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HCRAWG ACA Rate Increase Mitigation Subgroup Discussion Paper on
Rate Increase Mitigation Strategies
April 1, 2013

Introduction

The Affordable Care Act (ACA) introduces a number of substantial changes to the commercial individual and small group health insurance markets, such as single risk pool rating, guaranteed issue, restrictions on allowable rating factors, actuarial value “metal” tiers and essential health benefits. Some of these reforms are expected to increase claims costs for health insurers and drive increases in rates on an aggregate, market-wide basis. Other changes may affect the distribution of rates across the market – based on age, geographic rating area, or family structure – and drive rate increases for specific populations. Still, other changes such as the temporary reinsurance program and the risk adjustment program will have the effect of moderating rate increases in certain markets. States will obviously need to consider how these new market rules will interact with their existing market rules before deciding on any particular rate increase mitigation strategy. States will also need to consider how these strategies may interact with federal and other rate increase mitigation programs.

This paper outlines several strategies states may undertake to mitigate these rate increases and discuss implementation considerations. Strategies are distinguished between those that target aggregate rate levels and those designed to affect the distribution of rates across the market. However, many of the strategies discussed herein may have both aggregate and distributive effects. For example, the implementation of caps on aggregate rate changes may result in changes to specific rating factors rather than uniform application of the cap to all insured members. Several of these strategies require immediate action and may necessitate statutory changes, while others may be implemented later in 2013 or in subsequent years to mitigate future rate increases. As 2014 rate filings will be submitted by April or May of 2013, it is important that states act quickly to define and communicate any immediate rate mitigation strategies to health insurers and other stakeholders.

Strategies to Address Aggregate Rate Levels

The single risk pool, guaranteed issue, minimum actuarial value and essential health benefit provisions of the ACA are expected to lead to aggregate increases in claims costs in many states as individuals covered through high risk pools and portability plans, as well as those who are currently uninsured, enter the commercial health insurance market. The ACA implements three federal risk mitigation programs – risk adjustment, reinsurance, and risk corridor – to address these increases. Of these three programs, known collectively as the “3 Rs,” only risk adjustment is intended to be permanent. States may wish to consider additional strategies to further mitigate increases in aggregate rate levels, both in the short term and in future years.

This section presents the following strategies, with those requiring most immediate action listed first:

- State supplemental reinsurance programs;
- Alternative state-based reinsurance programs;
- Phase-out of state high risk pools;
- Caps on aggregate rate changes;
- Limitation of down-side risk for health insurance issuer; and
- Consumer outreach and communication strategies.

State Supplemental Reinsurance Programs

The ACA's transitional reinsurance program is designed to protect non-grandfathered health benefit plans in the individual market from the risks associated with insuring high cost individuals, thereby stabilizing health insurance premiums in the individual market during the transition to the guaranteed issue, modified community rating environment starting in 2014. Federal regulations split the transitional reinsurance program into two separate programs: (1) a mandatory national reinsurance program, and (2) a voluntary state supplemental reinsurance program. As stated in the regulatory impact analysis included in the final payment notice, the U.S. Department of Health and Human Services (HHS) estimates that payments made under the national reinsurance program will reduce average 2014 premiums in the individual market by between 10% to 15% in 2014; this may be significantly less than the expected average premium increase in the individual market in some states.

In order to further mitigate the expected premium increases, states may establish a supplemental reinsurance program to provide reinsurance benefits that are more generous than those provided under the national program. This option may be attractive to states expecting a large influx of high-cost individuals into the individual health insurance market in 2014 due to a large uninsured population with higher than average morbidity and/or a relatively large high risk pool.

However, there are several considerations that states should take into account when deciding if a supplemental reinsurance program is appropriate.

