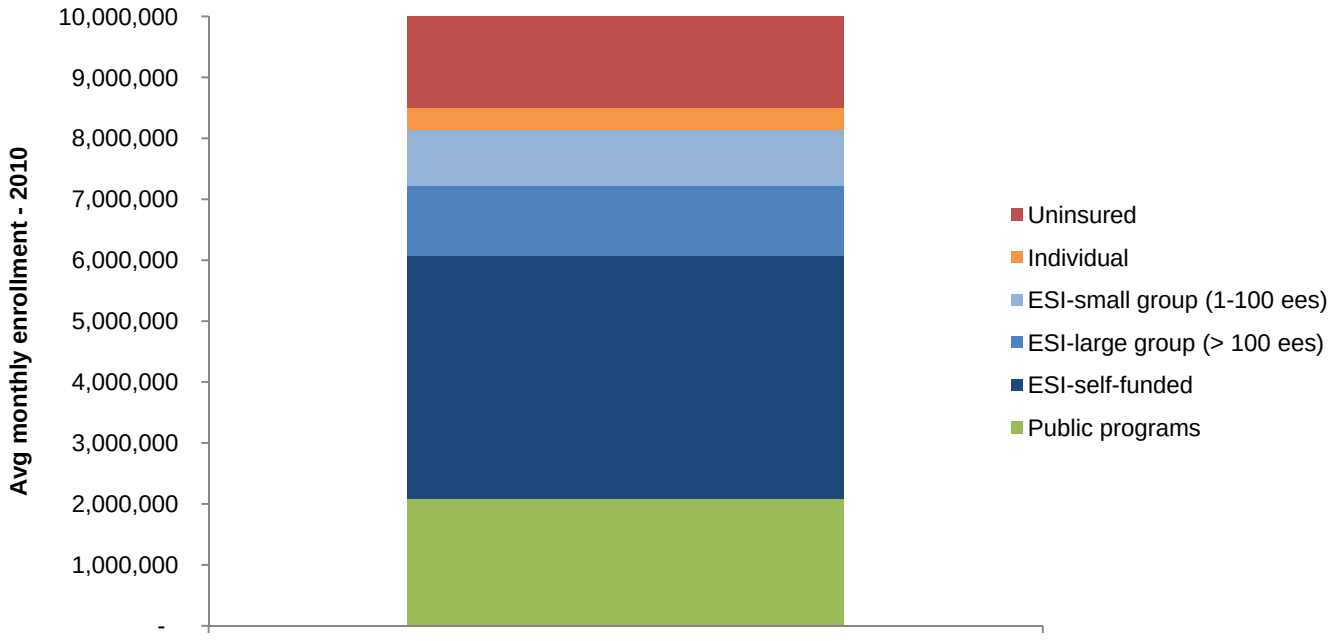
3. SUMMARY OF CURRENT MARKETS AND POPULATIONS

a. Estimated population by source of health insurance coverage

The ACA introduces significant changes in covered benefits, premium rating and underwriting, carrier regulation, and the overall issuance of health insurance coverage in 2014. In order to understand the implications of these changes, it is important to understand the current marketplace. This section summarizes key demographic characteristics of the 2010 Ohio population in each of the following current markets: individual, employer-sponsored (ESI), public programs, and uninsured. The estimated population and associated characteristics were based on the 2010 Ohio Family Health Survey (OFHS). The market groups were determined using a combination of the December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline data, LLC and the 2010 Ohio insurance carrier survey. [2, 3]

Figure 3-1 illustrates the estimated calendar year 2010 source of health insurance coverage for non-elderly (under age 65) Ohioans. The largest concentration of health insurance coverage is from ESI-self-funded plans, providing health insurance to approximately 4 million Ohioans. Approximately 2.1 million additional Ohioans receive health insurance in the ESI-small group and ESI-large group insured markets, bringing the percentage of Ohioans who receive health insurance through their employers to over 60%. Public programs, consisting of Medicaid, Medicare, TRICARE, and other government programs, cover an estimated 2.1 million individuals. The individual health insurance market is the smallest source of health insurance coverage, with approximately 350,000 purchasing comprehensive individual coverage. Individual coverage as defined in this report excludes benefit plans that do not provide comprehensive insurance coverage, such as mini-med plans, dread disease, and accident policies. Therefore, the estimated number of lives with individual coverage may be less than other publicly reported data. An estimated 1.5 million individuals are uninsured, which represents approximately 15% of the state's non-elderly population.

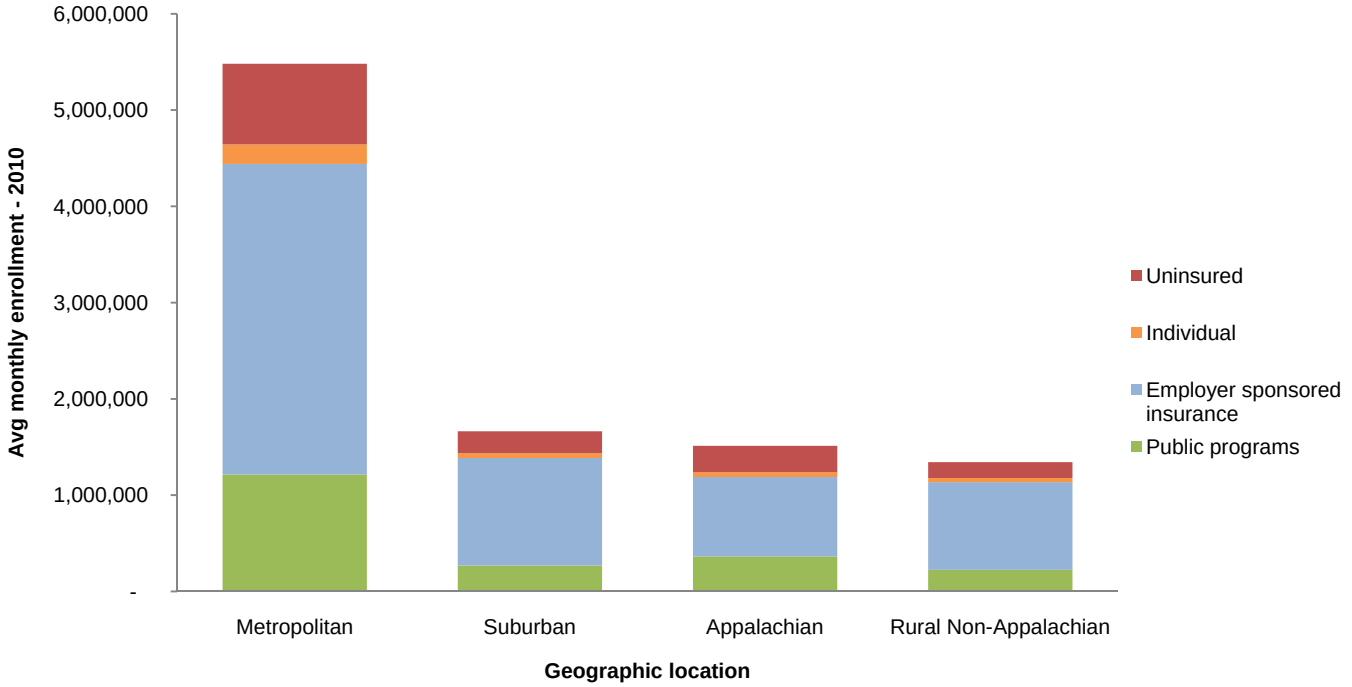
Figure 3-1: Ohio non-elderly population by source of current health insurance coverage – 2010



Source: 2010 Ohio Family Health Survey, adjusted based on December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [2, 3, 51]

Figure 3-2 illustrates the estimated 2010 non-elderly population by source of insurance coverage and geographic location. In each of the four defined geographic locations, approximately 60% of the non-elderly population has health insurance through employers. Individual health insurance is less prevalent in suburban areas, which may be attributable to a slightly higher percentage of suburban Ohioans having ESI coverage (67%) versus other geographic locations (60%). The percentage of individuals with public program coverage is highest in the Appalachian and metropolitan geographic locations (23%).

Figure 3-2: Ohio non-elderly population by geographic location – 2010

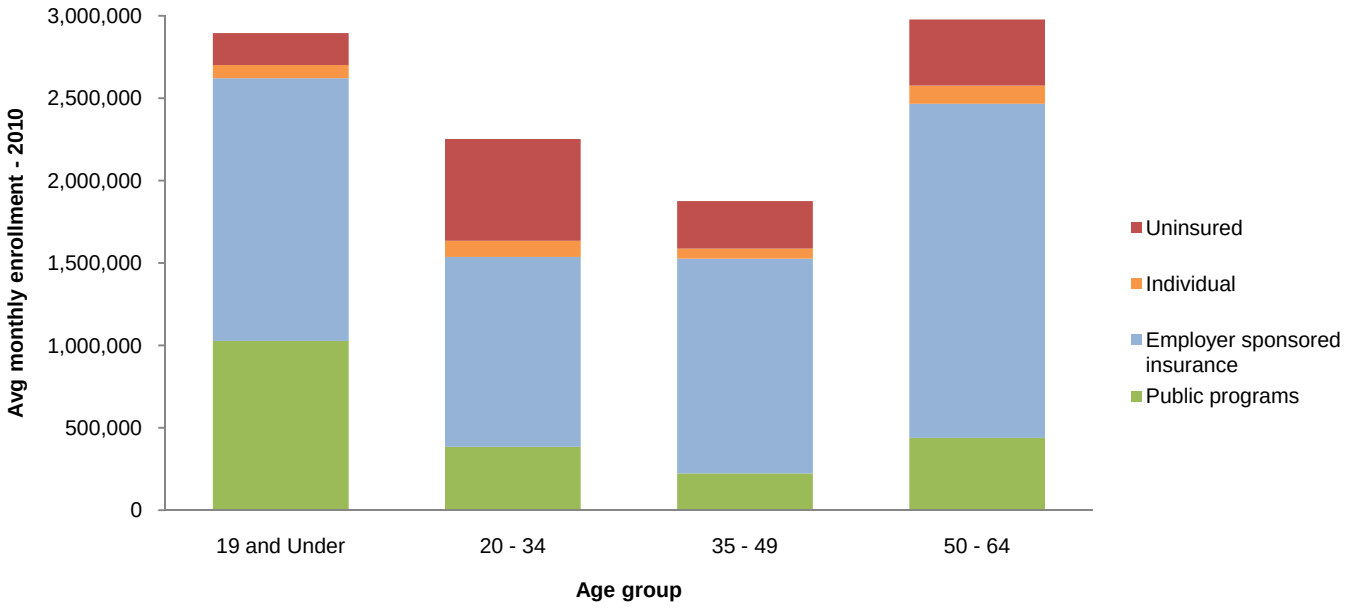


Source: 2010 Ohio Family Health Survey, adjusted based on December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [2, 3, 51]

Figure 3-3 provides a summary of calendar year 2010 health insurance coverage by age group. The 19 and under population has a substantially larger proportion of individuals with public program coverage due to Medicaid eligibility income limits being significantly higher for children than adults. In the 20-34 age group, 27% of individuals are uninsured. This is a significantly higher rate than the older adult populations that have a 14% uninsured rate. The high percentage of uninsured individuals in the 20-34 age group may be attributable to several factors, including:

- Lower demand for insurance due to perceived favorable health status ("young invincibles")
- Lower level of household income
- Lower offer rate of ESI coverage relative to older adult populations
- Previous Medicaid eligibility terminating due to age limitations

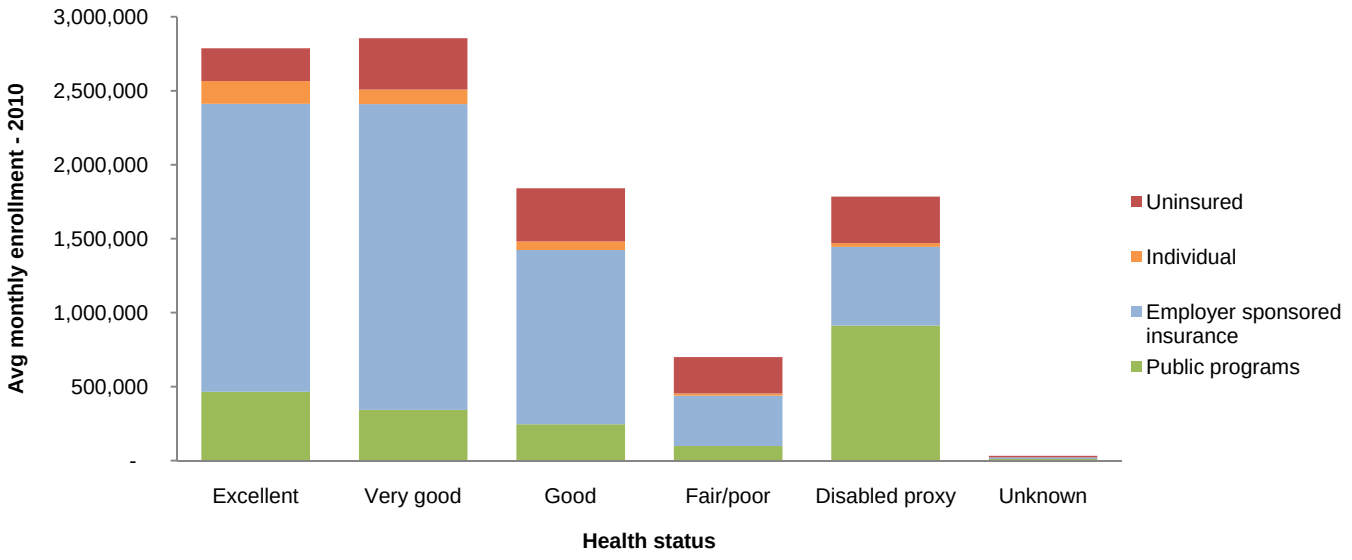
Figure 3-3: Ohio non-elderly population by age - 2010



Source: 2010 Ohio Family Health Survey, adjusted based on December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [2, 3, 51]

Figure 3-4 illustrates the self-reported health status from the Ohio Family Health Survey (OFHS) by insurance coverage source. Individuals responding to the survey were asked to assess their current health status. The categories for health status included: excellent, very good, good, fair/poor, and disabled proxy. The disabled proxy indicator was imputed from survey data for: people who indicated greater long-term need for assistance or medical care; people who indicated they are in fair or poor health and have daily or domestic assistance needs; people who have a mental health condition that they indicated has limited their normal activity for at least 20 of 30 days; and people under the age of 65 who are currently covered by Medicare, Medicaid ABD, Bureau for Children with Mental Handicaps (BCMH), or a Medicaid Home and Community-Based Services Waiver program. This definition of disabled proxy was determined after collaboration between Milliman and Ohio Department of Job and Family Services for use with the OFHS data.[2] The self-assessed health status was replaced with disabled proxy for individuals who met the above-mentioned criteria.

Figure 3-4: Ohio non-elderly population by health status - 2010

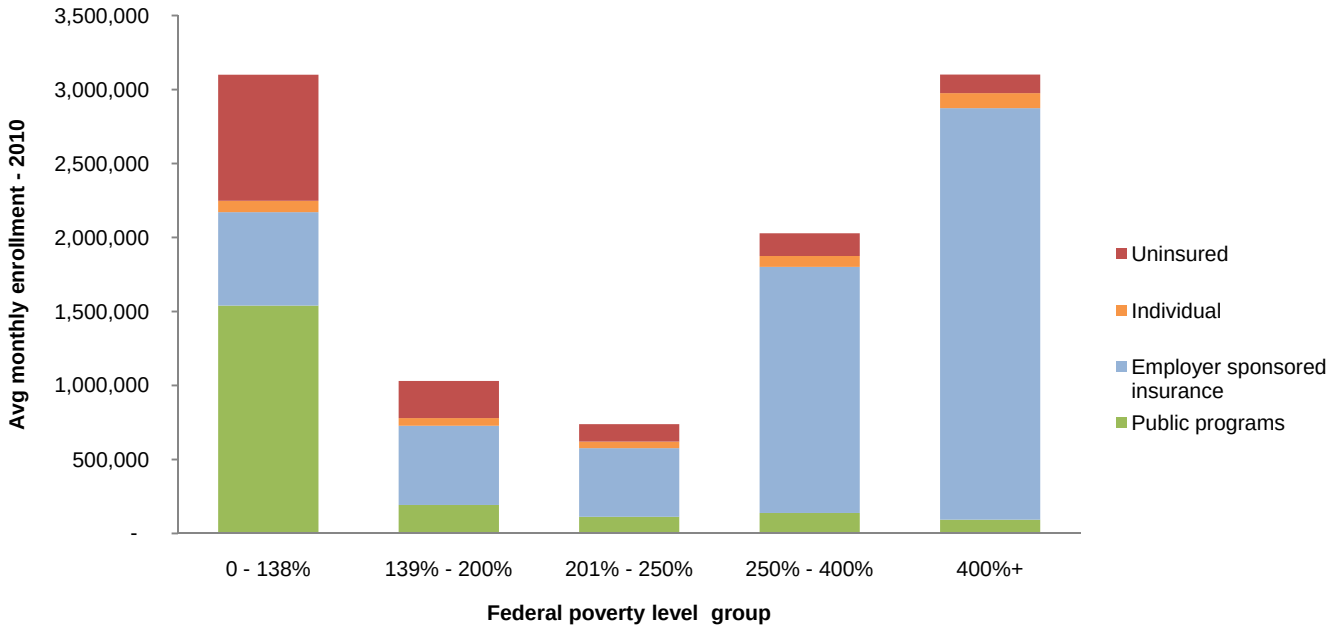


Source: 2010 Ohio Family Health Survey, adjusted based on December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [2, 3, 51]

The uninsured population reported less favorable health statuses than the populations covered under either ESI or individual health insurance. Only 38% of uninsured individuals reported a health status of excellent or very good, relative to approximately 66% of the ESI and individual health insurance market populations. The uninsured population also shows a high rate of disabled proxy relative to the ESI and individual health insurance market populations, with 21% versus 9%. A large percentage of the uninsured population will enter either Medicaid or the individual health insurance market beginning in 2014. Therefore, the health status of the currently uninsured population will materially impact premium rates and costs in these markets.

Figure 3-5 illustrates the distribution of current insurance coverage source by percentage of the FPL group. As expected, the public programs and uninsured rates are highest for individuals in the 0%-138% FPL category and decreases as income levels increase. Conversely, the 0%-138% FPL category has the lowest rate of ESI coverage and the rate of ESI coverage increases significantly as household income rises. Nearly 90% of the households at 400%+ FPL have ESI coverage, relative to only 20% of the households below 139% FPL.

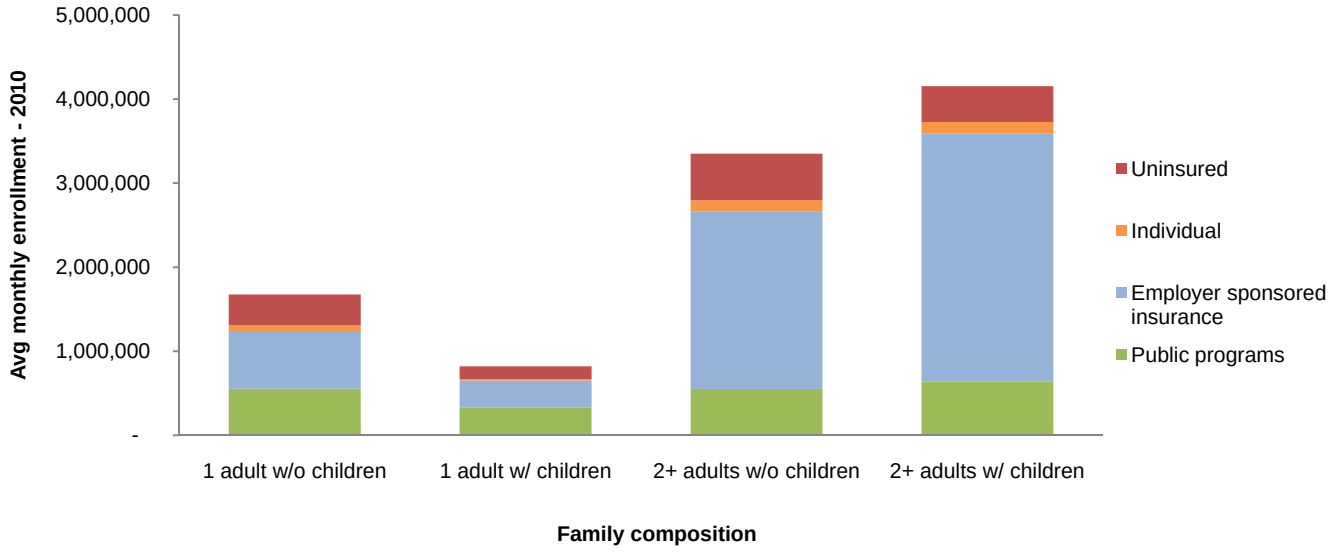
Figure 3-5: Ohio non-elderly population by % FPL - 2010



Source: 2010 Ohio Family Health Survey, adjusted based on December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [2, 3, 51]

Figure 3-6 illustrates the distribution of current insurance coverage sources by family type. Family types indicate the characteristics of the entire family, regardless of the subset who may be enrolling in health insurance coverage. For example, a family type of "2+ adults w/ children" may only enroll the children into a public program due to lack of eligibility of the parents. The uninsured population has a higher proportion of families without children. The ESI and individual populations are primarily families with two or more adults, and the public program population has a higher proportion of families with one adult and children.

Figure 3-6: Ohio non-elderly population by family type - 2010



Source: 2010 Ohio Family Health Survey, adjusted based on December 31, 2010 NAIC annual statements summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [2, 3, 51]

b. Insured and self-insured market profile

Summary of current insured markets

Ohio's current health insurance market is defined by a high level of carrier competition and significant consumer choice. The carriers competing in the state consist of both large national corporations as well as carriers with the majority of their business concentrated in Ohio. Figure 3-7 provides a comparison of Ohio's health insurance markets relative to a 50-state average in terms of carrier competition and viable consumer choice. As Figure 3-7 illustrates, Ohio has a lower portion of covered lives concentrated with one carrier relative to the national norm. In each of the three insurance markets, 90% of covered lives are distributed among six companies, versus less than five companies on average in other states.

Figure 3-7: 2010 Ohio insurance markets relative to other states

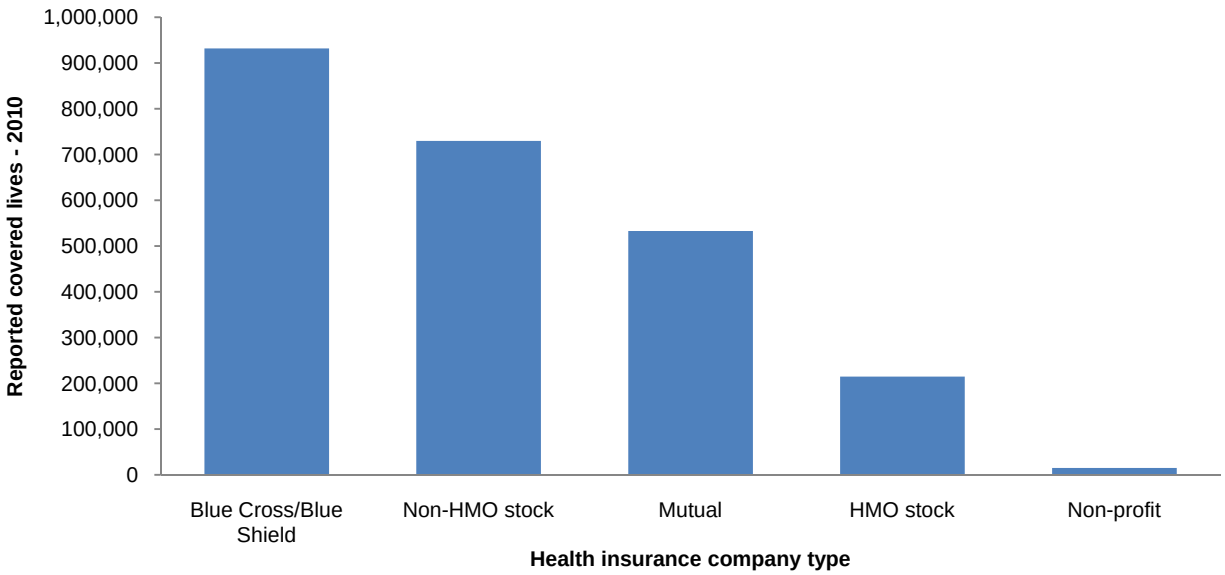
	PERCENT OF COVERED LIVES INSURED BY MARKET LEADER		NUMBER OF COMPANIES TO ACHIEVE 90% COVERED LIVES	
MARKET	OHIO	NATIONAL AVERAGE	OHIO	NATIONAL AVERAGE
Individual	37%	54%	6	4.9
ESI-small group	36%	52%	6	4.5
ESI-large group	42%	58%	6	4.0

1. Sources:
a. December 31, 2010 Supplemental Health Exhibits. Data summarized using Insurance Analyst Pro®, Highline Data, LLC.[3]
b. 2010 Ohio Carrier Survey Data.[51]
2. Subsidiaries have been grouped into their parent companies.

The next series of charts provides a more detailed summary of Ohio's leading insurance carriers in each insurance market. The charts were developed from the Supplemental Health Exhibit filed with the National Association of Insurance Commissioners (NAIC) December 31, 2010 Annual Statement.[3] Subsidiary companies have been grouped as part of their parent companies. The annual statement data was supplemented with information from the 2010 Ohio Insurance Carrier Survey.[51]

Figure 3-8 illustrates the 2010 commercially insured (ESI and individual) covered lives distribution by company type. Blue Cross/Blue Shield companies represent 38% of the covered lives. Stock companies, split between HMO and non-HMO companies, represent 39% of the covered lives. The remaining covered lives are represented by mutual companies, 22%, and non-profit companies, 1%.

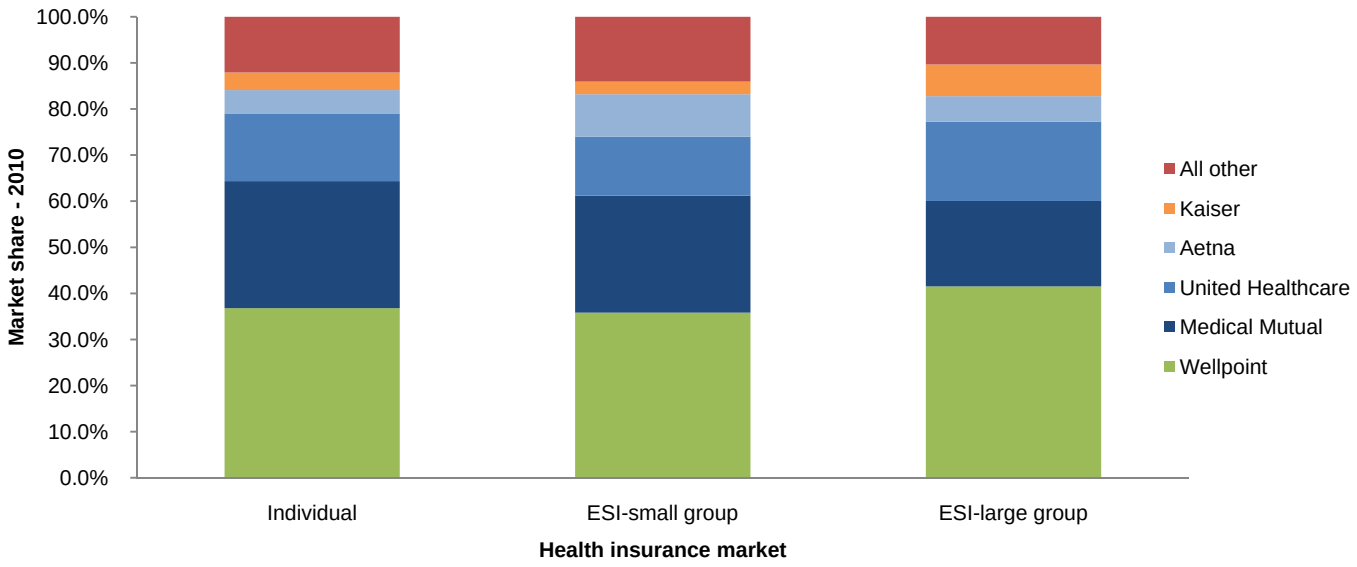
Figure 3-8: Ohio non-elderly insured covered lives distribution by company type - 2010



Source: December 31, 2010 NAIC annual statement Supplemental Health Exhibit summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [3, 51]

Figure 3-9 provides the distribution of covered lives by carrier for the individual, ESI-small group, and ESI-large group health insurance markets.

Figure 3-9: Ohio non-elderly carrier market share by insurance market - 2010



Source: December 31, 2010 NAIC annual statement Supplemental Health Exhibit summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [3, 51]

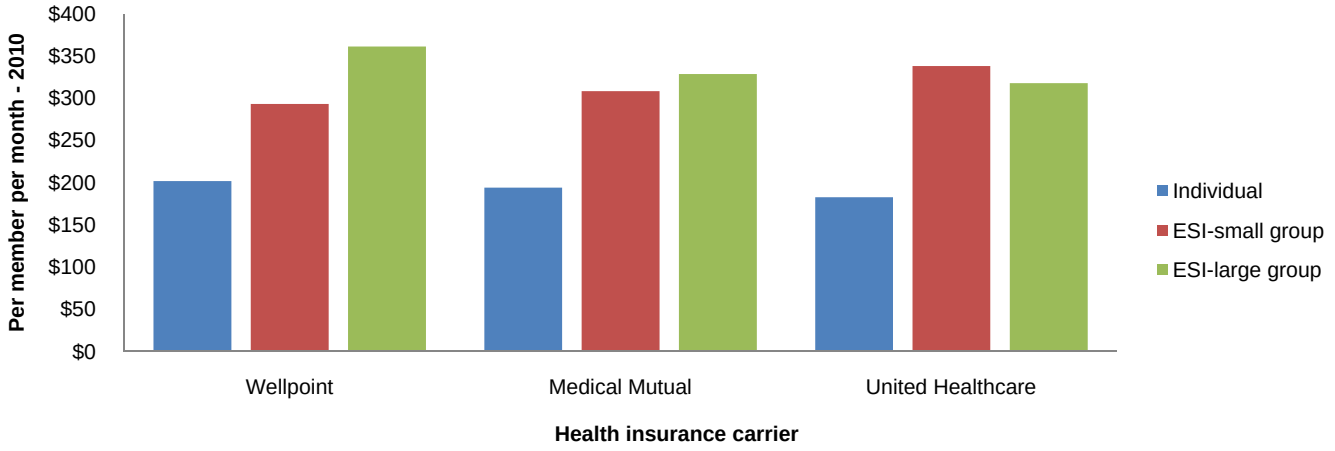
For the individual health insurance market, 12 companies covered at least 1,000 lives in the December 31, 2010 Supplemental Health Exhibit. The market leader was Wellpoint with 37% of the covered lives in the market. Medical Mutual of Ohio represented the second-highest market share with 28% of the covered lives. United Healthcare had the third-highest market share at 15% of the covered lives. The combination of Aetna and Kaiser's market shares represented an additional 9% of the covered lives.

For the ESI-small group market, 16 companies reported at least 1,000 covered lives in the December 31, 2010 Supplemental Health Exhibit. As in the individual insurance market, Wellpoint, Medical Mutual, and United Healthcare were the leading carriers in the ESI-small group market. Aetna also had a sizeable market share with 9% of covered lives.

For the ESI-large group market, 14 companies reported at least 1,000 covered lives in the December 31, 2010 Supplemental Healthcare Exhibit. As in the ESI-small group and individual health insurance markets, Wellpoint, Medical Mutual, and United Healthcare were the only carriers with double-digit market share. Kaiser and Aetna both had a material market share, with 7% and 6% of covered lives, respectively.

Figure 3-10 estimates the average per member per month premium for calendar year 2010 for the individual, ESI-small group, and ESI-large group markets for Wellpoint, Medical Mutual, and United Healthcare.

Figure 3-10: Average Ohio premiums (per member per month) by market for largest carriers - 2010



Source: December 31, 2010 NAIC annual statement Supplemental Health Exhibit summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [3, 51]

For each of the three carriers, the premiums for the individual health insurance market are substantially lower than the ESI group markets. The lower premium costs are attributable to the following primary factors:

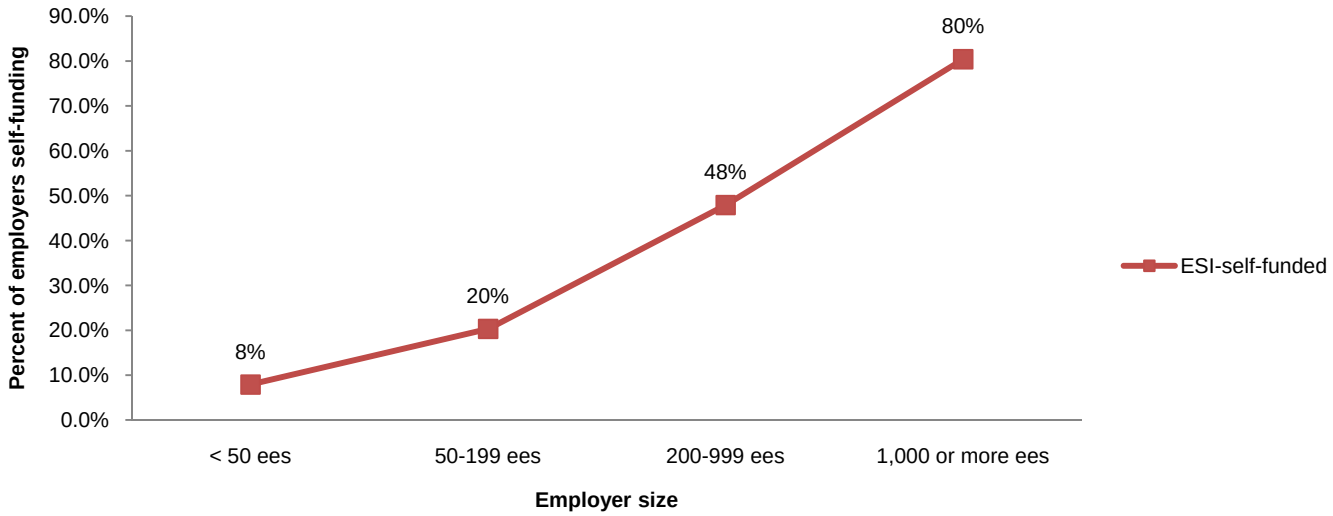
- Individual insurance policies have higher cost-sharing requirements than group products in general
- Individual insurance policies may exclude certain services from coverage, such as maternity services
- Carriers are not required to issue insurance coverage to every applicant who applies. Therefore, individuals who have high-cost health conditions may be prevented from entering the insurance pool. (Ohio does have an open enrollment program which offers a way for higher-risk individuals to obtain coverage; however the program has low enrollment, likely due to high premiums.)

The ESI-large group market has higher insurance premiums than the ESI-small group market (with the exception of United Healthcare). Large groups tend to have greater financial resources. Therefore benefit plans are generally richer than for small groups. The richer benefit plans result in higher premiums relative to the ESI-small group market.

Summary of current ESI-self-funded market

An estimated 4 million Ohioans receive health insurance through ESI-self-funded plans. ESI-self-funded plans represent plans for single employers as well as multi-employer plans. The likelihood that an employer will self-fund its plan, rather than purchase insurance coverage from a carrier, increases as numbers of employees (ees) increase; as shown in Figure 3-11.

Figure 3-11: Employer decision to self-fund (national basis)



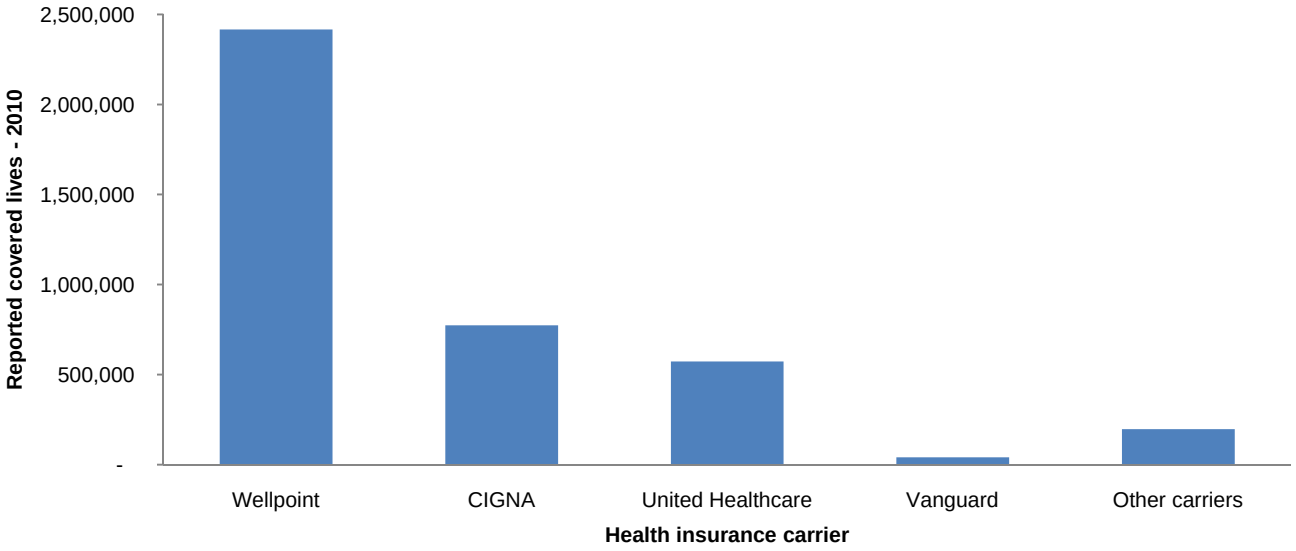
Source: Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010. Table 3.2. Rand Corporation, March 2011. [4]
Note: Employees abbreviated as 'ees'.

Based on a Rand Corporation's survey, the primary incentives given by employers to self-fund in today's market include: [4]

- Ability to create customized benefit designs, rather than rely on designs offered by carrier
- Potential avoidance of state-mandated benefits
- Lower administrative costs relative to fully-insured product
- Easier access to utilization and claims data, improving the employer's ability to evaluate health benefit costs and implement cost containment measures
- Avoidance of state insurance premium taxes
- Potential for investment earnings on cash reserves
- Improved cash flow
- Lower profit and risk charge paid to carrier

Although not all ESI-self-funded plan lives are reported in the NAIC supplemental healthcare exhibit, the majority of estimated total ESI-self-funded lives are reported by the carriers administering the plans. Figure 3-12 illustrates that approximately 2.4 million ESI-self-funded lives are in plans administered by Wellpoint, which represents approximately 60% of the total market. CIGNA, which does not have a sizeable market share in any of the commercially insured (ESI-small group, ESI-large group, and individual) markets, does have a significant number of ESI-self-funded lives in the state. Conversely, Medical Mutual, which has significant market share in the ESI-group and individual health insurance markets, did not report any ESI-self-funded lives. United Healthcare's estimated ESI-self-funded market share is comparable to its market share in the three commercially insured markets.

Figure 3-12: Ohio estimated ESI-self-funded covered lives by carrier - 2010



Source: December 31, 2010 NAIC annual statement Supplemental Health Exhibit summarized using Insurance Analyst Pro®, Highline Data, LLC and 2010 Ohio Insurance Carrier Survey. [3, 51]

Rating rules

Beginning in 2014, the ACA prescribes substantially different rating rules for the ESI-small group and individual health insurance markets relative to current Ohio regulations. The ACA permits only the use of adjusted community rating (ACR) for both the ESI-small group and individual health insurance markets. Rather than a group or individual's premiums being tied to their expected future medical costs during the premium rate period, premiums developed through ACR reflect the expected experience of all insured lives in the risk pool. Instead of strictly using "pure community rating", where every group or individual would pay an identical premium, the ACA does allow insurance carriers to adjust premiums by benefit plan design, geographic location, age rating (limited to a ratio of 3:1), family status, and tobacco usage (limited to a ratio of 1.5:1).

Figure 3-13 and Figure 3-14 provide a summary of the current rating rules in the individual health insurance and ESI-small group markets relative to the ACA prescribed rating rules which will begin in 2014.

