TESTIMONY

Tarren Bragdon, CEO
The Foundation for Government Accountability

Hearing titled
"Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Flexibility"

Before the
Senate Committee on Health, Education, Labor, and Pensions

September 12, 2017

Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for the privilege of testifying. I am Tarren Bragdon, the Founder and CEO of the Foundation for Government Accountability (FGA). FGA works at the state and federal level to advance policy reforms to free more Americans to experience the power of work and reduce the biggest payroll deduction for most Americans, the cost of health coverage. Our model reforms were introduced in 41 states this year and have passed in 29 states over the past three years.

As this committee leads with bipartisan ways to improve cost and coverage, I offer three recommendations for your consideration:

First, Americans with pre-existing conditions need premium relief as well as access to individual insurance, without being segregated to plans with fewer benefits or higher premiums than those available to everyone else. This can be achieved by employing proven strategies that have successfully brought down premiums and reduced the number of uninsured.

Second, states need real policy flexibility to allow a greater continuum of health coverage, particularly for those buying their own insurance on the individual market, with a clearly defined and reasonable process and timeline.

Third, bipartisan reforms that reduce the cost of health care should be carefully considered under any bipartisan reform effort, as ultimately the cost of coverage reflects the cost of care.

1. Lowering the cost of coverage for those with pre-existing conditions and everyone else with invisible risk sharing

As my fellow panelist from Oliver Wyman and, separately, actuarial firm Milliman[i] have noted, the guaranteed issue mandate is the main driver of individual insurance premium increases under the ACA (up to 45 percent premium increase on average, according to Milliman). Congress must embrace a reform with a record of success to both lower premiums and maintain access for everyone buying insurance on their own.

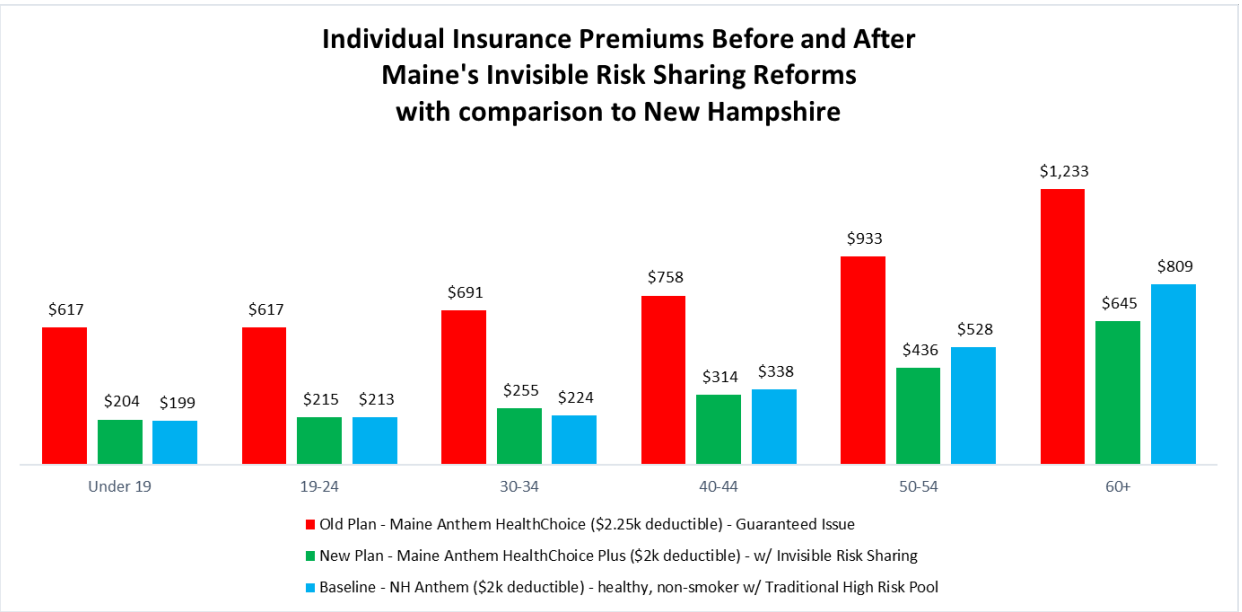
Prior to the ACA, most states segregated those with pre-existing conditions to high risk pools, which sometimes meant higher premiums or fewer benefits for enrollees. However, both Idaho (first) and Maine (later) pioneered a better and more sophisticated approach that lowered premiums without forcing those with pre-existing conditions to buy different plans. It is far more effective than an open-ended reinsurance program that costs more and is not as effective at reducing premiums.

Guarantee issue is a driver of higher premiums because of the open-ended risk and the higher costs it creates for insurers and, ultimately, policyholders by requiring insurers to accept all applicants.

Maine used an invisible risk sharing approach to both limit the risk and cap the cost for those individuals with pre-existing conditions, but did so with no negative impact on those same individuals. With this approach, those with pre-existing conditions are treated the same as everyone else while still having access to the same plans and benefits and most importantly, lower premiums.

In 2012 with invisible risk sharing, Maine dramatically lowered premiums in the individual market (by up to 70 percent) and increased voluntary enrollment with the active carrier (up 13 percent in 18 months). When combined with expanded age rating, this approach lowered annual premium costs by up to $5,000 for someone in their 20s and up to $7,000 for someone in their 60s (Maine was more restrictive than the ACA with 1.5:1 age bands and moved to 3:1.) Individuals could keep their current plans, and only transitioned to new plans if they chose to do so.[ii]

As the chart below shows, the premium impact of Maine's invisible risk sharing meant that those who were healthy or had pre-existing conditions in Maine had the same or lower premiums as healthy, non-smokers in neighboring New Hampshire (which had a traditional high-risk pool at the time).



Source: Anthem rate filings in Maine and New Hampshire
(Maine Bureau of Insurance, New Hampshire Insurance Department)

We contracted with Milliman to produce an independent actuarial study to show the impact nationally of using invisible risk sharing under a similar structure. That independent study in its entirety is attached to my testimony. Under this model, insurers paid claims for only those individuals with pre-existing conditions which are identified upon application, and insurers cover the first $10,000 of claims per person per year. Insurers contribute 90 percent of premiums collected for those eligible for this risk sharing arrangement, which dramatically lowers the cost of the program (covering 40 percent of costs) and prevents gaming by insurers (dumping more individuals into risk sharing).

