The Affordable Care Act in Brief: A Look Into January 2014 Changes

The Affordable Care Act (ACA) introduces many new mechanisms into the insurance marketplace that significantly impact business as usual. Although the changes are of great magnitude and, at times, intertwined with each other, this article sets out to introduce many of the changes in a simplified format. The 2014 changes will impact each market (individual, small-group, large-group and self-insured) in a different manner. This overview highlights those differences and includes a discussion of each.

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The Affordable Care Act (ACA) introduces many new mechanisms into the insurance marketplace that significantly impact business as usual. Many changes have already been implemented (e.g., 100% preventive care services and dependent coverage until the age of 26), while many are set to begin in 2014. Most stakeholders have navigated through current changes and are beginning to focus on what to expect in January 2014. Although the changes are of great magnitude and, at times, intertwined with each other, this article sets out to introduce many of the changes in a simplified format. The 2014 changes will impact each market (individual, small-group, large-group and self-insured) in a different manner. This overview highlights those differences and includes a discussion of each.

Please note that several rules are in the proposed stage and may change when the Department of Health and Human Services (HHS) publishes the final rules.

ACA market changes highlighted in this article include:
- Risk adjustment
- Reinsurance
- Assessments
- Demographic rating restrictions
- Essential health benefits
- Open enrollment rules
- Minimum loss ratio rule
- Risk corridors
- Actuarial value calculator
- Underwriting.

Wakely has been hired to conduct research and analysis regarding changes under ACA on behalf of several states through grants funded by the Robert Wood Johnson Foundation’s (RWJF) State Health Reform Assistance Network (SHRAN) program. Many concepts discussed in this article were generated from analyses funded by RWJF.

Risk Adjustment

The risk adjustment program under ACA is a permanent program that will begin in 2014. This program is intended to protect health plans operating in the individual and small-group markets, both inside and outside the Affordable In-
insurance Exchanges, from attracting a higher-than-average health risk after consideration of the allowable rating variables (age-limited to 3:1, family size/composition, tobacco use and geographic area). Risk adjustment will be applied separately to each market. A plan operating in both markets will have separate risk scores. The program will move funds within each market such that overall market revenue neutrality is achieved. Funds will transfer between plans with risk scores less than 1.00 to plans with a higher risk profile. Note that this program is not applicable to grandfathered individual plans and will not impact the large-group and self-insured markets.

Understanding a plan’s risk profile relative to the market will be an important consideration when setting individual and small-group rates in 2014. An important consideration for the individual market is the size and risk score for the currently uninsured, small employer market groups of one, and high-risk pool members expected to join the individual market as new entrants in 2014. Wakely currently is helping plans understand their relative risk profile by conducting a national simulation study.

Reinsurance

The transitional reinsurance program under ACA helps to stabilize premiums for coverage in the individual market during the years 2014 through 2016. All health insurance issuers for commercial group and individual business, and third-party administrators (TPAs) on behalf of self-funded group health plans, will submit contributions to support reinsurance payments to issuers that cover high-cost individuals in nongrandfathered (NG) individual market plans. Essentially, the assessments will result in increased premium rates for the commercial group and self-funded markets, while subsidizing the NG individual market. The 2014 assessment is $5.25 per member per month (PMPM).

States have limited flexibility in regard to how the program is operated. The amounts in Table I are minimum requirements; states may choose individually to increase the reinsurance funding for their state. However, states may do so only as enhancements to the federal reinsurance parameters—i.e., a $60,000 attachment point, an 80% coinsurance rate and a $250,000 reinsurance cap. The federal government will distribute funds to each state based on the federal reinsurance parameters. States that choose to enhance the parameters may elect to lower the threshold, increase the coinsurance rate or extend the reinsurance cap. Such an increase in reinsurance coverage will need to be funded by the state (e.g., additional assessment on the market). Unlike with risk adjustment, states that do not operate an exchange will have the option to operate reinsurance or elect to have HHS operate the program. Operation of the program may include contribution collection, parameter (attachment point, coinsurance and cap) enhancement and payment distribution. HHS published the actual minimum contribution rate ($5.25 PMPM) in the October 2012 advance notice in addition to program parameters—attachment point ($60,000), coinsurance rate (80%) and cap ($250,000).