Figure 3-13: Ohio individual health insurance market rating rules – pre and post ACA (2014)

DESCRIPTION	PRE – ACA[1]	POST – ACA[2]
Guaranteed issue	No (except for limited open enrollment[1])	Yes
Pre-existing condition limitations	Yes	No
Individual mandate	No	Yes
Subsidies available	No	Yes
Health status underwriting	Yes	No
Age rating	Yes (unlimited)	Yes (3:1 ratio)
Open enrollment period	No [3]	Yes
Gender rating	Yes	No
Tobacco surcharge	Yes (unlimited)	Yes (1.5 ratio)
Required essential benefits	No [4]	Yes
Minimum actuarial value	No	Yes (60%)

1. Rating rules for the current Ohio individual health insurance market are defined in ORC 3923.[5]
2. Rating rules for the post-ACA individual health insurance market are defined in Section 1201 of the ACA.[7]
3. The current Ohio individual market includes an open enrollment program defined in ORC 3923.58. The program currently has limited enrollment and allows above market premium rates for qualifying individuals. [5]
4. Current Ohio health insurance law requires certain benefits be provided (i.e. "mandated benefits"). [5]

Figure 3-14: Ohio ESI-small group market rating rules – pre and post ACA (2014)

DESCRIPTION	PRE – ACA[1]	POST – ACA[2]
Guaranteed issue	Yes	Yes
Pre-existing condition limitations	Yes	No
Individual mandate	No	Yes
Employer open enrollment period	Yes	Yes
Age rating	Yes (unlimited)	Yes (3:1 ratio)
Gender rating	Yes	No
Tobacco surcharge	Yes (unlimited)	Yes (1.5 ratio)
Industry classification	+/-15%	No
Health status rating limitation	+/-40%	No
Low claims discount	5% [3]	No
Required essential benefits	No [4]	Yes
Minimum actuarial value	No	Yes (60%)

1. Rating rules for the current Ohio ESI-small group health insurance market are defined in ORC 3924.[6]
2. Rating rules for the post-ACA ESI-small group health insurance market are defined in Section 1201 of the ACA.[7]
3. A premium rate may fall outside the 40% health status rating limitation if a low claims discount is applied to the group.
4. Current Ohio health insurance law requires certain benefits be provided (i.e. "mandated benefits"). [5]

The elimination of medical underwriting in the ESI-small group and individual health insurance markets will likely cause premium increases for the healthy and premium decreases for the less healthy lives. Assuming the mixture of health status among groups or individuals in the risk pool is static; overall market premiums would not change. However, given substantial premium increases or decreases for population cohorts within these markets, purchasing decisions may be affected.

In the individual health insurance market, young, healthy males will have the largest premium increases due to adjusted community rating. Their premium rates will be driven upward by the elimination of gender rating, the 3:1 age rating limitation, and lack of medical underwriting. Actual healthcare costs between young adults and adults approaching age 65 vary by an approximate 6:1 ratio. The 3:1 ratio mandated by the ACA will result in the premium subsidization of the older individuals by the younger individuals in the risk pool. Similarly, the elimination of gender rating will result in males subsidizing the premiums of females. For the average male between the ages of 20 and 34, premium rates may increase substantially due to the combination of the ACA's age and gender rating changes. These individuals will make a choice between the individual mandate penalty and remaining in the individual health insurance risk pool based on which choice has greater economic value to them.

Conversely, individuals who have chronic illnesses and pre-existing health conditions may be charged lower premium rates due to adjusted community rating. With the introduction of the premium and cost-sharing subsidies for qualifying individuals and adjusted community rating, individuals who cannot currently afford to purchase individual health insurance may be more likely to purchase coverage.

The ESI-small group market will be similarly impacted at the group level. In an extreme scenario, a group with the lowest-risk industry classification, the lowest health status rating, and a 5% low claims discount could receive a 150% premium increase due to the introduction of adjusted community rating. However, a group with the highest-risk industry classification and highest health status rating would receive a 38% premium decrease. Premium rate changes may influence small groups to drop coverage, purchase coverage, or self-fund their plans.

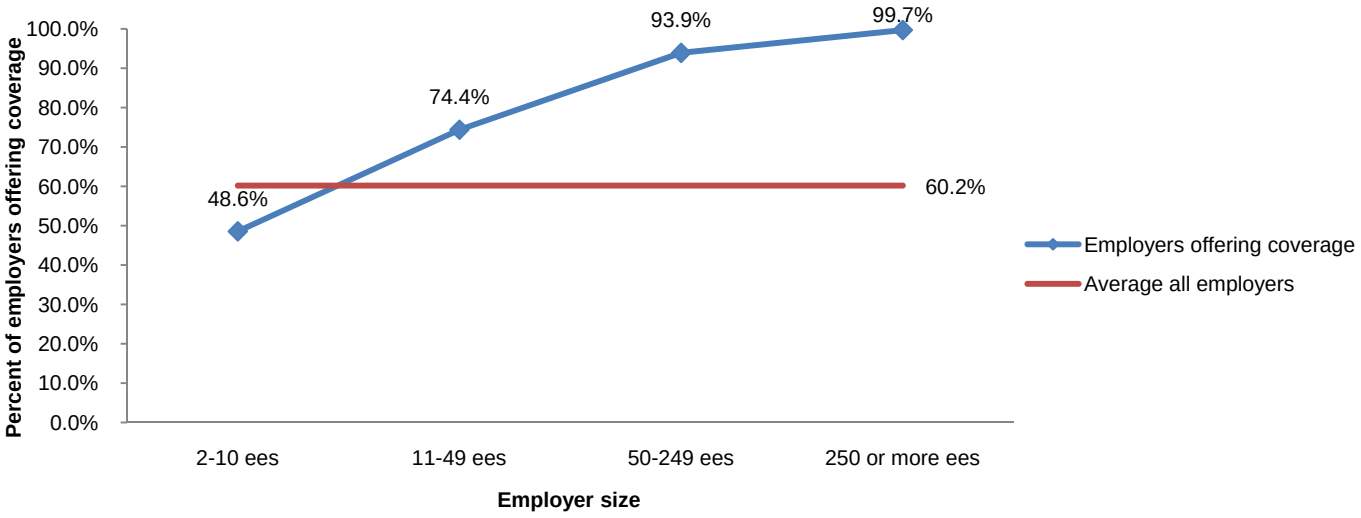
Health insurance is subject to elasticity of demand. Individuals and groups will make purchasing decisions based on the cost of insurance, insurance options in other markets, and consideration of the consequences of being uninsured. Actuarial modeling done to estimate enrollment in future insurance markets (i.e. post-ACA) is an attempt to estimate group and individual behaviors in the ACA's framework of health insurance choices, subsidies, coverage mandates, rating rules, and tax consequences.

c. Employer market characteristics

Approximately 60% of non-elderly Ohioans receive their health insurance coverage from employer-sponsored insurance (ESI). The ESI market is comprised of employers, small and large, offering subsidized plans to their employees and dependents as part of overall compensation package. According to the data collected in the 2011 Ohio employer health survey, the amount of subsidy, or employer contribution, varies by firm size and other factors but typically amounts to at least 50% of the total premium cost.

Figure 3-15 represents the percentage of firms offering health insurance in the 2011 Ohio Employer Benefits Health Survey (OEHS).[8] As shown in the exhibit, the average offer rate for all firm sizes is approximately 60% (consistent with the proportion of Ohioans receiving ESI coverage). More importantly, this exhibit illustrates that there is a clear difference in offer rates by firm size. Specifically, the offer rate for small firms is approximately 50% while the offer rate for large firms is near 100%.

Figure 3-15: Ohio employer health insurance offer rates by firm size

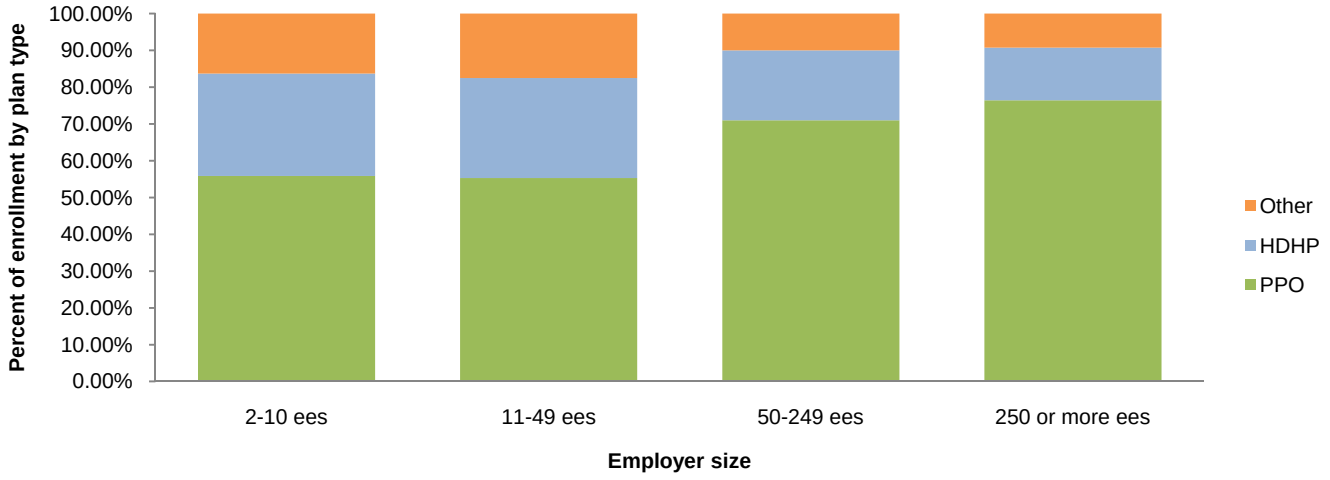


Source: The 2011 Ohio Employer Benefits Health Survey: descriptive report to the state of Ohio; Ohio Family Health Survey research team; June 30, 2011. [8]
Note: Employees abbreviated as 'ees'.

The type of insurance plans offered by Ohio employers varies by the firm's size. Health insurance plans have many complex characteristics but the key distinguishing factor for a plan is how much of the total healthcare cost it covers versus how much is left to the insured individual or family to pay in addition to any premium costs. These costs are referred to as out-of-pocket costs or cost-sharing. Cost-sharing includes deductibles, co-payments, and coinsurance.

Figure 3-16 illustrates the distribution of plan types by firm size in Ohio. The categories include preferred provider organization (PPO), high deductible health plan (HDHP), and other. PPO plans are generally comprehensive, flexible network plans that offer coverage to both in-network ("preferred") and out-of-network providers. The out-of-network benefits often require higher member cost-sharing. HDHPs are plans that require higher cost-sharing in the form of an increased up-front deductible. Often these plans are combined with a tax-deferred health savings account (HSA) that may or may not be partially funded by the employer. "Other" plan types may include: health maintenance organizations (HMO) plans and limited benefit plans, among others. As shown in Figure 3-16, smaller firms offer more HDHPs and other types of plans as the primary or sole option compared to larger firms, which offer primarily PPO plans.

Figure 3-16: Ohio employer health insurance plan types by firm size

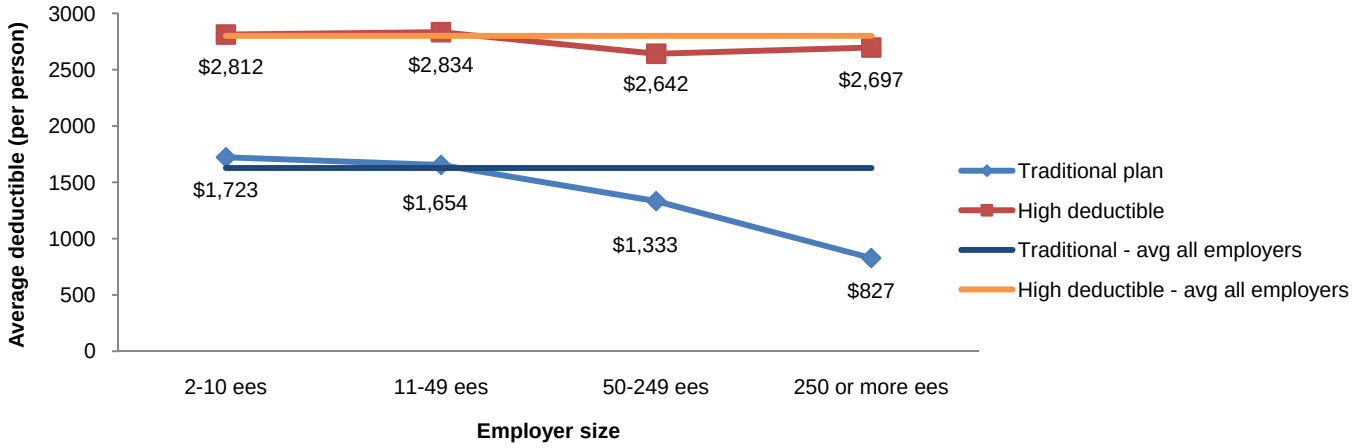


Source: The 2011 Ohio Employer Benefits Health Survey: descriptive report to the state of Ohio; Ohio Family Health Survey research team; June 30, 2011. [8]

The annual deductible is a key metric in comparing benefit plan out-of-pocket costs. The annual deductible is the amount of expense the insured person or family must pay before the insurance benefit begins sharing in the cost. The higher the deductible, the more the insured has to pay out-of-pocket.

Figure 3-17 illustrates the average annual deductible by firm size in Ohio. The amounts are displayed for traditional plans and HDHPs. The PPO plans illustrated in the previous exhibit would be considered a traditional plan in this context. The HDHPs used in this exhibit would also include plans with a tax-deferred health savings account which can be funded by both the employee and employer within statutory limits and be used to fund the out-of-pocket costs, including the deductible. As shown in the exhibit, smaller firms offer higher deductibles for traditional plans compared to larger firms. Deductibles in HDHPs do not vary greatly by plan size, likely due primarily to the minimum and maximum requirements dictated by IRS statute.

Figure 3-17: Ohio employer health insurance average annual deductible (per person) by firm size

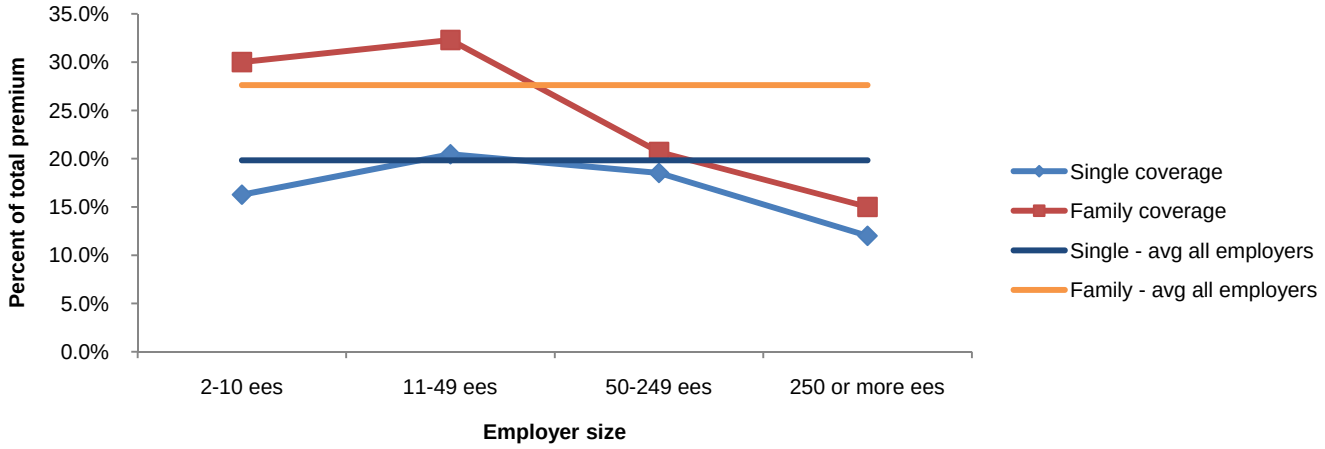


Source: The 2011 Ohio Employer Benefits Health Survey: descriptive report to the state of Ohio; Ohio Family Health Survey research team; June 30, 2011. [8]

The amount the employee contributes in premium costs to participate in the employer plan varies based on the coverage tier (e.g., employee-only or family coverage) and by firm size. The process involves an employer selecting a plan (or plans) for the entire group and offering these plans to the eligible employee population based on a monthly or bi-weekly contribution rate. The contribution rates may vary by employee location, job level, or wage, but do not typically vary by age or gender of the employee or dependents.

Figure 3-18 illustrates the percentage of the total premium contributed by the employee, by coverage tier and firm size. In general, smaller firms require a higher employee contribution rate compared to larger firms, especially for family coverage. In aggregate, employers require employees to share in the premium expense at 20% for single coverage and 28% for family coverage.

Figure 3-18: Ohio employee premium contribution rates by coverage tier and firm size



Source: The 2011 Ohio Employer Benefits Health Survey: descriptive report to the state of Ohio; Ohio Family Health Survey research team; June 30, 2011. [8]

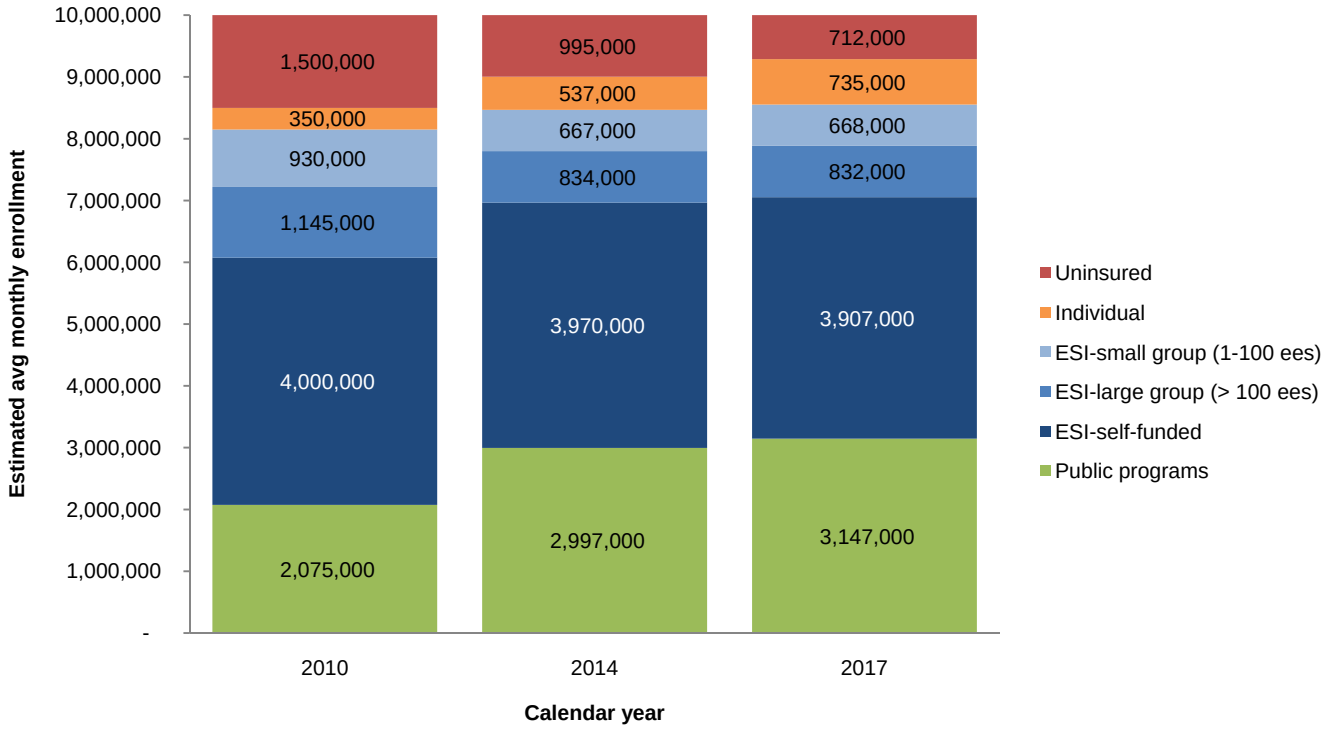
4. PROJECTION OF MARKETS AND POPULATIONS

a. Population projections

The ACA will change the health insurance marketplace in significant ways. Medicaid expansion, federal premium and cost-sharing subsidies, the individual mandate, health insurance market reforms, and employer mandates will all change the way Ohioans receive healthcare benefits beginning in 2014. This report estimates the potential changes in the source of insurance coverage for the Ohio population. For purposes of illustration, overall population changes for future years have not been included so that comparisons are focused on the specific impacts of the ACA.

Figure 4-1 illustrates the estimated insurance market changes from 2010 to 2014 and 2017. The 2014 estimates assume an initial first-year migration and the 2017 estimates assume that market changes due to the ACA have reached a fully mature state. The estimated values for 2014 and 2017 do not include increases for overall population growth and assume that the state does not implement a Basic Health Program.

Figure 4-1: Ohio non-elderly covered lives by source of coverage – changes from 2010 to 2014 and 2017



The enrollment estimates in Figure 4-2 illustrate that significant change to all market segments can be expected beginning in 2014 and stabilizing in 2017. The individual health insurance market, public programs, and uninsured population are estimated to have the greatest changes from 2010 to 2017.

The anticipated market changes are dynamic in that each current market segment has multiple forces acting upon it which are estimated to generate the ultimate enrollment in 2014 and 2017. Figure 4-2 illustrates the estimated composition of the 2017 insurance markets based on the migration of covered lives from the current 2010 insurance markets.

Figure 4-2: Ohio insurance market composition – based on current insurance coverage source – 2017

	2017 INSURANCE MARKET					
2010 Coverage source (coming from)	Individual (including exchange)	Public programs	Uninsured	ESI-small group (including SHOP)	ESI-large group	ESI-self-funded
Individual	242,000	85,000	23,000	<1,000	<1,000	<1,000
Public programs	<1,000	2,075,000	<1,000	<1,000	<1,000	<1,000
Uninsured	289,000	503,000	684,000	4,000	5,000	16,000
ESI-insured	92,000	183,000	5,000	664,000	827,000	304,000
ESI-self-funded	112,000	301,000	<1,000	<1,000	<1,000	3,587,000
Total 2017	**735,000**	**3,147,000**	**712,000**	**668,000**	**832,000**	**3,907,000**
Low Take-Up 2017	**571,000**	**3,000,000**	**944,000**	**738,000**	**941,000**	**3,806,000**
High Take-Up 2017	**886,000**	**3,272,000**	**515,000**	**601,000**	**723,000**	**4,003,000**

Note: Values have been rounded.

Figure 4-2 above illustrates the estimated composition of each health insurance market segment in 2017 on a best estimate, low assumed take-up rate, and high assumed take-up rate basis. The low take-up rate assumptions reflect a smaller level of enrollment in the exchange and Medicaid expansion programs. Similarly, the high take-up rate assumptions reflect a larger level of new enrollment in the exchange and Medicaid programs. The range is intended to illustrate that these values are not certain and that actual take-up rates will likely vary from the best estimate based on resulting individual behavior. The key assumptions driving the population distribution among markets include total uninsured participation rates, employer plan termination rates, employee ESI plan opt-out rates, employer option to self-fund, changes in retirement rates of pre-65 active workers, and ESI plan conversion for early retirees.

The primary observations from Figure 4-2 by market segment include:

- *Individual* – The individual health insurance market is estimated to more than double in size. The growth is expected to be primarily the entry of currently uninsured individuals who are expected to enroll due to the individual mandate, guaranteed issue requirements, and federal premium credits and cost-sharing subsidies contained in the ACA. Growth in the individual health insurance market will also occur from individuals who either have ESI coverage terminated or have non-qualified (employer insurance requiring employee contributions exceeding 9.5% of household income and/or not meeting minimum essential benefits) ESI coverage. [9]

- *Public programs* – The population covered by public programs will grow significantly due to the expansion of Medicaid eligibility. The Medicaid expansion population will consist of individuals previously uninsured but will also have individuals previously with ESI and individual coverage.

- *Uninsured* – This report estimates that the uninsured population will decrease from 15% to between 5% and 9% with the expansion of Medicaid eligibility and the introduction of premium and cost-sharing subsidies for policies purchased through the exchange.

- *ESI-small group* – The ESI-small group market in 2017 is estimated to consist of individuals who currently have ESI-group insurance coverage. This report estimates that due to the adjusted community rating rules imposed on the ESI-small group market beginning in 2014, a portion of insured groups with less than 100 employees will switch to self-funding.

- *ESI-large group* – The ESI-large group market in 2017 is estimated to consist of individuals who currently have ESI-group insurance coverage. This report anticipates some attrition of current large groups to the self-funding category as well as individual employees to Medicaid and the individual health insurance market.

- *ESI-self-funded* – The ESI-self-funded market in 2017 is estimated to consist of individuals who currently have ESI-self-funded coverage as well as a portion of currently ESI-insured groups converting to a self-funded basis.

Individual (both inside and outside the exchange)

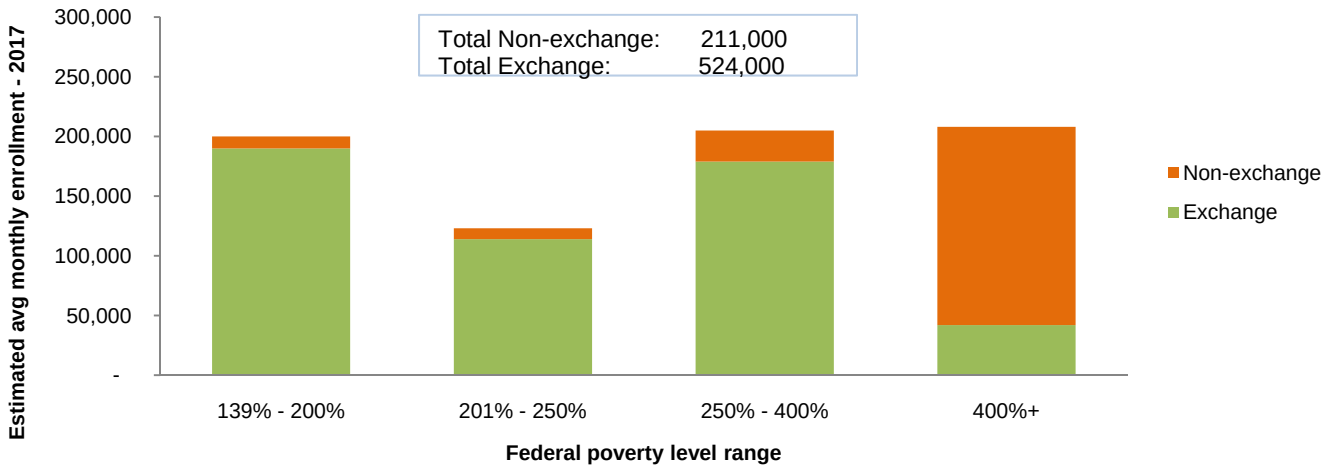
The individual health insurance market is expected to undergo significant changes between 2010 and 2017. This report estimates that only 33% of the 2017 individual health insurance market will consist of individuals currently in this market as of 2010. An estimated 39% of the market will represent individuals who are uninsured in 2010.

The resulting 2017 individual health insurance market will consist of individuals who were previously enrolled in ESI coverage which will be either terminated or determined not to meet minimum requirements. This report estimates the impact to be greatest for the smallest employers. This is due to the absence of an employer tax penalty, generally lower benefits levels, and generally higher premium contribution requirements for ESI-small groups.

Additionally, the individual health insurance market will be comprised of enrollment both inside and outside the exchange. Individual premium and cost-sharing subsidies will only be available in the exchange. Therefore, individuals qualifying for subsidies will have strong financial incentives to purchase coverage through the exchange rather than in the outside market. This report estimates that 95% of individuals with household income between 139% and 200% FPL purchasing individual insurance in 2017 will elect to use the exchange. This percentage is estimated to decrease slightly for individuals with household income between 200% and 400% FPL. Even at the 400% FPL threshold, the subsidies will have significant value for many of these individuals and families. For individuals with household income above 400% FPL, this report estimates significantly lower exchange enrollment due to the lack of subsidies.

Figure 4-3 summarizes estimated 2017 individual health insurance enrollment by FPL both inside and outside the exchange.

Figure 4-3: Individual health insurance market – estimated 2017 exchange enrollment by FPL



Public programs

Approximately 34% of individuals with public program coverage during 2017 will be new Medicaid enrollees who qualify due to the expansion of the state Medicaid program to include all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the FPL based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

A portion of these enrollees may have qualified under existing Medicaid eligibility rules but did not apply for coverage. Approximately 47% of the new Medicaid enrollees are estimated to come from the currently uninsured population. The other half of new Medicaid enrollees will consist of individuals who currently have ESI or individual coverage. When the exchanges and premium subsidies are implemented in 2014, a household at or below 138% FPL will not be eligible for a premium subsidy in the individual health insurance market and must enroll in Medicaid.

Uninsured

The uninsured population is expected to be substantially smaller in 2017. This report estimates that those remaining uninsured will consist primarily of individuals who are currently voluntarily uninsured and will not be compelled by the individual mandate to purchase coverage. A small portion of the 2017 uninsured population will be individuals who currently have individual health insurance coverage and drop their coverage due to significant premium increases. The rest of the 2017 uninsured population is expected to be individuals who currently have ESI coverage but whose employer terminates coverage. A portion of the individuals with terminated ESI coverage may elect not to purchase coverage in the individual health insurance market.

This report estimates that the highest health insurance take-up rates among the currently uninsured will occur for the lowest-income populations, with take-up rates decreasing as household income increases. For low-income households, insurance coverage will be significantly less expensive due to the expansion of Medicaid coverage and the availability of premium and cost-sharing subsidies through the exchange. For many high-income individuals who

are currently uninsured, the choice to remain uninsured may be voluntary rather than due to financial constraints. A substantial portion of these individuals will likely elect to purchase insurance due to the individual mandate. However, it is expected that the health insurance take-up rate will be less than the take-up rate for low-income individuals. This report estimates that the total number of uninsured Ohioans will decrease from 1.5 million to between 500,000 and 900,000 (5% - 9%) non-elderly (under age 65) Ohioans.

The individual mandate tax penalty will not be fully implemented until 2016. In 2014 and 2015, health insurance take-up rates may be lower due to lower penalty amounts for not purchasing insurance coverage. Additionally, public awareness of the Medicaid expansion and premium and cost-sharing subsidies in the exchange may be limited during 2014 and 2015.

ESI-small group (inside and outside the SHOP exchange)

The enrollment decline estimated in the ESI-small group market is attributable to a number of factors. First, the ACA will not impose any penalties on small groups with less than 50 employees that do not offer or choose to terminate their sponsored health plans. For small groups with a significant number of low-income workers, offering health insurance may no longer be a tool to retain and attract employees due to the availability of premium and cost-sharing subsidies in the exchange. Such employers may see greater benefit value by transferring money spent on health insurance costs to employee retirement plans or increased wages. The ESI-small group tax credit is available to certain small groups with low income employees. However, the tax credit is currently scheduled to end prior to the 2016 benefit year (for employers receiving the credit in 2014 and 2015).

Another contributing factor to the decline in the ESI-small group market is the ability for small groups to self-fund their plans. Currently, rating in the ESI-small group market is allowed to vary by +/-40% based on a group's health status. Therefore, the premiums being charged in the market largely reflect the group's expected future healthcare costs. With the introduction of adjusted community rating in 2014, healthy groups will subsidize the unhealthy groups in the risk pool. Self-funding may not be feasible for very small employer groups, but for larger employers self-funding may provide an opportunity for employer populations with healthier groups to avoid subsidizing higher morbidity populations in the insured risk pool.

The resulting 2017 ESI-small group market will be comprised of enrollment both inside and outside the SHOP exchange. The specific choice to enroll inside or outside the SHOP exchange will depend on the advantages it offers relative to the traditional non-exchange health insurance market. Unlike the individual exchange where the premium and cost-sharing subsidies may create large net premium differences for consumers between the exchange and outside market, there may be little, if any, premium variation between qualified health plans (QHPs) offered inside the SHOP exchange versus plans offered in the outside market. For QHPs selling ESI-small group coverage outside of the exchange, premium rates will be required to be identical to those offered inside the SHOP exchange. Any potential premium rate impact that exists because of morbidity inside and outside the exchange is intended to be minimized, since risk adjustment will be applied to plans both inside and outside the SHOP exchange.

The primary stakeholders in the SHOP exchange will be the employers (buyers) and carriers (sellers). SHOP exchange enrollment will depend upon whether these two parties believe the SHOP exchange offers advantages to the outside market.

From the carriers' perspective, the SHOP exchange needs to be an effective distribution channel for their products. Carriers will want to participate in the SHOP exchange and increase their product offerings in the exchange if they are able to market and sell their products effectively and efficiently in the new distribution channel. A SHOP exchange with a diverse number of carriers and plans may result in higher enrollment.

From the employers' perspective, participation in the SHOP exchange may be desirable if it meets one or more of the following criteria:

- *Reduces the employer's healthcare premium costs* – While aggregate premium rates are unlikely to vary significantly between the SHOP exchange and outside market, Section 1421 of the ACA creates a Small Business Tax Credit (SBTC) for qualifying small groups that purchase coverage through the SHOP exchange. Beginning in 2014, the SBTC is renewable for two years for qualifying employers (limited to small groups with low-income workers).[10] For this reason, the SBTC is only a limited-scope, short-term, competitive advantage for the SHOP exchange relative to the outside market.

- *Reduces the administrative requirements of offering health insurance* – If the SHOP exchange allows employers to purchase and administer employee health insurance in a more efficient manner than the current producer/broker model, employers will view the SHOP exchange in a favorable manner. Conversely, if the SHOP exchange is difficult to navigate or results in more employer reporting requirements, employers are unlikely to deviate from the traditional producer/broker model.

- *Valued by employees* – Employers who currently offer health insurance do so because they believe it is perceived as an important part of overall compensation by employees. If the perceived value of the employee health insurance benefit can be enhanced by the SHOP exchange through greater employee choice, employers will be more likely to obtain coverage through the SHOP exchange.

Figure 4-4 provides a summary of factors that may influence enrollment in the SHOP exchange. On the left side are characteristics of a SHOP exchange that are likely to result in limited levels of enrollment, and on the right side are characteristics of a SHOP exchange that are likely to result in higher levels of enrollment.

Figure 4-4: Factors influencing SHOP exchange enrollment

Lower SHOP Enrollment	Higher SHOP Enrollment
• Administratively cumbersome for small employers or carriers.	• Effective distribution channel for carriers.
• Employers are comfortable with producer/broker relationships.	• Available products provide greater perceived employee value than outside market.
• Large prevalence of small employers terminate coverage completely.	• Limited administrative requirements for employers.
• Choice is restricted to a few plans at a given metallic benefit level.	• Provides greater individual employee choice than outside market.
• Small business tax credit does not provide sufficient financial incentives for employers to offer/maintain coverage.	• Small business tax credit establishes initial employer base.
• Outside market has better or similar product offerings.	• Limited number of ESI-small group benefit plans in outside market.
• Low number of participating carriers.	• High number of participating carriers.
	• Steerage from brokers and agents.
Potential for 5% to 10% of 2017 ESI-small group market (approximately 30,000 to 70,000 lives)	**Potential for 15% to 25% of 2017 ESI-small group market (approximately 100,000 to 170,000 lives)**

Relative to the total ESI-small group market, this report estimates that the SHOP exchange will have between 5% and 25% of total 2017 ESI-small group enrollment. The smallest employers (those with fewer than 10 employees) are anticipated to be the most likely to use the SHOP exchange. Actual enrollment will depend upon Ohio's design and regulation of the SHOP exchange.

There are a number of financial tradeoffs that must be made when designing the SHOP exchange. For example, for employers to use the SHOP exchange, it must operate efficiently and smoothly. However, improving the administrative capabilities of the SHOP exchange will also require increased operating costs. It may require an increased level of exchange staffing to answer employer questions. Another major design choice that must be made concerns employee choice. From the perspective of employees, they would prefer being able to choose any plan offered in the SHOP exchange at any benefit level (e.g., platinum, gold, etc.). However, this increases the risk of adverse selection inside the SHOP exchange as the healthy employees will gravitate toward bronze plans and the sickest employees will more likely choose gold or platinum plans. Adverse selection will result in higher premiums in the ESI-small group market, which may result in a higher rate of employers terminating coverage.

ESI-large group and ESI-self-funded

Population decreases in the ESI-large group and ESI-self-funded markets will be driven by low-income individuals opting out of these plans for Medicaid. Note, in the high take-up scenario, it is estimated that a larger number of ESI-large groups will switch to self-funding, which results in a slight increase in the expected number of individuals enrolled in a self-funded plan in 2017. There will not be limitations on Medicaid eligibility due to existing ESI coverage.

Currently, Medicaid provides nearly free healthcare, so it is estimated that a large percentage of Medicaid eligible individuals and families who currently have ESI coverage will enter the Medicaid market.

ESI-large group and ESI-self-funded employers are not likely to terminate their existing plans due to the tax benefits that ESI will continue to receive. However, segments of individuals who are currently covered in these two markets may migrate to the individual health insurance market.

Individuals who do not have qualified ESI coverage may enter the individual health insurance market. For an employer's plan to meet the definition of qualified coverage, it must meet the following requirements:

- An actuarial value of at least 60%
- Employee contributions to participate in the employer's plan (for employee-only coverage) cannot exceed 9.5% of household income

The vast majority of ESI-large group and ESI-self-funded employers already offer a plan that has an actuarial value of at least 60%. However, for low-income employees, required contributions to participate in the employer's plan may exceed 9.5% of household income. Employees who do not have qualified coverage become eligible for the premium and cost-sharing subsidies in the individual exchange (provided that their household income does not exceed 400% FPL). Employees with income less than 200% FPL without qualified coverage are most likely to enter the individual exchange because low required premiums and cost-sharing subsidies are generous relative to many employer plans. It is important to note that there are tax penalties for employers who do not offer qualified coverage to their employees when applicable employees receive a premium subsidy tax credit (groups under 50 are exempt).[9]

For employers who offer pre-65 retiree health benefits, the introduction of the individual exchange, adjusted community rating, and premium and cost-sharing subsidies may offer an attractive alternative to continuing the employer's existing retiree health benefit program. Employers could alternatively provide a defined contribution amount to allow retirees to purchase coverage in the individual exchange. Adjusted community rating will provide an implicit subsidy for an employer's pre-65 retiree population due to the 3:1 age rating limitations. Additionally, a portion of retirees will qualify for premium and cost-sharing subsidies, which will pay for several thousand dollars of the total annual premium, even for employees with household income up to 400% FPL.

Currently, for active employees who are near retirement but not yet age 65, ESI coverage may be the only source of affordable health insurance coverage. ESI coverage may provide a strong incentive for some individuals to continue active employment until age 65 (Medicare eligibility). However, with the introduction of the exchanges and premium and cost-sharing subsidies in 2014, a portion of active workers are estimated to retire and enter the individual health insurance market because ESI coverage would no longer offer the same marginal value.

b. Premiums in ESI-small group, ESI-large group, and individual health insurance markets (inside and outside exchange)

The ACA will introduce significant changes in covered benefits, rating rules, carrier regulation, and the issuing of health insurance to Ohio's ESI and individual health insurance markets beginning in 2014. The expansion of Medicaid eligibility and availability of premium and cost-sharing subsidies in the individual exchange will increase the access and affordability of health insurance for a significant portion of the currently uninsured and individually insured population.

Additionally, ESI-large group premiums may be impacted by certain ACA requirements while being exempt from others. The ACA's impact on premium rates in the ESI-small group and individual health insurance markets should be understood from the context of the individual or entity purchasing insurance and for the markets as a whole.

ACA aggregate average premium impact

Figure 4-5 provides the estimated overall premium rate impact, prior to the payment of available subsidies, in the individual, ESI-small group, and ESI-large group markets. Premium rate impacts for specific individuals or groups will vary significantly. Individual health insurance premiums will increase substantially due to benefit expansion and risk pool composition changes. The ACA premium impact in the ESI-small group and ESI-large group markets will be limited due to greater stability in the level of benefits and risk pool composition.

Figure 4-5: ACA premium rate impact (prior to application of premium tax credit subsidy)

MARKET	LOW ESTIMATE	HIGH ESTIMATE
Individual	55%	85%
ESI-small group	5%	15%
ESI-large group	3%	5%

Note: The estimated premium impacts exclude the impacts of anticipated healthcare inflation. Individual premium impact excludes application of the premium tax credit subsidy.

Prior to the application of the premium tax credit subsidy, the individual health insurance market premiums are estimated to increase by 55% to 85% above current market average rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits. Current insured benefit expenses in the individual market are approximately 40% less than the ESI-small group market.[3] This is attributable to the current individual market having leaner covered benefits, such as the exclusion of maternity services, and a lower-cost population relative to the ESI markets. It is estimated that the individual market after the ACA reforms have been implemented will result in average benefit coverage levels comparable to the small group market. It is anticipated that the post-ACA individual market will be less healthy relative to the ESI market populations. This is the result of previously uninsured individuals, individuals currently in the Pre-existing Condition Insurance Program (PCIP), and the potential for pre-65 retirees currently covered under an employer plan entering the individual market. For a given level of benefit coverage and age group, premiums in the individual health insurance market post-reform are estimated to be 8%-12% higher than the ESI-small group market.

The average market premium changes in the ESI markets will be less severe than those in the individual health insurance market. This is attributable to minimal expansion of covered benefits and a more static insured risk pool. However, the ESI-small group market at the employer level will be impacted significantly by the introduction of Adjusted Community Rating (ACR), which may increase the level of adverse selection within the market and contribute to market premium increases. An employer with lower than average health care costs may select against the market by self-funding its plan rather than subsidizing less healthy groups in the risk pool. An employer with

higher than average health care costs may select against the market by either beginning to offer coverage or choosing a richer benefit level, both as the result of lower quoted premium rates because of ACR.