Combined with expansion of age brackets, invisible risk sharing would lower individual premiums by up to 31 percent in the individual market for those buying outside of the exchange, without any reduction in benefits or increases in cost-sharing. In addition, these lower premiums would mean up to 2 million more Americans would voluntarily buy individual insurance on their own, without any increase in subsidies. Milliman estimated that the cost of this approach nationally would be between $3-5 billion annually, excluding premium contributions from insurers.[iii]

Furthermore, invisible risk sharing money is only spent to reimburse the actual claims of those with pre-existing conditions or those in the risk sharing program. It is not a general reinsurance subsidy with an unspecific impact on premiums. A good contrast is how Alaska's 1332 reinsurance program reduced a projected premium increase from 42 percent to just a 7 percent increase[iv] whereas the Maine invisible risk sharing alone *reduced* premiums from the baseline by 20 percent or more. In other words, invisible risk sharing gets us a far better bang for our buck, because far fewer resources are needed to reduce premiums even more than under traditional reinsurance or a traditional high-risk pool.

Invisible risk sharing works because, at time of application, it caps the claim costs for insurers to cover those individuals with known pre-existing conditions, removing both the open-ended risk as well as limiting the high claims costs of these individuals. Premiums spike with guarantee issue because of this risk and the high claims

costs it creates. Invisible risk sharing mitigates both, with a targeted approach. Effectively, one can receive the benefit of guarantee issue without experiencing the premium increases guarantee issue would normally create.

We would recommend that the federal government jumpstart the invisible risk sharing program initially and then, after two to three years, transition to the states. This would allow for the fastest and greatest amount of premium relief, while allowing states to customize their approaches over time. Maine started its program just 13 months after the legislation was passed and signed into law. A federal program could begin during 2018, say next fall, and create a special enrollment period for new applicants so that they could immediately reap the benefits of lower premiums, should they choose to do so.

2. Real policy flexibility for states and patients with expanded 1332 waivers

FGA's work in numerous states has revealed bipartisan hesitations about Section 1332 of the Affordable Care Act. As evidence of this, only 8 states even introduced 1332 authorizing legislation this year. There is hesitation due to the cost of the planning process, the higher barriers states must clear before an application will be considered, and the unclear timeframe of waiver approvals as well as the unclear coverage and premium benefits to individuals and families.

Put another way, with the current entry barriers and the structure of 1332s, the legislative "squeeze" necessary to get it done in a state is not worth the policy "juice" produced.

But the individual market is in crisis. There has been a 20 percent drop in those with unsubsidized ACA individual insurance this year, as healthy people drop high cost coverage they determine is not worth it.[v] That unsubsidized individual market is now at least 2 million people smaller than it was pre-ACA.[vi] To put this in perspective, only 4 million IRS returns this year paid the individual mandate penalty.[vii] In addition, since 2013, the number of individuals covered through small businesses has dropped 24 percent, showing that individuals are not simply migrating to group coverage as the economy improves.[viii]

Only 1 in 3 of those with individual insurance are eligible for both Cost Sharing Reductions (CSR) and tax credits. That means 2 in 3 in the individual market face the full brunt of higher deductibles and some, if not all, of the premium increases under the ACA. For the majority of people in the individual market, the battle over CSRs is of little consequence. This does not minimize the CSR impact on those with low incomes, but simply shows that premium relief and flexibility through expanded 1332 waivers would impact vastly more Americans.

To be clear, I do not believe that changes to the current federal guidance is sufficient. Legislative changes are needed in both the entry barriers for states and what policy flexibility states can achieve with a 1332 waiver. The four current statutory entry barriers are too high, and almost mutually exclusive, to allow a state to even apply without that state committing millions or billions of additional taxpayer dollars. Keeping the guardrail of federal budget neutrality makes sense, but reforming the other three is vital.

Section 1332 could also be of more interest to states if there was a clearer glide path toward timely approval of waiver applications and more policy flexibility. As FGA has noted in Health Affairs, the likely process is cumbersome as Section 1115 waivers, with decades of precedent, take an average of 323 days to win approval. Section 1332 waivers require bilateral approval by Treasury and the Department of Health and Human Services. If states are to change the ACA subsidy structure, the IRS has advised that states may need to waive certain tax provisions altogether and replace them with state-administered tax programs, something almost impossible for the seven states with no state income tax and extremely costly for all other states to do.[ix]

These practical and process concerns demand a simplified set of statutory guardrails, a clearer and fixed timeline path for approval, and more policy flexibility for states.

For those concerned about the types of coverage offered at the state level under a revised 1332 waiver, it is important to remember that states have more than 2,200 mandated provider and coverage benefits on the books.[x]

In short, state policymakers need a greater continuum of individual insurance plans to be allowed if premium relief is going to flow to the vast majority of the individual market and if more individuals and families are going to voluntarily buy insurance outside their employer without new or increased subsidies. The way to empower states to create this more affordable continuum is to give them more policy flexibility in how individual insurance plans are regulated under a revised and expanded 1332 framework. No one should be shut out of the individual market due to health. But evidence from actuaries and families shows that if more affordable range of plans are allowed, then more individuals will buy one that gives them the protection they want at a price they can pay. Policy flexibility for states through a revised 1332 structure is needed to accomplish this.

3. Reducing the cost of health care through transparency and empowering patients

To finish, I want to focus on the root cause of so much of the heart burn and controversy about costly efforts to increase coverage--the underlying cost of health care. There is bipartisan support for greater transparency and consumer protection in health care. This year, the divided legislature in Maine passed into law--with ***unanimous bipartisan support***--PL 232, "An Act to Encourage Maine Consumers to Comparison-shop for Certain Health Care Procedures and to Lower Health Care Costs."[xi]

PL 232 is a first-of-its kind reform. It builds on transparency efforts passed into law in Massachusetts in 2012, and a successful incentive program for state employees in Kentucky and New Hampshire, but also includes an additional key consumer protection for patients facing higher deductibles, narrower insurer networks, and the insurers' typical black box of provider prices.

The reform grants patients the right to shop for the best value care regardless of the network status of a provider. To be clear, this is not "any willing provider," as the patient can only leave an insurer network if the actual cost out of network is below the average in-network price (think of it as a "any competitive provider" patient right).

Let me give you a real-life example of why this matters:

> Jennifer is a single-mother working hard to provide for her two girls and has health insurance from her small employer with a $2,000 deductible. She was recently referred for physical therapy. She had used a physical therapist two years ago that she loved, but when she tried to return to that provider she was told they were now out-of-network and she would need to pay the full cost of any service and none of that cost would apply to her in-network deductible or annual out-of-pocket threshold.
>
> The in-network physical therapist cost $225 an hour, three times more than her previous one at $75 an hour. But Jennifer is stuck paying more and having to go to someone new and unproven. That's not fair and drives up the cost of health care and health insurance for Jennifer and everyone else.