Assessments

In order to fund the temporary transitional reinsurance program and provide a contribution to the U.S. Treasury, ACA includes two assessments: (1) an insurer fee that applies to for-profit health insurance companies’ commercial and public program enrollees, and (2) an assessment on all health insurance companies’ (including nonprofit) commercial business and TPAs for self-funded employer group business. The insurer fee does

<table>
<thead>
<tr>
<th>Year</th>
<th>Insurer Fee Amount (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$8.0</td>
</tr>
<tr>
<td>2015</td>
<td>$11.3</td>
</tr>
<tr>
<td>2016</td>
<td>$11.3</td>
</tr>
<tr>
<td>2017</td>
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<td>$15.0</td>
</tr>
<tr>
<td>2020</td>
<td>$15.8</td>
</tr>
<tr>
<td>2021</td>
<td>$16.7</td>
</tr>
<tr>
<td>2022</td>
<td>$17.5</td>
</tr>
<tr>
<td>2023</td>
<td>$18.5</td>
</tr>
</tbody>
</table>

Insurer Fee National Contribution Requirements
benefits quarterly second quarter 2013

TABLE II

National Reinsurance / Treasury National Contribution Requirements (in Billions)

<table>
<thead>
<tr>
<th>Program</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurance</td>
<td>$10.0</td>
<td>$6.0</td>
<td>$4.0</td>
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<tr>
<td>Reinsurance Administration</td>
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<td>$0.5</td>
</tr>
<tr>
<td>Treasury</td>
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<td>$2.0</td>
<td>$1.0</td>
</tr>
<tr>
<td>Total</td>
<td>$12.5</td>
<td>$8.5</td>
<td>$5.5</td>
</tr>
</tbody>
</table>

not apply to TPAs for self-insured plans. The reinsurance and treasury assessments do not apply to insurance companies’ public program enrollees, but they apply to both for-profit and nonprofit insurance companies.

The insurer fees to be collected by year according to ACA are shown in Table I.4

The insurer fee will be assessed equally as a percentage of applicable premiums (besides excluding nonprofit companies, the first $25 million of premium, and 50% of premium from $25 million to $50 million for an organization, are not assessed). The insurer fee is not a tax-deductible expense for federal corporate tax purposes.

Table II shows the reinsurance assessment and contribution to the Treasury, by year, according to ACA.

The reinsurance assessment will be assessed on a per capita basis. All health insurance companies including nonprofits and tax-exempt organizations must pay the assessment. Based on current guidance, high-risk pool enrollment appears to be exempt from the fee (although most high-risk pools should cease operation in 2014).

Table III shows Wakely’s estimates for the insurer fee and reinsurance assessments. (The 2014 reinsurance fee PMPM is an actual amount.)

Table III’s estimates are inherently uncertain and subject to change based on emerging information. The premium adjustment will vary by organization, depending on its tax and for-profit status, size and market participation. In addition, changes in market proportions will affect the amounts paid as a percentage of revenue, because the insurer fee assessments actually are made based on revenue in the year prior to the contract year (2013 market share for 2014, for example).

Demographic Rating Restrictions

Many different rating factors are used in today’s individual and small-group health insurance markets to develop premium rates, such as health status, duration, age, gender, area, occupation and smoking status. The variation in factors can be attributed to insurance company rating methods or different state regulations. Under ACA, rating factors for these markets are limited to age, smoking status, area and contract type (individual vs. family). Age is restricted to a 3:1 ratio in which the rate for an older adult cannot be more than three times the rate for a younger adult. Rates for tobacco users cannot exceed 150% of the rate for a nonsmoker.

In many states, insurance carriers are allowed to use health status as a rating variable. Most limit the rating factor variation from 0.75 to 1.25. In 2014, all groups will be rated based on 1.00 rating factors (ignoring the allowed rating differences). Healthier groups with a 0.75 health status rating factor will face a 33% increase in premium rates from this change, and less healthy groups with a 1.25 factor will experience a 25% decrease in rates. This premium impact could lead to changes in the marketplace. For example, some healthier small employers could drop coverage and offer vouchers for the individual market exchange or purchase stop-loss coverage and self-insure. Such a scenario changes the expected morbidity of the small-group market, leading to a further impact for the small employers that purchase coverage.