The values illustrated in Figure 4-5 represent the estimated **average** potential premium impact to each of the market segments. It is important to note that individual policyholders and ESI-group policy premiums will have significant variability as a result of the ACA requirement for ACR. Individuals and smaller employers will observe the greatest impacts since they are more likely to be at one extreme or the other of the total current premium range (i.e. health status tier, age band, and gender category). For example, a healthy, young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%. In the ESI-small group, rating changes may result in a premium increase of 150% for groups at the lower end of the current rating structure. These estimated premium impacts include the combination of items impacting the entire market (such as minimum benefits and risk pool composition changes) as well as the items that mainly impact the lowest or highest extremes of the current premium range (such as restriction of age rating to a 3:1 ratio, removal of health status underwriting, and the elimination of gender rating). Similarly, individuals and ESI-small groups who consist of older ages, higher health risks, and higher female concentration will experience lower than average premium rate changes as a result of the subsidies created by ACR.

Section 1341 of the ACA allows states to establish a transitional reinsurance program for the individual insured market in calendar years 2014 through 2016. The reinsurance program is intended to make payments to health insurance issuers that cover high risk individuals in the individual insured market. The State may coordinate a high risk-pool with the program.[42] **Due to currently undefined regulations governing the reinsurance program and temporary nature of the program, the impact of the transitional reinsurance program has not been quantified for this analysis. However, the reinsurance program may have a material impact on market premium rates.**

The estimates of premium rate impacts provided assume a minimal number of individuals and plans will maintain grandfathered status through 2014, as discussed in a later section of this report. It is assumed the non-grandfathered premium rates will not be impacted in a substantial manner. To the extent that the prevalence of individuals or plans having grandfathered status is higher, premium rates may additionally increase for non-grandfathered plans.

Summary of major factors impacting premium rates

While the magnitude of the ACA's impact on premium rates in each insurance market cannot be known with certainty, the combination of the following factors are expected to result in greater premium increases in the individual insurance market and more limited increases in the ESI-small group and ESI-large group health insurance markets:

- *Benefit expansion* – Increases in the quantity and intensity of healthcare services covered by health insurance may be expected to occur, particularly in the individual health insurance market, to meet minimum essential benefits requirements. **Individual health insurance market premium rates are estimated to increase between 20% and 30% on average due to benefit expansion requirements.** Although the ACA will require a plan to have a minimum actuarial value of 60% (excluding catastrophic coverage for eligible individuals), it is estimated that the average individual policy will have an actuarial value of approximately 70%, relative to an estimated 55% in the current market. Individuals who are eligible for cost-sharing subsidies must purchase a silver plan (70% actuarial value). Since the value of the cost-sharing subsidies is significant for individuals with household income below 200% FPL, the majority of these enrollees can be expected to purchase silver plan level coverage. The combination of premium subsidies and adjusted community rating may also allow individuals with pre-existing conditions and chronic illnesses to purchase a higher level of coverage than in the current health insurance market. Current benefit level differences between the ESI-small group and individual health insurance markets were used to estimate the impact of the ACA benefit coverage requirements. Reported per person medical costs in the ESI-small group market by Ohio insurers in calendar year 2010 are approximately 30% higher than the individual health insurance market, net of estimated morbidity differences between the two populations.

ESI-small group and ESI-large group premiums are not estimated to be materially impacted by the benefit expansion requirements.

- *Risk pool composition changes* – The population enrolling in the individual health insurance market in 2014 is estimated to have a higher level of morbidity compared to the 2010 Ohio health insurance market populations. **Individual health insurance market premium rates are estimated to increase between 35% and 40% due to changes in the underlying morbidity of the individual health insurance market enrollees**. A significant portion of this increase is driven by adverse selection occurring because of a higher propensity for less healthy uninsured individuals to purchase insurance. In the ESI-small group and ESI-large group markets, risk pool composition changes are not expected to be as substantial.

- *Benefit coverage adverse selection* – A higher propensity for less healthy individuals to increase their insurance coverage level beyond minimum requirements.

- *Manufacturer and carrier fees pass-through* – ACA provider and carrier assessments will be included in the development of premium rates.

- *Provider cost shifting* – The significant expansion of the Medicaid population may result in increased charges to commercial payors to account for low provider reimbursement under Medicaid.

- *Minimum medical loss ratios* – Offsetting the potential drivers of premium increases, a decrease in carrier non-benefit expenses as a percentage of total premium may occur due to ACA minimum medical loss rate requirements for the ESI-small group, ESI-large group, and individual health insurance markets. The reduction in non-benefit expenses will be reflected in decreased premium rates or in the form of a rebate if the carrier exceeds the minimum requirements.

Figure 4-6: Summary ACA average composite premium rate impacts (prior to application of premium tax credit subsidy)

	INDIVIDUAL	ESI-SMALL GROUP	ESI-LARGE GROUP
Benefit expansion	20% - 30%	1% - 2%	0% - 1%
Risk pool composition changes	35% - 40%	0% - 1%	(2%) - (1%)
Benefit coverage adverse selection	2% - 5%	3% - 5%	0%
Manufacturer and carrier fees pass-through	2% - 3%	2% - 3%	2% - 3%
Provider cost shifting	0% - 2%	0% - 2%	0% - 2%
Administrative costs	(10%) - (8%)	(2%) - 0%	(1%) - 0%
Composite premium increases	55% - 85%	5% - 15%	0% - 5%

Note: Premium rate impacts have a multiplicative effect, rather than an additive effect, on the composite increase.

Although many of the above factors are not within the state's control, the issue of adverse selection may be influenced by state policy. Adverse selection is created by the ACA due to guaranteed issue requirements in combination with a limited individual mandate and rating limitations (particularly in the ESI-small group market). The state may wish to consider policies that promote a high insurance participation rate to mitigate the risk of adverse selection.

From the individual health insurance consumer's perspective, premium rates may decrease for the households currently insured with income below 400% FPL since they will be eligible for premium and cost-sharing subsidies in the exchange. If the individual currently has an insurance plan below the minimum benefit level mandated by the ACA, the increase in required benefits will increase premium amounts. Households with income above 400% FPL in the individual health insurance market could experience premium increases due to expansion of insured benefits, adverse selection, and changes in the population composition of the individual health insurance market.

In the ESI-small group market, adverse selection is created between the group-insured risk pool and option to self-fund the employer plan. The rating limitations imposed by the ACA on the ESI-small group market and the carrier fee pass-through will create financial incentive for ESI-small groups, particularly those with relatively young, healthy workforces, to opt-out of the group-insured risk pool in favor of self-funding.

The following sections provide a detailed discussion of the factors impacting premium rates.

Benefit expansion

The pricing of health insurance is fundamentally based on estimates of future healthcare costs during the premium rate period that the insurer is contractually required to pay. Future ACA regulations will specify which healthcare services are considered "minimum essential benefits" and must be covered through health insurance. Additionally, the ACA defines the percentage of essential benefits that must be paid by the insurance contract (actuarial value). With the exception of the catastrophic plans for individuals under 30, a person must have health insurance covering at least 60% of expected essential healthcare costs. Enrollees in the exchange can choose a plan that covers 60%, 70%, 80%, or 90% of estimated healthcare costs. Given that individuals must purchase a silver plan (70% actuarial value) to qualify for cost-sharing subsidies, the benefit expansion relative to the current individual health insurance market is benchmarked to silver plan coverage.

Premiums will increase for individuals or employers who currently have a health insurance policy with covered benefits below the required level under the ACA. Requirements under the ACA to cover preventive services at 0% cost-sharing have already caused premiums to increase. However, premium increases should also be viewed in the context of the total healthcare spending for the policyholder, which is a combination of insurance premiums and out-of-pocket healthcare expenses. While the ACA will increase healthcare spending on insurance premiums, for some policyholders it will decrease patient out-of-pocket healthcare expenses by implementing cost-sharing subsidies, assuming their medical service utilization does not change.

With the introduction of premium and cost-sharing subsidies for households up to 400% of FPL, a richer benefit plan will be more affordable for these households. Therefore, while the average total premium for an individual health insurance policy may increase due to the increased covered health expenses, the out-of-pocket cost for households eligible for the premium and cost-sharing subsidies may decrease relative to today's market.

Adverse selection created by guaranteed issue

The ACA requires that ESI-small group and individual health insurance be guaranteed issue in 2014, without any pre-existing condition limitations. In order for a health insurance market to function under guaranteed issue, the participation of healthy individuals in the risk pool is necessary. Otherwise, the insured risk pool would be limited to individuals with known health conditions who have adversely selected against the insurance market by purchasing coverage. To reduce the impact of adverse selection under guarantee issue, the ACA imposes an individual mandate, with exceptions, for an individual to either purchase insurance or pay a financial penalty. However, the penalty is significantly below the cost of insurance coverage, especially in calendar year 2014 when the penalty is the greater of $95 or 1% of household income.[31] Other requirements, such as fixed open enrollment periods, can be used in combination with the individual mandate to reduce adverse selection and encourage greater participation in the

insurance pool. If the combination of the individual mandate and other state policies does not impel the participation of young and healthy individuals in the insurance pool, composite average premium rates for the remaining insured markets will likely rise.

In addition to adverse selection occurring with the decision to purchase insurance, it will also occur among the four benefit tiers offered in the individual and SHOP exchanges. For individuals with chronic health conditions, it will be in their best financial interests to purchase insurance that will cover a large percentage of their healthcare expenses during the coverage period, e.g., the gold (80% actuarial value) or platinum (90% actuarial value) plans. However, healthy individuals will be more inclined to purchase a bronze plan (60% actuarial value) because it will have the lowest premium cost. This leads to adverse selection among the four benefit levels, which will raise the composite average premium rates in the market. Examples of policies to mitigate adverse selection include locking an individual into a benefit tier for more than one year or allowing a policyholder to increase or decrease their benefit level by only one tier each year.

Adverse selection created by rating requirements

Premium rates in the Ohio ESI-small group and individual health insurance markets are currently developed based largely on underwriting using the individual or group health status and adjusting the rates at time of issue and on renewal dates. Under the ACA, premiums for all ESI-small group and individual health insurance markets are to be developed using adjusted community rating. This methodology does not allow health status to be used in rating and only allows rate variation based on benefit plan design, geographic location, age rating (limited to a ratio of 3:1), family status, and tobacco usage (limited to a ratio of 1.5:1). Premiums for groups or individuals with above average expected healthcare costs will decrease, while conversely the premiums for groups or individuals who have relatively low expected healthcare costs will increase to the average of the community.

The ACA rating requirements limit the premium adjustment factors for age to a 3:1 ratio. The actual variation in healthcare costs in the adult population of ages 19-64 is approximately a 6:1 ratio, but can vary by carrier and plan design. Similar to how the removal of health status leads to increased subsidies of the sick by the healthy; the age rating restrictions will result in the younger insured population subsidizing the insured costs of the older population in the insured risk pool. Like the subsidies of health status, these subsidies by age will occur in the ESI-small group and individual health insurance markets as they change through reform. Employers with younger than average workforces and young individuals will have material premium increases due to the 3:1 age rating limitation.

As the cost of health insurance rises for young and healthy individuals, this will create a greater financial barrier to purchase insurance coverage and incentive to pay the individual mandate penalty. The incentive to be uninsured is mitigated by the rising cost of the penalty and the availability of premium and cost-sharing subsidies for households with income below 400% FPL. If a significant number of healthy individuals do not participate in the individual risk pool, then this change in the insured population will increase the composite premium rates of the markets. Pursuing a strategy of high participation rates for health insurance is critical for the long term viability of the markets.

As employer workforce size increases, the employer has the option of purchasing a group insurance policy from a carrier or self-funding the plan. Under an ESI-self-funded plan, a small group would be at risk for its employees' healthcare expenses, protecting itself against catastrophic expenses through the purchase of stop-loss coverage from a reinsurer. In the current Ohio ESI-small group market, the benefit of an ESI-self-funded plan is limited for small groups since carriers are allowed to vary premiums by +/-40% between employers based on the group's health status. Because of the health status rating allowance in the current market, a small group's premium rates are largely reflecting its estimated future healthcare costs. Starting in 2014, this will no longer necessarily be the case as variation in premium due to the average health status of the group will not be allowed, giving incentive to healthier and low cost groups to exit the fully insured marketplace.

However, in combination with the 3:1 age rating requirement for the ESI-small group market in the ACA, a cost advantage may be created for small groups with young, healthy workforces that self-fund their plans, rather than subsidizing other employers in the ESI-small group insured risk pool. As the employer size increases, the likelihood of self-funding will increase because annual healthcare costs become more predictable with a larger risk pool. If a significant portion of young and healthy small groups drop out of the ESI-small group insured risk pool, the premium costs for the employers remaining in the insured risk pool will further escalate.

Risk pool composition changes

Related to the issue of adverse selection, the premiums in the ESI-small group and individual health insurance markets will depend upon the health status of the individuals enrolling in the risk pools. Relative to the individual health insurance risk pool today, the ACA will create significant changes to the covered population in the risk pool that will increase the average morbidity relative to today's market.

The following populations will likely be covered in the individual health insurance risk pool beginning in 2014:

- *Individually insured* – The majority of individuals currently in the individual health insurance market will remain in the market, with the exception of individuals with household income at or below 133% of the FPL based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard, who will become Medicaid-eligible. Note that, if Ohio elects to operate a Basic Health Program (BHP) for the population with household income between 139% and 200% FPL, individuals in this FPL range who are currently insured will leave the individual health insurance market. Individuals who have significant premiums increases may voluntarily become uninsured.

- *Uninsured* – A significant portion of the uninsured population with household income above 138% FPL (200% FPL if the state operates a BHP) will enroll in the individual health insurance market. A portion of the uninsured will obtain ESI coverage that they had previously opted not to join. The uninsured population may have pent-up demand for healthcare services, as experienced when the Healthy Indiana Plan (HIP) was implemented for the non-elderly adult population in Indiana.[11]

- *High risk pool* – Individuals in Ohio's pre-existing condition insurance program (Ohio's temporary high risk pool) will enter the individual health insurance market if their household income is above 138% FPL (200% FPL if the state operates a BHP). As of August 15, 2011, there were approximately 1,800 Ohioans enrolled in the pre-existing condition insurance program.

- *Active employees with ESI coverage* – Individuals who currently have ESI coverage will enter the individual health insurance market if their employer terminates coverage or if their employer coverage is considered non-qualified (triggering eligibility for the premium and cost-sharing subsidies). Low-wage employers will be more likely to terminate plans due to the availability of the premium and cost-sharing subsidies available in the exchange for employees in the absence of the ESI coverage.

- *Retired employees with ESI coverage* – Due to the lack of a mandate to continue ESI coverage for retirees, the 3:1 age rating limitation, and the availability of premium and cost-sharing subsidies for households with income below 400% FPL, employers may begin providing pre-65 retirees with specified dollar amounts to purchase health insurance in the individual health insurance market to reduce the employer's healthcare costs.

- *Active employees maintaining work status for ESI coverage* – For individuals with chronic health conditions, individual health insurance in today's market can be prohibitively expensive. For this reason, an individual or spouse who might otherwise retire from the work force maintains active employment until Medicare eligibility for the sole purpose of the ESI benefit. With adjusted community rating, guaranteed issue, and premium and

cost-sharing subsidies in the exchange, the value of individual health insurance coverage will be increased. Therefore, Ohio should anticipate a small reduction in the percentage of individuals of ages 55-64 with active employment. These new retirees will enter the individual health insurance risk pool.

The ACA will also allow individuals under age 30 to purchase a catastrophic health plan in the individual health insurance market, versus a plan with minimum creditable coverage (60% actuarial value), which further allows young adults to adversely select against the standard benefit plan levels in the exchange. The 3:1 age rating limitations will also result in the young adult population receiving premium increases relative to today's market.

In the ESI-small group market, the risk pool composition will largely be driven by two factors. First, the prevalence of healthier employer groups electing to self-fund or drop coverage, rather than staying in the ESI-small group risk pool. Second, the number of low-wage small groups that will terminate their plan due to the availability of premium subsidies for employees in the individual exchange. If a large percentage of low-wage small groups terminate their plan, this may reduce the morbidity in the ESI-small group insured risk pool, as low-wage employees tend to have higher morbidity relative to high wage earners. If low-wage employers leave the market, this may reduce the rate at which employers choose to self-fund or drop coverage, as the morbidity of the overall risk pool will improve and result in lower market premiums.

Manufacturer and carrier fee pass-throughs

The ACA will impose new fees on pharmaceutical manufacturers, medical device manufacturers, and health insurance carriers. As with any tax on business, these fees will be passed along to the consumer to the extent possible. While the fees on pharmaceutical and medical device manufacturers will be spread across all payors (commercial ESI and individual health insurance, ESI-self-funded plans, public programs, government employee plans), the health insurance carrier assessment may significantly impact premiums in the ESI-small group, ESI-large group, and individual insured risk pools. The national non-tax deductible carrier assessment amount will be $8.0 billion in calendar year 2014, increasing to $14.3 billion in calendar year 2018. The assessments will be allocated across the health insurance industry by market share. However, ESI-self-funded plans, government entities, and non-profit plans meeting certain requirements will be exempted from the assessments.[12] Given that most large employers are already self-funded and certain small groups may elect to become self-funded in the future, the assessment amounts will fall on the remaining ESI-small group and individual insured risk pools and may result in increased premiums in these markets.

Provider cost shifting due to expansion of Medicaid eligibility

The ACA mandates minimum Medicaid eligibility for all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the FPL based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard. This is a significant expansion of Medicaid eligibility for many populations, such as parents and childless adults in Ohio. Although the majority of the newly eligible Medicaid population is uninsured, a portion of the expansion population will consist of individuals who currently have ESI coverage or individual health insurance.

The Medicaid program has struggled to create sufficient provider access for Medicaid beneficiaries on a national basis. In Ohio, Medicaid provider payments are approximately 60% of Medicare and 40% of commercial payors, which make many providers reluctant to serve Medicaid beneficiaries. These values are assumptions which have been made based upon our experience in working with the Ohio Medicaid program. They are for illustrative purposes only and do not impact any of the values provided in this report. In order for the providers who serve Medicaid beneficiaries to be financially solvent, commercial payors are charged higher costs to balance the low payments made by government payors. This practice is known as "cost shifting".

Milliman has estimated that Ohio's Medicaid population will increase approximately 50% due to the new ACA Medicaid eligibility standard. For providers who will continue to serve the Medicaid eligible population, this will increase the proportion of their patient population and revenue from Medicaid. In order to maintain the financial stability of their practices, these providers will have to increase their charges to commercial payors. Since the premium for any health insurance policy is based on the underlying expected claim expenses, this will result in higher premiums in the commercial market, including the ESI and individual health insurance markets. The degree of cost shifting that will occur may be mitigated if Ohio increases its Medicaid fee schedule and could be exacerbated if the state creates a Basic Health Program.

Capping the carrier non-benefit expense costs

The ACA mandates that carriers in the ESI and individual health insurance markets meet a minimum medical loss ratio (MLR) percentage. The minimum medical loss ratio percentage is the carrier's benefit expense divided by the total premium revenue (the actual minimum MLR calculation under the ACA has several additional considerations). The portion of premium that is not paid towards policyholder benefit expenses consists of administrative costs, capital requirements, and profit. Carriers not meeting the minimum MLR standard are required to provide rebates to policyholders. The minimum MLR requirements are contained in the ACA to prevent carriers from making excess profits during the changes caused by reform and to encourage administrative efficiency. With the absence of medical underwriting in the ESI-small group and individual health insurance markets, administrative costs related to the issuing of policies will be reduced. However, ACA requirements such as quality reporting, risk adjustment, and exchange enrollment reconciliation will increase administrative costs. As carriers will be competing largely based on premium rates in the ESI-small group and individual health insurance markets in 2014, administrative savings achieved by carriers may be passed along to the healthcare consumer.

On a per member basis, administrative costs are not assumed to decrease. However, since administrative costs will not increase at the same rate as underlying claim expense, they are likely to be a lower percentage of the overall premium cost.

Premium rate change variability – individual health insurance market

The elimination of medical underwriting gender rating and the 3:1 age rating limitation will create premium rate changes for particular individuals which will vary significantly from the individual health insurance market averages. Young males (under age 35) in good health will experience the largest premium rate increases within the market.

In the individual health insurance market, individuals with chronic illnesses or pre-existing conditions, who may not be offered coverage outside of the open enrollment program, may have premium decreases relative to their current available coverage.

Premium rate change variability – ESI-small group market

Although the estimated overall premium rate change in the ESI-small group market is significantly less than the individual health insurance market, large premium rate volatility may be experienced by employers due to the implementation of adjusted community rating. Premium rate changes are likely to be greatest for small employers with fewer than 10 employees. The following factors will contribute to high premium rate variability for the ESI-small group market:

- *Age* – Employees may be concentrated in a narrow age band. For larger employers, the employee population may consist of a more diverse age mixture. Employers with employees concentrated at the youngest ages will have premium increases, while employers with employees predominately older than age 55 will have premium decreases (holding other rating assumptions constant).

- *Gender* – Employees may be primarily one gender. Employers with employees who are predominantly female will have different impacts than employers with employees who are predominantly male. The impact of eliminating gender rating will also depend on the number of spouses covered under the plan. For example, if all employees had spouses covered under the employer's plan, the elimination of gender rating would not significantly impact the group's premium rates. Employer groups with a high proportion of adult males will have larger premium increases relative to groups with a high proportion of adult females.

- *Health Status* – Ohio's current ESI-small group rating laws allow health insurance premium rates to vary by +/-40% based on health status, with an additional 5% discount allowed for favorable claims experience. Employers with fewer than 10 employees could have a single employee in poor health, which would result in much higher premium rates than a similar size employer with all employees having favorable health status. Larger employers may experience less variance in the composite health status of insured groups, as the health risks of a single employee can be spread over the larger employee base. The ACA's provision to remove health status as a rating variable will likely decrease premiums for groups with individuals in poor health and increase premiums for groups with a healthier employee population.

- *Industry Rating* – Ohio's current ESI-small group rating laws allow for an industry rating adjustment of +/-15%. This will impact employers of all sizes in the ESI-small group market.

- *Group Size* – Carriers in the current ESI-small group market are allowed to charge different rates based on the number of employees and dependents covered under the employer plan. Although group size adjustments vary by carrier, the elimination of this rating adjustment will reduce premiums for groups with 10 or fewer members while increasing premiums for larger small groups.

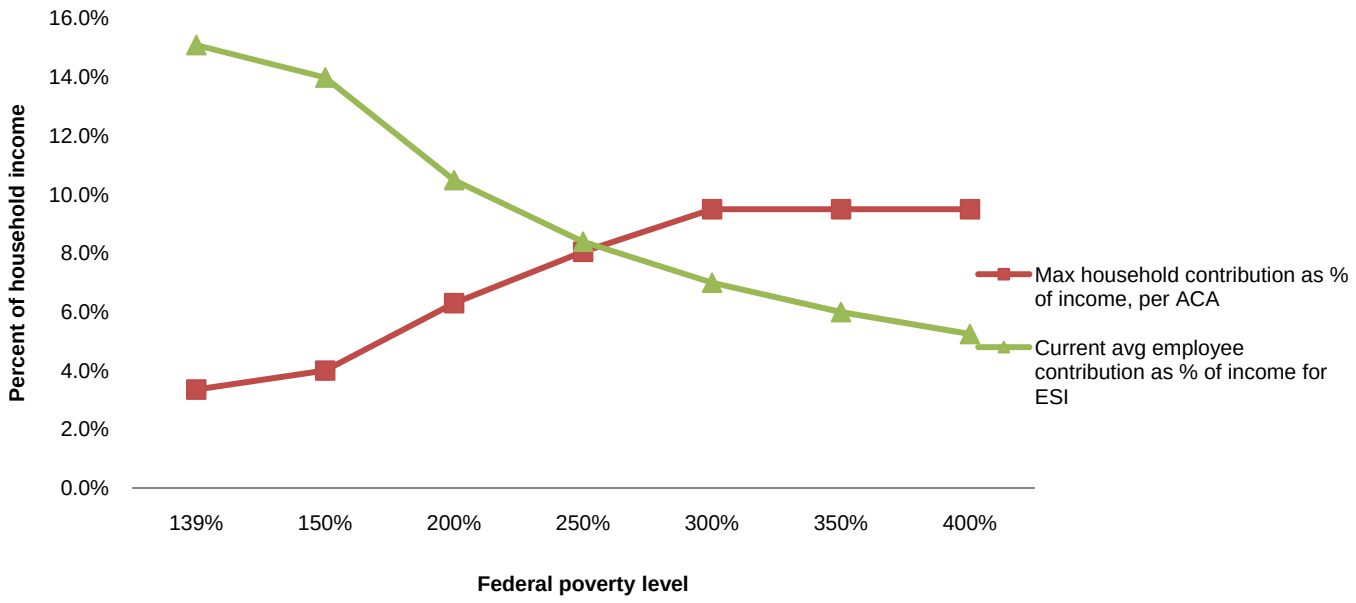
The cumulative effect of these rating changes may result in a majority of ESI-small groups experiencing premium rate increases or decreases beyond the average estimated market change of 5% to 15%. In many cases these changes could be greater than 25%, ignoring changes in medical inflation. Premium rate volatility may affect the stability of the ESI-small group market by creating greater financial incentives for employers to self-fund or terminate their plan. Employers wanting to continue their plan may address the issue of substantial premium rate increases by changing plan designs to shift more cost to employees, as current benefit plans may become unaffordable.

c. Exchange premium and cost-sharing subsidies

Premium subsidies

Figure 4-7 illustrates the value of the premium tax credit subsidy relative to the average family contribution in a typical employer plan, as estimated by the 2011 Milliman Medical Index.[1] The premium subsidy will cap a household's premium contribution at a percentage of their household income. As Figure 4-7 indicates, this percentage (as shown by the red line) ranges from just above 3% for households with income at 139% FPL, to 9.5% for households with income at 300% FPL or higher. Households with income above 400% FPL are not eligible for a premium subsidy.[9] The maximum percentage, converted to a dollar amount for a family of four, translates to an annual premium contribution of approximately $1,000 for a family with household income at 139% FPL, increasing to a maximum premium of $8,500 for a family with household income at 400% FPL. The average required family tier contribution for ESI coverage is represented as a percentage of the household income with the green line. As Figure 4-7 indicates, for households with income at 250% FPL or less, the required premium contribution in the exchange for family coverage may be less than the current typical employer plan contribution. However, for households with income above 250% FPL, a family's premium cost in the exchange will be greater than the average employer plan, assuming ESI is available.

Figure 4-7: ACA maximum household premium contribution – family of 4



Source: Maximum household contribution as a percentage of household income is defined in Section 1401 of the ACA.[9] Current average employee contribution as a percentage of income for employer-sponsored coverage is referenced from the 2011 Milliman Medical Index.[1]

The premium subsidies will be tied to the second-lowest silver plan in the exchange. Figure 4-8 illustrates the premium subsidy calculation for a family of four with income at 150% FPL and 399% FPL.

Figure 4-8: Illustration of premium subsidy calculation – family of 4

	150% FPL	399% FPL
Income	$33,600	$89,376
2nd lowest cost silver plan premium	$14,000	$14,000
Maximum household premium %	4%	9.5%
Maximum household premium $	$1,344	$8,491
Premium subsidy value	$12,656	$5,509

Note: Premium values are for illustrative purposes only. FPL% is based on calendar year 2011 federal guidelines. All other fields are based on Section 1401 of the ACA.[9]

Each family can apply its calculated premium subsidy value to any plan and benefit tier offered in the exchange. Figure 4-9 illustrates how the actual premium paid by the family could vary by the benefit tier.

Figure 4-9: Illustration of sample family premium rates by benefit tier

		PREMIUM SUBSIDY		FAMILY CONTRIBUTION	
BENEFIT TIER	TOTAL PREMIUM	150% FPL	399% FPL	150% FPL	399% FPL
Bronze	$ 12,000	$ 12,656	$ 5,509	$ 0	$6,491
Silver	$ 14,000	$ 12,656	$ 5,509	$ 1,344	$8,491
Gold	$ 16,000	$ 12,656	$ 5,509	$ 3,344	$10,491
Platinum	$ 18,000	$ 12,656	$ 5,509	$ 5,344	$12,491

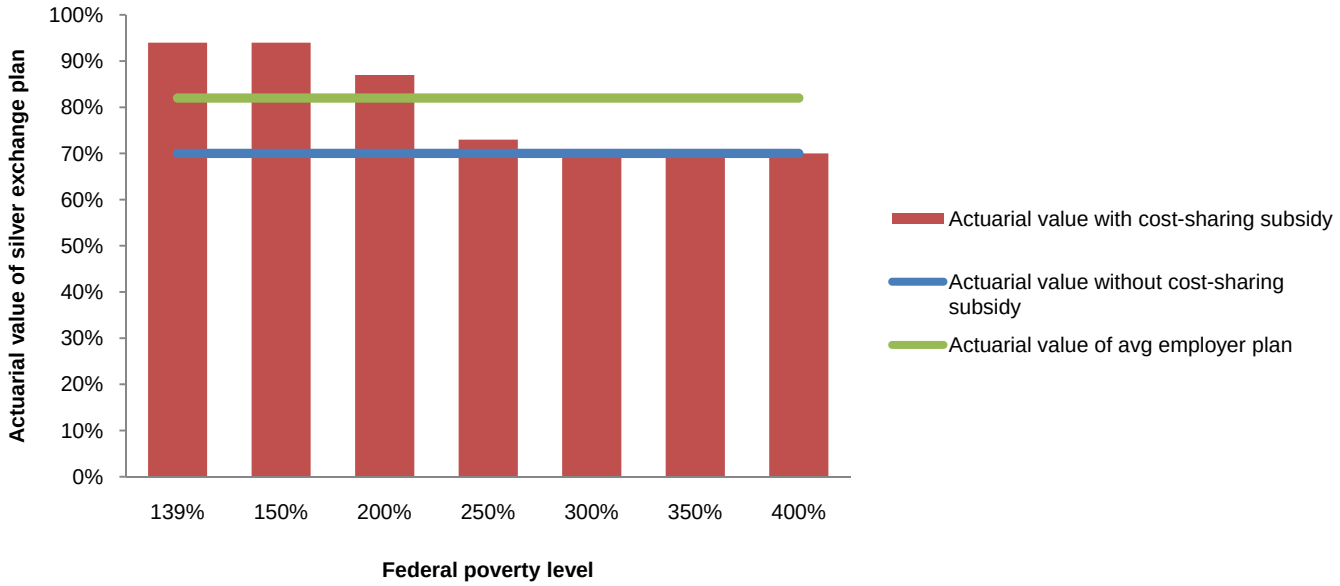
Note: Premium rates are for illustration purposes only.

The illustrative total premium rates for the four benefit tiers vary by approximately 10% to represent the actuarial value difference between them. As shown in Figure 4-9, the relative premiums that the families will actually pay between benefit tiers may vary significantly more than the total premium relativities. For the family with income at 150% FPL, a family's premium cost is $0 for the bronze plan. The family's premium contribution doubles going from the silver plan to the gold plan. Even for the family with income at 399% FPL, the family premium contribution between the benefit tiers varies by significantly more than the actual benefit relativity on a percentage basis. It should be noted that most individuals with income below 250% FPL are expected to select the silver plan in order to access the cost-sharing subsidies. This is discussed more in the following section.

Cost-sharing subsidies

In addition to the premium tax credit subsidy, the ACA also provides cost-sharing subsidies to individuals with a household income below 250% FPL. To receive the cost-sharing subsidy, individuals must purchase a silver plan in the exchange.[13] As shown in Figure 4-10, the cost-sharing subsidies increase the actuarial value of the silver plan to as much as 94% actuarial value. For comparison purposes, the average actuarial value of a typical employer plan is 83%, based on estimates from the 2011 Milliman Medical Index. [1]

Figure 4-10: Illustration of actuarial values – silver exchange plan



Source: Cost-sharing subsidies are defined in Section 1402 of the ACA.[13] Actuarial value of an average employer-sponsored plan is referenced in the 2011 Milliman Medical Index.[1]

5. ALTERNATIVE REFORM SCENARIOS

a. Merge ESI-small group and individual insured risk pools

Section 1312 of the ACA requires that individual health insurance enrollment inside and outside of the state's exchange be members of a single risk pool. It requires the same for the ESI-small group market. However, Section 1312 of the ACA gives states the flexibility to merge the ESI-small group and individual health insurance markets within the state. [14]

The ESI-small group and individual health insurance markets in Ohio are currently separate markets, so merging them would be a change from the current status and would likely require a change in statute.

Merging defined

Merging the ESI-small group and individual health insurance markets within a state means that individual premium amounts and ESI-small group premium amounts are based on the combined health cost experience of the ESI-small group and individual health insurance risk pools. This does not automatically require benefit plans and premium amounts in the ESI-small group and individual health insurance markets to be the same. For example, health insurance carriers could use the merged risk pool experience as the starting point for their premium development, assuming state law and regulation allows it. They could then make actuarial adjustments for the benefit plans sold to each market and add market-specific administrative expenses, broker commissions, and other retention charges to arrive at total premium amounts.

Merging in this context does not indicate the method that the state will use to implement and manage the programs on an administrative basis. For example, the state may select to keep the ESI-small group and individual health insurance markets segmented (i.e., not merged) for purposes of premium rates and risk pools, but perform joint operation and administration for purposes of administrative efficiency.

Impacts of merging the ESI-small group and individual markets

Merging the ESI-small group and individual health insurance markets in Ohio may impact the following areas:

- *Health benefit plan costs* – This report estimates that health benefit plan costs (premium plus member cost-sharing) in Ohio will decrease 3% to 7% for individuals and increase 4% to 8% for small groups if the markets were to merge. These changes are in comparison to the expected health benefit plan costs in a mature post-ACA year if the markets are not merged (i.e. in addition to the estimated premium rate impacts discussed in Section 4b of this report). As was illustrated in Figure 4-6 (see the "risk pool composition changes" line), this inverse relationship is expected because the average health status of the 2017 individual health insurance market is estimated to be less favorable than the average health status of the ESI-small group market. The individual health insurance market has three subgroups: actively working without employer health coverage; disabled and not working; and not disabled and not working. The ESI-small group market's average health status is similar to the first of these three subgroups because the ESI-small group market is composed of actively working people. The disabled and not working subgroups of the individual health insurance market tend to have higher morbidity than the actively working, resulting in a less favorable average health status for this market. For these reasons, premiums in the individual health insurance market for a given age are estimated to be 8% to 12% higher than the ESI-small group market.

- *Enrollment* – This report estimates that merging the ESI-small group and individual health insurance markets in Ohio is expected to result in a 30,000-50,000 decrease in enrollment for the ESI-small group market and a

20,000-40,000 increase in enrollment for the individual health insurance market. Higher benefit plan costs for the ESI-small group market will lead some small groups to self-insure and others to drop healthcare coverage, thereby reducing enrollment in the ESI-small group market. Some of the people who lose coverage will move to the individual health insurance market. Lower benefit plan costs will encourage enrollment of the uninsured population into the individual health insurance market since their alternative would be paying the ACA-imposed tax penalty.

- *Carrier participation* – In Ohio today, carriers can make separate decisions regarding their participation in the ESI-small group and individual health insurance markets. If the markets were to merge, a requirement for carriers to participate in the merged market may be necessary to avoid a situation where carriers choose to participate in only the preferred health status ESI-small group market. Some carriers may not have the capability or desire to serve both markets and therefore may choose to exit if the markets were merged. Merging the markets may also limit new carrier entry. Fewer carriers in the market may lead to less competition and higher premiums.

- *Flexibility* – Merging the ESI-small group and individual health insurance markets may afford the state and health insurance carriers less flexibility to respond to the differing benefit and service needs of the populations. Merging the markets may also present challenges for large groups to access Ohio's SHOP exchange beginning in 2017, as the ACA allows.

- *Market stability* – Merging the ESI-small group and individual health insurance markets may lead to short-term instability in premium rates, health benefit plans, and carrier earnings as consumers, employers, carriers, and others react to the changes. Over the long term, merging the markets will yield a larger risk pool on which premium rates will be based and may help reduce instability in premium rates, risk adjustment, and carrier earnings.

Bottom line

The ESI-small group and individual health insurance markets in Ohio will experience significant change over the next several years as the various provisions of ACA and its related regulations are implemented. If Ohio requires the merger of the ESI-small group and individual health insurance markets more changes are imminent. As ACA does not dictate a timeline for merging the two markets, Ohio may wish to monitor the emerging experience resulting from the ACA-required changes to the markets before making a decision to merge them. Stakeholder input on this topic of merging the ESI-small group and individual health insurance markets may be more objective and concrete after the impacts of the ACA rules and regulations are better understood through experience.

b. Basic Health Program option

Section 1331 of the ACA gives states the flexibility to offer a Basic Health Program (BHP) to certain low-income individuals not eligible for Medicaid. This primarily impacts individuals with household income between 139% and 200% of FPL, as well as unqualified legal aliens with income under 138% of FPL who are not eligible for Medicaid.[15]

The decision about whether (and how) to implement a BHP is a complex issue that impacts many stakeholders. This report focuses on the potential impact a BHP could have on an exchange. The details of the BHP (administrative, financial, and policy) are outside the scope of this analysis.

Expected impacts to an exchange of offering a Basic Health Program

The ACA explicitly precludes members from joining the exchange and receiving federal subsidies if they are eligible for a BHP. The exchange enrollment (without a BHP) is expected to primarily serve individuals with income between 139% and 400% FPL, with a smaller proportion of individuals above 400% FPL. This is due to the income threshold for federal premium and cost-sharing subsidies. Further, due to the scaling of subsidies by income and the higher volume of uninsured lives in the lower income categories, the exchange is expected to have a significant proportion of members from the BHP-eligible population.

Exchange participation

This report estimates that approximately 30%-40% of the potential exchange population will be removed upon implementation of a BHP. This volume decrease will require fixed costs in operating the exchange to be spread over fewer insured lives.

The decline in exchange enrollment due to a BHP could create additional burden on the financing component of the exchange. This could be a material issue since the ACA requires the exchange to be financially self-sustaining by 2015.

Provider reimbursement

Provider reimbursement both inside and outside the exchange could be impacted by the introduction of a BHP. In the current market, providers offset losses from reimbursement for government programs like Medicare and Medicaid by increasing reimbursement in the commercial market (ESI and individual). This practice is likely to continue as the ACA Medicaid enrollment begins expanding in 2014. With a BHP, this issue could increase further. While the specific reimbursement for a BHP is not directly tied to Medicaid, it is expected that Medicaid (or close to Medicaid) reimbursement will be required in order for the BHP to be sustainable. This would mean that more healthcare dollars would need to be subsidized by the commercial market.

Churning

One of the key qualitative advantages of a BHP option is that it shifts the crossover point of the exchange from 139% FPL to 201% FPL. This would potentially soften the churning issues (individuals going back and forth between Medicaid and the individual insurance exchange) since individuals would move from Medicaid to the BHP (Medicaid-like program) and then to the exchange.

Risk pool

Based on a review of the Ohio Family Health Survey data, the BHP is expected to reduce the average cost profile of individuals in the exchange (and thus lower premiums) since the BHP-eligible population is estimated to have higher average morbidity.[2] In general, health status has been observed to improve with income level, which would indicate that the BHP-eligible population (income between 139% and 200% FPL) is likely to be a higher cost population compared to those with incomes at 201% FPL and greater.

Bottom line

The BHP is a complex issue that has many impacts to various stakeholders. With respect to the exchange, the BHP offers advantages and disadvantages. The primary advantages include the reduction of eligibility churning between Medicaid and the exchange and a lower average morbidity for the remaining exchange population. The primary disadvantages include the reduction of members who will cover operational costs of the exchange, the potential increase in commercial (ESI and individual) premiums due to increased provider cost shifting to the commercial markets, and the financial risk of the BHP to the state (the risk that costs are greater than revenue).

6. DISCUSSION OF KEY REFORM ISSUES

a. Understanding movement of individuals among markets

The primary analyses contained in this report focus on the aggregate changes in enrollment for the various health insurance markets. This method inherently averages individual movement among markets, plans, and delivery systems. At any given point, there will be individuals coming in and going out of the exchange for a variety of reasons.

The issue of individuals moving between markets is referred to as “churn”. Churning is a common phenomenon in Medicaid as individual income volatility causes individuals to gain and lose Medicaid eligibility frequently. It also occurs as individuals move between employment that offers insurance coverage and employment that does not (or they become unemployed). This issue becomes more complex in the context of the ACA. The ACA includes expansion of Medicaid eligibility, federal premium and cost-sharing subsidies in the exchange, and guaranteed issue of health insurance coverage in the ESI-small group and individual health insurance market, among other things.

How movement among market segments occurs

Churn, as it is defined in this report, will be focused on the movement of individuals between Medicaid, the exchange, and ESI coverage. The primary driver of this churn is the amount of income volatility experienced by individuals who will shift their eligibility between Medicaid and the exchange. Additional movement will occur due to employment fluctuation and whether employers offer coverage. It should be noted that there is an employer tax penalty for not offering health coverage to employees, but it does not apply to small groups with less than 50 employees and may not be large enough to entice all large groups to offer coverage. Additionally, churn will increase due to the ability of individuals to move among markets in a guaranteed issue environment. Finally, the issue of including a Basic Health Program (BHP) option complicates the discussion of churn as it adds another program between Medicaid and the exchange. The BHP option is discussed in another section of this report.