- ***Structure.*** States administering a reinsurance program will have to contract with or establish a non-profit "applicable reinsurance entity" to administer the program. Federal regulations give states significant latitude in defining the reinsurance entity; however, time constraints may limit a state's options. States that currently administer a high risk pool or a reinsurance program may already have much of the infrastructure needed to implement the supplemental reinsurance program and will therefore be in the best position to implement the program in the compressed timeframes. States may need to obtain statutory authority to make any changes necessary to ensure compliance with the ACA. Contracting with third-party administrators to perform the administrative functions of the program may be a prudent way to expedite the implementation without exerting additional strain on existing state resources.

States will also have to determine which state agency will have oversight authority over the reinsurance entity. In deciding on the oversight authority, states should consider the expertise, regulatory authority, and potential conflicts of interest of potential candidate agencies. For many states, the insurance department or the department of health and human services may be the best choice.

The final federal regulations detail the ways in which states can alter the payment parameters for a supplemental reinsurance program. The supplemental parameters are limited to the following:

- A lower attachment point than \$60,000;
- A coinsurance rate that is higher than 80%; and/or
- A higher reinsurance cap than \$250,000.

The supplemental reinsurance program may provide reinsurance benefits in excess of any benefits payable under the uniform parameters of the national program. However, the supplemental reinsurance program cannot make up for any shortfall experienced under the national program if actual payments are less than the amounts expected under the uniform parameters.

- **Funding.** HHS will not collect assessments to fund supplemental reinsurance programs. Additionally, states do not have the authority to collect assessments from self-insured plans. Therefore, states will have to find alternate sources of funding for a supplemental reinsurance program. The best options for a state will be those funding sources that spread the cost as widely as possible. Potential sources of funding include:
 - Additional assessments on insurers;
 - Redirection of other insurer assessments (e.g., current assessments for high-risk pools or current reinsurance programs);
 - Redirection of a portion of premium taxes collected;
 - Redirection of other state funds; and/or
 - Private funding sources.
- **Timing.** In order to implement a supplemental reinsurance program, there are many things that will have to fall into place very quickly. Statutory changes may be needed in order to provide the appropriate state agency with the statutory authority to oversee and/or administer the program. Statutory changes may also be needed to establish the “applicable reinsurance entity,” and to establish funding sources for the program. Therefore, a state’s legislative calendar may ultimately determine whether it is feasible to implement a supplemental reinsurance program by January 1, 2014. A state administering a supplemental reinsurance program will need to inform HHS of its intent and issue a notice of its parameters by April 5, 2013. In order for insurers to reflect the supplemental program into its pricing for 2014, these parameters should be published as soon as possible. States may also consider implementing a supplemental program in 2015 or later if there are concerns regarding future premium stability as the federal program phases out.

Implementation of a state supplemental reinsurance program can provide much-needed short-term relief to consumers in that state by mitigating the impact of expected rate increases in the individual market. Given the compressed timeframes, implementation of this program may be most feasible in states with the following:

- Current legislative authority to administer a reinsurance program or an ability to obtain that authority within a short time frame;
- Existing structures such as a high-risk pool or existing reinsurance program that can be repurposed to carry out the functions of the supplemental reinsurance program, especially if few changes would be needed for compliance with the ACA;
- Available source(s) of funding for the program; and
- An amenable political environment to facilitate efficient legislative changes.

Alternative State-Based Reinsurance Programs

States may also consider implementing an alternative reinsurance program that is not consistent with section 1341 of the ACA. The preamble to the final payment notice states that “... nothing in these final rules prevents a State from establishing a separate program that would operate alongside the reinsurance program established under section 1341 of the Affordable Care Act. A State establishing such a program is free to implement the collections methodology and payment formula of its own choosing.” This opens up the possibility for states to design a reinsurance program to meet its unique needs and further mitigate expected premium increases.