This is not an isolated incident. The number of consumers facing increased cost sharing has spiked. Small business employees who faced $1,000 single-deductibles was just 16 percent in 2006. By 2016, the percentage spiked to 65 percent.[xii]

Increasing health care costs are harming patients, driving up insurance premiums, putting independent providers out-of-business, setting up massive health systems that will be too big to fail, and too often preventing doctors from making the best care decisions with their patients. It is time we sent a life boat to patients and give them the *right to shop*, with the true price transparency and access that allows them to do so. If we want to truly lower health care costs, we must take these steps forward.

With bipartisan leadership, this committee and this Congress can lower premiums for those with pre-existing conditions and everyone else, create a more affordable continuum of health coverage, and actually lower the cost of health care with the three recommendations outlined above.

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[i] James O'Conner, "Comprehensive Assessment of ACA Factors that will Affect Individual Market Premiums in 2014," Milliman, prepared for America's Health Insurance Plans (April 2013), http://www.iss4all.com/MillimanACAPremiumReport4252013.pdf

[ii] Joel Allumbaugh, Tarren Bragdon, and Josh Archambault, "Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions," Health Affairs (April 2017), http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/

[iii] Kathleen Ely, Thomas Murawski and William Thompson, "The Federal Invisible Risk Pool," Milliman, prepared for the Foundation for Government Accountability (April 2017), https://thefga.org/wp-content/uploads/2017/04/The-Federal-Invisible-High-Risk-Pool.pdf with summary available at: https://thefga.org/wp-content/uploads/2017/04/FIRSP-One-Pager-2.pdf

[iv] Virgil Dickson, "CMS Approves Alaska Waiver Aimed at Stabilizing Individual Market," Modern Healthcare (July 2017), http://www.modernhealthcare.com/article/20170711/NEWS/170719975

[v] Associated Press, "Frustration Mounts Over Premiums for Individual Health Plans," New York Times (Sept 2017), https://www.nytimes.com/aponline/2017/09/03/us/politics/ap-us-health-overhaul-paying-full-freight.html

[vi] Kurt Giesa and Peter Kaczmarek, "Stabilizing the Individual Health Insurance Market," Oliver Wyman (August 2017), http://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2017/aug/Market%20Stabilization_Final%20Version.pdf

[vii] "While the IRS Continues to Do a Reasonable Job in Administering the Affordable Care Act (ACA), Taxpayers Still Encounter Difficulties Attempting to Comply With the Complex Provisions," IRS Taxpayer Advocate (2017), https://taxpayeradvocate.irs.gov/Media/Default/Documents/2018-JRC/JRC18_Volume1_AOF_11.pdf

[viii] "An Analysis of Individual and Small Group Health Insurance Trends," Mark Farrah Associates (June 2017), http://www.markfarrah.com/healthcare-business-strategy/An-Analysis-of-Individual-and-Small-Group-Health-Insurance-Trends.aspx

[ix] Jonathan Ingram, Nic Horton, and Josh Archambault, "The ACA's Section 1332: Escape Hatch Or Straightjacket For Reform?," Health Affairs (May 2016), http://healthaffairs.org/blog/2016/05/26/the-acas-section-1332-escape-hatch-or-straightjacket-for-reform/

[x] "State Insurance Mandates and the ACA Essential Benefits Provisions," National Conference of State Legislatures (March 2017), http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

[xi] http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC232.asp

[xii] "2016 Employer Health Benefits Survey," Kaiser Family Foundation (Sept 2016), http://kff.org/report-section/ehbs-2016-summary-of-findings/

The Federal Invisible High Risk Pool

Effect on premium rates, individual marketplace enrollment and use of federal funds

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TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

Concept

The Federal Invisible High Risk Pool (FIHRP) is a proposed risk sharing/transfer mechanism to cover certain high-cost claimants in the individual health insurance market that also facilitates coverage for those with pre-existing conditions. Introduced as an amendment to the American Health Care Act of 2017 (AHCA), the FIHRP creates a high risk pool that covers claims for persons whose insured plan benefits exceed $10,000 per year; those healthcare providers are paid at a lower rate than what commercial carriers typically negotiate. The FIHRP is funded by a combination of carrier premium contributions along with proceeds from the Patient and State Stability Fund (PSSF).

Analysis

This paper addresses the following:

- The effect of a FIHRP on premiums in the individual insurance marketplace
- The cost of the program including how much PSSF or other funds would be needed to supplement the 90% of the policy premium that is paid to the FIHRP
- Individual insurance enrollment, including those maintaining their coverage and uninsured persons becoming insured, compared to enrollment levels without the FIHRP
- The effect that the rate reduction attributed to the FIHRP has on the rates by age if the 3:1 age curve is replaced by a 5:1 age curve

As requested by The Foundation for Government Accountability (FGA), we evaluated the effect of the FIHRP under two scenarios. The first scenario assumes that the persons insured under the existing ACA marketplace can remain in their current plans, with their current rating mechanisms, rate subsidies, and that a new program is created that can be priced to the expected healthcare costs of the persons enrolling in that program, with no risk adjustment between this new program and the existing risk pool. This initial scenario was reviewed first assuming the original ACA risk pool would not benefit from a FIHRP, and second assuming that the original risk pool would benefit from a FIHRP.

Throughout our analysis, we assumed that all of the existing ACA rules continue to apply, including but not limited to guaranteed issue, pre-existing condition exclusions, and the individual mandate. If any of these provisions were to change in any way, the results in this report will be different.

Scenario 1 Policy Assumptions

We have modeled a hypothetical Federal Invisible High Risk Pool with the following characteristics:

- The individual market is bifurcated into two risk pools and the FIHRP only applies to those in the new risk pool. (Although the impact of applying to both risk pools is also modeled.) The new risk pool does not provide for subsidies such as APTCs or CSRs.
- Carriers in the individual marketplace, both on and off exchange, must cede to the FIHRP any individual that has one of eight mandatory ceding medical conditions: chronic obstructive pulmonary disease (COPD), uterine cancer, prostate cancer, metastatic cancer, rheumatoid arthritis, congestive heart failure (CHF), renal failure, or HIV/AIDS.
- It allows voluntary ceding into the FIHRP of other lives at the discretion of the carriers, subject to eligibility requirements. The FIHRP eligibility requirements restrict coverage to newly insured lives and to persons who change carriers, at the time they make that change in carriers.
- Whenever an individual is ceded into the FIHRP, all persons covered under that individual's contract, including any covered dependents, must be ceded.