Movement between Medicaid and the exchange

The ACA will expand Medicaid eligibility to include all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard. Individuals with household income between 139% and 400% of FPL will be eligible for federal premium and cost-sharing subsidies through the exchange.

Eligibility migration between Medicaid and the exchange can be on a monthly basis for individuals with income near the crossover point (139% FPL). For example, consider a factory or service worker whose income one month is at 135% of FPL. This same worker could receive some overtime pay the following month, which would bring that income up to 145% of FPL, and then possibly fall back to the lower level in the third month.

According to a recent article published in the February 2011 edition of *Health Affairs*, 35% of adults (ages 19-60 with income initially less than 200% of FPL) would change eligibility within a six-month time period.[16] This percentage increases to 50% within a 12 month period.

This amount of churn is significant and will need to be appropriately addressed in order for an exchange to be successful.

Movement between the exchange and ESI-coverage

Individuals who move between jobs or lose employment altogether have certain options available to them for the continuation of healthcare coverage. Primary programs include COBRA extension of benefits and group conversion options. Individuals will also be able to purchase coverage on a guaranteed issue basis (i.e. regardless of their health status) in the individual health insurance market (inside and outside the exchange) beginning in 2014.

Suggestions for dealing with churning in the health insurance markets

The state may consider policy options to deal with the issue of churning. There are several policy areas that can support either a lower amount of churn or reduce the burden on the individuals who have a change in eligibility.

- *Basic Health Program (BHP)* – One of the key qualitative advantages of a BHP option is that it shifts the crossover point for the exchange from 139% FPL to 201% of FPL. This would potentially soften the churning issues since individuals would move from Medicaid to the BHP (Medicaid-like program) and then to the commercial exchange. There are likely to be fewer individuals with income at the 201% FPL crossover point as compared to the 139% FPL crossover point.

- *Continuous eligibility* – As stated above, churning is not a new issue, especially in the Medicaid universe. Several states have enacted (or considered enacting) continuous eligibility provisions for Medicaid populations for a period of one year (or another duration as defined by the state). The state may review what Medicaid rules are currently in place and consider changing policies to reduce the churning of individuals. Any increase in eligibility would likely be at a direct cost to the state. Eligibility for federal subsidies offered in the exchange will be determined on an annual basis. Therefore, based on our interpretation of the regulations, a household with income that qualifies them to be eligible for a premium tax credit may continue enrollment in the individual health insurance market for the entire calendar year, even if monthly income levels would qualify the household for Medicaid. However, the household can qualify for Medicaid if they request a redetermination for Medicaid eligibility during the calendar year. It can be expected that households with income decreases during the year will request a Medicaid eligibility redetermination because qualification would eliminate premium payments. Further guidance is needed from HHS regarding how the redetermination process will be operated.

- *Member communications* – Perhaps one of the most efficient and attainable initiatives the exchange can do is educate individuals and advocates of the income requirements and assist in the transition between markets. For some, the exchange will be the first time they are covered under a health insurance plan, and the rules regarding eligibility are complex even for a health insurance professional to fully comprehend.

Bottom line

There will be significant shifting between markets, especially between the exchange and Medicaid. The key will be to develop strategies to mitigate this issue and better inform individuals of the rules. There are ways for the state to reduce the burden of churning, but many will increase state costs.

b. Implementing ESI-small group definition change for up to 100 lives

For purposes of exchange eligibility, Section 1304(b)(2) of the ACA defines small groups as having 1-100 employees. Section 1304(b)(3) then gives states the option to elect to define small groups as employers who employ 1-50 employees until plan years beginning January 1, 2016.[17] Ohio currently defines small group as 2-50 employees.

The broader definition of small groups for purposes of exchange eligibility provides a potentially larger number of people over which to spread the fixed costs of the exchange. It also may result in more stable and predictable premiums, as well as less risk adjustment between carriers due to the larger risk pool. The larger population may also give the exchange more ability to influence costs and quality. Ohio will need to ensure a consistent definition of small groups both inside and outside of the SHOP exchange in order to avoid potential adverse selection.

Impact

There were an estimated 800,000 covered lives in the small group market with 50 or fewer employees and 130,000 covered lives in the small group market with 51-100 employees in Ohio. Enrollment in these markets is expected to decline beginning in 2014 as employers terminate coverage, move to self-funding, or employees become eligible for Medicaid. A greater percentage of the small groups with 51-100 employees are expected to move to self-funding than smaller groups, resulting in deterioration in the morbidity of the remaining insured market segments.

Given the relative size and morbidity of these two market segments in Ohio, little impact to the stability and predictability of average market premiums can be expected due to the larger risk pool under the expanded definition of small groups. Exchange enrollment will be dependent on the design of the exchange and its attractiveness to the ESI market.

Prior to 2016

Disruption is likely to occur for individual employers when the definition of small groups is expanded to include employers with 51-100 employees because it will subject these employers to adjusted community rating rules rather than basing their premiums, at least partially, on the health status of their group members. From a communications and administration perspective, Ohio may find it simpler to proceed with the change in 2014 along with the change in definition to include employers with one employee, as well as numerous other market changes. If the definition change is made in 2014, the risk adjustment program would not require recalibration in 2016.

However, postponing the small group definition change allows time to understand the new market (beginning in 2014) so that adjustments can be made for 2016 that employers with 51-100 employees will find more attractive. This may be helpful in preventing some of these employers from moving to self-funding or terminating their plan which helps keep a larger risk pool.

Bottom line

The decision of whether to cap small groups at the current 50 employees or move to the ACA required 100 employees is a matter of timing and convenience. There are many changes impacting the market in 2014 that may ultimately persuade Ohio to delay implementation until 2016, or it may be best to do it all at one time. There is expected to be little impact to market stability or level of premium rates resulting from this decision.

c. ESI-small group defined contribution

Section 1311(b)(1)(B) of the ACA creates the Small Business Health Options Program (SHOP) exchange.[18] One of the design features that states can consider is the option of a defined contribution approach for ESI-small groups. This would generally mean that an ESI-small group can provide a certain amount of premium dollars and allow employees the option of choosing the plans that best suit their individual income and health needs. This type of arrangement is not unlike what many small groups offer today, where a base premium contribution amount is set by the employer, but the employee has the choice of buying up or down his or her benefit level. However, the employee's choice is generally limited to one or two plan design choices, likely all from the same carrier.

Employee choice

The SHOP exchange has the potential to expand an employee's choice of health plans. At the state's and employer's discretion, the SHOP exchange may offer the following variations of employee choice:

- *Benefit Tiers* – The SHOP exchange may allow employers to offer plans only in a single benefit tier (bronze, silver, gold, and platinum) or multiple benefit tiers.
- *Carrier* – The SHOP exchange may allow employers to choose only a single insurance carrier or multiple insurance carriers for its employees.
- *Plan Design* – For each carrier and benefit tier, participating carriers may offer more than one plan design. The SHOP exchange may allow employers to choose only a single plan design or allow employees to choose any plan design the carrier offers.

Adverse selection

Although employee choice may be the largest advantage the SHOP exchange offers relative to ESI-small group coverage, it also poses the greatest risk to the success of the SHOP exchange and the overall morbidity of the ESI-small group risk pool. Adverse selection may increase with the introduction of employee choice among benefit tiers, carriers, and plan designs. The greatest adverse selection risk is created by allowing employees to choose plans in any benefit tier. As in the individual health insurance market, this may result in the healthiest employees selecting bronze or silver plans, and the sickest employees (or dependents) selecting gold or platinum plans. This would increase average premiums in the ESI-small group market. Adverse selection created by carrier and plan design choice within a single benefit tier may occur, but its impact would be less significant than selection among benefit tiers. Employees with known medical conditions will likely favor plans that offer the least required cost-sharing for the services that they expect to use. The design of the SHOP exchange will need to balance the benefit of employee choice with the need to minimize adverse selection.

Small Business Tax Credit

Section 1421 of the ACA creates a Small Business Tax Credit (SBTC) for qualifying ESI-small groups that purchase coverage through the SHOP exchange. Beginning in 2014, the SBTC is renewable for two years for qualifying employers. Section 45R of the Internal Revenue Code states an eligible employer must meet the following conditions to qualify for the full amount of the SBTC: [10, 19]

- The employer must have 10 or fewer full-time equivalent employees (FTEs) for the taxable year
- The average annual wages of its employees for the year must be less than $25,000 per FTE
- The employer must maintain a "qualifying arrangement", defined as paying at least 50% of the total self-only premium for each employee

Note that the SBTC is based on a sliding scale of group size and income such that the value is significantly reduced at the maximum qualifying group size and income level of 25 FTEs and average annual wages of $50,000.

Since the SBTC is only offered through the SHOP exchange, it may incentivize qualifying small groups to purchase insurance through the SHOP exchange rather than in the outside market. However, the third requirement for qualification for the SBTC may be problematic with a fixed-dollar defined contribution approach. The premiums in the SHOP exchange will be based on the age-rated premiums of individual employees. Therefore, a fixed-dollar employer contribution may exceed 50% for many employees, but be less than 50% of the total premium amount for other employees. For example, if an employer contributes $200 per employee per month, the fixed-dollar contribution may pay 100% of the monthly premium amount for a 25-year-old employee, but only 33% of the monthly premium for a 60-year-old employee, assuming an age-rated premium of $600 per month for the 60-year-old. For the employer to qualify for the SBTC, the employer must contribute a fixed-dollar amount that is at least 50% of the highest age-adjusted premium.

Age-rated employee premiums

As shown in the previous section, allowing individual employee SHOP exchange premium amounts to vary by age introduces difficulties for employers in determining qualification for the SBTC. Additionally, if individual employee premiums vary by age within the SHOP exchange, the percentage of healthcare premiums that must be paid will vary significantly between the youngest and oldest employees. The youngest employees may have a significant portion or their entire premiums paid by the employer, while the oldest employees may have a low percentage of their total premiums paid.

This also introduces a mechanism to allow employers to shift their oldest employees to the individual exchange, as the older employees would have a greater likelihood of paying more than 9.5% of household income to participate in a SHOP exchange plan.[31] The premium cost for the older employees of employers who are subject to the non-qualified coverage penalty (groups with more than 50 employees) will likely exceed the penalty amount ($3,000 in 2014).

Although allowing an employer to pay a fixed percentage of premium costs for each employee would allow them to ensure qualification for the SBTC (if desired), it does not solve the disparity in required premiums between the youngest and oldest employees. For example, if an employer pays 50% of the age-adjusted premium, the 25-year-old individual's premium would be $100 ($200 x 50%) and the 60-year-old individual's premium would be $300 ($600 x 50%), based on the previous example provided.

Therefore, if the state would like to alleviate premium disparities between the youngest and oldest employees in the SHOP exchange it must have a mechanism to allow employers to contribute a fixed-dollar amount per employee that would allow each employee to have the same costs for a specific plan. This specific plan can then be identified as a reference plan by which other employee selected plans can be compared.

The reference plan approach, as proposed by the *Institute for Health Policy Solutions*, would work in the following manner: [20]

- The employer selects a Qualified Health Plan (QHP) in the SHOP exchange as its reference plan.
- For each family category, the SHOP exchange calculates a composite adjusted community rated (ACR) premium (benefit plan design, geographic location, age rating, family status, and tobacco usage) for the selected reference plan.
- The employer selects the portion of premium it will cover for each family category. Therefore, each employee within a family category will have the same premium for the reference plan, regardless of age.

- At the employer's discretion, each employee would have the option of choosing other plans offered in the SHOP exchange. The employee premium amount for a plan would be the difference between the individually rated premium of the selected plan and reference plan, plus the employee contribution for the reference plan. Employer contributions would not change regardless of employee plan selection.

Figure 6-1 provides an illustration of how the reference plan approach would work in the SHOP exchange. While self-only coverage is illustrated in the figure, premium calculations for the other family categories would be developed in a similar manner.

Figure 6-1: SHOP employee premium calculation reference plan approach (self-only coverage example)

	EMPLOYEE 1	EMPLOYEE 2	EMPLOYEE 3	EMPLOYEE 4	COMPOSITE
a. Age	25	35	45	60	41
b. Reference plan composite premium	$400	$400	$400	$400	$400
c. Elected employer contribution	$200	$200	$200	$200	$200
d. Employee contribution (reference plan)	$200	$200	$200	$200	$200
e. Reference plan – individually rated	$285	$330	$425	$560	$400
f. Selected plan – individually rated	$295	$305	$550	$530	$420
g. Difference: reference plan less selected (e) - (f)	($10)	$25	($125)	$30	($20)
h. Employee contribution (selected plan) (d) - (g)	$210	$175	$325	$170	$220

Figure 6-1 illustrates that while the employer's cost is defined by the contribution to the reference plan, employee costs will vary depending if the employee selects a plan more or less expensive than the employer reference plan. For purposes of determining qualification for the SBTC, Section 45R of the Internal Revenue Code allows an employer to select a reference plan for testing the percentage level of its premium contributions.[19] Therefore, even though the employer is paying less than 50% of Employee 1 and Employee 3's total premium, it would not be prevented from qualifying for the SBTC (assuming other conditions were met).

Bottom line

While the reference plan approach to defined contribution poses administrative challenges to the SHOP exchange, it preserves the concept of identical premium requirements among employees regardless of age, consistent with the current ESI market. The defined contribution approach may allow greater employee plan choice, but employee choice must be balanced to mitigate adverse selection in the ESI-small group market.

d. Brokers and agents (inside and outside exchange)

Current role of brokers and agents

In the current health insurance market, brokers and agents play a significant role in the sale and implementation of an insurance contract between an individual or employer group and an insurance carrier. The services provided vary based on the line of business and the needs of the customer.

In the individual health insurance market, brokers and agents assist individuals in securing the most appropriate coverage for the individual and their families. They may shop different insurance carriers (or be employed by a particular carrier) and discuss cost and coverage issues. They advise on premium rate changes and offer different benefit designs to lower the monthly premium costs.

In the ESI-small group and ESI-large group markets, brokers and agents perform similar cost comparisons and benefit options for their clients, while also hosting more complex services. For example, brokers and agents act as a benefits consultant and advisor, providing coverage strategies and benchmarking services. Many brokers and agents provide information related to wellness programs and opportunities for tax advantaged healthcare reimbursement arrangements (HRAs).

Brokers and agents have a role in the ESI-self-funded market as the agent of record for stop loss coverage, benefits consulting, and overall advisor to the human resources department of the employer.

For their services, brokers and agents are most often compensated on a percentage of premium or a per member/contract per month basis.

ACA provisions impacting the role and commission for brokers and agents

The ACA contains provisions that have the potential to impact the role of agents and brokers beyond 2014 with the introduction of the exchange and revised insurance market rules. Brokers and agents will still likely exist in the post ACA era. However, their role (and possibly compensation) will evolve to fit the changing landscape. The following briefly discusses the primary ACA provisions and their potential impact to brokers and agents.

- *Navigators/exchange* – Section 1311 of the ACA establishes the requirement for exchanges to provide grant funding for navigators to assist in the enrollment, education, and outreach efforts of the exchange.[18] While the navigator can be a licensed broker or agent, to qualify they must not accept compensation from a carrier for the sale of a policy. For this reason, many brokers and agents will likely not attempt to be a qualified navigator unless the grant funding amounts are a fair compensation for their services. To the extent that brokers and agents are competing with navigators, the exchange will need to be explicit in its intentions for the various entities to co-exist.

- *MLR provision* – The ACA mandates that carriers in the ESI-insured and individual health insurance markets meet a minimum medical loss ratio (MLR) percentage. The minimum MLR percentage is the carrier's benefit expense divided by the total premium revenue (the actual minimum MLR calculation under the ACA has several additional considerations). The portion of premium that is not paid towards policyholder benefit expenses consists of administrative costs, capital requirements, profit, and broker/agent commissions.

  The minimum MLR provisions will put pressure on all non-benefit expenses, including broker/agent commissions. That is, unless it is determined that these commissions can be excluded from the calculation. There is a current house bill (H.R. 1206) which would remove commissions from the calculation of the MLR, but it remains uncertain whether this bill will be passed and ultimately enacted.[21]

- *Benefit simplification* – Section 1302 of the ACA establishes minimum benefit levels and four benefit product levels to be sold through the exchange.[22] The intent of the requirements for standardization of benefits is to make consumer choices more transparent and allow better comparability among plans. This has the potential to diminish the role of brokers and agents as their specialized benefit design skills may have lower perceived value. However, the specific benefits and cost-sharing that carriers will use to arrive at the benefit tiers are likely to vary substantially, and the brokers and agents can assist customers in selecting the best fit for their situations. As such, while there is some standardization and transparency in the new benefit requirements, the role of brokers and agents is likely to continue.

- *Enrollment/application* – With the introduction of the exchange and the expansion/simplification of Medicaid eligibility, enrollment and application assistance will need to be a joint effort among the state, navigators, and brokers and agents. Individuals will be coming to the exchange and may be directed to Medicaid or other programs. Brokers and agents may be part of the solution for this massive effort. They can support eligibility determination for exchange subsidies or Medicaid coverage.

  The role of the brokers and agents with respect to enrollment and application will likely increase as there are additional layers of complexity adding to the purchase of health insurance in the ESI and individual health insurance markets, including the availability of premium tax credits in the individual exchange.

Potential roles for brokers and agents in the exchange

The state will need to consider many policies related to the use and compensation of brokers and agents as the exchange is defined and implemented. These policies will drive the potential roles for brokers and agents in the exchange. For example, the state will need to consider:

- *Permitted use of brokers and agents (both inside and outside the exchange)* – The current use of brokers and agents outside an exchange will need to continue; otherwise there could be significant market disruption. This is especially true with the SHOP exchange, because it is likely to represent only a small percentage of the ESI-small group market. The key question then becomes how to handle brokers and agents within the exchange. The state's decisions on the use of brokers and agents may influence the level of enrollment and competition that emerges between the exchange and non-exchange markets. For example, if brokers and agents are excluded from the exchange, it is likely that they will steer customers to the outside market.

- *Compensation for brokers and agents (both inside and outside the exchange)* – Compensation of brokers and agents is perhaps the most important and contentious issue for state policy. A determination will need to be made for whether to let the market manage this issue or to have it addressed by state regulation. Steerage by brokers and agents may be a powerful mechanism since they are in the middle of the insurance transaction. Lower (or fixed) compensation in the exchanges could push more ESI-small groups and individuals outside of the exchange. Again, this is more likely an issue for the SHOP since individuals will have a strong financial incentive to be in the exchange if they qualify for federal premium and cost-sharing subsidies.

- *Brokers and agents as qualified navigators in the exchange* – The ACA defines the availability of navigators in the exchange to assist in the transaction process. The law allows for brokers and agents to qualify as navigators. However, it will require grant funding and may not be commensurate with typical or market-based compensation. The relationship and interaction of brokers and agents with navigators will be a policy consideration as the exchange rules are developed.

- *Differences in policy between the ESI-small group and individual health insurance markets* – Brokers and agents currently serve both of these commercial markets. There is currently a distinction in compensation structures and services provided between these markets for brokers and agents. When setting policy for brokers and agents, it will be important to separate the markets and possibly differentiate the rules for each.

Bottom line

Brokers and agents play an important role in the current ESI-small group and individual health insurance markets and will ultimately find the best fit for their services and skills in the post ACA healthcare marketplace. The MLR issue may have an impact on their future role as compensation could be reduced to meet these demands. The state will need to consider how the brokers and agents should interact in the post ACA marketplace and develop policies to meet this expectation both inside and outside the exchanges.

e. Limited benefit medical plan market

The current health insurance market contains a segment of policies which have limited benefits or relatively low maximum reimbursement provisions. These plans offer an employer or individual the opportunity to obtain insurance coverage for a portion of their expected claim needs. However, these plans often lack the coverage for situations where insurance is needed the most. For example, some do not cover inpatient hospital stays, and some have maximum annual payments of $50,000 or less. This leaves a substantial amount of risk that is not covered in the event of a catastrophic illness or accident.

Impact of the ACA on limited benefit medical plans

The limited nature of these plans goes against the underlying coverage philosophy of the ACA, and many are in direct violation of several of the minimum essential benefits and prohibition of annual and lifetime benefit provisions. For this reason, limited benefit plans will not meet the minimum essential coverage requirements to avoid payment of the individual mandate penalty. Additionally, the primary market for these policies will either have Medicaid or subsidized coverage in the individual exchange beginning in 2014.

Individuals and employers offering these types of plans will need to figure out another solution to obtaining coverage that complies with the ACA such as:

- Individuals obtain policies in the exchange on a subsidized basis if their income qualifies
- Employers drop coverage and push the individuals to the exchange
- Employers increase coverage to minimum levels (at increased costs)
- Employers allocate previous contributions to a defined contribution type program in the exchange or SHOP (see Section 6c)

Current coverage by limited benefit medical plans

The specific number of individuals covered by limited benefit plans in Ohio is not known, but many public sources have estimated the number to be 1.4 million nationwide. A ballpark estimate for Ohio is approximately 50,000 individuals based on population size compared to the national population. [23]

Bottom line

The ACA essentially outlaws limited benefit plans in 2014 (and prior except for specific waivers). These current plans will need to adapt to the new rules and could force some small groups to cease coverage altogether. There are ways for employers to maintain offering health insurance coverage through a defined contribution approach on the SHOP exchange. Many individuals who currently subscribe to a limited benefit plan will qualify for subsidies in the exchange beginning in 2014.

f. Grandfathered plans

The ACA requires significant changes in the current health insurance markets with respect to benefits, eligibility, and premium rate calculations. Most of the changes will be effective beginning January 1, 2014, although there are several impacts which are already in place, or will be prior to 2014. Section 1251 of the ACA allows for insurance plans to be grandfathered, making them exempt from certain provisions of the ACA while requiring compliance with others.[24] Figure 6-2 below identifies the primary ACA provisions which will impact benefits and underwriting requirements and indicates the compliance requirements for grandfathered and non-grandfathered plans. The changes have varying effective dates, so the cumulative requirements as of January 1, 2014 are illustrated below.

Figure 6-2: ACA requirements for grandfathered and non-grandfathered plans

ACA REQUIREMENT	GRANDFATHERED PLANS	NON-GRANDFATHERED PLANS
Elimination of lifetime dollar limits	Required	Required
Elimination of internal annual dollar limits	Required	Required
Prohibition of pre-existing condition limitations	Required	Required
Minimum loss ratio standards	Required	Required
Limitation on the waiting period for group plans	Required	Required
Prohibition on rescission of coverage	Required	Required
Dependent coverage to age 26	Required	Required
First dollar preventive services	**Exempt**	Required
Minimum essential benefits	**Exempt**	Required
Minimum actuarial value	**Exempt**	Required
Rating rules (e.g. no health status, gender or industry rating and age rating limited to ratio of 3:1)	**Exempt**	Required

As shown in Figure 6-2, the primary benefit of grandfathered status is the exemption from certain minimum benefits and premium rating rules. This could be especially appealing to groups of younger, healthier lives since they would be required to subsidize older, less healthy lives in the event they become non-grandfathered.

Maintaining grandfathered status requires that the benefit plan not be changed over time with the exception of limited inflation-indexed changes. Also, the individual or employer cannot change insurance carriers, and employers cannot reduce employer contributions by more than 5%. Once a plan loses grandfathered status, it cannot be regained. Further, many individuals or fully-insured employer plans may not be eligible for grandfathered status if their insurance carriers do not create a grandfathered plan option for them. Many insurers may find it too burdensome to offer and track multiple sets of benefit plans to accommodate grandfathered options.

Estimated prevalence of grandfathered plans post 2014

The estimated prevalence of grandfathered plans is expected to diminish quickly and be almost non-existent by 2014. This assumption is based on the following primary reasons: [25]

- Once grandfathered status is lost, it cannot be regained
- Carriers must offer and maintain separate plans for individuals and fully-insured group plans in order for their plans to be considered grandfathered
- Group plans may find that the restrictions in benefit plan changes allowed will offset any value they are yielding with respect to maintaining grandfathered status
- Individual policies have a high turnover rate which is likely to reduce the number of qualifying plans within a short period of time (such as one to three years)

Impact of grandfathered plans on the exchange

In addition to the exemption for some of the benefit and premium rating limitations mentioned above, grandfathered plans will also have an impact on the resulting risk pool both inside and outside the exchange. Grandfathered plans will not be included in the risk adjustment program, and they may increase the overall morbidity of the ESI-small group and individual health insurance markets. This is due to the likelihood that the largest advantage of being grandfathered is expected to be for younger healthier lives.

Bottom line

The existence of grandfathered plans may have a negative impact on the non-grandfathered risk pool. However, the prevalence of grandfathered plans is expected to be minimal in 2014 and beyond. The state can consider certain policies that may decrease the impact of grandfathered plans if the prevalence becomes material. For example, the state may consider whether to require carriers to pool grandfathered plans and non-grandfathered plans for purposes of developing premium rates.

g. Catastrophic plans

Section 1302(e) of the ACA allows carriers to offer catastrophic (high deductible) plans to persons under the age of 30 in the individual health insurance market. Individuals meeting affordability or hardship requirements under Section 5000A of the Internal Revenue Code of 1986 are also eligible to enroll in catastrophic plans. [22, 26]

The availability of catastrophic plans will impact the individual health insurance market in several ways.

- *Higher enrollment in the individual health insurance market* – Catastrophic plans provide a lower cost health insurance option than non-catastrophic plans. Lower premiums will encourage eligible individuals to enroll in the catastrophic plans rather than remaining uninsured.

- *Lower enrollment in non-catastrophic plans* – Catastrophic plans may attract enrollment from individuals who would have enrolled in non-catastrophic plans if catastrophic plans were not available.

- *Higher morbidity in non-catastrophic plans* – Enrollment in catastrophic plans will likely be predominantly young, healthy individuals, resulting in an older, less healthy risk pool in non-catastrophic plans. For individuals under the age of 30, the population enrolled in non-catastrophic plans will likely have a higher morbidity than the population enrolled in catastrophic plans.

- *Potential adverse selection* – The ACA age rating limitations (3:1 ratio) and adjusted community rating standards will result in younger adults subsidizing older adults and healthy individuals subsidizing less healthy individuals. With a young, healthy population concentrated in the catastrophic plans, there would be less overall subsidy available in the non-catastrophic plans since these plans are expected to be lower cost. This adverse selection will result in higher overall premiums in the individual health insurance market. However, the increased health insurance participation rate among young, healthy individuals may mitigate this effect.

h. Minimizing adverse selection

Adverse selection is a significant concern for health insurance exchanges. Many exchanges, purchasing alliances, high risk pools, and association group plans have failed historically. This has been primarily because of adverse selection, which created unsustainable risk pools. An exchange needs to be a competitive, attractive, and viable marketplace in order to avoid adverse selection.

There are four sources of adverse selection to consider in the establishment and operation of an exchange:

- Individual enrollment
- Inside versus outside the exchange
- Among health benefit coverage tiers and carriers within the exchange
- Insured versus self-funded markets

Many ACA provisions were designed to help mitigate adverse selection in the insurance markets. However, the ACA provisions do not eliminate adverse selection, and as such, states should consider additional laws and regulations that are appropriate to support or supplement the ACA.

This report relies on several public sources of information which supplemented the knowledge of the subject matter for the discussion of adverse selection in this section. While the sources are not directly quoted, some of the main ideas are used in conjunction with each other as well as independent ideas, and we believe it is appropriate to provide proper source identification. Sources for this section include:

- A white paper from the NAIC Exchanges (B) subgroup regarding adverse selection [27]
- A letter from members of the American Academy of Actuaries in response to the above mentioned white paper [28]
- A report from the Center on Budget and Policy Priorities regarding exchanges and adverse selection [29]
- A report from the US Government Accountability Office regarding expert views on voluntary enrollment [30]

Individual enrollment

Adverse selection through enrollment results when individuals defer the purchase of insurance until it is needed. The ACA contains several provisions to encourage individuals to purchase insurance in order to mitigate the impacts of adverse selection:

- *Tax penalty* – Section 1501 imposes a tax penalty on individuals who do not maintain minimum essential coverage. [31]

- *Tax credits* – Section 1401 provides tax credits for premiums paid by individuals with household income up to 400% of FPL to purchase insurance via a health insurance exchange. The tax credits are intended to create greater health insurance participation by making it affordable for lower-income households. [9]

- *Cost-sharing subsidies* – Section 1402 provides cost-sharing subsidies for individuals with household income up to 250% of FPL for insurance purchased via a health insurance exchange. [13]

- *Annual open enrollment* – Section 1311(c)(6) specifies that an exchange provide annual open enrollment periods.[18]

Within the exchange environment, and potentially outside the exchange, a state may consider additional means to mitigate adverse selection related to the individual enrollment election.

- *Penalty for delayed enrollment* – Individuals who do not enroll when first eligible could be assessed a penalty. The penalty could be based on the length of time since first eligible. The penalty could take the form of a lump sum, increased premiums for a period of time, or higher cost-sharing.

- *Restricted access to coverage* – Individuals who do not enroll when first eligible could be restricted to enroll in certain plan designs or be limited to certain provider networks, among others. Such restrictions may require a waiver of federal law or regulations.

- *Outreach and personal assistance* – Public education and outreach regarding the availability of health insurance via an exchange and about the ACA tax penalty, premium subsidies, and cost-sharing subsidies may encourage enrollment via an exchange. Additionally, simplified enrollment and access to personal assistance for enrollment may also encourage enrollment via an exchange.

- *Other measures* – Other measures that could be considered to help minimize adverse selection include requiring or encouraging credit rating agencies to use health insurance status as a factor in determining credit ratings or requiring proof of health insurance coverage as a condition for receiving certain government services.

Inside versus outside the exchange

Adverse selection may occur to the extent that health insurance market rules outside the exchange are not the same as inside the exchange. The ACA imposes several requirements on exchanges, for example: Section 1311(c) (and related forthcoming regulations) imposes requirements regarding marketing practices and provider network access; Section 1311(d) requires exchanges to offer qualified health plans; and Section 1312(a)(2) allows employees to select any health benefit plan from the benefit tier level that their employer has chosen.[13,14] Federal legislation and regulations are not able to impose these same requirements outside the exchanges. Fewer requirements outside the exchange gives the market more flexibility to meet consumer needs, so the market outside the exchange may be a more attractive alternative, particularly for those not eligible for premium or cost-sharing subsidies within the exchange.

In recognition of the potential for adverse selection inside versus outside an exchange, the ACA includes several provisions to mitigate this potential:

- *Single risk pool inside and outside exchange* – Section 1312(c) requires a single risk pool for individual health insurance sold both inside and outside the exchange.[14] It also requires a single risk pool for ESI-small group health insurance sold both inside and outside the state exchange. Only grandfathered plans can be excluded from these risk pools.

- *Same premium inside and outside exchange* – Section 1301(a)(1)(C)(iii) requires the same premium inside and outside the exchange for plan designs that are sold via the exchange.[32]

- *Consistent rating rules inside and outside exchange* – Section 1252 requires health insurance rating rules to apply consistently inside and outside the exchange. [33]

- *Risk adjustment* – Section 1343 provides for risk adjustment charges and payments from/to carriers within the ESI-small group and individual health insurance markets both inside and outside the exchange. [34]

Some states may consider provisions beyond those within the ACA by considering the following means to mitigate adverse selection.

- Consistent rules inside and outside the exchange
- Requirements for carrier participation inside and outside the exchange
- Requirements for covered benefits inside and outside the exchange
- Requirements for benefit levels inside and outside the exchange
- Requirements for risk adjustment mechanisms
- Fees to cover exchange costs inside and outside the exchange
- Rules for carriers aggregating legal entities inside and outside the exchange
- Broker and agent commissions on insurance policies inside and outside the exchange

Among health benefit plans and carriers within an exchange

Another potential source of adverse selection is when individuals have the opportunity to choose among carriers and/or health benefit plans within an exchange. Consumers will be given a choice of plans ranging from an actuarial value of 60% to 90%, with higher premiums charged as the actuarial value of the plan increases. Individuals will choose to enroll with the carrier and plan design that best meets their personal circumstances, such as income and health status. Individuals with known health conditions will be the most likely to purchase richer benefit coverage, as the reduced out-of-pocket health expenses may outweigh the additional premium costs. Although this phenomenon cannot be eliminated, the state could limit individual movement between carriers and plan designs in order to mitigate this source of adverse selection. For example, individuals could be limited to changing their carriers and/or plan designs once per year, or changes between plan designs could be limited to only one benefit tier per year. This would help mitigate the potential for individuals buying richer health insurance coverage only when a known health condition occurs.

Insured versus self-funded plans

Given the absence of health status rating beginning in 2014, ESI-small groups with healthier populations and a minimum number of employees will have a financial incentive to self-insure their health benefit coverage rather than purchase health insurance from the insured risk pool. Keeping the healthier employer groups within the insured market will provide a larger pool over which to spread risk, and result in lower per member market premiums.

The state may consider regulation concerning minimum employer size or attachment points for stop-loss insurance coverage. A small employer who self-funds their plan will purchase stop-loss coverage to cap its potential claims expense and avoid the financial consequences of a catastrophic claim. Regulation requiring stop-loss insurance to be sold only to employers with a minimum number of employees or at a minimum attachment point will reduce the feasibility for small employers to self-fund their plans. However, such regulation may also result in employers terminating their sponsored health coverage if faced with significant premium increases in the insured market.

Additional discussion of open enrollment

Open enrollment periods limit the time during which individuals are eligible to enroll for insurance, thereby creating an incentive for individuals to maintain continuous coverage. This will result in a more stable risk pool and help to minimize adverse selection.

Section 1311(c)(6) of the ACA requires an exchange to provide for an initial open enrollment period as well as annual open enrollment periods.[18] In a notice for proposed rulemaking (NPRM) for Parts 155 and 156 – Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (issued in the Federal Register on

July 15, 2011) an initial open enrollment period from October 1, 2013 through February 28, 2014 and annual open enrollment periods from October 15 through December 7 each year have been proposed for exchanges.[35] The ACA-required annual open enrollment period in the exchange will result in less adverse selection than an open enrollment period. The NPRM also outlines qualifying life events that will allow for exchange enrollment such as loss of ESI coverage, marriage, change of residence, qualification for a premium tax credit, and addition of a family dependent.

While the ACA imposes annual open enrollment periods on exchanges, and federal regulations for exchanges will specify the timing of those annual open enrollment periods, there are no such requirements for the insured markets outside the exchanges. Unrestricted enrollment may lead to adverse selection outside the exchange. Though adverse selection inside the exchange is usually of more concern, states may consider imposing open enrollment period requirements outside the exchange, or giving carriers the option to do so. The open enrollment period requirements should be the same both inside and outside the exchange to minimize adverse selection.

Bottom line

The exchange and health insurance market regulators must be vigilant in assessing the prevalence of adverse selection on an ongoing, routine basis. Adverse selection may not be readily apparent and it can develop slowly over time. To avoid market disruptions, regulators may chose to implement initial regulations to minimize adverse selection, and then make future adjustments as market conditions warrant.

i. Encouraging a competitive environment and carrier participation in the exchange

An exchange is a distribution channel that must compete with other available options, such as the broker channels in the insurance market outside the exchange, as well as alliances. The exchange will not be an attractive and viable marketplace for health insurance without strong purchasing by employers, individuals, and carriers.

Employers

To encourage employers to participate in an exchange, the exchange must provide services consistent with the services that employers receive in alternative distribution channels. Examples include benefit management services, such as online enrollment and automated billing, assistance with applying for the Small Business Tax Credit (SBTC), management of COBRA coverage, and cafeteria plans. Benefit plan choices within the exchange need to be at least as attractive as the plan design choices in alternative distribution channels. Employers desiring HSA-compatible plans, for example, will purchase in alternative distribution channels if such plans are not available in an exchange.

In addition to offering services and benefit plans consistent with alternative distribution channels, an exchange should consider capabilities that are not available in alternative distribution channels. Such a competitive advantage will likely be needed to encourage an employer to move from its current distribution channel, where it may have a strong relationship with its broker, to an exchange. Defined contribution capabilities are one possible way an exchange may create a competitive advantage, as discussed elsewhere in this report. Any capability contemplated to create a competitive advantage over alternative distribution channels must also be reviewed for the possibility it may create adverse selection.

The SHOP exchange may offer a greater level of employee plan choices than the traditional broker/producer distribution channel. The degree of choice offered by the exchange is at the state and employer's discretion. Employees may be offered the flexibility to choose plans from multiple carriers, benefit tiers, or plan designs.

Individuals

The premium and cost-sharing subsidies available to individuals with household income below 400% of FPL will incentivize many individuals to purchase their health insurance coverage via the exchange since the subsidies are not available outside the exchange. For the subsidy-eligible population, practical choices will be to purchase coverage through an exchange or go uninsured. Ways to encourage exchange participation of the subsidy-eligible population are the same ways in which to minimize the adverse selection that is due to individual enrollment, as discussed earlier in this report:

- Penalty for delayed enrollment
- Restricted access to coverage for those that don't enroll when first eligible
- Outreach and personal assistance
- Other measures such as supporting use of insurance status in credit rating and requiring proof of insurance coverage as a condition for receiving certain government services

For individuals who are not eligible for premium or cost-sharing subsidies via an exchange, encouraging participation in the exchange is similar to encouraging employers to participate in the exchange, as discussed in this section. Services and benefit plans offered to non-subsidy eligible individuals must be consistent with what is offered in alternative distribution channels. Offering services or benefit plans beyond what is available in alternative distribution channels in order to create a competitive advantage for the exchange should be considered in light of the potential for adverse selection.

Carriers

Carriers considering participation in an exchange will weigh membership potential and exchange participation requirements with their ability to compete effectively for the membership. Exchange participation requirements, such as reporting requirements, system capabilities, and fees, cannot be so onerous as to outweigh the value of incremental membership that a carrier will get via an exchange. Risk selection is a primary concern of carriers regarding their abilities to compete effectively in an exchange. If risk adjustment and other risk-spreading mechanisms do not work effectively, carriers will need to focus on competing based on risk selection rather than the quality and efficiency of the services they provide. Risk adjustment and other risk-spreading mechanisms are discussed in a later section of this report.

Bottom line

Exchange participation by employers, individuals, and carriers is paramount to having a competitive exchange. The more employers and individuals who participate, the more carriers are likely to participate because of the size of the opportunity. Carriers will be innovative and strive for excellence in order to attract the most membership.

j. Risk adjustment approaches and impacts

In addition to the sources listed throughout this section, this report relies on several public sources of information which supplemented the knowledge of the subject matter for the discussion of risk adjustment and reinsurance. While the sources are not directly quoted, some of the main ideas are used in conjunction with each other as well as independent ideas, and we believe it is appropriate to provide proper source identification. Sources for this section include:

- An American Academy of Actuaries issue brief regarding risk assessment and risk adjustment [36]
- A Milliman Healthcare Reform Briefing paper regarding risk adjustment systems [37]
- Two Milliman Client reports regarding risk adjustment prepared for the Massachusetts Medical Society [38,39]

The ACA specifies three programs to mitigate the impact of adverse selection and stabilize premiums in insurance markets: a risk adjustment program; a risk corridor program; and a reinsurance program. Figure 6-3 below summarizes these programs.

Figure 6-3: ACA risk adjustment and reinsurance provisions

	RISK ADJUSTMENT	RISK CORRIDOR	REINSURANCE
Program objective	Transfer funds from lower risk plans to higher-risk plans	Limit carrier losses (and gains)	Provide funding to carriers with high-cost enrollees
Time frame	Permanent beginning in 2014	2014-2016	2014-2016
Program oversight	State option	U.S. Department of Health and Human Services	State (unless federally operated exchange)
Markets	ESI-small group and individual markets, excluding grandfathered plans, inside and outside exchange	ESI-small group and individual markets, inside exchange only	Individual market, excluding grandfathered plans, inside and outside exchange

With the health insurance rating restrictions imposed by the ACA, risk adjustment is an important mechanism to minimize the impact of adverse selection to carriers. An effective risk adjustment mechanism allows carriers to focus on competing based on quality and efficiency of the services they provide rather than on risk selection. Medicare Advantage, Medicare prescription drug, many Medicaid programs, and the Massachusetts' Commonwealth Care program are examples of health insurance programs where risk adjustment is being used today.

Section 1343(a) of the ACA requires states to assess a charge on carriers whose membership has actuarial risk lower than the market average and it also requires states to provide a payment to carriers whose membership has actuarial risk higher than the market average.[34] Risk adjustment is required to be applied to the ESI-small group and individual health insurance markets (or merged ESI-small group and individual market if the state elects to merge these risk pools), excluding grandfathered plans, both inside and outside the exchange on a combined basis beginning in 2014.

Section 1343(b) of the ACA further requires, "The Secretary, in consultation with the States, shall establish criteria and methods to be used in carrying out the risk adjustment activities…."[34] To that end, a notice for proposed rulemaking (NPRM) for Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act was issued in the Federal Register on July 15, 2011.[40] Highlights of the NPRM that are important to this discussion of risk adjustment methodologies include:

- States must commence calculating payment and charges with the 2014 benefit year

- The Department of Health and Human Services (HHS) will provide a federally-certified risk adjustment methodology to be published in an annual federal notice of benefits and payment parameters
- States may submit other risk adjustment methodologies for review and certification by HHS as a federally-certified risk adjustment methodology
- Carriers are to submit required risk adjustment data, including but not limited to claims and encounter data, enrollment and demographic information, and prescription drug utilization data

Therefore, states will need to decide whether they will use the HHS-provided risk adjustment methodology or submit their own methodology for review and certification by HHS.