An alternative reinsurance program may give states some additional flexibility since it does not have to comply with the ACA requirements and may be designed to fit the specific needs of the state. Such a program may be implemented at any time as states evaluate the impact of the ACA reforms. Some potential goals of an alternative reinsurance program may be to:

- Cover payment shortfalls under the national reinsurance program;

- Target reinsurance payments to policies held by current high-risk enrollees;
- Reimburse insurers for certain high-cost medical conditions; and/or
- Create a permanent reinsurance program.

An alternative reinsurance program will also need to be coordinated with the ACA reinsurance program(s) to avoid duplicative payments.

Phase-out of State High Risk Pools

ACA section 1101(g)(3)(A) stated that “coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.” However, subsequent regulations left the choice to terminate the state run high risk pool to the state. The final market rules specified that “[s]tates will continue to have the discretion to determine whether each state continues to have a high risk pool in order to ease the transition of enrollees to other products...” This option recognizes the high cost of participants in high risk pools and that merging the pool with the individual or small employer markets will result in a higher average cost, leading to higher premiums for all participants in the market.

The decision to continue a state high risk pool should include an analysis of the following points:

- ***Percentage of market participating in the high risk pool.*** The higher the percentage of the current market participating in the high risk pool, the greater the impact of maintaining a separate pool.
- ***Morbidity of the high risk pool participants.*** The greater the discrepancy between the high risk pool cost and the market cost, the greater the impact of maintaining a separate pool.
- ***Funding of the high risk pool.*** The funding mechanism may limit the benefit of continuing a high risk pool. If the pool is funded through annual assessments which are limited to the market of the pool (individual or small employer), then there may be limited benefit of the pool continuing with the federal risk adjustment, reinsurance, and risk corridor programs in place. If the pool is funded more broadly (across all markets or through premium taxes, etc.) or if the pool has existing funds, the continuance of the high risk pool will likely reduce the market premiums and ease the transition to some degree. It is anticipated that no federal funds will be available to state high risk pools after January 1, 2014.
- ***Statutory requirements.*** There may be legal limitations on the pool operations that will make the plans or premiums not feasible or not reasonable when compared to the ACA compliant plans or premiums. There may also be a statutory requirement to continue the pool until legislation is enacted authorizing the termination of the pool.
- ***Value to participants.*** A portion of the high risk pool participants may be advantaged by remaining in the pool, rather than transitioning to an ACA compliant plan. This may be due to significant subsidies or greater variability in the rating factors than allowed with ACA compliant plans. The value to participants who are better served by remaining in the pool should be compared to the cost to continue the pool and the cost to the participants who would be better served in an ACA compliant plan but may not move due to inertia.

As with the state supplemental reinsurance program, continuation of a state’s high risk pool requires that decisions be made quickly to maintain existing legislative authority, secure funding, and provide sufficient information to insurers in advance of ratemaking decisions.

Caps on Aggregate Rate Changes

In order to minimize the impact of rate increases, states may consider establishing annual maximum average rate increases on an aggregate, market-wide basis and essentially force insurers to either operate at a short-term loss or find alternative ways to reduce costs.

This approach is somewhat similar to the long-term care pricing issue today where states are regulating rate increase requests. However, the significant difference is that health insurance will be mandatory beginning in 2014, while long-term care insurance remains a voluntary purchase. This creates an inelastic demand for health benefit plans, providing insurers with significant pricing power on the supply side. In the initial years of ACA market reforms, it will take time for insurers to build claims experience and adjust premiums to more accurately reflect this experience. During this adjustment period, insurers may use their pricing power to set premiums based on conservative assumptions, reflecting the uncertainty of future claims experience.

State regulators can play a critical role by limiting rate increases in the initial years of ACA. Caps on rate increases can mitigate initial rate increases, allowing policyholders to adjust to the effects of the market reforms over time. Caps on rate increases can also incentivize insurers to increase efficiencies and better manage costs.

It is critical to note that too much restriction on rate increases can negatively impact the quality and supply of health insurance, as insurers may opt out of the state market. Caps can also delay actuarially justifiable rate increases and result in higher future rate increases or threaten insurer solvency. Conversely, no or minimal restriction on rate increases in less competitive markets can negatively impact the demand for health insurance, as premiums may become unaffordable to much of the population.