- The FIHRP premium (the amount paid by the insurance carrier to the FIHRP) is set at 90% of the insurer's premium charged for the lives that are ceded to the FIHRP. Under the current ACA rules, we assume this means the premium paid by the covered person along with any premium tax credits provided.
- The FIHRP will have additional funds available to it, by making use of a state's proceeds from the PSSF.
- FIHRP benefits and payment rates to healthcare providers will be paid based on 100% of Medicare-allowed reimbursement, rather than a carrier's regular commercial reimbursement arrangements.
- FIHRP benefits attach at $10,000 of benefits paid by the insurer per individual per year, with 100% of benefits in excess of $10,000 covered by the FIHRP.

Outcomes

In a scenario under which a new and separate risk pool is created and operates alongside the current ACA risk pool, the introduction of the FIHRP would impact only to this new pool may:

- Reduce average premiums in the new risk pool in the individual marketplace by 12% to 31%
- Reduce the number of uninsured individuals by 1.1 to 2.2 million
- Require the Federal government to spend $3.3 billion to $16.7 billion in the first year (PSSF or similar program funds)

Our range of estimates is based on several key FIHRP program characteristics that are unknown at this time. As a result, we evaluated the FIHRP under various implementation scenarios. Two key assumptions are risk pooling and eligibility. In the 12% to 31% premium reduction scenario, we assume that individuals who are newly insured or who change carriers are included in a new separate risk pool. In this new separate risk pool scenario, we focus on the effect of the FIHRP in the new risk pool; we also evaluate the effect of the FIHRP on the grandfathered risk pool in the individual health insurance market if the FIHRP is or is not available in that risk pool.

Scenario 2 Policy Assumptions and Outcomes

The second scenario assumes the existing ACA requirements of a single risk pool continues to apply; all carriers are required to price all products to the individual marketplace average morbidity, with risk adjustment among carriers after the end of the year to adjust all carriers to that marketplace average. The FIHRP would be implemented into the existing risk pool.

We estimate that introduction of the FIHRP into that current marketplace may:

- Reduce average premiums in the individual marketplace by 2% to 11%
- Reduce the number of uninsured individuals by 740,000 to 1.6 million
- Increase federal government costs by $5.4 billion to $17.0 billion in the first year (PSSF or similar program funds)

Range of Factors Impact Outcomes

While we observe that the average premiums decreased with the FIHRP, the magnitude of the premium reduction varies considerably depending on a number of variables addressed in this report. There are four inter-related elements that affect the balance between reduced premiums and PSSF funding needed in our analysis:

- Healthcare provider reimbursement at 100% of Medicare allowable rates for the claims in excess of $10,000 that are incurred by high cost claimants who are ceded to FIHRP
- 90% of direct policy premiums for lives ceded to FIHRP are used to help fund FIHRP
- Eligibility of inclusion in risk transfer program
- Level of PSSF or similar proceeds from state of federal agencies

In addition, the rules for eligibility for inclusion in FIHRP and the extent of improved risk pool morbidity as younger and healthier members enroll due to reduced premiums also effect the magnitude of rate decreases as well as the change in number of persons insured in the individual marketplace.

We expect that the number of uninsured individuals will decrease with the FIHRP. Reduced premiums provide additional incentive to uninsured individuals to obtain coverage, which leads to enrollment growth in the individual health insurance market. We anticipate that greater premium reductions will lead to an increased number of individuals who purchase coverage.

Additional funding will be required from state or federal agencies to supplement the FIHRP premiums contributed by individual insurance carriers on behalf of program enrollees. The amount of additional funding depends on a number of variables, including eligibility rules and the basis for setting the FIHRP premiums.

II. INTRODUCTION

The American Health Care Act of 2017 (AHCA) was introduced as H.R.1628 in March 2017. A subsequent amendment included a provision for a high risk pool program.[1] The amendment, named the Federal Invisible High Risk Pool (FIHRP), establishes a risk transfer mechanism to fund high cost claimants in the individual marketplace. Using portions of a state's Patient & State Stability Fund (PSSF), FIHRP premiums at 90% of adjusted premiums charged by carriers, and with benefits under FIHRP being covered at 100% of Medicare allowed amounts, the FIHRP is intended to reduce premiums in the individual marketplace, both on and off exchange, which encourages increased enrollment and results in fewer uninsured lives.

The FIHRP is similar to a reinsurance program established in Maine in 2012, named the Maine Guaranteed Access Reinsurance Association (MGARA). MGARA is widely credited as the cause of reducing rates materially in the Maine individual marketplace.[2]

Milliman serves as the actuary for MGARA, so we were contacted to evaluate the FIHRP.

This report replaces the April 7, 2017 report with the same subject; the only change is the addition of the rate reduction percentages in Scenario 2 of Attachment A.

[1] The full amendment is available at http://amendments-rules.house.gov/amendments/Palmer322170833193319.pdf.
[2] Allumbaugh, J., Bragdon, T., & Archambault, J. (March 2, 2017). Invisible high-risk pools: How Congress can lower premiums and deal with pre-existing conditions. Health Affairs Blog. Retrieved April 5, 2017, from http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/.

III. BACKGROUND

We have modeled a hypothetical Federal Invisible High Risk Pool with the following characteristics:

- Carriers in the individual marketplace, both on and off exchange, must cede to FIHRP any individual that has one of eight mandatory ceding medical conditions: chronic obstructive pulmonary disease (COPD), uterine cancer, prostate cancer, metastatic cancer, rheumatoid arthritis, congestive heart failure (CHF), renal failure, or HIV/AIDS.
- It allows voluntary ceding into FIHRP of other lives at the discretion of the carriers, subject to eligibility requirements. The FIHRP eligibility requirements restrict coverage to newly insured lives and to persons who change carriers, at the time they make that change in carriers.
- Whenever an individual is ceded into FIHRP, all persons covered under that individual's contract, including any covered dependents, must be ceded.
- The FIHRP premium (the amount paid by the insurance carrier to the FIHRP to reinsure the members) is set at 90% of the insurer's premium charged for the lives that are ceded to FIHRP. Under the current Patient Protection and Affordable Care Act (ACA) rules, we assume this means the premium paid by the covered person along with any premium tax credits provided.
- The FIHRP will have additional funds available to it, by making use of a state's proceeds from the PSSF. Although the specific details are still unclear, our analysis assumes that some alternative funding mechanism will be adopted at the federal and/or state levels. This additional funding is necessary to cover the portion of the FIHRP costs in excess of the premium revenue (i.e., the 90% collected from carriers).
- FIHRP benefits and payment rates to healthcare providers will be paid based on 100% of Medicare allowed reimbursement, rather than a carrier's regular commercial reimbursement arrangements.
- FIHRP benefits attach at $10,000 of benefits paid by the insurer per individual per year, with 100% of benefits in excess of $10,000 covered by the FIHRP.