To a lesser extent than health status rating, the removal of age-rating factor restrictions and gender rating will impact premium rates for certain demographics. Relative to today’s rates, these changes are expected to lower premium rates for older adults and raise them for younger adults. Younger males may also experience a higher rate increase as the cost associated with pregnancy will be spread across males and females.

States maintain the option to fur-
ther restrict rating in the individual and small-group markets as long as the rules under ACA are met. These factors do not impact the large-group or small-group markets with one exception: By 2016, states are required to expand the definition of a small group from 2-50 employees to 2-99 employees. Groups with 51-99 employees may have significant premium rate changes when the small-group definition is expanded. States can implement the expanded small group at an earlier date.

**Essential Health Benefits**

Starting in 2014, ACA will require small-group and individual health insurance plans to cover a range of services within ten basic categories. The determination of essential health benefits (EHBs) is delegated to the states for plan years 2014 and 2015. Under this approach, each state selects a benchmark plan from among the ten possible plans, based on first quarter 2012 enrollment, as described below:

- The three largest small-group insurance products in the state’s small-group market based on enrollment
- Any of the largest three state employee health benefit plans by enrollment
- Any of the largest three national federal employee health benefit plan options by enrollment, or
- The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

If a state chooses a benchmark plan that does not cover all of the state-mandated benefits enacted prior to December 31, 2011, the state is then responsible for the cost of the mandated benefits. The nonfederal benchmark options typically would cover all state-mandated benefits. None of the three federal plans covers autism spectrum disorders, fertility drugs or assisted reproductive technology. The federal EHB requirements mandate the state EHB package to include coverage of all ten basic categories including habilitative, pediatric dental, pediatric vision and others, regardless of whether the benchmark option includes such coverage.

A benefit comparison should be created showing the differences in benefits between an issuer’s product offerings and the EHB option selected by the state, with a focus on the difference in benefits underlying the data used in pricing (likely calendar year 2012 for 2014 rate filings). Pricing estimates should be developed using industry data, adjusted where possible for health plan or at least state-specific utilization and cost assumptions. The coverage of additional services may also increase administrative costs. However, applying the existing percentage of premium assumption to the cost for the expanded services may overstate expenses because of fixed administrative costs that are included in the overall, current percentage of premium values.

**Open Enrollment Rules**

Exchanges must establish a navi-
gator program to provide to entities with relationships to employers and employees, consumers or self-employed individuals. Navigators will distribute information concerning enrollment in plans and facilitate enrollment. The navigator would be available for people looking to enroll in either individual or small-group coverage. ACA also lays out specific guidance around the allowed open enrollment periods for the exchanges.

**Individuals**

For individuals, exchanges must provide for an initial open enrollment period, annual open enrollment periods after the initial period, special enrollment periods under circumstances similar to those for Medicare prescription drug plans and a special enrollment period for Native Americans.

Individual coverage is expected to reflect calendar-year policies. The initial open enrollment allows a qualified individual to enroll in a qualified health plan (QHP) from October 1, 2013 through March 31, 2014. The summary of benefits and coverage (SBC) needed to be ready for all plans by September 23, 2012. The SBCs will be available well before the initial open enrollment date and will need to be accessible for any potential enrollee. The SBC highlights the key cost sharing included in a plan as well as any limitations and exclusions. It does not include any premium information. The final rules do note that premium information should be available on Plan Finder (www.healthcare.gov).

The goal of the lengthy initial enrollment period is to ensure that qualified individuals have sufficient time to be educated, compare options and enroll. This may result in some people being enrolled for less than 12 months in the first year. The effective date for coverage will be January 1, 2014 if the QHP selection is received before December 7, 2013. In general, selection by the seventh of the month is the cutoff date to have an effective date of the following month, but ACA leaves it to the exchange to define. States may make up to the first day of the second month following selection of the effective date. Annual enrollment is to be from October 15 through December 7 each year, with a policy effective date of January 1 of the following year. The special enrollment period would happen up to 60 days from the date of a triggering event, although state regulation may specify otherwise. The triggers are:

- A qualified individual and any dependents losing other minimum essential coverage
- A qualified individual gaining or becoming a dependent through marriage, birth, adoption or placement for adoption
- An individual, not previously lawfully present, gaining status as a citizen, national or lawfully present individual in the United States
- Consistent with the Medicare Prescription Drug Program, a qualified individual experiencing an error in enrollment
- An individual enrolled in a QHP adequately demonstrating to the exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract
- An individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions
- New QHPs offered through the exchange becoming available to a qualified individual or enrollee as a result of a permanent move
- The individual is an Indian, as defined by the Indian Health Care Improvement Act
- A qualified individual or enrollee meeting other exceptional circumstances, as determined by the exchange or HHS.