Limitation of Down-Side Risk for Health Insurers

As discussed in the previous section, states may choose to impose some form of rate caps to mitigate large rate increases in 2014. States may also consider strategies to make rate caps more acceptable to insurers by absorbing some of the down-side risk.

The federal government is already poised to absorb some risk, both down-side and up-side, through the risk corridor program. States may evaluate whether the risk corridor program is strong enough to support the proposed rate caps while protecting the solvency of health insurers and may investigate opportunities within the constraints of state and federal law to strengthen that program, if necessary. Specifically, a state may consider a program similar to the federal risk corridor that will absorb additional down-side risk. This type of state program differs from a state supplemental reinsurance program in the following ways:

- It protects against random fluctuations in experience, not only against attracting identifiable high-risk insured individuals;
- It can apply to the small group market as well as the individual market, and it may or may not move funds between markets; and
- It accepts risk on the part of the state to fund the program.

A risk corridor program assumes up-side as well as down-side risk. However, in the context of rate caps, a state program for which federal law makes no specific provision may not be able to collect much money from insurers that turn an unexpected profit. To the extent that insurers do not meet the federally prescribed medical loss ratio (MLR) standard, they will be required to rebate excess profits to their members. Unlike payments under the federal 3 Rs, payments under a program initiated voluntarily by a state may not be deductible from premiums in the MLR calculation. The treatment of such payments may depend on whether they are deductible state taxes and fees. A legal opinion will be needed.

The feasibility of a supplemental risk corridor program is subject to the same considerations regarding structure, funding, and timing outlined in the discussion of the supplemental reinsurance program, but it also depends on a state's willingness to assume risk.

Consumer Outreach and Communication Strategies

One key factor in maintaining premium stability and reducing pricing uncertainty in 2014 is the existence of a robust single risk pool. In addition to more technical mechanisms for mitigating rate increases, states should consider communication strategies to encourage full participation by its population in the health insurance market. While other NAIC working groups are addressing communications in general, the following discussion focuses on measures that would result in increasing the take-up rate and reducing anti-selection, thereby keeping rates lower for all market participants.

The navigator program (as well as in-person assisters and certified application counselors), established to assist consumers and small employers in purchasing coverage through exchanges, provides several opportunities for states to disseminate information to the public. States should consider strategies to create and maintain a high quality navigator program. One example is the creation of a non-profit state navigator organization to take ownership of the navigator program, including coordination with exchanges, recruitment, preparation of grant requests, and certification. To support this organization, states can:

- ***Create a dedicated navigator hotline within state insurance departments to provide answers to key questions.*** This can be a direct line housed within a state's consumer assistance division and answered by staff with specific navigator expertise. Only navigators would have this number, and they could use it as a tool while working with consumers.
- ***Develop a navigator web site to provide information of specific interest and support to the navigator program.*** Insurance departments can also create reference sheets for consumer assistance representatives that can be leveraged for this purpose.
- ***Develop an electronic tool for reporting navigator activities and assessing navigator effectiveness, including feedback from consumers assisted by navigators.*** Insurance departments can use this information to complement consumer complaint data. Insurance departments may consider collecting information on the following:
 - ***Navigator enrollments.*** In states with federally facilitated exchanges, CCIIO will have access to this information, but insurance departments may not have a way to track this information independently.
- ***Identify demographics that would best benefit from navigators and then recruit navigators to serve those targeted groups.*** This should be in addition to the overall navigator program. Care must be taken to ensure this effort isn't viewed as unfairly discriminatory.
- ***The navigators should not target populations based on health status.***
- ***Create a rewards program for navigators based on both quantity and quality of enrollees, as measured by subsequent experience and persistency rates.*** Navigators cannot receive compensation from insurers, but states may want to explore other ways to provide incentives, while being aware of restrictions regarding gifts to employees, grantees, or agents of government agencies. The definition of enrollee "quality" would need to be written carefully so as not to be unfairly discriminatory or identify individuals based on medical conditions or another factor that may result in adverse selection. One possible approach is to define "quality" based on enrollment during the first or second meeting between a navigator and the consumer, indicating that the navigator upheld his/her responsibility to inform the consumer of the information required for enrollment.
- ***Establish a managing board to include members from the insurance department, health insurers, health care providers, consumer advocates, and the public, particularly from target groups.***