All states must participate in the FIHRP, and all healthcare providers would have to accept 100% of Medicare allowed amounts as payment in full for the claims in excess of $10,000 with no balance billing to patients.

The introduction of the FIHRP requires that persons who are eligible to be ceded to the FIHRP complete a health questionnaire to be used by the carrier to determine if the person will be ceded. The definition of who is eligible to be ceded is one of the variables in our analysis. One possibility is that a carrier can cede anyone they insure, whether the person is newly insured with the carrier, changing plans, or staying with a current plan. The other possibility is that persons staying with the same plans with their current carriers are not eligible to be ceded to the FIHRP.

Ceding of risk to the FIHRP is mandatory within the eligible class of persons for anyone who has one of the eight prescribed medical conditions. Carriers may elect to cede others to the FIHRP based on the information contained in the medical questionnaire. If a person is ceded to the FIHRP, all persons covered under that person's insurance contract must also be ceded.

As noted above, one underlying premise of the FIHRP program is that carriers pay a premium to the FIHRP that is equal to 90% of the policyholder premium adjusted to reflect the value of the ceded claims being paid at 100% of Medicare (rather than at the usual, and presumably higher, negotiated commercial reimbursement rate).

We assume the carriers will reduce their current, pre-FIHRP rates, as follows:

- Remove the expected claim costs for claims in excess of $10,000 per life, based on the expected morbidity of the population that will be ceded, with claims paid based on commercial reimbursement
- Add the expected premium payable to the FIHRP that will cover the cost of the claims that have been removed
- Multiply the net of the items above by the percentage of the population that is expected to be ceded to the FIHRP.

In certain scenarios, we assumed that only individuals newly enrolled in a plan would be eligible to have their claims covered by the FIHRP. We took this to mean that eligible members are those who were previously uninsured and are newly insured, as well as members who previously had coverage but switched to a new insurance carrier.

We evaluated the effect of the FIHRP under two scenarios. The first assumes that the persons insured under the existing ACA marketplace are "grandfathered" into their current plans, rating mechanisms, and rate subsidies, and that a new program would be created that can be priced to the expected healthcare costs of the persons enrolling in that program, with no risk adjustment between this new program and the existing risk pool. This initial scenario was reviewed first assuming the original ACA risk pool would not benefit from the FIHRP, and second assuming that the original risk pool would benefit from the FIHRP.

The second scenario assumes that the existing ACA requirements of a single risk pool continue to apply; all carriers are required to price all products to the individual marketplace average morbidity, with risk adjustment among carriers after the end of the year to adjust all carriers to that marketplace average. The FIHRP would be implemented into the existing risk pool.

Based on our analysis, we conclude that the FIHRP will reduce the average premiums in the individual insurance market. This reduction is driven by two key factors. One is the definition of the premium the insurers will pay to the FIHRP. The Amendment to H.R.1628 states: "Each member insurer shall remit 90 percent of paid premiums for policies covering any individual ceded by the insurer to the FIHRP under this section. The FIHRP may consider adjustments to the premium rates charged coverage in FIHRP to reflect the use of effective cost containment and managed care arrangements by an insurer." We assume that "paid premiums for policies" is the total policy premium; that is, the sum of the amount paid by the insured plus any Premium Tax Credits. The "adjustments to the premium rates" is an important element in assessing the magnitude of premium reductions that may arise due to FIHRP. For purposes of this analysis, we have assumed that the provision allowing adjustments will be expanded to include an adjustment when FIHRP benefits are paid based on 100% of Medicare allowed amounts. The second factor is the total amount available from federal or state funds, such as the PSSF in the AHCA, that are available to support the FIHRP. The larger that amount, the greater the rate reduction.

To illustrate, if the FIHRP claims are paid based on regular commercial fees, and if the subsidy from federal and/or state funds is zero, the premium reduction would be 0%, assuming there is no charge for expenses to administer the FIHRP. The FIHRP claims are the claims over $10,000 that are built into the insurer's premium; their cost is being transferred from the insurer to the FIHRP. If the only source of funding for the claims is the FIHRP premiums, the premiums must cover all of the claims. Hence, for FIHRP in total, the premiums the FIHRP charges to carriers offsets the claims that the carriers cede to the FIHRP.

The existence of the Medicare reimbursement basis on FIHRP creates a favorable spread between the claims that the insurer has ceded and what the FIHRP will pay. That spread creates an additional element to be reflected in the sharing of the cost of FIHRP between the premiums paid to FIHRP and PSSF funds. For example, if the premiums paid by the carrier to FIHRP are not adjusted to reflect Medicare reimbursement, the PSSF share of the total cost will be reduced. Conversely, if the premiums paid by insurers to FIHRP can be reduced in anticipation of Medicare reimbursement, insured persons benefit by a lower premium, while PSSF funding would be higher.

SCOPE OF REVIEW

This paper addresses the following questions under each of the two scenarios described above:

1. How the enactment of FIHRP would affect the premiums in the individual insurance marketplace.
2. The cost of the program including how much PSSF or other funds would be needed to supplement the 90% of the policy premium that is paid to FIHRP.
3. Individual insurance enrollment, including those maintaining their coverage and uninsured persons becoming insured, compared with enrollment levels without the FIHRP.
4. The effect that the rate reduction attributed to the FIHRP has on the rates by age if the 3:1 age curve is replaced by a 5:1 age curve.

Milliman's nationwide databases[3] supplemented with the actual experience under Maine's MGARA program served as the source of the assumptions used in the analyses that developed the observations presented in this paper. We also relied on Milliman's Health Care Reform Financing Model, and Milliman's Managed Care Rating Model. The values presented herein are estimates based on analysis of the data, MGARA published actual experience, and consultant informed judgment. Actual results will differ from the values presented. Changes to any provisions of the FIHRP, as assumed here and as described in this report, will also affect the results; such effects could be material. Because of differences by state in the costs of healthcare, the distribution of insureds by income level, and the number of uninsureds, a given state's results will differ from the nationwide values.

In the first scenario we analyzed, we assumed that the existing ACA program at the beginning of 2017 remains in place for persons covered under that program. This includes retaining the 3:1 age curve, guaranteed issue, no pre-existing condition exclusions, and the individual mandate. In the newly established risk pool that is established alongside the existing one, rates are set based on the expected demographics and health characteristics of the persons expected to enroll, on a 5:1 age curve, and the presence of the FIHRP as described above. We expect that enrollment in this new risk pool will come largely from the currently uninsured population as well as persons insured in the individual marketplace today with little rate subsidy (i.e., the Advance Premium Tax Credit).