**Small Groups**

The small business health options programs’ (SHOP) initial open enrollment period is aligned with the individual exchange for the first opportunity when coverage may be purchased through SHOP. After that, there is a rolling enrollment in SHOP, which is consistent with current practice in the small-group market where plan years do not necessarily correspond to calendar years. The annual election/open enrollment periods for employers/employees must be at least 30 days. SHOP must provide newly qualified employees with a specified enrollment period.

SHOP offers the same special enrollment periods as
ACA states that every health insurance issuer in the individual or group markets must accept every employer and individual in the state that applies for coverage. There is no longer the ability to not offer a quote if requested.

The individual exchange, with the exception of changes in citizenship status or eligibility for insurance affordability programs.

**Minimum Loss Ratio Rule**

ACA established new federal rules governing how health insurers spend premium dollars. These rules commonly are referred to as minimum loss ratio (MLR) regulations—meaning that they specify the minimum share of premium income that an insurer must spend on claims costs and “activities that improve health care quality.” The minimum levels are set in ACA at 85% for large-group plans and 80% for small-group and individual plans. The statute explicitly excludes insurer payments of “federal and state taxes and licensing or regulatory fees” from the calculation of minimum loss ratios. ACA further stipulates that if an insurer spends less than the required minimum in a given year, then the insurer must refund the difference to policyholders through a rebate. Thus, for example, if an insurer is required to spend 80% of premium income on claims costs for a particular product but spends only 75%, the insurer is required to rebate 5% of the premium collected to policyholders.

MLR requirements apply to commercial health insurance issuers offering group or individual coverage, including both grandfathered and nongrandfathered plans. It initially excludes business associated with self-funded plans, stop-loss insurance, Medicare, Medicaid, short-term limited duration individual coverage and expected benefits under the Health Insurance Portability and Accountability Act (HIPAA). Some of these—for example, Medicare—will be required to report MLR starting in 2014.

The numerator for calculation of the MLR equals the incurred claims and expenditures for activities that improve health care quality, and the reporting of data for these categories’ expenses. The denominator for the MLR calculation equals the premium revenue minus federal and state taxes and licensing and regulatory fees. The denominator also will take into account payments or receipts for risk adjustments, risk corridors and reinsurance.

**Risk Corridors**

The reinsurance, risk adjustment and risk corridor programs often are called the “3Rs” of ACA. The risk corridor program is a temporary program, along with reinsurance. The risk corridor program will limit the gains and losses of a QHP operating in the exchange. This program will be in place for three years (2014-2016) and is intended to stabilize the market by sharing risk at a time when implementation of reform will make accurate rate setting challenging. The risk corridor program applies to both the individual and small-group business within the exchange but does not impact plans sold outside of the exchange.

The risk corridor mechanism compares the total allowable medical costs for a QHP (excluding nonmedical or administrative costs) to those projected or targeted by the QHP. If the actual al-
allowable costs are less than 97% of the QHP’s target amount, a percentage of these savings will be remitted to HHS (limiting gain). Similarly, if the actual allowable cost is more than 103% of the QHP’s target amount, a percentage of the difference will be paid back to the QHP (limiting loss). The QHP’s target amount is defined as the plan’s total premiums incurred, less allowable administrative costs. Allowable costs are defined as the QHP’s actual total paid medical costs, excluding allowable administrative costs, in providing the QHP’s covered benefits.

The calculation of the risk corridor will take place after the reinsurance and risk adjustment have been integrated into results. Thus, it will not be redundant with the rebalancing of the risk already performed.

The risk corridor calculation occurs prior to the calculation of the MLR. The MLR program further pays out rebates to policyholders if it is shown that the plan in that state paid too little of the adjusted premium in support of medical claims and other medical expenses. In contrast, though, the MLR is only a one-sided adjustment. It makes no payment to the QHP in the event that the MLR was above a specific threshold.