States can also create a multi-faceted communication strategy in collaboration with state-based or federally-facilitated/partnership exchanges. This strategy need not focus solely on exchange participation and may include the following elements:

- ***Creation of a single, toll-free phone number for consumers to call with questions.*** The number should be easy to remember and well-publicized. To support this program, states would need to:
 - Provide training, including simulations, to develop expertise among those staffing the line, and provide processes to certify their knowledge.
 - Advertise the toll-free number on radio stations, at libraries, schools, labor union halls, large retailers, hospitals, casinos, fast food restaurants, unemployment offices, Medicaid offices, state and county fairs, on billboards, at sporting events, etc.
- ***Development of a speakers' bureau to perform outreach in all areas of the state, including written and oral communication.*** States may recruit speakers and/or writers from the managing board of the non-profit navigator organization, the insurance department, the exchanges, health insurers, health care providers, agents, navigators, health-related foundations, target groups, and others.
- ***Development of contests, with prizes or other incentives, for the various target groups to test knowledge of the enrollment process, eligibility, and coverage purchase options.*** Winners can be recruited to become navigators or in-person assisters.

Strategies to Address Rate Distribution

In addition to factors that affect the average rate level in the health insurance market, the ACA implements changes to rating factors that will result in varying rate impacts across state populations. For example, the 3:1 limitation on age factors will result in higher rates for younger individuals and lower rates for older individuals in most states. Subsidies and tax credits will be available for those who qualify based on income, and catastrophic plans will be available to individuals under age 30 and those who can demonstrate financial hardship under the federal rules. The distributive effects of various rating restrictions may discourage certain groups from purchasing health insurance coverage, which may, in turn, affect average rate levels. Many states are particularly concerned with providing incentives for young, healthy individuals to purchase coverage as a means to increase stability in the risk pool and achieve public policy goals of expanding health coverage to the entire population.

This section outlines the following strategies:

- State-specific age curves.
- State subsidy programs.
- Definition of geographic rating areas.

All three strategies require timely action in order to be effective in 2014.

State-Specific Age Curves

Due to the new age rating restrictions under the ACA, young adults in many states are expected to experience significant rate increases in 2014. The availability of catastrophic plans for young adults and subsidies for lower income individuals may mitigate these increases for some individuals, but not for others.

The uniform national age curve flattens a cost-based age curve to the 3:1 ratio without addressing revenue neutrality. The index rate increases, and as a result, rates for young adults will increase significantly. For example, a study commissioned by the state of Oregon estimates that rates for 21-year-olds may increase by more than 60%. States have flexibility to define state-specific curves, and such a curve could be designed to be revenue neutral, spreading lost revenue over a wider range of age bands, and somewhat mitigating the highest increases. States must notify HHS of state-specific age curves within 30 days of the published final rules, by March 29, 2013.

States may wish to consider the following in evaluating and defining a state-based curve:

- Existing issuer age bands or historical costs can be used as a basis.
- Age curves should be recalibrated after guaranteed issue has been in effect for a period of time.
- There may not be enough time to develop and gain federal approval for a 2014 state-specific age curve.
- Delayed implementation (e.g., plan year 2015 or later) of a state-specific curve may disrupt the market a second time.
- Small group and individual age curves may differ significantly.
- The uniform national curve may be an adequate fit.
- The state-based curve may or may not be supported by the federal risk adjustment program.