In the second scenario we analyzed, we assumed that no changes are made to provisions of the Affordable Care Act (ACA) other than the items enumerated above. We also assumed that the eight mandatory ceding conditions, the premium of 90% of the policy premium paid to FIHRP, and 100% of Medicare as the basis for the FIHRP claims are prescribed values; as such, we have used them as given without analysis. Results will differ if any of these parameters change.

This report does not address administrative and operational issues and costs related to the implementation and operation of the FIHRP, nor does the report address the effect that the FIHRP benefits may have on risk adjustments payable or receivable or on cost sharing reduction payments. Geographic variations and the level of carrier participation will also affect the results.

[3] The Milliman research database contains nationwide administrative medical claim data for 2014 and includes several million commercially insured members and 3 million members from the individual market with ACA-related indicators.

IV. MAJOR FINDINGS

This section of the report addresses many different possible structural and financial arrangements under which FIHRP may be introduced. We have assessed changes within the existing individual marketplace single risk pool, introduction of a new, healthier, individual risk pool residing alongside the existing risk pool, FIHRP coverage being available to everyone in the individual marketplace or only to certain segments of the population, rates for coverage under FIHRP being set at different levels, and other factors.

Attachment A is a one-page summary of the results that we computed based on each of the major combinations of these elements. Attachment A includes the estimated premium rate reductions, changes in the number of uninsured lives, lives migrating to the new risk pool, federal savings in APTC payments, and subsidies needed from PSSF or similar sources.

The remainder of this section of the report describes these scenarios in more detail, providing context for the results summarized in Attachment A.

SCENARIO 1 – FIHRP IN NEW RISK POOL

The starting point for the analysis is the current ACA single risk pool for the individual marketplace. That program provides guaranteed issue, coverage of pre-existing conditions, and it includes Advance Premium Tax Credits (APTCs) and cost-sharing reductions (CSRs), along with a 3:1 age curve. The marketplace that provides insurance in this risk pool has several carriers in each marketplace, each one offering its own plans of benefits. Open enrollment occurs annually, during which time eligible persons can change plans within a carrier, switch carriers, become uninsured or, for the currently uninsured, purchase insurance. Changes to the current ACA risk pool rules will have an effect on the results presented in this report.

A new risk pool will be introduced that would operate along with the current risk pool.

Ceding of risk to the FIHRP is mandatory within the eligible class of persons for anyone who has one of the eight prescribed medical conditions. Carriers may elect to cede others based on the information contained in the medical questionnaire. If a person is ceded to the FIHRP, all persons covered under that person's insurance contract must also be ceded.

We performed our analysis and developed estimates based on our interpretation of the draft language of the amendment along with discussions with the Foundation for Government Accountability leadership. Many details of how the new risk pool would be created and managed would have to be described in regulations, should the bill become a law. Below is a list of the assumptions we made as to how the mechanics of the FIHRP and new risk pool would work.

The new risk pool would run alongside the current ACA risk pool. We made the following assumptions regarding the current risk pool:

- The premium rate level for the current risk pool does not change after migration of lives to the new risk pool. In reality, if the healthier lives in the current risk pool move to the new risk pool, the rates for the existing risk pool will need to be increased. *The more people that migrate to the new risk pool, the bigger the difference in the rate levels will be between pools. As a result, the existing pool's rates may spiral out of control until the only lives remaining in that pool are persons with CSRs and APTCs such that they pay little for their coverage.*
- We assumed insurance carriers who are participating in the current individual market will continue to do so. Any significant changes in carrier participation will affect these results.
- We assume the two risk pools, each operating in the individual market under different rules, can co-exist without disruptions other than what we have evaluated. Any regulatory measures necessary to assure that were outside the scope of this analysis.

- We test two alternatives, one in which the FIHRP applies only to the new risk pool, and one in which the FIHRP applies to the existing risk pool as well as the new risk pool.
- The current risk pool covers all of the APTC and CSR enrollees; the new risk pool does not provide for those features. In effect, the new risk pool operates like an off-exchange program.
- The current risk pool is not expected to enroll new lives other than APTC and CSR enrollees.

The new risk pool has the following characteristics:

- We assumed the new risk pool would truly be treated as a separate pool of members. Carriers would be able to develop separate rates and offer different plans for this new pool. It would operate as a new single risk pool. We assumed the same rating rules would still apply separately to the pool, including a mandated premium age rating curve, essential health benefit (EHB) requirements, unisex rating, etc.
- We assumed the plans of benefits in the new risk pool would be similar to those in the existing risk pool, such that plan design differences would not be a factor in an individual's decision to move to the new pool. The analyses are based on an average marketplace benefit plan, similar to a typical silver plan.
- We assumed that the ACA subsidies would still apply in the existing ACA risk pool and would **not** apply in the new risk pool. Specifically, members enrolled in the new risk pool would not have access to Advance Premium Tax Credits, Cost-Sharing Reduction subsidies, etc.
- We assumed that in the first year of operation, members currently enrolled in the existing ACA markets would have the option to migrate to the new risk pool. We also assumed that persons who are currently uninsured would have the option to enroll in either the new or existing risk pool. However, in our analysis, we assumed that the uninsured would enroll in the new risk pool if they were to choose to purchase insurance.

Effect of the FIHRP on Individual Marketplace Premium Rates

Table 1
Effect of FIHRP on Marketplace Rates
Reduction in Rate Levels from Current without FIHRP to New with FIHRP

FIHRP Premium as % of Direct Premium	FIHRP Reimbursement Basis	Rate Reduction
90%	Medicare	16-31%
90%	Commercial	12-23%

Under this scenario, we made significant simplifying assumptions, namely that the rates for the existing ACA products will remain unchanged from their current levels. This assumption implies there is no reduction in rates due to the FIHRP, which would be the scenario under which the FIHRP applies only to the newly created block of business. In several portions of the report below, we also consider and discuss the impact of having the FIHRP apply to the existing risk pool as well as the new risk pool. It also implies that the rates for the existing risk pool do not increase because of the outward migration of members to the new risk pool. As indicated earlier, the rates for the existing risk pool would need to increase as the healthier lives migrate from the existing risk pool to the new risk pool.

We further estimate that the persons who will enroll in this new risk pool are younger and healthier than those in the existing risk pool. Because there is no risk adjustment between pools in this scenario, the rates for this new product can reflect the lower medical costs of the anticipated covered population.