Prospective and retrospective risk adjustment methods

Risk adjustment methodologies fall into two general categories: prospective and retrospective. Retrospective methodologies are also referred to as concurrent.

Prospective risk adjustment methods use data from a historical period to predict the morbidity risk of insureds in a future period. They are focused on morbidity risk associated with chronic conditions of individuals. The impact of acute and one-time conditions is averaged at the age-gender level. There is typically a lag of 3 to 12 months between the historical period and the prediction period. The longer the lag is, the less accurate the prediction becomes.

Retrospective risk adjustment methods use data from a historical period to assess the morbidity risk of insureds during that historical period. Risk scores under retrospective risk adjustment methods are influenced by acute and one-time conditions in addition to reflecting chronic conditions. While they have more predictive accuracy than prospective risk adjustment methods and typically provide more differentiation among carriers, retrospective risk adjustment methods can be seen as giving carriers less incentive to manage the care of patients.

Prospective risk adjustment methods are often used with an individual approach to risk adjustment while retrospective risk adjustment methods are often used with an aggregate approach to risk adjustment. In an individual approach to risk adjustment, each insured's risk score follows the insured as he or she moves between carriers during the prediction period.

Considerations for risk adjustment programs

The best risk adjustment approach may not be the same for different risk adjustment purposes. A risk adjustment program for the ESI-small group or individual health insurance markets is for financial purposes, assessing the relative risk between carrier books of business. Risk adjustment can also be used from a delivery of care perspective, understanding drivers of risk such as age, chronic conditions, where the delivery system is impacted, and risk profiles of individuals. Though many of the considerations also apply to risk adjustment from a delivery of care perspective, the discussion in this section will focus on financial considerations for a risk adjustment program for the ESI-small group or individual health insurance markets.

There are many considerations in developing a risk adjustment program for the ESI-small group and individual health insurance markets. In proposed rule Subsection 153.330(a)(2), HHS outlines seven criteria in reviewing risk adjustment methodologies that states have submitted for review and certification as follows: [40]

> *'The request must include the extent to which the methodology;*
>
> *(i) Accurately explains the variation in the expenses of a given population;*
> *(ii) Links risk factors to daily clinical practice and are clinically meaningful to providers;*
> *(iii) Encourages favorable behavior among providers and health plans and discourages unfavorable behavior;*
> *(iv) Uses data that is complete, high in quality and available in timely fashion;*
> *(v) Is easy for stakeholders to understand and implement;*
> *(vi) Provides stable risk scores over time and across plans; and*
> *(vii) Minimizes administrative costs.'*

These same criteria can be used by a state considering the use of the HHS-provided risk adjustment methodology.

Transparency

Transparency of a risk adjustment program is important so that carriers understand the basis on which their revenue will be adjusted. Carriers will be more willing to participate in the market when they know the risk adjustment rules and can assess the impact the risk adjustment program will have on them. Involving carriers early and often during the development of Ohio's risk adjustment program will help to ensure its success. Ongoing reporting to carriers once the program is operational will also be important for long-term transparency and success of the program.

Data

Most risk adjustment methods in use today use historical claims and enrollment data. Diagnostic-based risk adjustment methods are based upon diagnosis codes on historical medical claims data, while pharmacy-based risk adjustment methods are based upon National Drug Codes (NDCs) on historical pharmacy claims data. Hybrid risk adjustment methods use both diagnosis codes on historical medical claims data and drug NDCs on historical pharmacy claims data. Enrollment data is used in these methods to identify the age, gender, and exposure period of insureds. Claim dollars and medical services are typically not used as predictive variables because they are subject to medical practice patterns, and therefore may create inappropriate bias in risk assessment.

The following are key data considerations in selecting a risk adjustment method:

- *Volume* – Detailed historical claims and enrollment data for individuals is needed for risk assessment, and this detailed data will produce large datasets. Detailed data is needed across all carriers and all individuals in the ESI-small group and individual health insurance markets. A hybrid risk adjustment method will require a larger volume of data than either a diagnosis-based or pharmacy-based risk adjustment method alone.

- *Availability* – Historical data is needed for individuals to be included in a risk adjustment program. The composition of the individual health insurance market will change dramatically beginning in 2014 with many of the new market insureds being previously uninsured. Historical data will not be available for many individuals. This may necessitate the use of a retrospective risk adjustment method, at least initially.

- *Timing* – Pharmacy claims are typically processed on the date of service and then paid within days. In contrast, it often takes 3 to 6 months from the date of service for most medical claims to be paid, and it may take two or more years for them to be fully paid. Inpatient hospital claims typically take longer to be fully paid

than claims for outpatient hospital services. If using only pharmacy claims or only medical claims (or a subset of medical claims such as inpatient hospital claims), there will not be information on insureds who did not use the chosen type of service.

- *Quality* – NDCs on pharmacy claims are objective and uniform across carriers while diagnosis codes on medical claims are subject to some (professional) interpretation. Some carriers have made efforts to "improve" their diagnosis coding of claims when used in risk adjustment programs. Another concern is that beginning October 2013, ICD-10-CM diagnosis codes are required to be used on medical claims rather than the current ICD-9-CM diagnosis codes used today. There will be a learning curve for clinical professionals in using ICD-10-CM diagnosis codes. There is also not a one-to-one crosswalk from ICD-9-CM diagnosis codes to ICD-10-CM diagnosis codes. This will impact the predictive accuracy of diagnosis-risk adjustment methods during the transition period.

- *Gaming* – Pharmacy-based risk adjustment methods have been modified to address low predictive, high volume prescription drugs to more closely align risk and payment. For diagnosis-based risk adjustment methods, inpatient hospital claims typically have little opportunity for gaming while outpatient hospital and physician claims are more discretionary and thus have more opportunity for gaming.

Hybrid risk adjustment methods are often used to balance the timing, quality, and gaming data issues described above. Proposed rule Part 153.610 indicates that carrier data submission requirements include the data to support a hybrid risk adjustment method.[40]

To supplement historical claim and enrollment data, there are possible data points that can be incorporated into a risk adjustment method if quality data is available across carriers. Examples of potential data points that may improve the accuracy of predicting morbidity risk include benefit level, previous coverage, lab and other diagnostic test results, ethnicity, disability status, lifestyle factors (such as diet and smoking), and socioeconomic factors (such as income, education, and employment status). A forthcoming Society of Actuaries research study will be looking at non-traditional predictor variables.

Predictive accuracy

Retrospective risk adjustment methods typically have higher predictive accuracy than prospective risk adjustment methods. Diagnosis-based risk adjustment methods typically have higher predictive accuracy than pharmacy-based methods. The results of diagnosis-based methods are more intuitive because they are linked to medical conditions, while pharmacy-based methods are sensitive to treatment and prescription patterns.

Measurement of predictive accuracy of a risk adjustment method is typically done at the individual level. However, for purposes of risk adjustment of the ESI-small group and individual health insurance markets, predictive accuracy is important for a carrier's block of business rather than at the individual level. Predictive accuracy for a carrier's block of business will be significantly better than at the individual level for most risk adjustment methods, and the method with the highest level of predictive accuracy at the individual level may not produce the highest level of predictive accuracy for a carrier's block of business.

Partial eligibility is an issue related to the concept of predictive accuracy. Risk adjustment methods typically use 12 months of historical data to assess risk. For insureds with less than 12 months of eligibility in that historical period, a determination is needed as to how to handle their risk assessment. A shorter period of time, such as 6 months, may be adequate to assess the insured's risk, depending on the chosen model. Individuals with too short of an eligibility span to assess their risk are often assigned risk based on their age and gender and/or based on some portion of the risk assessed in the carrier's population with full eligibility.

Cost

There are several costs involved with a risk adjustment program:

- *Data* – The volume and quality of the data used in the risk adjustment method will determine the cost of data collection, checking, standardization, and storing for the risk adjustment program.

- *Calibration* – Risk adjustment models need to be calibrated for the type of population for which they are being used. Risk adjustment models in use today have been calibrated for the Medicare, Medicaid, or commercial populations. Beginning in 2014, the individual insured market will have a different composition than that of the current individual insured market, resulting in the need to calibrate a risk adjustment model to this new market and recalibrate it as the market changes and becomes more stable. Calibration should exclude costs for which a carrier will not be responsible for due to a state reinsurance or other program.

  Another concern related to the cost of calibration is that pharmacy-based risk adjustment methods require more frequent recalibration, as often as every 6 months, as new drugs are introduced in the marketplace and there are new uses for existing drugs. In contrast, only a handful of new diagnosis codes are introduced each year, so recalibration of diagnosis-based risk adjustment methods are typically done yearly or every other year.

- *Application* – There are several risk adjustment programs commercially available today for commercial populations from vendors including Ingenix, John Hopkins University, MedAi, Milliman, 3M, and Verisk Health. Some of these risk adjustment programs are available at no cost, though many have a license cost plus a per insured fee associated with them. States can develop and administer their own risk adjustment program rather than working with a vendor.

- *Distribution of Funds* – Risk adjustment methods can measure the relative risk of one carrier's book of business in comparison to another carrier's book of business or to the market in total. The relative risk measures must then be used in a methodology to determine charges from carriers with a lower than average risk population and payments to carriers with a higher than average risk population. The charges and payments may be based on carrier-specific premiums or average market premiums, and the charges and payments need to balance to zero unless an additional source of funding is introduced through the risk adjustment program. There will be a cost associated with developing and applying the methodology, and then with billing and collecting payments.

- *Reporting* – Part 153.340 of the proposed rule requires states to collect data to determine risk scores and to make the data available to support the HHS recalibration of federally-certified risk adjustment models, HHS verification of risk corridor submissions, and summarized data for the state-administered temporary reinsurance program.[40] States will also need to consider reporting to carriers and other constituencies in order to encourage their ongoing support of the risk adjustment program.

This discussion has provided foundational information that can be applied as Ohio considers the risk adjustment methodology to be provided by HHS and alternative risk adjustment methodologies that can be submitted to HHS for review and certification. Ohio will need to move quickly so carriers can be given an assessment of the relative risk of their current ESI-small group and individual health insurance markets with sufficient time for carriers to incorporate this risk assessment into their pricing for January 2014.

Additionally, it should be recognized that the best approach to a risk adjustment program for the ESI-small group and individual health insurance markets in Ohio may change over time. For example, a retrospective risk adjustment method may be needed initially due to the lack of historical data available for a significant portion of the new individual health insurance market in 2014. The temporary risk corridor and reinsurance programs in effect from 2014 through 2016 may already limit carrier incentive to manage the care of patients (a common complaint of the retrospective

approach). Likewise, a pharmacy-based approach may be preferred until diagnosis coding under ICD-10-CM becomes stable.

Risk corridor

Section 1342 of the ACA provides for a federally-administered and funded risk corridor program for calendar years 2014, 2015, and 2016.[41] The program includes the ESI-small group and individual health insurance markets but is limited to business written through an exchange. A payment will be provided to a carrier when its cost of benefits, inclusive of payments under the state risk adjustment and reinsurance programs, exceeds its premiums less its administrative costs by more than 3%. The risk corridor program is two-sided, so a carrier will have to make a payment if its cost of benefits is less than its premiums less its administrative costs by more than 3%. In both situations, the payment will be equal to 50% of the amount between 3% and 8% plus 80% of the amount over 8%.

The federal temporary risk corridor program will protect against the uncertainty of setting individual rates during the first three years of the exchange. The program will essentially provide aggregate stop loss coverage to carriers for the business written through exchanges, protecting them from significantly large losses. Conversely, it will also limit a carrier participating in the exchange from experiencing a windfall financial gain.

Reinsurance

Section 1341 of the ACA requires states to establish a reinsurance program for the individual health insurance market, exclusive of grandfathered plans, for plan years beginning in 2014, 2015, and 2016.[42] The program is to be funded via contributions from all ESI-group and individual health programs, including grandfathered plans and self-insured programs. Payments are to be made to carriers for high-risk individuals on a basis that encourages the use of care coordination and care management programs for high risk conditions. The state transitional reinsurance program will provide protection for carriers participating in the individual health insurance market, both inside and outside an exchange. The program will reduce the uncertainty of insurance risk due to the entry of individuals with unknown health status into the individual health insurance risk pool.

A notice for proposed rulemaking (NPRM) for Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act was issued in the Federal Register on July 15, 2011.[40] The proposed rule provides for payments to carriers under a transitional reinsurance program to be based on patient incurred claims for essential health benefits, with the payment amount equal to a percentage of the claims between two dollar thresholds. Payments to carriers will be prorated if contributions are insufficient to cover the full amount of reinsurance-eligible claims. Federal thresholds and coinsurance percentages will be communicated for each year. States have the option to set their own parameters. The proposed rule also provides for a national contribution rate based on a percentage of premium for insured business and of total costs for self-funded business. States have the flexibility to increase the contribution rate to cover the administrative costs of the program and/or if additional contributions are needed to fund the reinsurance payments to carriers.

Subpart C of the Provisions of the Proposed Rule in the NPRM identifies three critical policy goals instrumental in defining the proposed rule: [40]

- The reinsurance program should offer protection to carriers against medical cost overruns for high-cost enrollees in the individual health insurance market
- The reinsurance program should provide for early and prompt payment of reinsurance funds, especially since the risk adjustment and risk corridor programs are likely to be at the end of a year
- The reinsurance program should require minimal administrative burden since it is a temporary program

The ACA requires that the payment policy for the transitional reinsurance program be established in consultation with the American Academy of Actuaries (AAA). A September 22, 2010 AAA letter regarding “Potential Approaches for Identifying High-Risk Individuals and Determining Payments under the Temporary Reinsurance Program” provides

discussion on several payment policy options.[43] Options considered during the development of the proposed rule are discussed in Subpart C of the Provisions of the Proposed Rule in the NPRM.[40]

The proposed rule for the transitional reinsurance program provides a balanced approach, including:

- Familiar specific stop loss insurance structure of a traditional reinsurance program
- Payments are matched to carrier costs
- Some ongoing incentive for carriers to continue to manage high-cost patients through a coinsurance of less than 100%, presumably
- Data for carriers to receive payment is already available for most carriers
- States have flexibility in defining payment thresholds and the coinsurance percentage, as well as incremental contributions, in order to meet state-specific objectives and respond to market conditions

The reinsurance program will require careful coordination with the risk adjustment program for the individual health insurance market to avoid over-reimbursement for the same risk and other unintended consequences. Since the reinsurance program applies only to the individual health insurance market, the risk adjustment program for the ESI-small group market may necessarily be different.

Assuming that the final rule for the reinsurance program is not substantively different than the proposed rule, Ohio will need to consider the following:

- *State or federal operation* – The proposed rule requires a state to establish a reinsurance program if it elects to operate an exchange. If a state elects to not operate an exchange, the proposed rule gives states the option to establish a reinsurance program. Thus, if Ohio elects to not operate an exchange, Ohio will need to consider if it wants to establish a reinsurance program or allow HHS to do so.

- *Geographic boundaries* – The proposed rule allows states to have more than one reinsurance entity defined by geographic boundaries. Multiple reinsurance entities for Ohio would add to Ohio's administrative oversight burden and also create the need for carriers in more than one geographic area within Ohio to work with multiple entities.

- *Payment parameters* – Ohio will need to assess the federal thresholds and coinsurance percentage to determine if expected payouts under the reinsurance program will exceed estimated funds to be collected. Ohio can then make adjustments up or down in the payment parameters, giving consideration to the funding available, how much additional funding Ohio wants to require, the short-term and long-term implications for the private reinsurance market, and the claim level at which carriers have limited ability to impact claim costs and outcomes. Payment parameters can be adjusted each year to reflect the declining funding of the reinsurance program or payment parameters can be set at a more constant level, thereby generating a funding surplus in 2014 that will be spent down by the conclusion of the program after 2016.

- *Additional contributions* – ACA Section 1341 requires aggregate contributions for the reinsurance programs across all states to total $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016, in addition to collecting $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016 for the U.S. Treasury.[42] HHS is to define a national percent of premium contribution rate each year. States have the option to require an additional amount if a state believes the amount will not be sufficient to fund the mandated reinsurance payments, treasury payments, and to cover the administrative expenses of the reinsurance program.

k. Public employee plans in an exchange

Public employee plans of small groups, such as town governments, will have access to the Small Business Health Option Program (SHOP) exchange. Public employee plans of large employers, such as the state of Ohio, would be allowed to access the exchange if Ohio chooses to extend exchange eligibility to large employers beginning in 2017 as permitted by ACA Section 1312(f)(2)(B).[14]

There are several considerations in extending exchange eligibility to large employers.

- *Competitive advantage* – An exchange will compete with the ESI-large group insured market as well as the ESI-self-funded market. Large employers, whether insured or self-funded, typically have flexibility in plan design, contribution strategies, and other areas. In addition, ESI-self-funded plans have premium tax and cash flow advantages, for example. An exchange would need a competitive advantage to attract large employers from their current offerings. With a larger population, an exchange may have more ability to influence costs and quality.

- *Qualified health plans* – The ACA does not require qualified health plans offered to the ESI-large group market via the exchange to be the same as those offered to the ESI-small group or individual health insurance markets. An exchange would likely need to offer qualified health plans to the ESI-large group market that differ from the qualified health plans offered to the ESI-small group and individual health insurance markets in order to compete effectively. This would expand exchange administration requirements, and may necessitate that an exchange work with different carriers than it does for the ESI-small group and individual health insurance markets.

- *Adverse selection* – The ACA does not require the ESI-large group risk pool to be merged with the ESI-small group or individual health insurance risk pools if SHOP exchange eligibility is extended to large employers. Therefore, pricing for the ESI-large group market would be distinct from ESI-small group and individual health insurance market pricing. The SHOP exchange would need to attract a significant enough ESI-large employer population to avoid adverse selection and have a viable exchange offering for large employers.

- *Exchange administration* – Extending SHOP exchange eligibility to large employers could result in a larger pool of people over which to spread the fixed administrative costs of operating the SHOP exchange. However, there are also likely to be substantial additional administrative costs for large employers if a SHOP exchange develops large employer capabilities that would result in a competitive advantage.

Once the SHOP exchange is operational in 2014, states should have adequate time to consider whether or not to extend exchange eligibility to large employers, and more specifically, large public employee plans. The considerations noted above will be important, as will other lessons learned during the development and implementation of the individual and SHOP exchanges.

I. Current Ohio mandated benefits in relation to minimum essential benefits

Section 1302 of the ACA establishes minimum benefit levels referred to as minimum essential benefits.[22] These minimum standards represent the level of coverage that all plans must satisfy. Most states, including Ohio, have minimum mandated benefits that have been in-force prior to passage of the ACA. The interaction between the state-mandated benefits and the minimum essential benefits is the focus of this section.

Current Ohio mandated benefits

Several sources of information were reviewed for this report relative to the benefits currently mandated in Ohio. The mandates for insurance contracts can be found in Ohio Revised Code (ORC) Section 3923.[5] Mandated benefits are usually categorized into one of three categories:

1. "Service mandates" define the types of service to be covered or define coverage for specified illnesses or treatment methods.
2. "Provider mandates" define the types of providers eligible for reimbursement under a health insurance contract.
3. "Beneficiary mandates" define the categories of individuals eligible to receive benefits under a health insurance contact.

ORC Section 3923 contains all three types of mandates.[5] The mandates are generally not a substitute for minimum essential benefits and should be considered a small set of "protected areas" that required legislation to ensure their coverage. Without such legislation, carriers may be more apt to exclude them from coverage.

ACA essential benefits

Section 1302 of the ACA defines "Essential Health Benefit Requirements" in general terms. Subsection (b)(1) defers the specific definition of essential health benefits to the Secretary of HHS but contains a list of general categories of service to be included as follows: [22]

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services (including behavioral health treatment)
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care

Subsection (b)(2) states that the scope of the essential health benefits be equal to the scope of benefits provided under a "typical employer plan." While the specific definition of essential health benefits has yet to be determined, some precedent has been set with regard to a "typical employer plan." The Centers for Medicare and Medicaid Services (CMS) has defined "benchmark plans" for services to be provided to Medicaid beneficiaries as including the following types of coverage: [44]

- Federal employee health benefit program (FEHBP) coverage
- State employee coverage
- Coverage offered under the largest insured commercial HMO in the state (by covered lives)
- Any other coverage approved by the Secretary

This report uses the FEHBP and the state of Ohio employee benefit plans as general guidelines for what constitutes "typical" employer coverage. It is important to note that in addition to the mandated benefits, "typical" health insurance plans often provide coverage for benefits that are not mandated and may also not be interpreted to be essential benefits.

Differences between current mandated benefits and minimum essential benefits under ACA

This report estimates the total cost of all of the Ohio benefit mandates that are not defined as essential benefits to constitute approximately less than 1% of costs for an average insured person, when the benefits are covered together. This estimate should be reviewed when regulations defining the essential benefit package are released. Figure 6-4 below illustrates the current Ohio mandated benefits, and whether each of them may be considered an essential benefit according to the ACA, as interpreted for this report.

Figure 6-4: Ohio mandated benefits compared to ACA essential benefits

BENEFIT DESCRIPTION	ACA ESSENTIAL
Alcoholism/Substance Abuse	Yes
Breast Reconstruction	Yes
Cervical Cancer/HPV Screening	Yes
Cancer Clinical Trial	Yes
Emergency Service	Yes
Mammography	Yes
Maternity Minimum Stay	Yes
Mental Health (General)	Yes
Mental Health Parity	Yes
Newborn Hearing Screening	Yes
Off Label Drug Use	Unknown
Well Child Care	Yes
Outpatient Kidney Dialysis	Yes

It is expected that existing Ohio coverage mandates will be comparable to the benefits included in the essential benefits package for almost all covered benefits and services. However, the extent to which off-label drug usage will be covered under the essential benefit package, and its relation to the state's existing coverage mandate, is unknown. Subsection 3923.60 of the ORC states that off-label drugs must be covered "provided that the drug has been recognized as safe and effective for treatment of that indication in one or more standard medical reference compendia specified in division (B)(1) or in medical literature that meets the criteria specified in division (B)(2)." [5] In 2010, 36 states had a coverage mandate for off label drug usage. [45] Medicare Part D also covers off-label anti-cancer drugs provided usage is supported in designated compendia. [46] The existing coverage of off-label drug usage may support an assumption that off-label drug usage will be included in the essential benefits package in some fashion. The extent to which off-label drug usage is included in the essential benefit package relative to Ohio's existing coverage mandate will need to be reviewed when the essential benefit package regulations are released.

If Ohio's coverage of mandated benefits exceeds the essential benefits, the state must pay the cost of those benefits for insurance provided through the exchange for members who qualify for premium and cost-sharing subsidies.

Differences between current beneficiary mandates and beneficiary mandates in the ACA

The state specifically requested information related to the difference in dependent eligibility between current Ohio law and that of the ACA. Ohio currently mandates that dependents be offered coverage by their parent's plan to age 28, whereas the ACA only requires offering coverage to age 26. The state asked for clarification regarding whether this higher standard would result in additional state costs related to the premium tax credits and cost-sharing subsidies. Our interpretation of the Department of Treasury's proposed rulemaking REG-131491-10 indicates an eligible-dependent who is a primary taxpayer (no other taxpayer claims them as a dependent) may receive premium tax credits and cost-sharing subsides for dependent coverage in the insurance exchange based on the dependent's income level.[47] For the eligible-dependent, the amount of the premium tax credit will be determined independently from the parental or guardian unit, and then applied to the premium cost of dependent coverage. Ohio is not expected to incur any additional costs because of the higher eligible dependent age, as the federal government's costs are not expected to change because of the state's provision.

Bottom line

Ohio can pursue one (or more) of several alternatives:

- Review and modify the benefits that are mandated in Ohio (drop benefits that are not defined as essential benefits under the ACA)
- Keep the current list of mandated benefits as it exists today
- Keep the list of mandated benefits only for the benefits provided outside the exchange

The decisions will impact the premium rates and possibly enrollment inside and outside the exchange depending on the specific requirements imposed.

m. High deductible health plans with health savings accounts

High deductible health plans (HDHP), in combination with a health savings account (HSA), have become increasingly prevalent in the individual and group insurance markets. For an individual to be eligible for a HSA, they must have a HDHP that meets the requirements provided in Figure 6-5. The amounts in Figure 6-5 are based on calendar year 2011 values. [48]

Figure 6-5: High Deductible Health Plan Cost Sharing Requirements

	COVERAGE TIER	
HDHP requirements	Self-only	Family
Minimum deductible	$1,200	$2,400
Maximum out-of-pocket annual expense	$5,959	$11,900

Cash contributions to HSAs are exempt from federal, payroll, and state taxes, and therefore, allow policyholders to pay for qualified healthcare expenses with pre-tax dollars. In the ESI markets, employers that offer a HDHP option may make a contribution to the employee's HSA on an annual basis. Employer contributions are limited to $3,050 for self-only coverage and $6,150 for family coverage in calendar year 2011. If the employer contributes less than the contribution limit, employees are allowed to make additional HSA contributions, provided the sum of the employee and employer contributions does not exceed the contribution limit. HDHP policyholders in the individual market are also allowed to make annual contributions up to the specified contribution limits.[48]

References in ACA

As a part of the requirements for minimum essential coverage under the ACA, cost-sharing incurred under a health plan in 2014 cannot exceed the maximum out-of-pocket annual expenses specified for HDHPs. Beginning in 2015, this amount will be indexed to premium adjustment percentage; defined in the ACA as "the percentage by which the average per capita premium for health insurance coverage in the U.S. for the preceding calendar year exceeds such average per capita premium for 2013." [22]

The ACA provides employers flexibility in meeting minimum actuarial value requirements for HDHPs. Contributions to a HSA are allowed to be considered in the actuarial value determination of an employer plan. For example, if the employer plan had a deductible amount of $3,000, but the employer contributed $1,500 annually to the HSA, the calculated actuarial value of the plan would be higher than if the employer had a stand-alone health plan with a $3,000 deductible. [22]

In the ESI-small group market, there is ambiguity in the treatment of HDHPs and HSAs. Section 1302 of the ACA states that ESI-small group plans cannot have a deductible that exceeds $2,000 for single only coverage or $4,000 for any other coverage tiers. [22] However, it states that these amounts may be increased by reimbursement amounts available to participants under a flexible spending arrangement described in Section 106(c)(2) of the Internal Revenue Code (IRC). Section 106(c)(2) governs Health Reimbursement Arrangements (HRAs); whereas Section 223 of the IRC is the applicable law for HSAs.[49, 50] Further regulatory guidance is needed to determine if ESI-small group deductible levels can be increased when an employer makes a HSA contribution.

Bottom line

While a portion of current HDHP plan designs may not meet the minimum 60% actuarial value requirement for creditable health insurance coverage in 2014, HDHPs will continue to be offered in both the ESI and individual health insurance markets. The 2011 Ohio employer health survey suggests that nearly 700,000 Ohioans were enrolled in HDHPs in 2010.[8] Individuals currently enrolled in HDHPs who are satisfied with their plans will likely want to maintain a consistent plan. HDHPs will be most prevalent in the bronze coverage tier in the individual and SHOP exchanges. Competitive pricing relative to traditional plan designs may attract a significant portion of exchange enrollment.

7. CONCLUSION

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), introduces significant changes to Ohio's current health insurance markets. Certain changes have already occurred, while the majority of the impacts will begin on January 1, 2014. This is the date when all states must have both an individual market exchange and a Small Business Health Options Program (SHOP) exchange in operation. The ACA also includes a significant expansion of Medicaid bringing in populations which have not been eligible in the past.

These changes are certain to impact the current source of health insurance coverage for a large number of Ohioans. The extent to which current insurance markets will be impacted will depend on numerous factors, including:

- The participation rate of healthy individuals in the health insurance market
- Employer decisions to continue, begin, or terminate employee health plans
- Carrier participation and competition in the individual and SHOP exchanges
- The degree of adverse selection present in the individual and ESI markets
- The role of brokers and agents in encouraging exchange enrollment

This report offers a potential view of the insurance markets following reform and the key decision points that Ohio will need to confront as the effective date draws near.

The task of implementing these regulations will require a significant amount of leadership and collaboration between the state, the carriers, and the employer market.

8. LIMITATIONS AND DATA RELIANCE

This report has been prepared solely for the internal use of and is only to be relied upon by the Ohio Department of Insurance (ODI). Although Milliman understands that this report may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In developing the projections, we relied on data and other information provided by ODI and other public sources of information. We have not audited or verified this data and other information. We performed a limited review of the data used directly in our analysis for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

The projections included in this report are based on our understanding of the ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of the ACA, necessitating an update to the projections included in this report. For this reason, this report should be considered time-sensitive material which may change as new information becomes available.

The views expressed in this report are made by the authors of this report and do not represent the opinions of Milliman, Inc.

9. QUALIFICATIONS

This report was created by Jeremy D. Palmer, Jill S. Herbold, and Paul R. Houchens. Mr. Palmer is a Principal and Consulting Actuary in the Indianapolis office of Milliman. Jeremy, Jill, and Paul are all Fellows of the Society of Actuaries and Members of the American Academy of Actuaries. They each meet the qualification standards for performing the analyses contained in this report.

10. REFERENCES

1 Mayne, L., Girod, C., Weltz, S. (May 2011). 2011 Milliman Medical Index. Milliman Research Report. Available at http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2011.pdf

2 Ohio Family Health Survey Team. (2010). Ohio Family Health Survey [Data file and code book]. Available at http://grc.osu.edu/ofhs

3 National Association of Insurance Commissioners Annual Statement Database. (December 2010). Delivered by Highline Data, LLC, a division of Summit Business Media, LLC, all rights reserved.

4 Eibner, C., Girosi, F., Miller, A., Cordova, A., McGlynn, E., Pace, N., Price, C., Vardavas, R., Gresenz, C. (March 2011). Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010. Rand Corporation Technical Report. Available at http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf

5 Ohio Revised Code. Title [39] XXXIX Insurance, Chapter 3923: Sickness and accident Insurance. http://codes.ohio.gov/orc/3923

6 Ohio Revised Code. Title [39] XXXIX Insurance, Chapter 3924: Small employer health benefit plans; Provisions of health care coverage. http://codes.ohio.gov/orc/3924

7 Patient Protection and Affordable Care Act. (March 2010). Section 1201. Amendment to the public health service act. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

8 Ohio Family Health Survey Team (2011). Ohio Employer Benefit Health Survey [Data file and code book]. Available at http://grc.osu.edu/ofhs/aboutus/ohioemployerhealthsurvey/index.cfm

9 Patient Protection and Affordable Care Act. (March 2010). Section 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

10 Patient Protection and Affordable Care Act. (March 2010). Section 1421. Credit for employee health insurance expenses of small businesses. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

11 Damler, R. (August 2009). Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured. Milliman Health Reform Briefing Paper. Available at http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf

12 Patient Protection and Affordable Care Act. (March 2010). Section 9010. Imposition of annual fee on health insurance providers. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

13 Patient Protection and Affordable Care Act. (March 2010). Section 1402. Reduced cost-sharing for individuals enrolling in qualified health plans. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

14 Patient Protection and Affordable Care Act. (March 2010). Section 1312. Consumer choice. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

15 Patient Protection and Affordable Care Act. (March 2010). Section 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

16 Sommers, B. & Rosenbaum, S. (February 2011). Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs.

17 Patient Protection and Affordable Care Act. (March 2010). Section 1304. Related definitions. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

18 Patient Protection and Affordable Care Act. (March 2010). Section 1311. Affordable choices of health benefit plans. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

19 Internal Revenue Code. (2010). Section 45R Average premium for small group market for determining the small employer health insurance credit. Department of the Treasury.

20 Curtis, R. & Neuschler, E. (June 2011). Small Employer ("SHOP") Exchange Issues. Institute for Health Policy Solutions. Available at http://www.ihps.org/pubs/Small%20Employer%20Exchange%20Issues%20Calif%20FINAL+4%20June2011.pdf

21 Access to Professional Health Insurance Advisors Act of 2011. (March 2011). House bill H.R.1206

22 Patient Protection and Affordable Care Act. (March 2010). Section 1302. Essential health benefits requirements. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

23 Shutan, B. (September 2010). Mini-meds' outlook lacks clarity: Future of mini-med plans uncertain as employers await HHS guidance on how to preserve coverage through 2014. Employee Benefit News. Available at http://ebn.benefitnews.com/news/mini-meds-outlook-lacks-clarity-2684177-1.html

24 Patient Protection and Affordable Care Act. (March 2010). Section 1251. Preservation of right to maintain existing coverage. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

25 O'Connor, J. (March 2011). Patient Protection and Affordable Care Act: Implications of status as a grandfathered plan. Benefits Quarterly.

26 Internal Revenue Code. (1986). Section 5000A. Department of the Treasury.

27 NAIC Exchanges (B) Subgroup (2011). Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act. National Association of Insurance Commissioners. Available at http://www.naic.org/documents/committees_b_110706_adverse_selection_white_paper.pdf

28 Jamilkowski, M. (April 2011). Letter to NAIC Exchanges (B) Subgroup re: NAIC White Paper on Adverse Selection. American Academy of Actuaries. Available at http://www.naic.org/documents/committees_b_exchanges_comments_rcvd_110322_adverse_selection.pdf

29 Lueck, S. (August 2010). States Should Structure Insurance Exchanges to Minimize Adverse Selection. Center on Budget and Policy Priorities. Available at http://www.cbpp.org/files/8-17-10health.pdf

30 Dicken, J. (February 2011). Private Health Insurance Coverage: Expert Views on Approaches to Encourage Voluntary Enrollment. United States Government Accountability Office. Available at http://www.gao.gov/new.items/d11392r.pdf

31 Patient Protection and Affordable Care Act. (March 2010). Section 1501. Requirement to maintain minimum essential coverage. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

32 Patient Protection and Affordable Care Act. (March 2010). Section 1301. Qualified health plan defined. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

33 Patient Protection and Affordable Care Act. (March 2010). Section 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

34 Patient Protection and Affordable Care Act. (March 2010). Section 1343. Risk adjustment. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

35 Department of Health and Human Services (July 2011). 45 CFR 155 and 156 – Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Federal Register. Available at http://www.healthcare.gov/center/regulations/exchanges07112011a.pdf

36 Lodh, M., Raleigh, M. Uccello, C. & Winkelman, R. (May 2010). Risk Assessment and Risk Adjustment. Amercian Academy of Actuaries. Available at http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf

37 Yi, R. & Laurent, D. (October 2010). What Kind of Risk Adjustment Systems Are Necessary For Health Insurance Exchanges? Milliman Healthcare Reform Briefing Paper. Available at http://publications.milliman.com/publications/healthreform/pdfs/what-kind-risk-adjustment.pdf

38 Yi, R., Shreve, J. & Bluhm, W. (June 2011). Risk Adjustment and Its Application in Global Payments to Providers. Milliman Client Report prepared for the Massachusetts Medical Society. Available at http://www.massmed.org/AM/TemplateRedirect.cfm?Template=/CM/ContentDisplay.cfm&ContentID=57564

39 Yi, R., Shreve, J. & Bluhm, W. (June 2011). Risk Adjustment: Important considerations for global payments to providers. Milliman Client Report prepared for the Massachusetts Medical Society. Available at http://www.massmed.org/AM/Template.cfm?Section=Research_Reports_and_Studies2&CONTENTID=57565&TEMPLATE=/CM/ContentDisplay.cfm

40 Department of Health and Human Services. (July 2011). 45 CFR 153 Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. Federal Register. Available at http://www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0022-0001

41 Patient Protection and Affordable Care Act. (March 2010). Section 1342. Establishment of risk corridors for plans in individual and small group markets. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

42 Patient Protection and Affordable Care Act. (March 2010). Section 1341. Transitional reinsurance program for individual market in each state. Available at http://docs.house.gov/energycommerce/ppacacon.pdf

43 Lodh, M. & Bachler, R. (September 2010). Potential Approaches for Identifying High-Risk Individuals and Determining Payments Under the Temporary Reinsurance Program. American Academy of Actuaries. Available at http://www.actuary.org/pdf/health/Reinsurance%20Options%209%2022%202010.pdf

44 Social Security Act. (March 2010). Section 1937(B)(2). Benchmark-equivalent coverage. Social Security Administration. Available at http://www.ssa.gov/OP_Home/ssact/title19/1937.htm

45 Bunce, V. & Wieske, J. (2010). Health Insurance Mandates in the States 2010. Council for Affordable Health Insurance. Available at http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf

46 National Health Council. (September 2010). Essential Health Benefits White Paper. Available at http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_WhitePaper.pdf

47 Department of the Treasury. (August 2011). 26 CFR Part 1. [Reg-131491-10] Health Insurance Premium Tax Credit Federal Register. Available at http://www.ofr.gov/OFRUpload/OFRData/2011-20728_PI.pdf

48 Internal Revenue Service. (2010). Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans. http://www.irs.gov/pub/irs-pdf/p969.pdf

49 Internal Revenue Code. Section 106: Contributions by employer to accident and health plans. Available at http://www.law.cornell.edu/uscode/usc_sec_26_00000106----000-.html

50 Internal Revenue Service. (January 2004). Notice 2004-2: Health Savings Accounts (HSAs). Available at http://www.irs.gov/irb/2004-02_IRB/ar09.html

51 Ohio Department of Insurance. 2010 Insurance Carrier Survey.

Planning Ohio's Health Benefit Exchange

Financing options to sustain Ohio's Exchange

August 31, 2011

Prepared for:

Ohio Department of Insurance

Prepared by:

Andrew L. Naugle, MBA
Principal and Healthcare Management Consultant

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

Milliman, Inc.

Chase Center/Circle
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639 1000
Fax +1 317 639 1001

milliman.com

Contents

I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA) – requires states to establish an American Health Benefit Exchange (Exchange) that after December 31, 2014 will be financially self-sustaining or default to a federally-run exchange.

Table 1.1 below presents our estimate of the annual non-IT operating costs[1]) to run an Exchange that Ohio might establish, expressed as a total dollar amount, as per member per year costs, and as a percentage of premiums. These costs are for the year 2015 – the first year in which the Exchange must be self-sustaining – in current (2011) dollars, and are shown for two Exchange design scenarios: a "Baseline" scenario and a "Robust" scenario. Under the Baseline scenario, the Exchange provides the minimum services required under ACA; whereas under the "Robust" scenario the Exchange provides more intensive Exchange services.

Item	Baseline scenario	Robust scenario
A. Exchange participation		
Members (thousands)	**530**	**640**
Annual premiums (thousands)	**$ 2,263,000**	**$ 2,722,000**
B. Annual non-IT operating cost		
Total (thousands)	**$ 19,162**	**$ 33,766**
Per member per year (excluding IT)		
For Exchange members	**$ 36**	**$ 53**
For all private fully-insured members	**$ 9**	**$ 17**
Percentage of premiums (excluding IT)		
For Exchange members	**0.8%**	**1.2%**
For all private fully-insured members	**0.2%**	**0.4%**

Table 1.1: Estimated annual Exchange operating costs for 2015 (excluding IT maintenance and support)

In Table 1.1, Exchange participation for the Baseline scenario corresponds to the "best-estimate participation scenario" in the companion Milliman report.[2] Because the Robust design scenario in Table 1.1 includes more intense marketing and outreach for the Exchange, its Exchange participation corresponds to the "high participation scenario" of the companion report. For both scenarios, money

[1] The costs of maintaining and supporting the IT infrastructure of the Exchange (including, but not limited to, the core transaction processing systems, database and analytics systems, and website) are intentionally excluded from this analysis. The State has contracted with another vendor to estimate these costs, and to avoid duplication, has requested that Milliman exclude these costs from this report.

[2] The companion report was prepared in August 2011 for the Ohio Department of Insurance, and is titled, "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefits Exchange."

amounts are in thousands of current dollars (to facilitate comparison between years, no inflation is assumed).

The annual revenue that the Exchange will require to be financially self-sustaining is equal to the annual operating cost amount (or perhaps slightly greater than the annual operating cost amount, in order to build up an operating reserve). The State may decide to collect revenue from health insurers participating in the Exchange based on covered members in the Exchange, either as a per member fee or as a percentage of premium. To spread the costs over a wider population, the State could also decide to collect revenue from all health insurers based on all private fully-insured members in the State.

However, there are other potential sources of revenue that could supplement revenue based on covered members, such as insurer Exchange participation fees, general revenue, excise taxes, and ACA penalty income.

Note that the costs above are only the operating costs needed to run an Exchange. They do not include the start-up costs of planning or establishing an Exchange. Such start-up costs may be substantially higher than one year of operating costs for running the Exchange.

Regarding the maintenance of financial sustainability for Ohio's Exchange, we make the following recommendations:

1. **Use a defined process, with specified decision criteria, to select a financing method.** Because the means of funding the Exchange are complex, we suggest using a defined process to select a financing method, a process that involves healthcare stakeholders and specific decision criteria.
2. **Establish a financial surplus.** Because Exchange membership may build slowly and may experience considerable volatility in the early years until it reaches a steady state, and because operating expenses cannot be immediately adjusted to reflect membership changes, we suggest establishing a financial surplus of 20 to 25 percent of the annual operating budget. We further suggest starting to establish this surplus in 2014.

II. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA) – requires states to establish an American Health Benefit Exchange (Exchange) that beginning January 1, 2015 will be financially self-sustaining or be defaulted to a federally-run Exchange.[4] (For more about Exchanges, see the sidebar.)

This report presents our estimates of the potential annual non-IT costs of operating the Exchange as well as the potential revenue to cover these costs so that the Exchange can be financially self-sustaining. In the report, we examine potential costs and revenue for two Exchange design scenarios, one in which the Exchange provides minimal services, and another in which it provides more robust services. Section III (Results summary) of the report presents summary results for the two scenarios, Section IV (Discussion) discusses the results, and Section V (Recommendations) presents our associated recommendations. The report's appendices describe the methodology underlying the results and provide detailed results for the two scenarios selected for this report.

The purpose of the report is to help Ohio understand the potential range of non-IT operating costs associated with various Exchange design alternatives, and the potential revenue sources to cover these costs, so that the State can plan an Exchange that will fit its needs and that will be financially sustainable.

Ohio's Exchange

ACA requires States to establish an American Health Benefit Exchange (Exchange) no later than January 1, 2014, or else default to a federally-run Exchange.

The primary purpose of the Exchange is to provide a marketplace for certain individuals and small employers (so-called "qualified individuals" and "qualified small employers") to purchase "qualified health insurance plans" that provide a minimum level of covered healthcare services (the so-called "essential benefits").[3]

Each qualified plan must belong to one of four "metallic tiers." A metallic tier is defined according to the percentage of full actuarial value for plan benefits that are covered by the plan's premium (with the remaining percentage being the responsibility of the covered person):

- Bronze: 60%
- Silver: 70%
- Gold: 80%
- Platinum: 90%

Although ACA mandates several facets of Exchanges, it also gives States latitude in how they design their Exchanges. This report explores the potential operating costs associated with alternative Exchange designs.

[3] ACA § 1311(b)(1)

[4] ACA § 1311(d)(5)(A): "In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."

In this report, we do not recommend a specific Exchange design for Ohio. Nor do we attempt to provide a precise cost estimate for any particular Exchange design. Such specifics will come later in Ohio's Exchange planning process, as the State focuses on particular Exchange designs that are most suitable for its needs. We made certain assumptions regarding the Exchange that may impact the operating costs estimated in this report, including:

- Ohio does not elect to operate a Basic Health Program.
- Small group is defined as 1-100 employees.
- Ohio does not establish multiple regional Exchanges.

Also, in this report, we address only the non-IT operating costs needed to run an Exchange during the three years 2014-2016, and the revenue required to cover these costs. We do not address the costs of planning or setting up an Exchange. Initial investments in technology and other infrastructure could be significantly greater than the annual operating costs of the Exchange.

Further, we estimate the revenue required to cover operating costs for 2014 even though federal grants may cover these operating costs. In this case, the revenue collection for 2014 may be focused on the development of a financial surplus for the Exchange.

Finally, the costs of operating the Exchange are highly dependent on a variety of factors including enrollment levels, transaction volumes, product mix, labor costs, etc. Any variation in actual inputs versus modeled inputs will generate different actual costs. In addition, the staffing assumptions used in preparing this analysis inherently assume levels of information systems sophistication, integration, and automation. These assumptions were developed independent of the IT cost estimates and hence must be reconciled to ensure the information system design and capabilities will actually provide the automation efficiencies assumed in developing the staffing.

The report was prepared for the Ohio Department of Insurance (ODI), in response to its request to assist with the first year of planning for the design and implementation of its Exchange.[5]

[5] The specific request giving rise to this report is contained in Section 4 (Study of financing options and sustainability) of RFP# CSP904311, issued April 8, 2011.

III. RESULTS SUMMARY

This section presents a summary of our estimates of the potential annual non-IT operating costs for two examples of an Ohio Exchange for each of the three years 2014-2016, as well as the potential revenue to cover these costs so that the Exchange will be financially self-sustaining beginning in 2015.

To illustrate the potential variation in annual non-IT operating costs, and the corresponding variation in required revenue, we present estimates of potential costs and revenue for two Exchange design scenarios: a "Baseline" scenario and a "Robust" scenario. (For more information about Exchange design scenarios, see the sidebar and Appendix 2).

A. BASELINE SCENARIO RESULTS

Table 3.2 on the next page summarizes the estimated income and expense for the "Baseline" design scenario. Under the Baseline scenario, the Exchange provides the minimum services described by the Center for Consumer Information and Insurance Oversight (CCIIO), found in Appendix 3. Following are the specific design choices for the Baseline design scenario:

Design element	Choice
Structural	
1. Governance	**Quasi-public**
2. Exchange coverage type	**Small Group and Individual**
Operational	
1. Insurer and product selection	**Low intensity**
2. Eligibility determination	**Low intensity**
3. Enrollment	**Low intensity**
4. Premium and subsidy administration	**Low intensity**
5. Communications and appeals	**Low intensity**
6. Navigator services	**Low intensity**
7. Marketing	**Low intensity**

Table 3.1: Specific design elements for the Baseline scenario

Exchange design scenarios

We refer to each possible alternative for designing the Ohio Exchange as a "design scenario." Each design scenario is made up of "design elements," of which there are two major categories: "structural" design elements that relate to the overall structure of the Exchange, and "operational" design elements that relate to operational characteristics of the Exchange.

There are two "structural" design elements:
1. **Governance.** The type of Exchange organization (quasi-public, existing government agency, or new government agency).
2. **Exchange coverage type.** The types of Exchange health insurance coverage (Small Group and Individual, Small Group only, Individual only).

There are seven "operational" design elements, corresponding to the basic functions that the Exchange must perform. For each function, there are three options: "Low intensity" (minimum required services), "Medium intensity," and "High intensity" (maximal useful and viable services).
1. **Insurer and product selection**. How the Exchange determines the insurers and plans to offer.
2. **Eligibility determination**. How the Exchange determines participation and subsidy eligibility.
3. **Enrollment**. How the Exchange helps consumers select a plan and enroll.
4. **Premium and subsidy administration**. How the Exchange collects, distributes, and reconciles premiums and subsidies.
5. **Communications and appeals**. How the Exchange helps consumers with their questions and complaints.
6. **Navigator services**. How the Exchange helps consumers navigate its plans and services
7. **Marketing**. How the Exchange markets its services.

For more information, see Appendix 2.

A. BASELINE SCENARIO RESULTS CONTINUED

As Table 3.2 shows, we estimate that total non-IT expenses for the Baseline design scenario will be approximately $18-20 million for each year of the period 2014-2016, in current dollars (that is, without future inflation). We have included income for each year that approximates the costs. Staff salaries are the largest component of this cost, at about $8-9 million.

Appendix 4 gives the detailed expense results for the Baseline design, including a breakdown by the following functional groups:

- Executive management
- Operations
- Marketing
- Information systems (omitted)
- Finance and actuarial
- Infrastructure

It shows that the largest expenditures are for Operations ($7-8 million) and Marketing ($5-6 million).

These expenditures are based on a total Exchange staff (excluding IT personnel) of about 170-190 full-time employees. Appendix 4 gives detailed staffing results. It shows that we estimate the largest staff will be for the Operations function (105-120 full-time employees).

To support these expenses, we estimate that it will require revenue of approximately $34-36 per Exchange member per year, or about 0.8 percent of Exchange member premiums. Appendix 4 presents detailed income results.

Category	2014	2015	2016
A. Income (thousands)			
Revenue from assessments	$ 17,640	$ 19,080	$ 19,720
Additional revenue #1	-	-	-
Additional revenue #2	-	-	-
Additional revenue #3	-	-	-
Total	$ 17,640	$ 19,080	$ 19,720
B. Expenses (thousands)			
Direct labor costs			
Salary	$ 7,792	$ 8,697	$ 8,909
Benefits	2,571	2,870	2,940
Bonuses	-	-	-
Payroll taxes	623	696	713
Total	$ 10,987	$ 12,263	$ 12,562
Salary-driven costs			
Communications	$ 39	$ 43	$ 45
Education	19	22	22
Equipment rent	136	152	156
Insurance	117	130	134
Outside legal fees	117	130	134
Postage	39	43	45
Repairs	78	87	89
Supplies	39	43	45
Board, bureau, and association fees	19	22	22
Financial auditing	58	65	67
Bank fees	8	9	9
Travel	19	22	22
Utilities	19	22	22
Total	$ 709	$ 791	$ 811
Other direct costs			
Rent	$ 501	$ 558	$ 579
Branding and promotion	1,490	1,530	1,580
Leased lines	-	-	-
Navigator grants	1,552	1,552	1,552
Website maintenance & development	-	-	-
Consulting & professional support	1,490	1,530	1,580
Furniture	-	38	14
Core system maintenance & license	-	-	-
Plan performance/quality reporting	-	-	-
Computer workstations	-	25	9
Computer equipment	-	-	-
CAHPS audit	700	700	700
Lobbying	148	156	166
Accounting system	-	-	-
Recruiting	-	19	7
Total	$ 5,881	$ 6,108	$ 6,187
Total expenses (thousands)	$ 17,577	$ 19,162	$ 19,560
Net income (thousands)	$ 63	$ (82)	$ 160

Table 3.2: Estimated income and expenses for the Baseline design scenario
(Income: $34-36 per Exchange member per year; Inflation: 0%)
(dollar amounts are in thousands)

B. ROBUST SCENARIO RESULTS

Table 3.4 on the next page summarizes the estimated income and expense results for the "Robust" design scenario. Under the Robust scenario, the Exchange provides maximal Exchange services for each of the seven operational design elements. Thus, the choice for each operational design element is "High intensity."

For consistency, the Structural design choices for the Robust scenario are the same as those for the Baseline scenario. Following are the specific design choices for the Robust design scenario. These design choices are described in Appendix 2.

Design element	Choice
Structural	
1. Governance	**Quasi public**
2. Exchange coverage type	**Small Group and Individual**
Operational	
1. Insurer and product selection	**High intensity**
2. Eligibility determination	**High intensity**
3. Enrollment	**High intensity**
4. Premium and subsidy administration	**High intensity**
5. Communications and appeals	**High intensity**
6. Navigator services	**High intensity**
7. Marketing	**High intensity**

Table 3.3: Specific design elements for the Robust scenario

It is important to note the "high intensity" or "low intensity" Operational Design Element choice does not necessarily produce the highest or lowest operating cost. There are certain cases, such as the Eligibility Determination design element, where the "high intensity" choice actually produces the lowest operating cost, and the "low intensity" choice produces the highest operating cost. Also, for the Premium and Subsidy Administration design element, the "medium intensity" choice actually results in a higher operating cost than the "high intensity" choice. Although these results may seem counterintuitive, they are driven by operating cost reductions due to up-front investments in technology, which are expected to reduce transaction workload or reduce labor required to process transactions.

B. ROBUST SCENARIO RESULTS CONTINUED

As Table 3.4 shows, we estimate that total non-IT expenses for the Robust design scenario will be approximately $32-35 million for each year of the period 2014-2016, in current dollars (that is, without future inflation). We have included income for each year that approximates the costs. Staff salaries are the largest component of this cost, at about $11-12 million.

Appendix 4 gives detailed expense results for the Robust scenario. It shows that the largest expenditures are for Marketing ($14-15 million), Operations ($8-10 million), and Finance and Actuarial ($6-7 million).

These expenditures are based on a total Exchange staff (excluding IT personnel) of approximately 230-260 full-time employees. Appendix 4 gives detailed staffing results. It shows that we estimate the largest staff will be for the Operations function (130-150 full-time employees).

To support these expenses after 2014, we estimate that it will require approximately $50-56 per Exchange member per year, or about 1.2 percent of Exchange member premiums. Appendix 4 presents detailed income results.

Category	2014	2015	2016
A. Income (thousands)			
Revenue from assessments	$ 32,480	$ 33,920	$ 35,000
Additional revenue #1	-	-	-
Additional revenue #2	-	-	-
Additional revenue #3	-	-	-
Total	$ 32,480	$ 33,920	$ 35,000
B. Expenses (thousands)			
Direct labor costs			
Salary	$ 10,992	$ 11,658	$ 12,392
Benefits	3,627	3,847	4,089
Bonuses	-	-	-
Payroll taxes	879	933	991
Total	$ 15,499	$ 16,438	$ 17,473
Salary-driven costs			
Communications	$ 55	$ 58	$ 62
Education	27	29	31
Equipment rent	192	204	217
Insurance	165	175	186
Outside legal fees	165	175	186
Postage	55	58	62
Repairs	110	117	124
Supplies	55	58	62
Board, bureau, and association fees	27	29	31
Financial auditing	82	87	93
Bank fees	11	12	12
Travel	27	29	31
Utilities	27	29	31
Total	$ 1,000	$ 1,061	$ 1,128
Other direct costs			
Rent	$ 690	$ 738	$ 786
Branding and promotion	2,740	2,920	3,100
Leased lines	-	-	-
Navigator grants	7,423	7,423	7,423
Website maintenance & development	-	-	-
Consulting & professional support	4,180	4,240	4,300
Furniture	-	32	32
Core system maintenance & license	-	-	-
Plan performance/quality reporting	-	-	-
Computer workstations	-	21	21
Computer equipment	-	-	-
CAHPS audit	700	700	700
Lobbying	166	178	190
Accounting system	-	-	-
Recruiting	-	16	16
Total	$ 15,899	$ 16,268	$ 16,568
Total expenses (thousands)	$ 32,398	$ 33,766	$ 35,168
Net income (thousands)	$ 82	$ 154	$ (168)

Table 3.4: Estimated income and expenses for the Robust design option
(Income: $50-56 per Exchange member per year; Inflation: 0%)
(dollar amounts are in thousands)

C. OTHER SCENARIO RESULTS

Tables 3.6 and 3.7 illustrate the incremental 2015 costs for scenarios that are simple variations of the Baseline scenario. Table 3.6 illustrates variations in structural design elements, and Table 3.7 shows variations in operational design elements. Each cost amount in the table is obtained by varying only one of the structural design elements or operational design elements of the Baseline scenario at a time. (For ease of reference, the design choices for the Baseline scenario are shown in Table 3.5 to the right.)

For example, the annual cost for the variation of the Baseline scenario in which governance is performed through an existing government agency rather than a quasi-government agency is $16,287,000. This may be compared to the 2015 cost for the pure Baseline scenario of $19,162,000, resulting in a decrease of $ 2,875,000.

Design element	Design choice
Structural	
Governance	**Quasi-public**
Exchange coverage type	**Small Group and Individual**
Operational	
Insurer and product selection	**Low intensity**
Eligibility determination	**Low intensity**
Enrollment	**Low intensity**
Premium and subsidy administration	**Low intensity**
Communications and appeals	**Low intensity**
Navigator services	**Low intensity**
Marketing	**Low intensity**

Table 3.5: Specific design elements for the Baseline scenario

Structural design element/ Incremental design choice	Incremental Non-IT Annual 2015 cost (thousands)
	Baseline cost PLUS:
Governance	
Existing government agency	**$ (2,875)**
New government agency	**$ (2,361)**
Exchange coverage type[6]	
Small group only	**$ (6,946)**
Individual only	**$ (1,747)**

Table 3.6: Estimated 2015 non-IT incremental annual cost for variations in the structural design elements of the Baseline scenario (inflation: 0%, dollar amounts are in thousands)

Operational design element/ Incremental design choice	Incremental non-IT Annual 2015 cost (thousands)	
	Medium intensity	High intensity
	Baseline cost PLUS:	
Insurer and product selection	**$ 411**	**$ 862**
Eligibility determination	**$ 100**	**$ (293)**
Enrollment	**$ (578)**	**$ (669)**
Premium and subsidy administration	**$ 2,464**	**$ 2,008**
Communications and appeals	**$ 526**	**$ 1,532**
Navigator services	**$ 3,315**	**$ 5,254**
Marketing	**$ 1,005**	**$ 1,937**

Table 3.7: Estimated 2015 non-IT incremental annual cost for variations in the operational design elements of the Baseline scenario (inflation: 0%, dollar amounts are in thousands)

[6] For the "Exchange coverage type" structural design element, to obtain the "Small group only" option result, the number of people covered by Individual insurance is set to zero in the Exchange Sustainability Model. And for the "Individual only" option, the number of people covered by Small group insurance is set to zero.

C. OTHER SCENARIOS CONTINUED

Certain results in Table 3.7 require explanation, because at first glance they appear anomalous:

- **Eligibility determination**. Whereas the Baseline total 2015 non-IT cost is $19,162,000, changing the choice for the Operational design element "Eligibility determination" from "Low intensity" to "Medium intensity" results in a cost increase to $19,262,000. Changing to "High intensity" results in a cost decrease to $18,869,000. As we move from "Low intensity" to "Medium intensity" there is an increase in "Consulting and professional support" assumed. As we move to "High intensity," there remains this incremental increase in "Consulting and professional support," but there are larger decreases offsetting costs as the Exchange becomes more automated in how eligibility determination is performed.
- **Enrollment results**. Changing the choice for the Operational design element "Enrollment" from "Low intensity" to "Medium intensity" or "High intensity" results in a non-IT cost decrease to $18,584,000 and $18,493,000, respectively. The reason for this decrease is that, as we move from "Low intensity" to "Medium intensity" and "High intensity," the Exchange becomes more automated in both how enrollment works and the types of shopping functionality offered. Consequently, the number of call agents is assumed to decrease. Greater automation and more website functionality are assumed to result in fewer call center calls. It should be noted that these calls are only about enrollment; they are not about eligibility issues or premium and subsidy issues, which are accounted for elsewhere.
- **Premium and subsidy administration**. Similarly, changing the choice for the Operational design element "Premium and subsidy administration" from "Medium intensity" to "High intensity" results in a non-IT cost decrease from $21,626,000 to $21,170,000. As we move from "Medium intensity" to "High intensity," the Exchange is assumed to become more automated, resulting in decreased operating costs.

IV. Discussion

Section III (Results summary) and Appendix 4 (Detailed results) provide our estimates of the annual non-IT operating costs for two Exchange design scenarios, along with the potential revenue to cover these costs. This section discusses these results. It addresses:

- primary revenue sources
- alternative revenue sources to fund the Exchange
- the experience of other States as it relates to revenue sources
- the sensitivity of results to assumption changes

A. Primary revenue sources

Table 4.1 summarizes the non-IT annual operating costs for the two Exchange design scenarios (the Baseline scenario and the Robust scenario) for 2015 and 2016, the first two years in which the Exchange must be self-sustaining.

Item	Baseline scenario		Robust scenario	
	2015	2016	2015	2016
A. Exchange participation				
Members (thousands)	**530**	**580**	**640**	**700**
Annual premiums (thousands)	**$ 2,263,000**	**$ 2,452,000**	**$ 2,722,000**	**$ 2,973,000**
B. Annual operating cost (excluding IT)				
Total (thousands)	**$ 19,162**	**$ 19,560**	**$ 33,766**	**$ 35,168**
Per member per year (excluding IT)				
For Exchange members	**$ 36**	**$ 34**	**$ 53**	**$ 50**
For all private fully-insured members	**$ 9**	**$ 9**	**$ 17**	**$ 16**
Percentage of premiums (excluding IT)				
For Exchange members	**0.8%**	**0.8%**	**1.2%**	**1.2%**
For all private fully-insured members	**0.2%**	**0.2%**	**0.4%**	**0.4%**

Table 4.1: Estimated annual Exchange non-IT operating costs for 2015 and 2016
(in thousands of current dollars)

Exchange participation in Table 4.1 for the Baseline scenario corresponds to the "best estimate participation scenario" in the companion Milliman report.[7] Because the Robust design scenario in Table 4.1 includes more intense marketing and outreach for the Exchange, its Exchange participation corresponds to the "high participation scenario" of the companion report. It should be noted that the enrollment estimates were illustrated for 2014 and 2017 only in the companion report as opposed to the 2014-2016 view provided in this report.

[7] The report was prepared in August 2011 for the Ohio Department of Insurance, and is titled, "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefits Exchange."

A. PRIMARY REVENUE SOURCES CONTINUED

To facilitate comparison between years, no inflation is assumed.

Table 4.1 illustrates four ways to collect revenue for the Exchange:

- As a per member per year fee for Exchange members
- As a per member per year fee for all private fully-insured people in the State
- As a percentage of premiums for Exchange members
- As a percentage of premiums for all private fully-insured people

This revenue could be collected directly from health insurance companies.

B. ALTERNATIVE REVENUE SOURCES

There are other sources of revenue that states are considering for their Exchanges. These include:

- **Insurer participation fee**. Health insurance companies that want to offer plans on the Exchange could be charged a participation fee.
- **General revenue**. States could fund the Exchange through general revenue collection.
- **Excise taxes**. States could impose special taxes on specified products or services.
- **Revenue diversion**. States could divert revenue from programs that will be phased out because of health reform.
- **Funds for other programs**. Under certain designs, the Exchange will assume responsibility for eligibility determination, referral, and perhaps even enrollment for other governmental programs. States could seek to reimburse associated Exchange administrative expenses from federal and state funds for such programs.

C. EXPERIENCE IN OTHER STATES

Only a few States have prescribed how their Exchanges will generate revenue:

- **Massachusetts**. The Massachusetts's Connector charges each member an annual participation fee.
- **Utah**. The Exchange charges a per member per month membership fee.
- **California**. The Exchange will be funded through the State's general revenue fund.
- **Maryland**. The Exchange is authorized to collect fees from health insurance companies offering health plans through it, but only to the extent that such fees do not create a competitive disadvantage for such companies.
- **Connecticut**. The Exchange is authorized to collect fees from all health insurance companies that could offer health plans through it, as well as from participating members and employers.
- **Oregon**. The Exchange can charge up to 5 percent of Exchange premiums where the total Exchange enrollment is no more than 175,000, up to 4 percent of premiums where enrollment is between 175,000 and 300,000, and up to 3 percent of premiums where enrollment is more than 300,000.[8]

[8] Kaiser Family Foundation, July 2011, Establishing Health Insurance Exchanges: an update on State efforts, from Focus on health reform.

D. SENSITIVITY ANALYSIS

The charts below show the sensitivity of 2015 Exchange non-IT operating cost to changes in Exchange participation, for the Baseline and Robust scenario results.

Chart 4.1: Sensitivity of 2015 Exchange non-IT operating cost to the number of Exchange participants

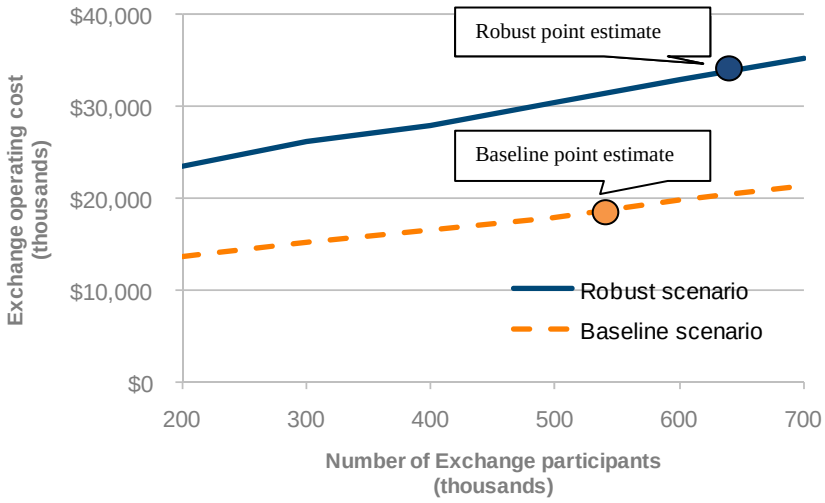
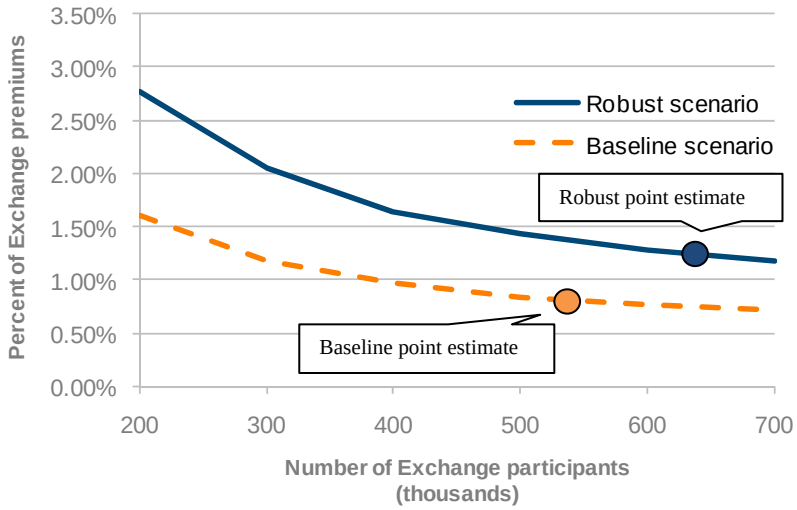


Chart 4.2: Sensitivity of 2015 Exchange non-IT operating cost as a percent of Exchange premiums to the number of Exchange participants



As the charts show, even though the dollar amount of 2015 Exchange non-IT operating cost will increase as the number of Exchange participants increases, as a percentage of Exchange premiums the cost will level off to about 0.7-0.8 percent of Exchange premiums for the Baseline scenario, and to about 1.1-1.2 percent of Exchange premiums for the Robust scenario, after Exchange enrollment reaches approximately 600,000-700,000 participants.

D. SENSITIVITY ANALYSIS CONTINUED

Table 4.2 below shows the sensitivity of annual Exchange non-IT operating cost (in thousands of dollars) to the distribution of calls to the call center. The table shows three call volume distributions:

- **Assumed in model**. This is the distribution used in the model underlying the results in this report. It assumes the highest call volume between noon and 2:00 PM.
- **More peaked**. This distributions reflects relatively more calls between noon and 1:00 PM
- **More flat**. This distribution reflects a more even distribution of calls throughout the day.

Item	Distribution of calls to call center		
	Assumed in model	More peaked	More flat
Time of day			
9:00 – 10:00 AM	7.50%	7.50%	10.00%
10:00 – 11:00 AM	10.00%	10.00%	10.00%
11:00 – 12:00 PM	12.50%	15.00%	15.00%
12:00 – 1:00 PM	20.00%	30.00%	15.00%
1:00 – 2:00 PM	20.00%	15.00%	15.00%
2:00 - 3:00 PM	12.50%	10.00%	15.00%
3:00 - 4:00 PM	10.00%	7.50%	10.00%
4:00 - 5:00 PM	7.50%	5.00%	10.00%
Call center staff			
Baseline scenario	59	80	48
Robust scenario	57	75	47
Incremental Exchange operating cost (excluding IT) (thousands of dollars)	Baseline non-IT operating cost PLUS:		
Baseline scenario		**$ 1,040**	**$ (612)**
Robust scenario		**$ 896**	**$ (560)**

Table 4.2: Sensitivity of annual Exchange non-IT operating cost (in thousands of dollars) to the distribution of calls to the call center

As the table shows, slight changes in the call volume distribution can add or (subtract) up to $1 million to the Exchange annual non-IT operating cost, under both the Baseline and Robust scenarios.

Note that the Robust scenario assumes fewer call center staff because of greater automation and more website functionality in this scenario is assumed to result in fewer call center calls.

V. RECOMMENDATIONS

Regarding the maintenance of financial sustainability for Ohio's Exchange, we make the following recommendations:

1. **Use a defined process, with specified decision criteria, to select a financing method.** Because the means of funding the Exchange are complex, we suggest using a defined process to select a financing method, a process that involves healthcare stakeholders and specific decision criteria. Such criteria may include:
   - **Alignment with the goals, design, and perceived value of the Exchange**.
   - **Minimizing disincentives for Exchange participation**. Some financing methods – such as assessing a fee for every contact within the Exchange – could deter Exchange participation, and would not be recommended.
   - **Minimizing financial risk**. Some financing sources are potentially more volatile than others. These should be considered carefully, and possibly combined with other more stable financing sources.
   - **Transparency**. Whatever financing method is chosen, it should be easy to communicate.
   - **Practicality**. The financing method chosen should be practical to implement. For example, because of ERISA regulations, it might prove impractical to collect assessments on privately self-insured populations that are not covered under stop-loss insurance.
   - **Minimizing adverse selection**. The financing method should not contribute to adverse selection in the healthcare marketplace.
2. **Establish a financial surplus.** Because Exchange membership may build slowly and may experience considerable volatility in the early years until it reaches a steady state, and because operating expenses cannot be immediately adjusted to reflect membership changes, we suggest establishing a financial surplus of 20 to 25 percent of the annual operating budget. We further suggest starting to establish this surplus in 2014.

VI. LIMITATIONS/QUALIFICATIONS

The information contained in this report has been prepared for the Ohio Department of Insurance (ODI). It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

This report is not intended to benefit third parties. Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the likely impact in Ohio associated with the implementation of a Health Benefit Exchange.

This analysis has relied extensively on data and assumptions as documented in this report. No independent audits were performed of the data. To the extent that errors or omissions are discovered in the source data, the results of our analysis would need to be modified.

This report specifically excludes operating costs associated with information technology (IT) infrastructure maintenance. Our projections must be accompanied by a separate estimate of these excluded costs to obtain a complete estimate of the total operating costs associated with the Exchange. Our understanding is that the State has retained a vendor that is specifically focused on the IT component of the Exchange operations and, as such, will be providing separate estimates for these items. The exclusion in this report is intended to avoid duplication.

This report was created by Andrew L. Naugle and Jeremy D. Palmer. Both Mr. Naugle and Mr. Palmer are Principals of Milliman. Mr. Palmer is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Mr. Palmer is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

APPENDIX 1. METHODOLOGY AND ASSUMPTIONS

This appendix describes the methodology and assumptions underlying the non-IT operating cost results in this report. It has the following sections:

- **General methodology**. In this section, we give an overview of the general methodology.
- **Staffing assumptions**. Here we describe the assumptions we used to staff Ohio Exchange design alternatives, including the responsibilities of the various staff positions, the staffing assumptions for the Baseline scenario, and how these assumptions change for Structural Design Elements and Operational Design Elements.
- **Call center volume assumptions**. This section describes the assumptions for call center volume results, which in turn underlie our results for staffing the call center.
- **Direct labor costs**. This section describes our assumptions for total direct compensation, including payroll taxes.
- **Indirect labor costs**. This section describes our assumptions regarding cost categories, other than direct labor costs, that can be estimated with compensation as a base, such as education, equipment, and travel.
- **Other direct costs**. This section describes our assumptions about costs that must be estimated individually such as system license fees, consulting and professional services, and marketing expense.

A. GENERAL METHODOLOGY

For each Exchange design scenario, we estimate Exchange annual costs as the sum of three cost categories:

- Direct labor costs
- Indirect labor costs
- Other direct costs

The other sections of this appendix describe the assumptions underlying each of these categories. In general, the annual cost for a particular Exchange design is equal to the cost of the Baseline scenario plus the incremental costs associated with each of the design choices for Structural Design Elements and for Operational Design Elements.

This methodology addresses only the non-IT operating costs needed to run an Exchange. It does not address costs of planning or setting up an Exchange and does not include IT related maintenance and support.

B. STAFFING ASSUMPTIONS

In this section, we describe the assumptions we used to staff Ohio Exchange design alternatives, including the responsibilities of the various staff positions, the staffing assumptions for the Baseline scenario, and how these assumptions change for Structural Design Elements and Operational Design Elements. For information about the Baseline scenario, Structural Design Elements, and Operational Design Elements, see Appendix 2 (Exchange design scenarios).

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
1. Executive management				
	The Exchange will have an Executive Office plus four operating units: Operations, Marketing, Finance, and Information Systems. An Executive Director will lead a management team comprised of Directors overseeing each of the four operating units.	Minimum staffing for this department is: ▪ 1 Executive Director ▪ 4 Directors (Operations, Marketing, Finance, and Information Systems) ▪ 5 Executive Assistants ▪ 1 Board Liaison Each Director will be supported by an administrative assistant, who will also support the staff in the department.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	The model assumes staffing for this unit will not be affected by the Operational Design Elements.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
2. Operations				
Plan Administration	This unit will be responsible for managing the Exchange's relationships with health insurance carriers and certifying plans that are offered in the Exchange.	Minimum staffing for this department is: ▪ 1 Manager ▪ 1 Carrier Liaison ▪ 1 Plan Certification Analyst ▪ 1 Clerk Staffing for the Carrier Liaison, Plan Certification Analyst, and Clerk positions will increase as the number of carriers participating in, or plans offered in, the Exchange increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Insurer and Product Selection. Staffing for the Carrier Liaison, Plan Certification Analyst, and Clerk positions will increase as the Exchange enrollment increases. Insurer and Product Selection. Staffing for the Plan Certification Analyst is assumed to decrease if fewer plans are offered through the Exchange. Enrollment. Staffing for the Carrier Liaison is assumed to increase when intensity drives more robust carrier coordination responsibilities.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
2. Operations continued				
Call Center	This unit will be responsible for responding to inquiries from consumers. We assumed the majority of these inquiries would be telephonic. However, the call center staff may also respond to written or electronic inquiries.	Staffing for this department includes: ▪ 1 manager per 50 call center agents ▪ 1 supervisor per 20 call center agents Call center agent staffing is based on an Erlang Model. Specific assumptions regarding the Erlang model are documented in the next section of this appendix.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	The model assumes that the call center workload will be affected in multiple ways by the Operational Design Elements. These assumptions are documented in the next section of this appendix.
Eligibility Processing	This unit will be responsible for assisting with eligibility determinations, and eligibility appeals.	Staffing for this department includes: ▪ 1 Supervisor ▪ 1 Eligibility Processor ▪ 1 Appeals Processor Staffing for the Eligibility Processor and Appeals Processor positions is assumed to increase as enrollment increases. Staffing for the Supervisor position is assumed to increase as staffing in the department increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Eligibility Determination. The model assumes that automation under the High intensity scenario reduces the Eligibility Processor staffing but increases Appeals Processor staffing. Communications and Appeals. Staffing for the Appeals processor is assumed to increase as the Exchange becomes involved in helping consumers resolve issues and complaints against insurers.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
2. Operations continued				
Plan Performance and Quality Reporting	This unit will be responsible for monitoring and reporting the performance of plans offered in the Exchange, and for collecting and reporting statistics.	Minimum staffing for this department includes: ▪ 1 Manager ▪ 2 Reporting Analysts ▪ 1 Report Developer The Report Developer position is responsible for designing the reporting infrastructure. The Reporting Analysts are responsible for analyzing and reporting plan performance and quality information to a wide range of constituencies. Staffing for the Reporting Analyst and Report Developer positions is assumed to increase as enrollment increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Insurer and Product Selection. Staffing for the Reporting Analyst and Report Developer positions is assumed to increase as the number of carriers increases. Premium and Subsidy Determination. Staffing for the Reporting Analyst and Report Developer positions is assumed to increase as the Exchange's role in determining premium and subsidy amounts increases. Communications and Appeals. Staffing for the Reporting Analyst and Report Developer positions is assumed to increase at the High Intensity level to support presentation of plan performance information on the website.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
2. Operations continued				
Enrollment Reporting	This unit will be responsible for handling preparation of enrollment reports and enrollment files.	Minimum staffing for this department includes: ▪ 1 Manager ▪ 1 Enrollment Reporting Analyst The Enrollment Reporting Analyst position may be involved in various aspects of enrollment processing and data handling including exchange of files between the Exchange and carriers, or between the Exchange and employers. Staffing for the Enrollment Reporting Analyst position is assumed to increase as enrollment increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Insurer and Product Selection. Staffing for the Enrollment Reporting Analyst is assumed to increase as the Exchange enrollment increases. Enrollment. Staffing for the Enrollment Reporting Analyst is assumed to increase to support more robust reporting and enrollment file transfers between the carriers and the Exchange. .

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
3. Marketing				
Exchange Marketing	This unit will be responsible for marketing the Exchange. This includes development and execution of a marketing plan.	Minimum staffing for this department includes: ▪ 1 Manager ▪ 2 Marketing Coordinators The Marketing Coordinator role is used to define a general marketing support position. Staffing for the Marketing Coordinator position is assumed to increase as enrollment increases. The model assumes that the Exchange will rely on vendors to support marketing and advertising functions such as creative and media buying.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Communications and Appeals. Staffing for the Marketing Coordinators is assumed to increase as the Exchange becomes involved in helping consumers resolve complaints and other issues, especially complaints against insurers. Marketing. Staffing for the Marketing Coordinators is assumed to increase as the Exchange's marketing efforts increase.
Navigator Services	This unit will be responsible for administering the Exchange's Navigator program.	Minimum staffing for this department includes: ▪ 1 Manager ▪ 1 Navigator Liaison The model does not assume that the Exchange will employ a staff of Navigators, but rather, that the Exchange will leverage community-based resources such as brokers or staff in social services organizations, to serve in the role of Navigator. Under this arrangement, the Navigator Liaisons will be responsible for coordinating with, training, and interfacing with the Navigators. Staffing for the Navigator Liaison position is assumed to increase as enrollment increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Navigator Services. Staffing for the Navigator Liaison position is assumed to increase as the Navigators' responsibilities increase.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
3. Marketing				
Materials and Fulfillment	This unit will be responsible for developing consumer-facing materials such as handbooks.	Minimum staffing for this department includes: ▪ 1 Supervisor ▪ 1 Copywriter ▪ 1 Graphics Designer ▪ 1 Clerk Staffing for the Copywriter, Graphics Designer, and Clerk positions is assumed to increase as enrollment increases. Staffing for the Supervisor position increases as the number of department staff increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Enrollment. Staffing for the Copywriter and Graphics Designer positions is assumed to increase to support increased website functionality and enrollment-related materials for consumers. Communications and Appeals. Staffing for the Copywriter, Graphics Designer, and Clerk positions is assumed to increase to support the Exchange's involvement in handling consumer complaints. Navigator Services. Staffing for the Copywriter, Graphics Designer, and Clerk positions is assumed to increase to support development of materials for the Navigator Program. Marketing. Staffing for the Copywriter, Graphics Designer, and Clerk positions is assumed to increase to support additional intensity of the marketing program.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
3. Marketing continued				
Government and Public Relations	This unit will be responsible for developing and executing the Exchange's Government and public relations strategy.	Minimum staffing for this department includes: ▪ 1 Manager ▪ 1 Public Relations Coordinator ▪ 1 Government Relations Coordinator ▪ 1 Grant Writer Staffing for the Public Relations Coordinator, Government Relations Coordinator, and Grant Writer positions is assumed to increase as enrollment increases.	The model assumes that staffing for this unit will be affected by the New Government Agency and Existing Government Agency Structural Design Elements. In either structural design alternative, the model assumes that these functions are provided by existing Government personnel. The model assumes that the Grant Writer position is not affected by the Structural Design Elements.	Communications and Appeals. Staffing for the Public Relations Coordinator will be affected by the Exchange's involvement in resolving consumer complaints against insurers.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
4. Information systems				
Information systems	This department will be responsible for maintaining the Exchange's information systems infrastructure.	***The staffing assumptions for this functional area have been omitted from this report. Another vendor is contracted to estimate the IT component of the exchange operations and, as such, ODI has requested that we omit these costs from our estimates to avoid duplication.*** ***Note, however, that staffing and/or costs in nearly all functional areas are affected by the sophistication, integration, and level of automation inherent in the information systems ultimately deployed for the Ohio Exchange.***		

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
5. Finance and actuarial				
Actuarial Analysis	This unit will be responsible for all actuarial functions, including complex modeling, analytics, and risk adjustment.	Minimum staffing for this unit includes 1 Actuary. Staffing for the Actuary position is assumed to increase as enrollment increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Insurer and Product Selection. Staffing for the Actuary position is assumed to increase to support more scrutiny and review of carriers and plans. Premium and Subsidy Determination. Staffing for the Actuary position is assumed to increase to support more involvement in premium analysis, including risk adjustment.
Financial Analysis	This unit will be responsible for all financial operations of the Exchange, including where appropriate, premium aggregation accounting.	Minimum staffing for this unit includes: ▪ 1 Controller ▪ 1 Staff Accountant ▪ 1 Financial Analyst Staffing for the Staff Accountant and Financial Analyst positions is assumed to increase as enrollment increases.	The model assumes that staffing for this unit will not be affected by any of the Structural Design Elements.	Eligibility Determination. Staffing for the Financial Analyst is assumed to increase at the High Intensity due to increased requirements for financial reporting. Premium and Subsidy Determination. Staffing for the Staff Accountant and Financial Analyst positions is assumed to increase in scenarios where the Exchange is involved in determining premium and subsidy amounts. Staffing for the Staff Accountant position increases significantly under the Medium intensity scenario, then to a lesser extent under the High intensity scenario.

B. STAFFING ASSUMPTIONS CONTINUED

Functional area	Responsibility	Baseline scenario	Structural Design Elements	Operational Design Elements
6. Infrastructure				
Infrastructure	These positions support the administrative infrastructure requirements of the Exchange. The modeling assumes that the Exchange operation uses vendors for functions like maintenance and janitorial.	Minimum staffing for this unit includes: ▪ 1 Human Resources Generalist ▪ 1 Payroll Specialist ▪ 2 Training Specialists ▪ 1 Attorney ▪ 1 Compliance Officer ▪ 1 Office Manager ▪ 1 Mail Clerk Staffing for these positions is assumed to increase as staffing increases.	The model assumes that staffing for this unit will be affected by the New Government Agency and Existing Government Agency Structural Design Elements. In either Structural Design Element, the model assumes that most of these functions are provided by existing Government personnel. However, the model assumes that the Training Specialist position is not affected by the Structural Design Elements.	The model assumes that staffing for these positions will not be affected by any of the Operational Design Elements.