State Subsidy Programs

The ACA also introduces federal subsidy and tax credit programs to provide assistance to those with low incomes, generally below 400% of the federal poverty level. States may consider a supplemental subsidy program funded through a portion of the increased premium tax revenue resulting from higher premiums. Subsidy programs can be designed to motivate health consumers to purchase individual coverage, small employers to purchase group coverage, and/or for insurers to invest in quality improvement programs.

To provide incentives for individual consumers and/or small groups to purchase coverage, states may consider the following:

- ***Providing supplemental premium subsidies to individuals based on income, age, or health status.*** Such a program could be administered through the state income tax program, reducing the tax owed or increasing the refund available. Individuals would need to file proof of eligibility as part of annual tax returns and/or estimated tax payments.
- ***Providing company income tax credits to small employers purchasing group coverage through the SHOP exchange.*** Subsidies could be based partly on the percentage of all employees that are covered, including part-time employees. If necessary, states could seek to increase the overall state company income tax rate.
- ***Raising the attachment level for stop loss insurance to \$60,000 or higher to discourage self-insurance by small groups.***

Like supplemental reinsurance, continuation of high risk pools, and state risk corridor programs, implementation of state subsidies will likely require legislative action. Additionally, these strategies may require collaboration with federal agencies, exchanges, and state departments of revenue.

Definition of Geographic Rating Areas

In many states, insurers currently define geographic areas as they see fit and develop specific geographic area rating factors. The ACA requires a uniform definition of geographic areas for each state to be utilized by all insurers marketing health benefit plans in the state. Insurers will still be free to set their own geographic area rating factors. The final market rules provide states with some flexibility regarding the maximum number of geographic rating areas within the state.

Transitioning from the current, insurer-specific designation of geographic rating areas that exists in many states to uniform geographic rating areas is expected to cause rate disruption in addition to other rate changes arising from the implementation of other provisions of the ACA. Some individuals will experience rate increases due to changes in geographic rating areas, while others will see rate reductions or no rate change due to these changes.

States should consider pursuing strategies that minimize such disruptions. In some states, studies show that introduction of new geographic rating areas will produce a material (additional) increase on the rates that some policyholders will see. The final market rules, per Section 147.102 (b)(3), allow states some flexibility to both set the number of geographic rating regions and determine how the regions are defined. States may define the number of rating areas, not to exceed the number of Metropolitan Statistical Areas (MSAs) in their states plus one (or a larger number if it was established by law, rule, regulation, bulletin, or other executive action before January 1, 2013)

HHS may approve a larger number of geographic rating areas if the state can demonstrate the geographic rating areas are

- actuarially justified,
- are not unfairly discriminatory,
- reflect significant differences in health care unit costs,
- lead to stability in rates over time,
- and apply uniformly to all issuers in a market.

The final rule takes away some flexibility by removing the ability of states to submit alternate actuarially justified geographic areas for approval by HHS. Specifically, the final rule restricts states to define their geographic areas based on a combination of state counties, three-digit zip codes, MSAs and non-MSAs..

States may define separate geographic rating areas for its individual and small group markets. States should, while working within the restrictions and flexibility allowed for by the final rule, define their uniform geographic areas with an eye on minimizing the resulting inevitable rate increases that some members of individual and small group markets will experience.

As with any other state initiatives affecting the implementation of the ACA, states must notify HHS of their proposed uniform geographic rating areas within 30 days of the published final rules, by March 29, 2013.

Conclusion

As states prepare for changes to their health insurance markets, they have a number of possible decision points and strategies available to stabilize rate levels. Most of the strategies focus on creating a robust risk pool and encouraging full market participation across each state, but some may be more feasible than others, depending on existing legislative authority, political climates, and current market dynamics. States should begin evaluating these and other strategies **immediately** in order to mitigate rate increases when the major market reforms take effect in 2014.