This assumption that the persons moving to the new risk pool are healthier than those in the existing risk pool implies that the rates for the existing risk pool should increase. Should such an adjustment be made, we would have a situation under which, as the current risk pool rates increase due to migration, more of the remaining people will migrate out, requiring the current risk pool rates to increase further. This results in a "death spiral" for the existing risk pool. In order for these two pools to operate alongside each other, managing the effect of the migration is essential.

Based on these assumptions, we expect the premium rate level in this new risk pool, for a product with the same benefits as the existing risk pool, could be 10% to 20% lower than the rate in the existing risk pool because of a healthier risk pool, before demographic adjustments and before introduction of FIHRP.

After incorporating the FIHRP with FIHRP benefits paid at 100% of Medicare and assuming that the rates paid by carriers to the FIHRP are adjusted downward from 90% of the policy premium to reflect Medicare reimbursement, the rate reduction becomes 16% to 31%. If FIHRP benefits are paid based on regular commercially negotiated fees, the rate reduction becomes 12% to 23%. A reduction to the required rate level, then sloped to a 5:1 age curve, will further reduce the average rate per member in the new risk pool because of the shift in demographic mix of the covered population. For example, a uniform reduction in the rate table of 25% could result in a reduction in the weighted average rate per covered life of 30% to 35% or more, with the difference from 25% being attributed to the risk pool having more younger lives and fewer older lives than the risk pool before the demographic shift.

Among the major items that affect the rate reduction are the following:

- Enrollment in this pool comes from the uninsured population that is eligible to enroll in a QHP along with migration of persons that are insured in the current risk pool and move to the new pool because of the lower premium rate.
- Based on data from Milliman's 2014 databases, the average risk score of insured persons off exchange is around 15% lower than that of persons insured on and off exchange combined. This difference is a combination of health status, demographics, and plan richness differences. The off exchange population, along with the on exchange population with little or no premium tax credits, are the segment of the insured population most likely to migrate to the new risk pool, as they will benefit from the full reduction in rates.
- The persons who are eligible to purchase a QHP but remain uninsured are assumed to be healthier than average, based on the premise that those persons who have medical conditions that generate substantial medical expenses are more likely to have already enrolled than those who do not.
- The magnitude of a person's rate reduction influences their likelihood of participating in this new individual marketplace risk pool. For example, persons presently insured under an individual policy have a greater likelihood of moving to the new program if their rate decrease is 20% compared with a rate decrease of 5%. We assume a greater reduction from current rates is needed to attract persons who are presently uninsured. For persons with subsidized premiums, the comparison is between 100% of the new premium and the subsidized rate they pay today.
- The shift from a 3:1 age curve to 5:1 in the new risk pool accompanied by an average rate reduction will give a bigger than average rate reduction to younger persons and less of a reduction, possibly even a rate increase, for older persons. As a result, we anticipate that the demographic composition of the new risk pool will be younger than the current risk pool.

Effect on the Number of Lives Insured in the Individual Marketplace

In this section of the report, we estimate the number of lives that will be covered in the individual marketplace. The estimates vary considerably based on assumptions about the likelihood that persons who are presently uninsured will become insured because the premium rates in the marketplace have been reduced. We strongly encourage the reader to review the estimates in context with the assumptions underlying their development.

Table 2 below shows estimated enrollment under the scenario where only the new risk pool benefits from the FIHRP. We estimate that around 1.3 million to 2.2 million (13% to 20%) of the uninsured population that is eligible to purchase a QHP today will enroll in this new program. In addition, 4.2 million to 5.7 million persons who receive no premium subsidy or very little premium subsidy will also migrate from the existing program to the new program. Table 2 illustrates the change from the existing marketplace enrollment status to the projected enrollment in each of the current and new risk pools under this scenario.

Table 2

	Estimated 2017 Lives by Insured Status, Before FIHRP	2017 Lives Remaining in Existing Pool	2017 Lives in New Risk Pool
Insured On Exchange:			
No Subsidy	1,601,000	411,000	1,612,000
With Subsidy	9,073,000	9,073,000	0
Insured On Exchange Total	10,674,000	9,484,000	1,612,000
Insured Off Exchange	5,100,000	1,310,000	5,133,000
Total Insured	**15,774,000**	**10,794,000**	**6,745,000**
Uninsured but Eligible for QHP	**10,700,000**	**8,935,000**	
Total QHP Eligible Individual Market	26,474,000		

More of the current uninsured population is likely to purchase coverage in this new risk pool than under Scenario 2; the driver is a 24% lower premium rate. The scenario below assumes that both the existing pool, with newly insured lives eligible for FIHRP, and the new risk pool will benefit from the FIHRP. We estimate that around 1.2 million to 2.0 million (11% to 19%) of the uninsured population that is eligible to purchase a QHP today will enroll in this new program. In addition, 3.6 million to 5.0 million persons who receive no premium subsidy or very little premium subsidy will also migrate from the existing program to the new program because of lower premium rates. Table 3 illustrates the change from the existing marketplace enrollment status to that projected under this scenario.

Table 3

	Estimated 2017 Lives by Insured Status, Before FIHRP	2017 Lives Remaining in Existing Pool	2017 Lives in New Risk Pool
Insured On Exchange:			
No Subsidy	1,601,000	574,000	1,409,000
With Subsidy	9,073,000	9,073,000	0
Insured On Exchange Total	10,674,000	9,647,000	1,409,000
Insured Off Exchange	5,100,000	1,827,000	4,491,000
Total Insured	**15,774,000**	**11,474,000**	**5,900,000**
Uninsured but Eligible for QHP	**10,700,000**	**9,100,000**	
Total QHP Eligible Individual Market	26,474,000		

The first column of Table 3 is the same as Table 2 — our estimate of the 2017 distribution of persons enrolled in individual insurance plans and the portion of the uninsured population that is eligible to purchase a qualified health plan. The second column estimates the lives remaining in the existing risk pool after the new pool has been created and lives migrate to that pool. The third column estimates the lives that have migrated into the new risk pool by segment of the population, along with the reduced number of uninsured persons.

Table 4 below shows the reduction in the estimated number of uninsured based on the rate reductions illustrated above.

Table 4
Scenario 1
Effect of FIHRP on # of Uninsured Lives

New Risk Pool Rate as % Current Rate	Current Risk Pool Rate as % Current Rate	Difference in Rate Levels Between Risk Pools	Reduction in Uninsured	% Reduction in Uninsured Eligible for QHP
76%	100%	24%	1.3-2.2 million	13%-20%
76%	94.5%	20%	1.2-2.0 million	11%-19%

PSSF or Similar Proceeds from State or Federal Agencies Required to Fund the FIHRP

Under this scenario, the existing ACA individual risk pool remains in place. For the following illustration, we assume that FIHRP applies only to the new risk pool. As a result, the PSSF subsidies needed to support the existing risk pool become zero. The PSSF subsidies would only be used for the FIHRP in the new risk pool.