C. CALL CENTER VOLUME ASSUMPTIONS

This section describes the assumptions for call center volume results, which in turn underlie our results for staffing the call center.

We used the "Erlang" model to estimate call center staffing for the Exchange. Use of an Erlang model is a common method for estimating call center staffing needs based on projected workload characteristics, such as the service level (i.e. percent of calls handled in a given amount of time), call duration, and call volume.

To estimate the number of agents required to staff the call center, we made assumptions about the number of calls that would be generated under various Operational Design Elements and intensities (low, medium, and high). The number of calls is related to the enrollment in the Exchange. We also made assumptions about the duration of calls, the documentation time, and the service level.

For all scenarios, we made the following assumptions:

- The baseline (low intensity) option assumes 80 percent of calls are answered in 30 seconds. This service level represents the performance target for most health insurance company call center operations.
- The medium intensity option assumes 80 percent of calls are answered in 20 seconds. This service level represents a higher standard than most health insurance company call center operations.
- The high intensity option assumes that 90 percent of calls are answered in 20 seconds. This service level represents a very high call center standard.
- The call center will operate 8 hours a day, 5 days a week for 52 weeks, or 260 days; and
- The call volume each hour will fluctuate, with the majority of calls occurring during hours 4 and 5 (i.e. in the middle of the day). This is a typical call distribution.

Note that as it relates to call center staffing, the model does not simulate a "ramp-up" of enrollment (and therefore call center activity) over the period of a year, but rather assumes a year-end enrollment. In practice, we expect enrollment in the Exchange to increase over a year, and call center workload, and therefore staffing, to increase over time. However, we would also expect that the Exchange call center would be subject to higher-than-average call volumes during the launch period and that higher than normal staffing would be needed at certain times of the year. For conservatism, we assumed year-end call center staffing would be applicable to the entire year. During the implementation, the Exchange will need to develop a workforce model that stages call center staffing to accommodate peak volumes and call center agent training.

C. CALL CENTER VOLUME ASSUMPTIONS CONTINUED

In the tables that follow we have provided the assumptions associated with each Operational Scenario Alternative and intensity level. We first provide such assumptions associated with Individual coverage, and then provide such assumptions for Small Group coverage.

Information shown in each table includes:

- **Intensity**. Assumptions vary for each Design Alternative (Low Intensity, Medium Intensity, and High Intensity and hence are separately shown.
- **Call Duration**. Indicates the duration of each call in seconds. The duration of the calls is expected to vary depending on the type of call. Note that the workload estimates assume each call covers only one topic. If a call covers multiple topics, we would expect that the volume of calls would be less, but that reduction would be partially offset by the duration of the call.
- **Documentation Duration**. Indicates the amount of time allotted for call "wrap-up." This assumption accommodates time between calls to allow for documentation of call notes in a database system.
- **Service Level**. Represents the percentage of calls answered in a given number of seconds. A higher service level means that more calls are answered more quickly. The industry standard for contact centers is 80% of calls answered in 20 or 30 seconds.
- **Calls PMPY**. Represents the assumed number of times a member will call about an issue per year. Design alternatives that include higher Exchange functionality are assumed to decrease the number of calls per member per year.
- **Annual Days**. Represents the number of working days per year. The model assumes the call center operates five days per week, 52 weeks per year. The assumption is not adjusted to reflect holidays.

C. CALL CENTER VOLUME ASSUMPTIONS CONTINUED

1. Individual Coverage

Intensity	Call duration (seconds)	Documentation Duration (seconds)	Service Level		Calls PMPY	Annual days
1. Eligibility						
Baseline (Low)	**180**	**30**	**80%**	**20 seconds**	**0.20**	**260**
Medium	**180**	**30**	**80%**	**20 seconds**	**0.20**	**260**
High	**180**	**30**	**90%**	**20 seconds**	**0.15**	**260**
Assumptions: As intensity increases, so will automation. Therefore, the number of calls per member per year (PMPY) will decrease.						
2. Enrollment						
Baseline (Low)	**480**	**30**	**80%**	**30 seconds**	**0.50**	**260**
Medium	**480**	**30**	**80%**	**20 seconds**	**0.25**	**260**
High	**480**	**30**	**90%**	**20 seconds**	**0.10**	**260**
Assumptions: As intensity increases, so will automation. Therefore, the number of calls per member per year (PMPY) will decrease.						
3. Premium and subsidy						
Baseline (Low)	**240**	**30**	**80%**	**30 seconds**	**0.30**	**260**
Medium	**240**	**30**	**80%**	**20 seconds**	**0.60**	**260**
High	**240**	**30**	**90%**	**20 seconds**	**0.50**	**260**
Assumptions: As intensity increases, the premium and subsidy process remains constant for individuals. Thus, the only change in scenario will be the percentage of calls answered in specified number of seconds.						
4. Communication and appeals						
Baseline (Low)	**240**	**30**	**80%**	**30 seconds**	**0.05**	**260**
Medium	**240**	**30**	**80%**	**20 seconds**	**0.05**	**260**
High	**480**	**30**	**90%**	**20 seconds**	**0.10**	**260**
Assumptions: In the high intensity option the Exchange will help resolve complaints against insurance companies. We assume this will increase the call time and the number of calls PMPY.						

C. CALL CENTER VOLUME ASSUMPTIONS CONTINUED

2. Small Group Coverage

In general, a small group purchaser will interact with the Exchange differently than an individual. We assumed that there will be a single representative at each small group who will contact the Exchange on behalf of its enrollees. Additionally, we assumed an average group size of 7.5 individuals.[9] We assumed that in general calls from a small group representative would be longer as a result of call representing multiple individuals' issues or complaints. As such, we also assumed a lower call volume because small group representatives will likely call less often with a list of issues vs. an individual that will call with only one or two issues.

Intensity	Call duration (seconds)	Documentation Duration (seconds)	Service Level		Calls PMPY	Annual days
1. Eligibility						
Baseline (Low)	**240**	**30**	**80%**	**20 seconds**	**0.10**	**260**
Medium	**240**	**30**	**80%**	**20 seconds**	**0.10**	**260**
High	**240**	**30**	**90%**	**20 seconds**	**0.10**	**260**
Assumptions: As intensity increases, so will automation. Therefore, the number of calls per member per year (PMPY) will decrease.						
2. Enrollment						
Baseline (Low)	**510**	**30**	**80%**	**30 seconds**	**0.30**	**260**
Medium	**510**	**30**	**80%**	**20 seconds**	**0.20**	**260**
High	**510**	**30**	**90%**	**20 seconds**	**0.075**	**260**
Assumptions: In the high intensity option the Exchange will help resolve complaints against insurance companies. We assumed this activity will increase the call time and the number of calls PMPY.						
3. Premium and subsidy						
Baseline (Low)	**270**	**30**	**80%**	**30 seconds**	**0**	**260**
Medium	**270**	**30**	**80%**	**20 seconds**	**0.20**	**260**
High	**270**	**30**	**90%**	**20 seconds**	**0.20**	**260**
Assumptions: In the medium and high intensity options, the Exchange will provide the premium aggregation function. We assumed this activity will generate additional call volume.						
4. Communication and appeals						
Baseline (Low)	**270**	**30**	**80%**	**30 seconds**	**0.03**	**260**
Medium	**270**	**30**	**80%**	**20 seconds**	**0.03**	**260**
High	**510**	**30**	**90%**	**20 seconds**	**0.075**	**260**
Assumptions: In the high intensity option the Exchange will help resolve complaints against insurance companies. We assumed this activity will increase the call time and the number of calls PMPY.						

[9] This assumption is consistent with assumptions in the companion Milliman report, and with insurer annual statements as of December 31, 2010. The companion report was prepared in August 2011 for the Ohio Department of Insurance, and is titled, "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefits Exchange."

D. DIRECT LABOR COSTS

This section describes our assumptions for base compensation, benefits, and payroll taxes.

Base Compensation

In the model, each position is assigned a salary (base compensation cost). These costs are based on third party salary data from multiple sources. The sources we used include: the Warren Survey, Salary.com, and proprietary Milliman salary surveys. Many of the positions that will be required to operate the Exchange are similar in function to positions within health insurance companies or other private sector entities. For each position, we developed a high-level job description, which we used as a basis for identifying comparable positions within the salary survey data. In some cases, such as the actuarial unit, we developed a blended salary rate based on an assumption that the department would be staffed with a combination of senior, mid-level, and junior personnel. We used professional judgment to develop that mix.

As the salary data was collected in 2010, we applied an inflation factor to estimate the appropriate base compensation cost for 2011. Note that the salaries used in this model reflect private sector compensation, which may vary from public sector compensation levels. Furthermore, Milliman makes no guarantee that the Exchange will actually be able to hire staff at these salary levels. A variety of factors -- such as local market demand, candidate qualifications and experience -- may impact the viability of these salaries at the point of hiring. The Exchange should conduct its own compensation studies to determine appropriate salaries for each position when actually hiring and negotiating with candidates.

Total salary cost is the product of estimated staffing for each position, multiplied by the appropriate salary for each position.

Benefits

We calculated benefits expense using a factor based on typical benefit loads we observe in health insurance companies and related entities (33 percent). The benefits factor is applied to base compensation.

Payroll Taxes

We calculated payroll tax cost as 8 percent of base compensation. This factor is based on an average tax rate and may not reflect tax rates in the jurisdiction where the Exchange will operate.

E. INDIRECT LABOR COSTS

This section describes our assumptions regarding cost categories that are tied to compensation costs, such as education, equipment, and travel.

We calculated indirect costs using "percent-of-salary" factors for each of the following cost categories:

- Communications
- Education
- Equipment rent
- Insurance
- Outside legal fees
- Postage
- Repairs
- Supplies
- Boards, bureaus, and association fees
- Financial auditing
- Bank fees
- Travel
- Utilities

We developed these factors using health insurance company annual statement data adjusted to reflect assumed differences between Exchange operations and health insurer operations. We used professional judgment to make these adjustments. For the two Structural Design Elements involving Government operation of the Exchange, we assumed that responsibility for the following functions would be assumed by other Government agencies: Insurance, Outside Legal Fees, and Financial Auditing. In these scenarios, no cost is included in the Exchange budget for these services.

F. OTHER DIRECT COSTS

This section describes our assumptions about costs that are not directly related to compensation, such as rent, recruiting, furniture, and computer systems. These costs are those line item costs that must be individually estimated based on expected consumption. We estimated these costs using combinations of four different allocation methods:

- Flat Amount
- Expense per 1,000 members
- Expense per new employee
- Expense per $1,000 in base compensation cost

A description of these assumptions is provided in the table below.

Item	Baseline Assumption	Structural Design Alternative Adjustments	Operational Design Alternative Adjustments
1. Executive management			
Rent	Assumes 150 square feet per employee and $20 per square foot gross lease rate. This estimate is inclusive of common space.	Assumes this expense is excluded for the Existing Government Agency scenario.	Assumes no impact to this expense.
Furniture	Assumes per new employee expense of $2,000.	Assumes no impact to this expense.	Assumes no impact to this expense.
Computer Workstations	Assumes per new employee expense of $1,300.	Assumes no impact to this expense.	Assumes no impact to this expense.
Recruiting	Assumes per new employee expense of $1,000.	Assumes reduction under the New Government Agency and Existing Government Agency scenarios.	Assumes no impact to this expense.
2. Operations			
Rent	Assumes 150 square feet per employee and $20 per square foot gross lease rate. This estimate is inclusive of common space.	Assumes this expense is excluded for the Existing Government Agency scenario.	Assumes no impact to this expense.
Furniture	Assumes per new employee expense of $2,000.	Assumes no impact to this expense.	Assumes no impact to this expense.

F. OTHER DIRECT COSTS CONTINUED

Item	Baseline Assumption	Structural Design Alternative Adjustments	Operational Design Alternative Adjustments
2. Operations continued			
Computer Workstations	Assumes per new employee expense of $1,300.	Assumes no impact to this expense.	Assumes no impact to this expense.
CAHPS Audit	Assumes flat fee based on set number of surveys per year. Model assumes there are 50 plans offered in the Exchange, 700 surveys per plan, and $20 per survey vendor fee.	Assumes no impact to this expense.	Assumes no impact to this expense.
Recruiting	Assumes per new employee expense of $1,000.	Assumes reduction under the New Government Agency and Existing Government Agency scenarios.	Assumes no impact to this expense.
3. Marketing			
Rent	Assumes 150 square feet per employee and $20 per square foot gross lease rate. This estimate is inclusive of common space.	Assumes this expense is excluded for the Existing Government Agency scenario.	Assumes no impact to this expense.
Branding and Promotion	Assumes marketing spend of $1 million plus $1 per member per year inclusive of media, promotional materials, postage, and other associated expenses.	Assumes no impact to this expense.	Assumes 100% marginal increase for medium scenario for Marketing. Assumes 200% marginal increase for high scenario for Marketing.
Navigator Grants	Assumes 10% of revenue is generated by Navigators and 0.75% of premium is paid in commissions or otherwise funded to support the Navigator Function	Assumes no impact to this expense.	For Medium Intensity, assumes 15% of revenue is generated by Navigators and 1% of premium is paid in commissions or otherwise funded to support the Navigator function. For High Intensity, assumes 18% of revenue of generated by Navigators and 1.25% of premium is paid in commissions or otherwise funded to support the Navigator function.
Furniture	Assumes per new employee expense of $2,000.	Assumes no impact to this expense.	Assumes no impact to this expense.
Computer Workstations	Assumes per new employee expense of $1,300.	Assumes no impact to this expense.	Assumes no impact to this expense.
Recruiting	Assumes per new employee expense of $1,000.	Assumes reduction under the New Government Agency and Existing Government Agency scenarios.	Assumes no impact to this expense.

F. OTHER DIRECT COSTS CONTINUED

Item	Baseline Assumption	Structural Design Alternative Adjustments	Operational Design Alternative Adjustments
4. Information systems			
The cost assumptions for this functional area have been omitted from this report. Another vendor is contracted to estimate the IT component of the exchange operations and, as such, ODI has requested that we omit these costs from our estimates to avoid duplication.			

F. OTHER DIRECT COSTS CONTINUED

Item	Baseline Assumption	Structural Design Alternative Adjustments	Operational Design Alternative Adjustments
5. Finance and actuarial			
Rent	Assumes 150 square feet per employee and $20 per square foot gross lease rate. This estimate is inclusive of common space.	Assumes this expense is excluded for the Existing Government Agency scenario.	Assumes no impact to this expense.
Consulting and Professional Support	Assumes $1 million plus $1 per member per year for consulting and professional services for multiple departments.	Assumes no impact to this expense.	Insurer and Product Selection. Assumes 10% base fee increase for medium scenario. Insurer and Product Selection. Assumes 25% base fee increase for high scenario. Eligibility Determination. Assumes 10% base fee increase for medium scenario. Eligibility Determination. Assumes 25% base fee increase for high scenario. Enrollment. Assumes 10% base fee increase for medium scenario. Enrollment. Assumes 25% base fee increase for high scenario. Premium and Subsidy Determination. Assumes 50% base fee increase for medium scenario. Premium and Subsidy Determination. Assumes 75% base fee increase for high scenario. Communications and Appeals. Assumes 15% base fee increase for medium scenario. Communications and Appeals. Assumes 30% base fee increase for high scenario. Navigator Services. Assumes 15% base fee increase for medium scenario. Navigator Services. Assumes 30% base fee increase for high scenario. Marketing. Assumes 25% base fee increase for medium scenario. Marketing. Assumes 50% base fee increase for high scenario.
Furniture	Assumes per new employee expense of $2,000.	Assumes no impact to this expense.	Assumes no impact to this expense.
Computer Workstations	Assumes per new employee expense of $1,300.	Assumes no impact to this expense.	Assumes no impact to this expense.

F. OTHER DIRECT COSTS CONTINUED

Item	Baseline Assumption	Structural Design Alternative Adjustments	Operational Design Alternative Adjustments
5. Finance and actuarial continued			
Recruiting	Assumes per new employee expense of $1,000.	Assumes reduction under the New Government Agency and Existing Government Agency scenarios.	Assumes no impact to this expense.
6. Infrastructure			
Rent	Assumes 150 square feet per employee and $20 per square foot gross lease rate. This estimate is inclusive of common space.	Assumes this expense is excluded for the Existing Government Agency scenario.	Assumes no impact to this expense.
Furniture	Assumes per new employee expense of $2,000.	Assumes no impact to this expense.	Assumes no impact to this expense.
Computer Workstations	Assumes per new employee expense of $1,300.	Assumes no impact to this expense.	Assumes no impact to this expense.
Lobbying	Assumes a flat expense plus an additional per-member fee to account for scale impact.	Assumes this expense is excluded for the New Government Agency and Existing Government Agency scenarios.	Assumes no impact to this expense.
Recruiting	Assumes per new employee expense of $1,000.	Assumes reduction under the New Government Agency and Existing Government Agency scenarios.	Assumes no impact to this expense.

APPENDIX 2. EXCHANGE DESIGN SCENARIOS

This appendix describes the Exchange design scenarios defined in this report. Each design scenario is made up of "design elements," of which there are two major categories: "structural" design elements that relate to the overall structure of the Exchange, and "operational" design elements that relate to operational characteristics of the Exchange.

A. STRUCTURAL DESIGN ELEMENTS

There are two structural design elements:

1. Governance

Governance refers to the type of organization chosen for the Exchange. For this design element, the model includes three options:

- **Quasi-public organization**: This type of organization is separate from state governmental organizations. As a result, it is not bound by state rules for hiring, compensation, infrastructure, contracting, or decision-making.
- **Existing government agency**: The Exchange is part of an existing governmental agency. In this case, the Exchange conforms to state rules for hiring, compensation, infrastructure, contracting, and decision-making. It shares certain infrastructure components and overhead functions with the existing agency.
- **New government agency**: The Exchange can also be a new government agency. In this case, the Exchange conforms to state rules for hiring, compensation, infrastructure, contracting, and decision-making, but must establish its own infrastructure and overhead functions.

2. Exchange coverage type

This design element refers to the types of health insurance coverage the Exchange will offer. The model includes three options:

- **Small Group and Individual**: This type of Exchange will offer both Small Group and Individual health insurance coverage. The operational processes of an Exchange will be different for these two types of coverage. As examples: For Individual coverage, the Exchange must include processes to handle federal premium subsidies and out-of-pocket cost reduction payments. And for Small Group coverage, the Exchange must have processes to deal directly with employers.
- **Small Group only**: This type of Exchange is a "Small Business Health Option Program" (SHOP) type of Exchange. It does not provide Individual insurance.
- **Individual only**: This type of Exchange only provides Individual health insurance.

B. OPERATIONAL DESIGN ELEMENTS

There are seven operational design elements, each corresponding to a basic function that the Exchange must perform. For each function, there are three options: Low intensity, Medium intensity, and High intensity. "Low intensity" corresponds to the minimum required services, as described by the Center for Consumer Information and Insurance Oversight (CCIIO) and in regulations (see Appendix 2). "High intensity" corresponds to the maximum services that an Exchange might provide that would be useful and viable. The level of automation is one variable that often differentiates the Medium Intensity and High Intensity choices from the Low intensity choice. It is important to note that in production operations, full automation of a process is rarely achievable. Often only components of a process can be automated. For modeling purposes, we have assumed that even scenarios involving "full automation" still require some staffing to, for example, initiate the process, conduct quality reviews, or handle exceptions that could not be completely handled via the automated process. These assumptions are based on the levels of automation we have seen other organizations, particularly health insurers, able to achieve. The staffing assumptions used in preparing this analysis inherently assume levels of information systems sophistication, integration, and automation. These assumptions were developed independent of the IT cost estimates (which were prepared by another vendor engaged by the State) and hence must be reconciled to ensure the information system design and capabilities will actually provide the automation efficiencies assumed in developing the staffing.

Following are descriptions of Low, Medium, and High intensity functions for each operational design element.

1. Insurer and product selection

This element refers to how the Exchange determines the insurers and plans to offer its members.

- **Low intensity**: The Exchange determines the insurers and plans to offer based on minimum criteria established by the federal government. It allows insurers to set premium levels, and to offer a variety of plan designs. It reviews an insurer's pattern of premium increases for reasonability.
- **Medium intensity**: Through published guidelines, the Exchange selects the scope of insurers, plans, and premium levels it offers.
- **High intensity:** The Exchange is more engaged in all levels of carrier and product offerings. More services are offered to support the insurance transaction for individuals, employees, and employers including more sophisticated reporting and communications.

B. OPERATIONAL DESIGN ELEMENTS CONTINUED

2. Eligibility determination

This element refers to how the Exchange determines participation and subsidy eligibility.

- **Low intensity**: The Exchange is moderately automated, determines final subsidy amounts, and provides one eligibility portal for all State programs.
- **Medium intensity**: The Exchange is similar in design to the low intensity scenario; however, additional costs are assumed related to "Consulting and professional support."
- **High intensity:** The Exchange eligibility process is highly automated and integrated with other State programs.

3. Enrollment

This element refers to how the Exchange helps consumers select a plan and enroll.

- **Low intensity**: The Exchange maintains a website to present plan options in a standardized format, assigns a price and quality rating to the plans, and provides basic enrollment support. It also provides a simple calculator on its website to help consumers determine the cost of coverage, and it operates a toll-free hotline. These tools accommodate a limited number of employer-specific choices for employees of participating employers.
- **Medium intensity**: The plan selection and enrollment process is more automated.
- **High intensity**: The Exchange offers a sophisticated, highly automated, plan selection and enrollment process. Its website provides advanced filtering tools that help consumers compare insurers, plans, and even provider networks. The website has advanced communication features that allow consumers to chat with or call an operator, and presents consumers with recommended plans based on their preferences.

4. Premium and subsidy administration

This element refers to how the Exchange handles the collection, distribution, and reconciliation of premiums and subsidies.

- **Low intensity**: For Individual coverage, the Exchange estimates an applicant's subsidies and out-of-pocket costs, generates a premium estimate, notifies the selected insurer, and sends applicant information to the federal government. The insurer collects premium payments from the member, as well as subsidies and out-of-pocket cost reduction amounts from the federal government. For Small Group coverage, the Exchange collects information about the employer, its employees, and the employees' plan selections (from one insurer), and sends the information to the selected insurer. The insurer collects premium payments from the employer.

B. OPERATIONAL DESIGN ELEMENTS CONTINUED

4. Premium and subsidy administration continued

- **Medium intensity**: For Individual coverage, the Exchange performs the low-intensity functions, but also collects premium payments from the member, as well as subsidies and out-of-pocket cost reduction amounts from the federal government. It remits these amounts to the insurer. For Small Group coverage, the Exchange collects information about the employer, its employees, and the employees' plan selections (from multiple insurers). It also collects premium payments from the employer, and remits the payments to the various insurers.
- **High intensity**: The functions are the same as for "medium intensity," except that they are all highly automated.

5. Communications and appeals

This element refers to how the Exchange helps consumers with their questions and complaints.

- **Low intensity**: The Exchange maintains a toll-free hotline and email service for basic technical support. It also carries out the required enrollee satisfaction surveys. It relies heavily on insurers, Navigators, and brokers to answer questions about the Exchange and the products it offers. It does not provide consumer support for complaints against insurers.
- **Medium intensity**: The Exchange is more involved in answering consumer questions, but it does not provide consumer support for complaints against insurers.
- **High intensity**: Through its call center, a chat function, and email, the Exchange handles a wide range of consumer questions about enrollment, billing, and plan services. The Exchange helps consumers resolve complaints against insurers. Its website incorporates customer feedback about insurer and plan performance.

6. Navigator services

This element refers to how the Exchange helps consumers navigate its plans and services.

- **Low intensity**: Navigators help consumers understand the Exchange concept, and then direct them to the Exchange's website or to customer service phone number.
- **Medium intensity**: Navigators offer consumers a limited amount of help.
- **High intensity**: Navigators offer consumers high-touch help. One-on-one, they help consumers navigate the Exchange website, find an appropriate plan, and enroll.

7. Marketing

This element refers to how the Exchange markets its services.

- **Low intensity**: The Exchange minimally mass-markets its services.
- **Medium intensity**: Marketing campaigns are more targeted to specific consumer groups.
- **High intensity**: The Exchange carries out highly robust and targeted marketing campaigns.

APPENDIX 3. REQUIRED EXCHANGE FUNCTIONS

In its document titled "Initial guidance to States on Exchanges"[10], the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services (CMS) provided the following guidance regarding required Exchange functions. These required functions are included in the Baseline scenario of this report.

The Affordable Care Act includes two basic types of federal requirements for Exchanges, most of which are found in Section 1311[11]. These include: 1) minimum functions Exchanges must undertake directly or, in some cases, by contract; and 2) oversight responsibilities the Exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (hereafter referred to as "plans"), as defined in Section 1301.

In defining the authority and duties of an Exchange, States in authorizing legislation or other governing documents should incorporate, by reference or explicit provisions, the federally-required Exchange functions and oversight responsibilities.

A. EXCHANGE FUNCTIONS

Section 1311(d)(4) specifies core functions that an Exchange must meet:

- Certification, recertification and decertification of plans
- Operation of a toll-free hotline
- Maintenance of a website for providing information on plans to current and prospective enrollees
- Assignment of a price and quality rating to plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Provision of information on certain individuals identified in Section 1311 (d)(4)(I) to the Treasury Department and to employers
- Establishment of a Navigator program that provides grants to entities assisting consumers as described in Section 1311(i)

[10] The document is found at: cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html.
[11] These citations refer to paragraphs in the Patient Protection and Affordable Care Act (ACA).

A. EXCHANGE FUNCTIONS CONTINUED

Additional Exchange functions include:

- Presentation of enrollee satisfaction survey results under Section 1311(c)(4)
- Provision for open enrollment periods under Section 1311(c)(6)
- Consultation with stakeholders, including tribes, under Section 1311(d)(6)
- Publication of data on the Exchange's administrative costs under Section 1311(d)(7)

B. OVERSIGHT RESPONSIBILITIES

Additional areas where Exchanges must ensure plan compliance with regulatory standards established by the Secretary include:

- Information on the availability of in-network and out-of-network providers as identified in Section 1311(c)(1)(B) and (C), including provider directories and availability of essential community providers
- Consideration of plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases under Section 1311(e)(2)
- Public disclosure of plan data identified in Section 1311(e)(3)(A), including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by the Secretary
- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers as described in Section 1311(e)(3)(C)
- Information for participants in group health plans as described in Section 1311(e)(3)(D)
- Information on plan quality improvement activities as specified in Section 1311(g)

APPENDIX 4. DETAILED RESULTS

This appendix provides the following detailed results for the "Baseline" design scenario and the "Robust" design scenario.

- **Parameters**. These are the parameters that define the scenario.
- **Income results**. These are the detailed Exchange income results.
- **Expense results**. These are the detailed expense results, for each of the following functional groups:
  - Executive management
  - Operations (call center, etc.)
  - Marketing
  - Information systems (omitted)
  - Finance and actuarial
  - Infrastructure
- **Staffing results**. These show the number of staff members and their salaries for each staff position.

A. BASELINE SCENARIO RESULTS

Parameters

On the next two pages are the parameters assumed for the Baseline scenario.

A. BASELINE SCENARIO RESULTS CONTINUED

Parameters continued

A. Scenario name

Scenario name **Baseline**

B. Health insurance coverage and premiums

Health insurance coverage category	2014 Number (thousands)	2014 Annual premiums (thousands)	2015 Number (thousands)	2015 Annual premiums (thousands)	2016 Number (thousands)	2016 Annual premiums (thousands)
Individual						
Inside Exchange	**400**	**$ 1,748,000**	**440**	**$ 1,942,000**	**490**	**$ 2,130,000**
Outside Exchange	**140**	**$ 664,000**	**170**	**$ 789,000**	**190**	**$ 922,000**
Total	540	$ 2,412,000	610	$ 2,731,000	680	$ 3,052,000
Small Group						
Inside Exchange	**90**	**$ 321,000**	**90**	**$ 321,000**	**90**	**$ 322,000**
Outside Exchange - fully insured	**580**	**$ 2,175,000**	**580**	**$ 2,177,000**	**580**	**$ 2,179,000**
Outside Exchange - self insured	**100**	**$ 346,000**	**100**	**$ 345,000**	**100**	**$ 345,000**
Total	770	$ 2,842,000	770	$ 2,843,000	770	$ 2,846,000
Other						
Large Group - fully insured	**830**	**$ 3,413,000**	**830**	**$ 3,412,000**	**830**	**$ 3,408,000**
Large Group - self insured	**3,870**	**$ 15,846,000**	**3,860**	**$ 15,791,000**	**3,840**	**$ 15,692,000**
Public plan coverage	**2,990**	**$ -**	**3,080**	**$ -**	**3,110**	**$ -**
Uninsured	**1,000**	**$ -**	**850**	**$ -**	**770**	**$ -**
Total	8,690	$ 19,259,000	8,620	$ 19,203,000	8,550	$ 19,100,000
Grand total	10,000	$ 24,513,000	10,000	$ 24,777,000	10,000	$ 24,998,000

A. BASELINE SCENARIO RESULTS CONTINUED

Parameters continued

C. Revenue

Health insurance coverage category	Assessment amounts					
	2014		2015		2016	
	Per member per year	Percentage of premium	Per member per year	Percentage of premium	Per member per year	Percentage of premium
Individual						
Inside Exchange	**$ 36**	**0.0%**	**$ 36**	**0.0%**	**$ 34**	**0.0%**
Outside Exchange	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Small Group						
Inside Exchange	**$ 36**	**0.0%**	**$ 36**	**0.0%**	**$ 34**	**0.0%**
Outside Exchange - fully insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Outside Exchange - self insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Other						
Large Group - fully insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Large Group - self insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Public plan coverage	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Uninsured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**

D. Structural design alternatives

1. Governance	**Quasi-public organization**
2. Exchange coverage type	**Small group and individual**

A. BASELINE SCENARIO RESULTS CONTINUED

Parameters continued

E. Operational design alternatives

Operational design option	Intensity level Low	Medium	High	Description
1. Insurer and product selection	◉	○	○	How the Exchange determines the insurers and plans to offer its members.
2. Eligibility determination	◉	○	○	How the Exchange determines who can participate, and who is eligible for subsidies.
3. Enrollment	◉	○	○	How the Exchange helps consumers select a plan and enroll.
4. Premium and subsidy administration	◉	○	○	How the Exchange handles the collection, distribution, and reconciliation of premiums and subsidies.
5. Communications and appeals	◉	○	○	How the Exchange helps consumers with their questions and complaints.
6. Navigator services	◉	○	○	How the Exchange helps consumers navigate its plans and services.
7. Marketing	◉	○	○	How the Exchange markets its services.

F. Inflation

2011 through 2013	**0%**
2014 and after	**0%**

Cumulative inflation	
2011 through 2014 (4 years)	**0.00%**
2011 through 2015 (5 years)	**0.00%**
2011 through 2016 (6 years)	**0.00%**

A. BASELINE SCENARIO RESULTS CONTINUED

Income results

Following are income results for 2014-2016.

Health insurance coverage	2014						
	Per member per year assessment			Percentage of premium assessment			
	Number of covered members (thousands)	Annual assessment amount	Total revenue (thousands)	Annual premiums (thousands)	Percent of premium assessment	Total revenue (thousands)	Grand total (thousands)
Individual							
Inside Exchange	**400**	**$ 36**	**$ 14,400**	**$ 1,748,000**	**0%**	**$ -**	**$ 14,400**
Outside Exchange	**140**	**-**	**-**	**664,000**	**0%**	**-**	**-**
Total	**540**		**$ 14,400**	**$ 2,412,000**		**$ -**	**$ 14,400**
Small Group							
Inside Exchange	**90**	**$ 36**	**$ 3,240**	**$ 321,000**	**0%**	**$ -**	**$ 3,240**
Outside Exchange - fully insured	**580**	**-**	**-**	**2,175,000**	**0%**	**-**	**-**
Outside Exchange - self insured	**100**	**-**	**-**	**346,000**	**0%**	**-**	**-**
Total	**770**		**$ 3,240**	**$ 2,842,000**		**$ -**	**$ 3,240**
Other							
Large Group - fully insured	**830**	**$ -**	**$ -**	**$ 3,413,000**	**0%**	**$ -**	**$ -**
Large Group - self insured	**3,870**	**-**	**-**	**15,846,000**	**0%**	**-**	**-**
Public plan coverage	**2,990**	**-**	**-**	**0**	**0%**	**-**	**-**
Uninsured	**1,000**	**-**	**-**	**0**	**0%**	**-**	**-**
Total	**8,690**		**$ -**	**$ 19,259,000**		**$ -**	**$ -**
Total	**10,000**		**$ 17,640**	**$ 24,513,000**		**$ -**	**$ 17,640**

Health insurance coverage category	2015						
	Per member per year assessment			Percentage of premium assessment			
	Number of covered members (thousands)	Annual assessment amount	Total revenue (thousands)	Annual premiums (thousands)	Percent of premium assessment	Total revenue (thousands)	Grand total (thousands)
Individual							
Inside Exchange	**440**	**$ 36**	**$ 15,840**	**$ 1,942,000**	**0%**	**$ -**	**$ 15,840**
Outside Exchange	**170**	**-**	**-**	**789,000**	**0%**	**-**	**-**
Total	**610**		**$ 15,840**	**$ 2,731,000**		**$ -**	**$ 15,840**
Small Group							
Inside Exchange	**90**	**$ 36**	**$ 3,240**	**$ 321,000**	**0%**	**$ -**	**$ 3,240**
Outside Exchange - fully insured	**580**	**-**	**-**	**2,177,000**	**0%**	**-**	**-**
Outside Exchange - self insured	**100**	**-**	**-**	**345,000**	**0%**	**-**	**-**
Total	**770**		**$ 3,240**	**$ 2,843,000**		**$ -**	**$ 3,240**
Other							
Large Group - fully insured	**830**	**$ -**	**$ -**	**$ 3,412,000**	**0%**	**$ -**	**$ -**
Large Group - self insured	**3,860**	**-**	**-**	**15,791,000**	**0%**	**-**	**-**
Other	**3,080**	**-**	**-**	**0**	**0%**	**-**	**-**
Large Group - fully insured	**850**	**-**	**-**	**0**	**0%**	**-**	**-**
Total	**8,620**		**$ -**	**$ 19,203,000**		**$ -**	**$ -**
Total	**10,000**		**$ 19,080**	**$ 24,777,000**		**$ -**	**$ 19,080**

A. BASELINE SCENARIO RESULTS CONTINUED

Income results continued

Health insurance coverage category	2016						
	Per member per year assessment			Percentage of premium assessment			
	Number of covered members (thousands)	Annual assessment amount	Total revenue (thousands)	Annual premiums (thousands)	Percent of premium assessment	Total revenue (thousands)	Grand total (thousands)
Individual							
Inside Exchange	**490**	**$ 34**	**$ 16,660**	**$ 2,130,000**	**0%**	**$ -**	**$ 16,660**
Outside Exchange	**190**	**-**	**-**	**922,000**	**0%**	**-**	**-**
Total	**680**		**$ 16,660**	**$ 3,052,000**		**$ -**	**$ 16,660**
Small Group							
Inside Exchange	**90**	**$ 34**	**$ 3,060**	**$ 322,000**	**0%**	**$ -**	**$ 3,060**
Outside Exchange - fully insured	**580**	**-**	**-**	**2,179,000**	**0%**	**-**	**-**
Outside Exchange - self insured	**100**	**-**	**-**	**345,000**	**0%**	**-**	**-**
Total	**770**		**$ 3,060**	**$ 2,846,000**		**$ -**	**$ 3,060**
Other							
Large Group - fully insured	**830**	**$ -**	**$ -**	**$ 3,408,000**	**0%**	**$ -**	**$ -**
Large Group - self insured	**3,840**	**-**	**-**	**15,692,000**	**0%**	**-**	**-**
to the minimum required service, as	**3,110**	**-**	**-**	**0**	**0%**	**-**	**-**
"High" intensity corresponds to the	**770**	**-**	**-**	**0**	**0%**	**-**	**-**
Total	**8,550**		**$ -**	**$ 19,100,000**		**$ -**	**$ -**
Total	**10,000**		**$ 19,720**	**$ 24,998,000**		**$ -**	**$ 19,720**

A. BASELINE SCENARIO RESULTS CONTINUED

Expense results

On this and the following two pages are detailed expense results by functional area for 2014-2016.