Risk corridors are calculated on the plan rather than the issuer level, and taxes and regulatory fees and reinsurance and risk adjustment payments or receipts are applied to adjust allowable costs rather than subtracted from the premium. No time line is given for applying risk corridor collections and payments.

**Actuarial Value Calculator**

The actuarial value (AV) of a plan design provides a relative measure of the value of EHBs offered. For any given plan/plan design, the AV is calculated as expected costs paid by the health plan divided by the expected allowed costs. As implied in the definition, only the costs associated with EHBs determine the AV; benefits excluded from the EHB list will not impact the AV calculation.

Beginning in 2014, there will be four primary levels of plan designs that may be offered, varying by their AV. The four metal level plans are bronze at 60% AV, silver at 70% AV, gold at 80% AV and platinum at 90% AV. De minimis variation allows for a 2% variation around each of the metal level AVs. For example, a platinum plan would have an AV ranging from 88% to 92%. While not all of the specifics of this requirement have been finalized, all insurers participating in both the individual market and the exchange will be required to offer one plan at the silver level and one at the gold level. In addition, most states will mirror these requirements in the market outside of the exchange (assuming such a market is allowed by the state).

Individuals who qualify for premium credits and are enrolled in a silver plan in the exchange will also be eligible for assistance in paying their cost sharing. Any plan in the exchange will already have a limit on the maximum out of pocket (MOOP), such that it cannot exceed the high-deductible health plan limit ($5,950 in 2011). The cost-sharing subsidies will further reduce these MOOP limits by two-thirds for individuals up to 200% of the federal poverty level (FPL), by one-half for individuals between 200% and 300% of FPL, and by one-third for individuals between 300% and 400% of FPL. Other forms of cost sharing such as deductibles, coinsurance and copays will be further subsidized, if necessary, to ensure that the health plan and subsidies cover the percentages of allowed health care expenses as required.

**Underwriting**

Several requirements related to underwriting will go into effect beginning on January 1, 2014. The requirements reduce the ability of health insurance issuers to select the type of risks they are willing to accept. The intent of the regulation is to provide more accessibility to health insurance for all individuals, irrespective of health status. The underwriting changes also are very closely tied to the restrictions on rating factors that may be used when determining the appropriate premium to charge an enrolling individual.

ACA states that every health insurance issuer in the individual or group markets must accept every employer and individual in the state that applies for coverage. There is no longer the ability to not offer a quote if requested. All issuers of health insurance in both the individual and group market must renew or continue coverage at the option of the plan sponsor or individual. Coverage may not be nonrenewed other than for reasons stated in the contract. The use of preexisting-condition exclusions or other discrimination based on health status is prohibited. Preexisting-condition exclusions historically have been used to limit the claims payments made
for conditions that were already present in the individual who newly received health insurance coverage. ACA prohibits discrimination against individual participants and beneficiaries based on health status. No insurance issuer can establish rules for eligibility of any individual to enroll in a plan based on any of the following factors: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. The regulations do not speak to whether this information can be collected and not used, or whether it may not be collected at all. No waiting periods exceeding 90 days are allowed to be applied to any health plans.\(^7\)

Authors’ note: This article borrows heavily from several reports published by Wakely Consulting Group. We recommend these reports for a more in-depth look into the topics discussed in this article. The reports are cited in the references section.

Endnotes

1. Through the creation of affordable insurance exchanges, ACA includes provisions to help establish a competitive private health insurance market. These state-based, competitive marketplaces are intended to provide individuals and small businesses with “one-stop shopping” for affordable coverage.

2. Further information on this study is available at www.WakelySimulation.com.


4. The amount of the statutory insurer fee is set through 2018 and estimated for each year beyond 2018. The statute states that after 2018, the insurer fee will equal the amount of the fee in the preceding year, increased by the rate of premium growth for the preceding calendar year.


6. If a state does not elect a benchmark plan, HHS proposes that the default benchmark plan for that state would be the largest plan by enrollment in the largest product in the state’s small-group market.

7. The full document with these sections can be found at www.healthcare.gov/law/resources/authorities/patient-protection.pdf.

References