Expenses	2014 Executive management	Operations	Marketing	Information systems	Finance and actuarial	Infrastructure	Total
Direct labor costs (thousands)							
Salary	$ 1,005.0	$ 3,883.0	$ 1,554.0	$ -	$ 576.0	$ 774.0	$ 7,792.0
Benefits	331.7	1,281.4	512.8	-	190.1	255.4	2,571.4
Bonus	-	-	-	-	-	-	-
Payroll tax	80.4	310.6	124.3	-	46.1	61.9	623.4
Total direct labor costs	$ 1,417.1	$ 5,475.0	$ 2,191.1	$ -	$ 812.2	$ 1,091.3	$ 10,986.7
Salary-driven costs (thousands)							
Communications	$ 5.0	$ 19.4	$ 7.8	$ -	$ 2.9	$ 3.9	$ 39.0
Education	2.5	9.7	3.9	-	1.4	1.9	19.5
Equipment rent	17.6	68.0	27.2	-	10.1	13.5	136.4
Insurance	15.1	58.2	23.3	-	8.6	11.6	116.9
Outside legal fees	15.1	58.2	23.3	-	8.6	11.6	116.9
Postage	5.0	19.4	7.8	-	2.9	3.9	39.0
Repairs	10.1	38.8	15.5	-	5.8	7.7	77.9
Supplies	5.0	19.4	7.8	-	2.9	3.9	39.0
Boards, bureaus, and association fees	2.5	9.7	3.9	-	1.4	1.9	19.5
Financial auditing	7.5	29.1	11.7	-	4.3	5.8	58.4
Bank fees	1.0	3.9	1.6	-	0.6	0.8	7.8
Travel	2.5	9.7	3.9	-	1.4	1.9	19.5
Utilities	2.5	9.7	3.9	-	1.4	1.9	19.5
Total salary-driven costs	$ 91.5	$ 353.4	$ 141.4	$ -	$ 52.4	$ 70.4	$ 709.1
Other direct costs (thousands)							
Rent	$ 33.0	$ 315.0	$ 84.0	$ -	$ 27.0	$ 42.0	$ 501.0
Branding and promotion	-	-	1,490.0	-	-	-	1,490.0
Leased lines	-	-	-	-	-	-	-
Navigator grants	-	-	1,552.0	-	-	-	1,552.0
Website maintenance & development	-	-	-	-	-	-	-
Consulting & professional support	-	-	-	-	1,490.0	-	1,490.0
Furniture	-	-	-	-	-	-	-
Core system maintenance & license	-	-	-	-	-	-	-
Plan performance/quality reporting	-	-	-	-	-	-	-
Computer workstations	-	-	-	-	-	-	-
Computer equipment	-	-	-	-	-	-	-
CAHPS audit	-	700.0	-	-	-	-	700.0
Lobbying	-	-	-	-	-	148.0	148.0
Accounting system	-	-	-	-	-	-	-
Recruiting	-	-	-	-	-	-	-
Total other direct costs	$ 33.0	$ 1,015.0	$ 3,126.0	$ -	$ 1,517.0	$ 190.0	$ 5,881.0
Total expenses (thousands)	$ 1,541.5	$ 6,843.4	$ 5,458.6	$ -	$ 2,381.6	$ 1,351.8	$ 17,576.8

A. BASELINE SCENARIO RESULTS CONTINUED

Expense results continued

Expenses	2015 Executive management	Operations	Marketing	Information systems	Finance and actuarial	Infrastructure	Total
Direct labor costs (thousands)							
Salary	$ 1,005.0	$ 4,324.0	$ 1,785.0	$ -	$ 721.0	$ 862.0	$ 8,697.0
Benefits	331.7	1,426.9	589.1	-	237.9	284.5	2,870.0
Bonus	-	-	-	-	-	-	-
Payroll tax	80.4	345.9	142.8	-	57.7	69.0	695.8
Total direct labor costs	$ 1,417.1	$ 6,096.8	$ 2,516.9	$ -	$ 1,016.6	$ 1,215.4	$ 12,262.8
Salary-driven costs (thousands)							
Communications	$ 5.0	$ 21.6	$ 8.9	$ -	$ 3.6	$ 4.3	$ 43.5
Education	2.5	10.8	4.5	-	1.8	2.2	21.7
Equipment rent	17.6	75.7	31.2	-	12.6	15.1	152.2
Insurance	15.1	64.9	26.8	-	10.8	12.9	130.5
Outside legal fees	15.1	64.9	26.8	-	10.8	12.9	130.5
Postage	5.0	21.6	8.9	-	3.6	4.3	43.5
Repairs	10.1	43.2	17.9	-	7.2	8.6	87.0
Supplies	5.0	21.6	8.9	-	3.6	4.3	43.5
Boards, bureaus, and association fees	2.5	10.8	4.5	-	1.8	2.2	21.7
Financial auditing	7.5	32.4	13.4	-	5.4	6.5	65.2
Bank fees	1.0	4.3	1.8	-	0.7	0.9	8.7
Travel	2.5	10.8	4.5	-	1.8	2.2	21.7
Utilities	2.5	10.8	4.5	-	1.8	2.2	21.7
Total salary-driven costs	$ 91.5	$ 393.5	$ 162.4	$ -	$ 65.6	$ 78.4	$ 791.4
Other direct costs (thousands)							
Rent	$ 33.0	$ 345.0	$ 99.0	$ -	$ 33.0	$ 48.0	$ 558.0
Branding and promotion	-	-	1,530.0	-	-	-	1,530.0
Leased lines	-	-	-	-	-	-	-
Navigator grants	-	-	1,552.0	-	-	-	1,552.0
Website maintenance & development	-	-	-	-	-	-	-
Consulting & professional support	-	-	-	-	1,530.0	-	1,530.0
Furniture	-	20.0	10.0	-	4.0	4.0	38.0
Core system maintenance & license	-	-	-	-	-	-	-
Plan performance/quality reporting	-	-	-	-	-	-	-
Computer workstations	-	13.0	6.5	-	2.6	2.6	24.7
Computer equipment	-	-	-	-	-	-	-
CAHPS audit	-	700.0	-	-	-	-	700.0
Lobbying	-	-	-	-	-	156.0	156.0
Accounting system	-	-	-	-	-	-	-
Recruiting	-	10.0	5.0	-	2.0	2.0	19.0
Total other direct costs	$ 33.0	$ 1,088.0	$ 3,202.5	$ -	$ 1,571.6	$ 212.6	$ 6,107.7
Total expenses (thousands)	$ 1,541.5	$ 7,578.3	$ 5,881.8	$ -	$ 2,653.8	$ 1,506.5	$ 19,161.9

A. BASELINE SCENARIO RESULTS CONTINUED

Expense results continued

Expenses	2016 Executive management	Operations	Marketing	Information systems	Finance and actuarial	Infrastructure	Total
Direct labor costs (thousands)							
Salary	$ 1,005.0	$ 4,536.0	$ 1,785.0	$ -	$ 721.0	$ 862.0	$ 8,909.0
Benefits	331.7	1,496.9	589.1	-	237.9	284.5	2,940.0
Bonus	-	-	-	-	-	-	-
Payroll tax	80.4	362.9	142.8	-	57.7	69.0	712.7
Total direct labor costs	$ 1,417.1	$ 6,395.8	$ 2,516.9	$ -	$ 1,016.6	$ 1,215.4	$ 12,561.7
Salary-driven costs (thousands)							
Communications	$ 5.0	$ 22.7	$ 8.9	$ -	$ 3.6	$ 4.3	$ 44.5
Education	2.5	11.3	4.5	-	1.8	2.2	22.3
Equipment rent	17.6	79.4	31.2	-	12.6	15.1	155.9
Insurance	15.1	68.0	26.8	-	10.8	12.9	133.6
Outside legal fees	15.1	68.0	26.8	-	10.8	12.9	133.6
Postage	5.0	22.7	8.9	-	3.6	4.3	44.5
Repairs	10.1	45.4	17.9	-	7.2	8.6	89.1
Supplies	5.0	22.7	8.9	-	3.6	4.3	44.5
Boards, bureaus, and association fees	2.5	11.3	4.5	-	1.8	2.2	22.3
Financial auditing	7.5	34.0	13.4	-	5.4	6.5	66.8
Bank fees	1.0	4.5	1.8	-	0.7	0.9	8.9
Travel	2.5	11.3	4.5	-	1.8	2.2	22.3
Utilities	2.5	11.3	4.5	-	1.8	2.2	22.3
Total salary-driven costs	$ 91.5	$ 412.8	$ 162.4	$ -	$ 65.6	$ 78.4	$ 810.7
Other direct costs (thousands)							
Rent	$ 33.0	$ 366.0	$ 99.0	$ -	$ 33.0	$ 48.0	$ 579.0
Branding and promotion	-	-	1,580.0	-	-	-	1,580.0
Leased lines	-	-	-	-	-	-	-
Navigator grants	-	-	1,552.0	-	-	-	1,552.0
Website maintenance & development	-	-	-	-	-	-	-
Consulting & professional support	-	-	-	-	1,580.0	-	1,580.0
Furniture	-	14.0	-	-	-	-	14.0
Core system maintenance & license	-	-	-	-	-	-	-
Plan performance/quality reporting	-	-	-	-	-	-	-
Computer workstations	-	9.1	-	-	-	-	9.1
Computer equipment	-	-	-	-	-	-	-
CAHPS audit	-	700.0	-	-	-	-	700.0
Lobbying	-	-	-	-	-	166.0	166.0
Accounting system	-	-	-	-	-	-	-
Recruiting	-	7.0	-	-	-	-	7.0
Total other direct costs	$ 33.0	$ 1,096.1	$ 3,231.0	$ -	$ 1,613.0	$ 214.0	$ 6,187.1
Total expenses (thousands)	$ 1,541.5	$ 7,904.6	$ 5,910.3	$ -	$ 2,695.2	$ 1,507.9	$ 19,559.5

A. BASELINE SCENARIO RESULTS CONTINUED

Staffing results

Following are detailed staffing and salary results for each staff position for 2014-2016.

Position	Number of staff members			Annual salary per staff member			Total salaries (thousands)		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
A. Executive management									
Executive director	1	1	1	$ 200,000	$ 200,000	$ 200,000	$ 200.0	$ 200.0	$ 200.0
Director of operations	1	1	1	150,000	150,000	150,000	150.0	150.0	150.0
Director of marketing	1	1	1	120,000	120,000	120,000	120.0	120.0	120.0
Director of information systems	1	1	1	150,000	150,000	150,000	150.0	150.0	150.0
Director of finance	1	1	1	140,000	140,000	140,000	140.0	140.0	140.0
Board liaison	1	1	1	70,000	70,000	70,000	70.0	70.0	70.0
Administrative assistant	5	5	5	35,000	35,000	35,000	175.0	175.0	175.0
Total	11	11	11				$ 1,005.0	$ 1,005.0	$ 1,005.0
B. Operations									
Plan administration									
Manager	1	1	1	$ 80,000	$ 80,000	$ 80,000	$ 80.0	$ 80.0	$ 80.0
Carrier liaison	3	4	4	50,000	50,000	50,000	150.0	200.0	200.0
Plan certification analyst	4	4	4	45,000	45,000	45,000	180.0	180.0	180.0
Clerk	3	3	3	29,000	29,000	29,000	87.0	87.0	87.0
Total	11	12	12				$ 497.0	$ 547.0	$ 547.0
Call center									
Manager	1	2	2	$ 80,000	$ 80,000	$ 80,000	$ 80.0	$ 160.0	$ 160.0
Supervisor	3	3	3	51,000	51,000	51,000	153.0	153.0	153.0
Agent	50	54	58	30,000	30,000	30,000	1,500.0	1,620.0	1,740.0
Total	54	59	63				$ 1,733.0	$ 1,933.0	$ 2,053.0
Eligibility processing									
Supervisor	2	3	3	$ 51,000	$ 51,000	$ 51,000	$ 102.0	$ 153.0	$ 153.0
Eligibility processor	16	17	19	30,000	30,000	30,000	480.0	510.0	570.0
Appeals processor	9	9	10	32,000	32,000	32,000	288.0	288.0	320.0
Total	27	29	32				$ 870.0	$ 951.0	$ 1,043.0
Plan performance and quality reporting									
Manager	1	1	1	$ 83,000	$ 83,000	$ 83,000	$ 83.0	$ 83.0	$ 83.0
Reporting analyst	5	6	6	60,000	60,000	60,000	300.0	360.0	360.0
Report developer	3	3	3	60,000	60,000	60,000	180.0	180.0	180.0
Total	9	10	10				$ 563.0	$ 623.0	$ 623.0
Enrollment reporting									
Manager	1	1	1	$ 70,000	$ 70,000	$ 70,000	$ 70.0	$ 70.0	$ 70.0
Enrollment reporting analyst	3	4	4	50,000	50,000	50,000	150.0	200.0	200.0
Total	4	5	5				$ 220.0	$ 270.0	$ 270.0
Operations grand total	105	115	122				$ 3,883.0	$ 4,324.0	$ 4,536.0

A. BASELINE SCENARIO RESULTS CONTINUED

Staffing results continued

Position	Number of staff members			Annual salary per staff member			Total salaries (thousands)		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
C. Marketing									
Exchange Marketing									
Manager	1	1	1	$ 86,000	$ 86,000	$ 86,000	$ 86.0	$ 86.0	$ 86.0
Marketing coordinator	5	5	5	50,000	50,000	50,000	250.0	250.0	250.0
Total	6	6	6				$ 336.0	$ 336.0	$ 336.0
Navigator services									
Manager	1	1	1	$ 85,000	$ 85,000	$ 85,000	$ 85.0	$ 85.0	$ 85.0
Navigator liaison	6	7	7	50,000	50,000	50,000	300.0	350.0	350.0
Total	7	8	8				$ 385.0	$ 435.0	$ 435.0
Materials and fulfillment									
Supervisor	2	2	2	$ 55,000	$ 55,000	$ 55,000	$ 110.0	$ 110.0	$ 110.0
Copywriter	2	3	3	51,000	51,000	51,000	102.0	153.0	153.0
Graphics Designer	2	3	3	47,000	47,000	47,000	94.0	141.0	141.0
Clerk	2	3	3	27,000	27,000	27,000	54.0	81.0	81.0
Total	8	11	11				$ 360.0	$ 485.0	$ 485.0
Government/Public relations									
Manager	1	1	1	$ 85,000	$ 85,000	$ 85,000	$ 85.0	$ 85.0	$ 85.0
Public relations coordinator	2	2	2	69,000	69,000	69,000	138.0	138.0	138.0
Government relations coordinator	2	2	2	69,000	69,000	69,000	138.0	138.0	138.0
Grant writer	2	3	3	56,000	56,000	56,000	112.0	168.0	168.0
Total	7	8	8				$ 473.0	$ 529.0	$ 529.0
Marketing grand total	28	33	33				$ 1,554.0	$ 1,785.0	$ 1,785.0
D. Information systems									
Network administrator	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -
Desktop support specialist	-	-	-	-	-	-	-	-	-
Systems program manager	-	-	-	-	-	-	-	-	-
Application developer	-	-	-	-	-	-	-	-	-
Database administrator	-	-	-	-	-	-	-	-	-
Database developer	-	-	-	-	-	-	-	-	-
Plan configuration specialist	-	-	-	-	-	-	-	-	-
EDI specialist	-	-	-	-	-	-	-	-	-
HIPAA compliance officer	-	-	-	-	-	-	-	-	-
Total	-	-	-				$ -	$ -	$ -
E. Finance and actuarial									
Actuarial analysis									
Actuary	2	3	3	$ 90,000	$ 90,000	$ 90,000	$ 180.0	$ 270.0	$ 270.0
Total	2	3	3				$ 180.0	$ 270.0	$ 270.0
Financial analysis									
Controller	1	1	1	$ 110,000	$ 110,000	$ 110,000	$ 110.0	$ 110.0	$ 110.0
Staff accountant	4	4	4	44,000	44,000	44,000	176.0	176.0	176.0
Financial analyst	2	3	3	55,000	55,000	55,000	110.0	165.0	165.0
Total	7	8	8				$ 396.0	$ 451.0	$ 451.0
Finance grand total	9	11	11				$ 576.0	$ 721.0	$ 721.0

A. BASELINE SCENARIO RESULTS CONTINUED

Staffing results continued

Position	Number of staff members			Annual salary per staff member			Total salaries (thousands)		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
F. Infrastructure									
Human resources generalist	**2**	**3**	**3**	**$ 42,000**	**$ 42,000**	**$ 42,000**	**$ 84.0**	**$ 126.0**	**$ 126.0**
Payroll specialist	**2**	**2**	**2**	**39,000**	**39,000**	**39,000**	**78.0**	**78.0**	**78.0**
Training specialist	**3**	**4**	**4**	**46,000**	**46,000**	**46,000**	**138.0**	**184.0**	**184.0**
Attorney	**2**	**2**	**2**	**105,000**	**105,000**	**105,000**	**210.0**	**210.0**	**210.0**
Compliance officer	**2**	**2**	**2**	**77,000**	**77,000**	**77,000**	**154.0**	**154.0**	**154.0**
Officer manager	**1**	**1**	**1**	**58,000**	**58,000**	**58,000**	**58.0**	**58.0**	**58.0**
Mail clerk	**2**	**2**	**2**	**26,000**	**26,000**	**26,000**	**52.0**	**52.0**	**52.0**
Total	**14**	**16**	**16**				**$ 774.0**	**$ 862.0**	**$ 862.0**
Grand totals									
A. Executive management	**11**	**11**	**11**				**$ 1,005.0**	**$ 1,005.0**	**$ 1,005.0**
B. Operations	**105**	**115**	**122**				**3,883.0**	**4,324.0**	**4,536.0**
C. Marketing	**28**	**33**	**33**				**1,554.0**	**1,785.0**	**1,785.0**
D. Information systems	**-**	**-**	**-**				**-**	**-**	**-**
E. Finance and actuarial	**9**	**11**	**11**				**576.0**	**721.0**	**721.0**
F. Infrastructure	**14**	**16**	**16**				**774.0**	**862.0**	**862.0**
Total	**167**	**186**	**193**				**$ 7,792.0**	**$ 8,697.0**	**$ 8,909.0**

B. ROBUST SCENARIO RESULTS

Parameters

On the next two pages are the parameters entered for the Robust scenario.

B. ROBUST SCENARIO RESULTS CONTINUED

Parameters continued

A. Scenario name

Scenario name	**Robust**

B. Health insurance coverage and premiums

Health insurance coverage category	2014 Number (thousands)	2014 Annual premiums (thousands)	2015 Number (thousands)	2015 Annual premiums (thousands)	2016 Number (thousands)	2016 Annual premiums (thousands)
Individual						
Inside Exchange	**460**	**$ 2,026,000**	**520**	**$ 2,274,000**	**580**	**$ 2,525,000**
Outside Exchange	**150**	**$ 737,000**	**190**	**$ 906,000**	**230**	**$ 1,101,000**
Total	610	$ 2,763,000	710	$ 3,180,000	810	$ 3,626,000
Small Group						
Inside Exchange	**120**	**$ 448,000**	**120**	**$ 448,000**	**120**	**$ 448,000**
Outside Exchange - fully insured	**480**	**$ 1,794,000**	**480**	**$ 1,797,000**	**480**	**$ 1,799,000**
Outside Exchange - self insured	**140**	**$ 510,000**	**140**	**$ 510,000**	**140**	**$ 510,000**
Total	740	$ 2,752,000	740	$ 2,755,000	740	$ 2,757,000
Other						
Large Group - fully insured	**730**	**$ 2,977,000**	**730**	**$ 2,975,000**	**730**	**$ 2,968,000**
Large Group - self insured	**3,960**	**$ 16,218,000**	**3,940**	**$ 16,126,000**	**3,900**	**$ 15,962,000**
Public plan coverage	**3,090**	**$ -**	**3,190**	**$ -**	**3,230**	**$ -**
Uninsured	**870**	**$ -**	**690**	**$ -**	**590**	**$ -**
Total	8,650	$ 19,195,000	8,550	$ 19,101,000	8,450	$ 18,930,000
Grand total	10,000	$ 24,710,000	10,000	$ 25,036,000	10,000	$ 25,313,000

B. ROBUST SCENARIO RESULTS CONTINUED

Parameters continued

C. Revenue

Health insurance coverage category	Assessment amounts					
	2014		2015		2016	
	Per member per year	Percentage of premium	Per member per year	Percentage of premium	Per member per year	Percentage of premium
Individual						
Inside Exchange	**$ 56**	**0.0%**	**$ 53**	**0.0%**	**$ 50**	**0.0%**
Outside Exchange	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Small Group						
Inside Exchange	**$ 56**	**0.0%**	**$ 53**	**0.0%**	**$ 50**	**0.0%**
Outside Exchange - fully insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Outside Exchange - self insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Other						
Large Group - fully insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Large Group - self insured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Public plan coverage	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Uninsured	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**

D. Structural design alternatives

1. Governance	**Quasi-public organization**
2. Exchange coverage type	**Small group and individual**

B. ROBUST SCENARIO RESULTS CONTINUED

Parameters continued

E. Operational design alternatives

Operational design option	Intensity level			Description
	Low	Medium	High	
1. Insurer and product selection	○	○	◉	How the Exchange determines the insurers and plans to offer its members.
2. Eligibility determination	○	○	◉	How the Exchange determines who can participate, and who is eligible for subsidies.
3. Enrollment	○	○	◉	How the Exchange helps consumers select a plan and enroll.
4. Premium and subsidy administration	○	○	◉	How the Exchange handles the collection, distribution, and reconciliation of premiums and subsidies.
5. Communications and appeals	○	○	◉	How the Exchange helps consumers with their questions and complaints.
6. Navigator services	○	○	◉	How the Exchange helps consumers navigate its plans and services.
7. Marketing	○	○	◉	How the Exchange markets its services.

F. Inflation

2011 through 2013	**0%**
2014 and after	**0%**

Cumulative inflation	
2011 through 2014 (4 years)	**0.00%**
2011 through 2015 (5 years)	**0.00%**
2011 through 2016 (6 years)	**0.00%**

B. ROBUST SCENARIO RESULTS CONTINUED

Income results

Following are income results for 2014-2016.

Health insurance coverage	2014						
	Per member per year assessment			Percentage of premium assessment			
	Number of covered members (thousands)	Annual assessment amount	Total revenue (thousands)	Annual premiums (thousands)	Percent of premium assessment	Total revenue (thousands)	Grand total (thousands)
Individual							
Inside Exchange	**460**	**$ 56**	**$ 25,760**	**$ 2,026,000**	**0%**	**$ -**	**$ 25,760**
Outside Exchange	**150**	**-**	**-**	**737,000**	**0%**	**-**	**-**
Total	**610**		**$ 25,760**	**$ 2,763,000**		**$ -**	**$ 25,760**
Small Group							
Inside Exchange	**120**	**$ 56**	**$ 6,720**	**$ 448,000**	**0%**	**$ -**	**$ 6,720**
Outside Exchange - fully insured	**480**	**-**	**-**	**1,794,000**	**0%**	**-**	**-**
Outside Exchange - self insured	**140**	**-**	**-**	**510,000**	**0%**	**-**	**-**
Total	**740**		**$ 6,720**	**$ 2,752,000**		**$ -**	**$ 6,720**
Other							
Large Group - fully insured	**730**	**$ -**	**$ -**	**$ 2,977,000**	**0%**	**$ -**	**$ -**
Large Group - self insured	**3,960**	**-**	**-**	**16,218,000**	**0%**	**-**	**-**
Public plan coverage	**3,090**	**-**	**-**	**0**	**0%**	**-**	**-**
Uninsured	**870**	**-**	**-**	**0**	**0%**	**-**	**-**
Total	**8,650**		**$ -**	**$ 19,195,000**		**$ -**	**$ -**
Total	**10,000**		**$ 32,480**	**$ 24,710,000**		**$ -**	**$ 32,480**

Health insurance coverage category	2015						
	Per member per year assessment			Percentage of premium assessment			
	Number of covered members (thousands)	Annual assessment amount	Total revenue (thousands)	Annual premiums (thousands)	Percent of premium assessment	Total revenue (thousands)	Grand total (thousands)
Individual							
Inside Exchange	**520**	**$ 53**	**$ 27,560**	**$ 2,274,000**	**0%**	**$ -**	**$ 27,560**
Outside Exchange	**190**	**-**	**-**	**906,000**	**0%**	**-**	**-**
Total	**710**		**$ 27,560**	**$ 3,180,000**		**$ -**	**$ 27,560**
Small Group							
Inside Exchange	**120**	**$ 53**	**$ 6,360**	**$ 448,000**	**0%**	**$ -**	**$ 6,360**
Outside Exchange - fully insured	**480**	**-**	**-**	**1,797,000**	**0%**	**-**	**-**
Outside Exchange - self insured	**140**	**-**	**-**	**510,000**	**0%**	**-**	**-**
Total	**740**		**$ 6,360**	**$ 2,755,000**		**$ -**	**$ 6,360**
Other							
Large Group - fully insured	**730**	**$ -**	**$ -**	**$ 2,975,000**	**0%**	**$ -**	**$ -**
Large Group - self insured	**3,940**	**-**	**-**	**16,126,000**	**0%**	**-**	**-**
Other	**3,190**	**-**	**-**	**0**	**0%**	**-**	**-**
Large Group - fully insured	**690**	**-**	**-**	**0**	**0%**	**-**	**-**
Total	**8,550**		**$ -**	**$ 19,101,000**		**$ -**	**$ -**
Total	**10,000**		**$ 33,920**	**$ 25,036,000**		**$ -**	**$ 33,920**

B. ROBUST SCENARIO RESULTS CONTINUED

Income results continued

Health insurance coverage category	2016						
	Per member per year assessment			Percentage of premium assessment			
	Number of covered members (thousands)	Annual assessment amount	Total revenue (thousands)	Annual premiums (thousands)	Percent of premium assessment	Total revenue (thousands)	Grand total (thousands)
Individual							
Inside Exchange	**580**	**$ 50**	**$ 29,000**	**$ 2,525,000**	**0%**	**$ -**	**$ 29,000**
Outside Exchange	**230**	**-**	**-**	**1,101,000**	**0%**	**-**	**-**
Total	**810**		**$ 29,000**	**$ 3,626,000**		**$ -**	**$ 29,000**
Small Group							
Inside Exchange	**120**	**$ 50**	**$ 6,000**	**$ 448,000**	**0%**	**$ -**	**$ 6,000**
Outside Exchange - fully insured	**480**	**-**	**-**	**1,799,000**	**0%**	**-**	**-**
Outside Exchange - self insured	**140**	**-**	**-**	**510,000**	**0%**	**-**	**-**
Total	**740**		**$ 6,000**	**$ 2,757,000**		**$ -**	**$ 6,000**
Other							
Large Group - fully insured	**730**	**$ -**	**$ -**	**$ 2,968,000**	**0%**	**$ -**	**$ -**
Large Group - self insured	**3,900**	**-**	**-**	**15,962,000**	**0%**	**-**	**-**
to the minimum required service, as	**3,230**	**-**	**-**	**0**	**0%**	**-**	**-**
"High" intensity corresponds to the	**590**	**-**	**-**	**0**	**0%**	**-**	**-**
Total	**8,450**		**$ -**	**$ 18,930,000**		**$ -**	**$ -**
Total	**10,000**		**$ 35,000**	**$ 25,313,000**		**$ -**	**$ 35,000**

B. ROBUST SCENARIO RESULTS CONTINUED

Expense results

On this and the following two pages are detailed expense results by functional area for 2014-2016.

Expenses	2014 Executive management	Operations	Marketing	Information systems	Finance and actuarial	Infrastructure	Total
Direct labor costs (thousands)							
Salary	$ 1,005.0	$ 4,969.0	$ 2,756.0	$ -	$ 1,400.0	$ 862.0	$ 10,992.0
Benefits	331.7	1,639.8	909.5	-	462.0	284.5	3,627.4
Bonus	-	-	-	-	-	-	-
Payroll tax	80.4	397.5	220.5	-	112.0	69.0	879.4
Total direct labor costs	$ 1,417.1	$ 7,006.3	$ 3,886.0	$ -	$ 1,974.0	$ 1,215.4	$ 15,498.7
Salary-driven costs (thousands)							
Communications	$ 5.0	$ 24.8	$ 13.8	$ -	$ 7.0	$ 4.3	$ 55.0
Education	2.5	12.4	6.9	-	3.5	2.2	27.5
Equipment rent	17.6	87.0	48.2	-	24.5	15.1	192.4
Insurance	15.1	74.5	41.3	-	21.0	12.9	164.9
Outside legal fees	15.1	74.5	41.3	-	21.0	12.9	164.9
Postage	5.0	24.8	13.8	-	7.0	4.3	55.0
Repairs	10.1	49.7	27.6	-	14.0	8.6	109.9
Supplies	5.0	24.8	13.8	-	7.0	4.3	55.0
Boards, bureaus, and association fees	2.5	12.4	6.9	-	3.5	2.2	27.5
Financial auditing	7.5	37.3	20.7	-	10.5	6.5	82.4
Bank fees	1.0	5.0	2.8	-	1.4	0.9	11.0
Travel	2.5	12.4	6.9	-	3.5	2.2	27.5
Utilities	2.5	12.4	6.9	-	3.5	2.2	27.5
Total salary-driven costs	$ 91.5	$ 452.2	$ 250.8	$ -	$ 127.4	$ 78.4	$ 1,000.3
Other direct costs (thousands)							
Rent	$ 33.0	$ 384.0	$ 159.0	$ -	$ 66.0	$ 48.0	$ 690.0
Branding and promotion	-	-	2,740.0	-	-	-	2,740.0
Leased lines	-	-	-	-	-	-	-
Navigator grants	-	-	7,423.0	-	-	-	7,423.0
Website maintenance & development	-	-	-	-	-	-	-
Consulting & professional support	-	-	-	-	4,180.0	-	4,180.0
Furniture	-	-	-	-	-	-	-
Core system maintenance & license	-	-	-	-	-	-	-
Plan performance/quality reporting	-	-	-	-	-	-	-
Computer workstations	-	-	-	-	-	-	-
Computer equipment	-	-	-	-	-	-	-
CAHPS audit	-	700.0	-	-	-	-	700.0
Lobbying	-	-	-	-	-	166.0	166.0
Accounting system	-	-	-	-	-	-	-
Recruiting	-	-	-	-	-	-	-
Total other direct costs	$ 33.0	$ 1,084.0	$ 10,322.0	$ -	$ 4,246.0	$ 214.0	$ 15,899.0
Total expenses (thousands)	$ 1,541.5	$ 8,542.5	$ 14,458.8	$ -	$ 6,347.4	$ 1,507.9	$ 32,398.0

B. ROBUST SCENARIO RESULTS CONTINUED

Expense results continued

Expenses	2015 Executive management	Operations	Marketing	Information systems	Finance and actuarial	Infrastructure	Total
Direct labor costs (thousands)							
Salary	$ 1,005.0	$ 5,413.0	$ 2,934.0	$ -	$ 1,444.0	$ 862.0	$ 11,658.0
Benefits	331.7	1,786.3	968.2	-	476.5	284.5	3,847.1
Bonus	-	-	-	-	-	-	-
Payroll tax	80.4	433.0	234.7	-	115.5	69.0	932.6
Total direct labor costs	$ 1,417.1	$ 7,632.3	$ 4,136.9	$ -	$ 2,036.0	$ 1,215.4	$ 16,437.8
Salary-driven costs (thousands)							
Communications	$ 5.0	$ 27.1	$ 14.7	$ -	$ 7.2	$ 4.3	$ 58.3
Education	2.5	13.5	7.3	-	3.6	2.2	29.1
Equipment rent	17.6	94.7	51.3	-	25.3	15.1	204.0
Insurance	15.1	81.2	44.0	-	21.7	12.9	174.9
Outside legal fees	15.1	81.2	44.0	-	21.7	12.9	174.9
Postage	5.0	27.1	14.7	-	7.2	4.3	58.3
Repairs	10.1	54.1	29.3	-	14.4	8.6	116.6
Supplies	5.0	27.1	14.7	-	7.2	4.3	58.3
Boards, bureaus, and association fees	2.5	13.5	7.3	-	3.6	2.2	29.1
Financial auditing	7.5	40.6	22.0	-	10.8	6.5	87.4
Bank fees	1.0	5.4	2.9	-	1.4	0.9	11.7
Travel	2.5	13.5	7.3	-	3.6	2.2	29.1
Utilities	2.5	13.5	7.3	-	3.6	2.2	29.1
Total salary-driven costs	$ 91.5	$ 492.6	$ 267.0	$ -	$ 131.4	$ 78.4	$ 1,060.9
Other direct costs (thousands)							
Rent	$ 33.0	$ 417.0	$ 171.0	$ -	$ 69.0	$ 48.0	$ 738.0
Branding and promotion	-	-	2,920.0	-	-	-	2,920.0
Leased lines	-	-	-	-	-	-	-
Navigator grants	-	-	7,423.0	-	-	-	7,423.0
Website maintenance & development	-	-	-	-	-	-	-
Consulting & professional support	-	-	-	-	4,240.0	-	4,240.0
Furniture	-	22.0	8.0	-	2.0	-	32.0
Core system maintenance & license	-	-	-	-	-	-	-
Plan performance/quality reporting	-	-	-	-	-	-	-
Computer workstations	-	14.3	5.2	-	1.3	-	20.8
Computer equipment	-	-	-	-	-	-	-
CAHPS audit	-	700.0	-	-	-	-	700.0
Lobbying	-	-	-	-	-	178.0	178.0
Accounting system	-	-	-	-	-	-	-
Recruiting	-	11.0	4.0	-	1.0	-	16.0
Total other direct costs	$ 33.0	$ 1,164.3	$ 10,531.2	$ -	$ 4,313.3	$ 226.0	$ 16,267.8
Total expenses (thousands)	$ 1,541.5	$ 9,289.2	$ 14,935.1	$ -	$ 6,480.7	$ 1,519.9	$ 33,766.5

B. ROBUST SCENARIO RESULTS CONTINUED

Expense results continued

Expenses	2016						
	Executive management	Operations	Marketing	Information systems	Finance and actuarial	Infrastructure	Total
Direct labor costs (thousands)							
Salary	$ 1,005.0	$ 5,789.0	$ 3,103.0	$ -	$ 1,633.0	$ 862.0	$ 12,392.0
Benefits	331.7	1,910.4	1,024.0	-	538.9	284.5	4,089.4
Bonus	-	-	-	-	-	-	-
Payroll tax	80.4	463.1	248.2	-	130.6	69.0	991.4
Total direct labor costs	$ 1,417.1	$ 8,162.5	$ 4,375.2	$ -	$ 2,302.5	$ 1,215.4	$ 17,472.7
Salary-driven costs (thousands)							
Communications	$ 5.0	$ 28.9	$ 15.5	$ -	$ 8.2	$ 4.3	$ 62.0
Education	2.5	14.5	7.8	-	4.1	2.2	31.0
Equipment rent	17.6	101.3	54.3	-	28.6	15.1	216.9
Insurance	15.1	86.8	46.5	-	24.5	12.9	185.9
Outside legal fees	15.1	86.8	46.5	-	24.5	12.9	185.9
Postage	5.0	28.9	15.5	-	8.2	4.3	62.0
Repairs	10.1	57.9	31.0	-	16.3	8.6	123.9
Supplies	5.0	28.9	15.5	-	8.2	4.3	62.0
Boards, bureaus, and association fees	2.5	14.5	7.8	-	4.1	2.2	31.0
Financial auditing	7.5	43.4	23.3	-	12.2	6.5	92.9
Bank fees	1.0	5.8	3.1	-	1.6	0.9	12.4
Travel	2.5	14.5	7.8	-	4.1	2.2	31.0
Utilities	2.5	14.5	7.8	-	4.1	2.2	31.0
Total salary-driven costs	$ 91.5	$ 526.8	$ 282.4	$ -	$ 148.6	$ 78.4	$ 1,127.7
Other direct costs (thousands)							
Rent	$ 33.0	$ 447.0	$ 180.0	$ -	$ 78.0	$ 48.0	$ 786.0
Branding and promotion	-	-	3,100.0	-	-	-	3,100.0
Leased lines	-	-	-	-	-	-	-
Navigator grants	-	-	7,423.0	-	-	-	7,423.0
Website maintenance & development	-	-	-	-	-	-	-
Consulting & professional support	-	-	-	-	4,300.0	-	4,300.0
Furniture	-	20.0	6.0	-	6.0	-	32.0
Core system maintenance & license	-	-	-	-	-	-	-
Plan performance/quality reporting	-	-	-	-	-	-	-
Computer workstations	-	13.0	3.9	-	3.9	-	20.8
Computer equipment	-	-	-	-	-	-	-
CAHPS audit	-	700.0	-	-	-	-	700.0
Lobbying	-	-	-	-	-	190.0	190.0
Accounting system	-	-	-	-	-	-	-
Recruiting	-	10.0	3.0	-	3.0	-	16.0
Total other direct costs	$ 33.0	$ 1,190.0	$ 10,715.9	$ -	$ 4,390.9	$ 238.0	$ 16,567.8
Total expenses (thousands)	$ 1,541.5	$ 9,879.3	$ 15,373.5	$ -	$ 6,842.0	$ 1,531.9	$ 35,168.2

B. ROBUST SCENARIO RESULTS CONTINUED

Staffing results

Following are detailed staffing and salary results for each staff position for 2014-2016.

Position	Number of staff members			Annual salary per staff member			Total salaries (thousands)		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
A. Executive management									
Executive director	1	1	1	$ 200,000	$ 200,000	$ 200,000	$ 200.0	$ 200.0	$ 200.0
Director of operations	1	1	1	150,000	150,000	150,000	150.0	150.0	150.0
Director of marketing	1	1	1	120,000	120,000	120,000	120.0	120.0	120.0
Director of information systems	1	1	1	150,000	150,000	150,000	150.0	150.0	150.0
Director of finance	1	1	1	140,000	140,000	140,000	140.0	140.0	140.0
Board liaison	1	1	1	70,000	70,000	70,000	70.0	70.0	70.0
Administrative assistant	5	5	5	35,000	35,000	35,000	175.0	175.0	175.0
Total	11	11	11				$ 1,005.0	$ 1,005.0	$ 1,005.0
B. Operations									
Plan administration									
Manager	1	1	1	$ 80,000	$ 80,000	$ 80,000	$ 80.0	$ 80.0	$ 80.0
Carrier liaison	6	6	7	50,000	50,000	50,000	300.0	300.0	350.0
Plan certification analyst	6	6	6	45,000	45,000	45,000	270.0	270.0	270.0
Clerk	4	4	4	29,000	29,000	29,000	116.0	116.0	116.0
Total	17	17	18				$ 766.0	$ 766.0	$ 816.0
Call center									
Manager	1	2	2	$ 80,000	$ 80,000	$ 80,000	$ 80.0	$ 160.0	$ 160.0
Supervisor	3	3	3	51,000	51,000	51,000	153.0	153.0	153.0
Agent	47	52	56	30,000	30,000	30,000	1,410.0	1,560.0	1,680.0
Total	51	57	61				$ 1,643.0	$ 1,873.0	$ 1,993.0
Eligibility processing									
Supervisor	1	1	1	$ 51,000	$ 51,000	$ 51,000	$ 51.0	$ 51.0	$ 51.0
Eligibility processor	7	8	8	30,000	30,000	30,000	210.0	240.0	240.0
Appeals processor	28	30	33	32,000	32,000	32,000	896.0	960.0	1,056.0
Total	36	39	42				$ 1,157.0	$ 1,251.0	$ 1,347.0
Plan performance and quality reporting									
Manager	1	1	1	$ 83,000	$ 83,000	$ 83,000	$ 83.0	$ 83.0	$ 83.0
Reporting analyst	9	10	11	60,000	60,000	60,000	540.0	600.0	660.0
Report developer	6	7	7	60,000	60,000	60,000	360.0	420.0	420.0
Total	16	18	19				$ 983.0	$ 1,103.0	$ 1,163.0
Enrollment reporting									
Manager	1	1	1	$ 70,000	$ 70,000	$ 70,000	$ 70.0	$ 70.0	$ 70.0
Enrollment reporting analyst	7	7	8	50,000	50,000	50,000	350.0	350.0	400.0
Total	8	8	9				$ 420.0	$ 420.0	$ 470.0
Operations grand total	128	139	149				$ 4,969.0	$ 5,413.0	$ 5,789.0

B. ROBUST SCENARIO RESULTS CONTINUED

Staffing results continued

Position	Number of staff members			Annual salary per staff member			Total salaries (thousands)		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
C. Marketing									
Exchange Marketing									
Manager	1	1	1	$ 86,000	$ 86,000	$ 86,000	$ 86.0	$ 86.0	$ 86.0
Marketing coordinator	14	15	16	50,000	50,000	50,000	700.0	750.0	800.0
Total	15	16	17				$ 786.0	$ 836.0	$ 886.0
Navigator services									
Manager	1	1	1	$ 85,000	$ 85,000	$ 85,000	$ 85.0	$ 85.0	$ 85.0
Navigator liaison	11	12	13	50,000	50,000	50,000	550.0	600.0	650.0
Total	12	13	14				$ 635.0	$ 685.0	$ 735.0
Materials and fulfillment									
Supervisor	2	2	2	$ 55,000	$ 55,000	$ 55,000	$ 110.0	$ 110.0	$ 110.0
Copywriter	6	7	7	51,000	51,000	51,000	306.0	357.0	357.0
Graphics Designer	6	6	6	47,000	47,000	47,000	282.0	282.0	282.0
Clerk	4	5	5	27,000	27,000	27,000	108.0	135.0	135.0
Total	18	20	20				$ 806.0	$ 884.0	$ 884.0
Government/Public relations									
Manager	1	1	1	$ 85,000	$ 85,000	$ 85,000	$ 85.0	$ 85.0	$ 85.0
Public relations coordinator	2	2	3	69,000	69,000	69,000	138.0	138.0	207.0
Government relations coordinator	2	2	2	69,000	69,000	69,000	138.0	138.0	138.0
Grant writer	3	3	3	56,000	56,000	56,000	168.0	168.0	168.0
Total	8	8	9				$ 529.0	$ 529.0	$ 598.0
Marketing grand total	53	57	60				$ 2,756.0	$ 2,934.0	$ 3,103.0
D. Information systems									
Network administrator	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -
Desktop support specialist	-	-	-	-	-	-	-	-	-
Systems program manager	-	-	-	-	-	-	-	-	-
Application developer	-	-	-	-	-	-	-	-	-
Database administrator	-	-	-	-	-	-	-	-	-
Database developer	-	-	-	-	-	-	-	-	-
Plan configuration specialist	-	-	-	-	-	-	-	-	-
EDI specialist	-	-	-	-	-	-	-	-	-
HIPAA compliance officer	-	-	-	-	-	-	-	-	-
Total	-	-	-				$ -	$ -	$ -
E. Finance and actuarial									
Actuarial analysis									
Actuary	7	7	8	$ 90,000	$ 90,000	$ 90,000	$ 630.0	$ 630.0	$ 720.0
Total	7	7	8				$ 630.0	$ 630.0	$ 720.0
Financial analysis									
Controller	1	1	1	$ 110,000	$ 110,000	$ 110,000	$ 110.0	$ 110.0	$ 110.0
Staff accountant	10	11	12	44,000	44,000	44,000	440.0	484.0	528.0
Financial analyst	4	4	5	55,000	55,000	55,000	220.0	220.0	275.0
Total	15	16	18				$ 770.0	$ 814.0	$ 913.0
Finance grand total	22	23	26				$ 1,400.0	$ 1,444.0	$ 1,633.0

B. ROBUST SCENARIO RESULTS CONTINUED

Staffing results continued

Position	Number of staff members			Annual salary per staff member			Total salaries (thousands)		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
F. Infrastructure									
Human resources generalist	**3**	**3**	**3**	**$ 42,000**	**$ 42,000**	**$ 42,000**	**$ 126.0**	**$ 126.0**	**$ 126.0**
Payroll specialist	**2**	**2**	**2**	**39,000**	**39,000**	**39,000**	**78.0**	**78.0**	**78.0**
Training specialist	**4**	**4**	**4**	**46,000**	**46,000**	**46,000**	**184.0**	**184.0**	**184.0**
Attorney	**2**	**2**	**2**	**105,000**	**105,000**	**105,000**	**210.0**	**210.0**	**210.0**
Compliance officer	**2**	**2**	**2**	**77,000**	**77,000**	**77,000**	**154.0**	**154.0**	**154.0**
Officer manager	**1**	**1**	**1**	**58,000**	**58,000**	**58,000**	**58.0**	**58.0**	**58.0**
Mail clerk	**2**	**2**	**2**	**26,000**	**26,000**	**26,000**	**52.0**	**52.0**	**52.0**
Total	**16**	**16**	**16**				**$ 862.0**	**$ 862.0**	**$ 862.0**
Grand totals									
A. Executive management	**11**	**11**	**11**				**$ 1,005.0**	**$ 1,005.0**	**$ 1,005.0**
B. Operations	**128**	**139**	**149**				**4,969.0**	**5,413.0**	**5,789.0**
C. Marketing	**53**	**57**	**60**				**2,756.0**	**2,934.0**	**3,103.0**
D. Information systems	**-**	**-**	**-**				**-**	**-**	**-**
E. Finance and actuarial	**22**	**23**	**26**				**1,400.0**	**1,444.0**	**1,633.0**
F. Infrastructure	**16**	**16**	**16**				**862.0**	**862.0**	**862.0**
Total	**230**	**246**	**262**				**$ 10,992.0**	**$ 11,658.0**	**$ 12,392.0**