For persons covered under the new risk pool, we estimate the FIHRP premiums paid by the carriers for ceded lives will need to be supplemented by around $3.3 billion per year in PSSF or other funds provided by the federal government and/or states. This amount is based on rates being 24% lower than current marketplace rates and 17% of the lives covered by the pool being ceded, which is due either to the mandatory ceding conditions or voluntary ceding.

Table 5
Cost of FIHRP measured by funding needed to supplement Premiums paid to FIHRP

FIHRP Premium as % of Direct Premium	FIHRP Payment Basis	Include Closed Block?	Additional Annual Funding Needed
90%	Medicare	Yes	$3.3 billion

Effect That the Rate Reduction Will Have on the Change in Rate Slope From 3:1 to 5:1

The rates in this new risk pool are established using a 5:1 age curve. We have compared the rates under the existing risk pool before the FIHRP, with a 3:1 age curve, to the rates under the new risk pool, after the FIHRP, with a 5:1 age curve.

Table 6 below shows the combined effect of changing the age-curve from 3:1 to 5:1, along with an assumed 24% rate reduction arising from implementing the FIHRP and from the expected morbidity difference of the new risk pool. Note that the premiums shown in the first column using the 3:1 age curve represent premiums that would be payable today in the current risk pool. This is because the premiums shown below in this scenario assumes that the FIHRP only applies to the new risk pool. Members deciding whether or not to migrate into the new risk pool will base their decisions on the rate change shown in the table below.

Table 6
Changes in Average 2017 Premiums – 3:1 Before FIHRP v. 5:1 After FIHRP

Age Band	Before FIHRP 3:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$265	$151	-$114	-43.0%
20-29	$339	$199	-$139	-41.2%
30-39	$397	$265	-$132	-33.2%
40-49	$480	$360	-$120	-25.0%
50-59	$724	$638	-$86	-11.9%
60+	$950	$896	-$54	-5.7%

The potential rate change for members between the existing and new risk pools range from -43.0% for members under age 20 to -5.7% for members over age 60. Figure 1 below graphs the premiums by age under the 3:1 and 5:1 age curves before the FIHRP, and the 5:1 age-curve after the FIHRP for Scenario 1.

Figure 1

Scenario 1 - Premiums by Age in 3:1 Age Band Before FIHRP, 5:1 Age Band Before FIHRP, 5:1 Age Band After FIHRP

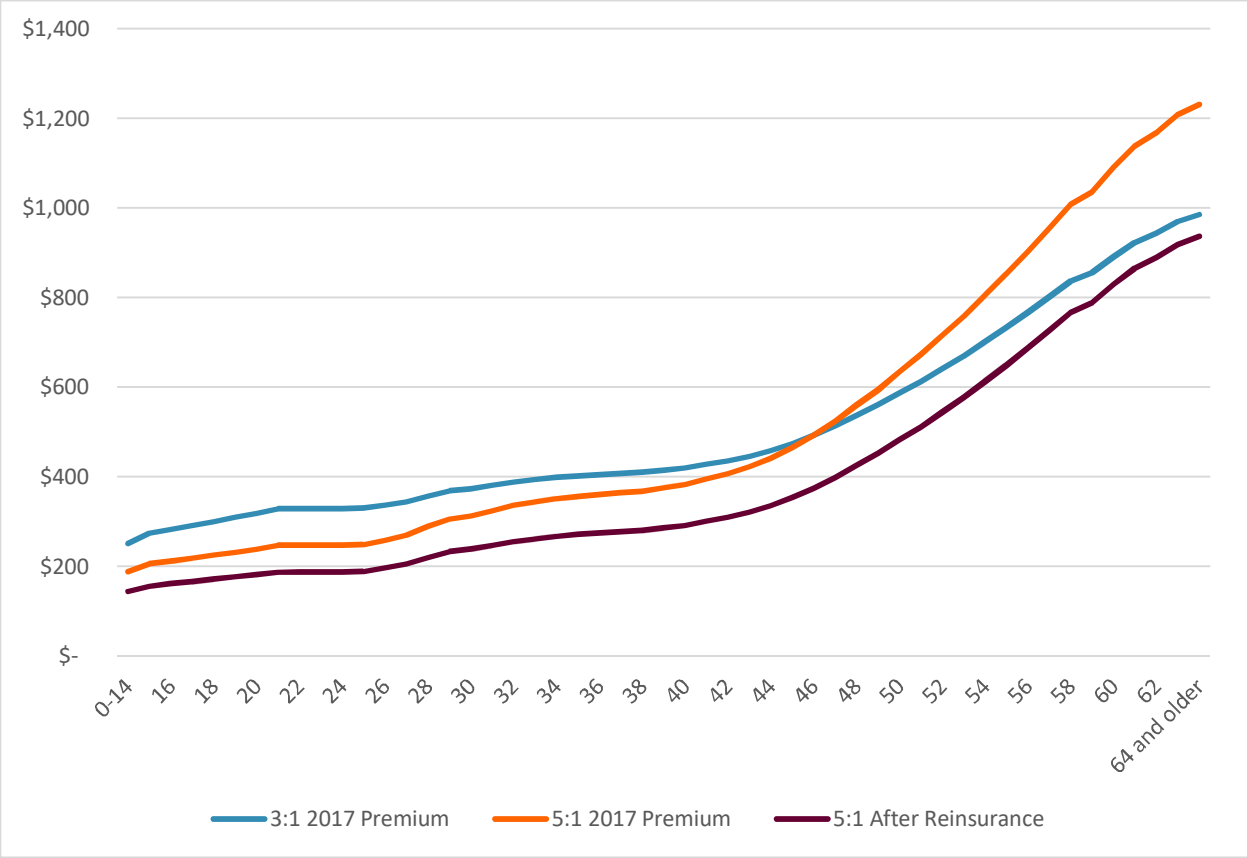


Table 7 provides a comparison similar to Table 6 with one change. It is assumed that the FIHRP applies in the current risk pool for newly insured lives of those that change carriers. Table 7 below shows the combined effect of changing the age-curve from 3:1 to 5:1, along with an assumed 15% rate reduction arising from the expected morbidity difference of the new risk pool and the claims covered by the FIHRP. Note that the premiums shown in the first column using the 3:1 age curve are 5% lower than the

premiums shown in Table 6. This is to reflect the impact of the FIHRP on the rates for the existing risk pool. The members deciding whether or not to migrate into the new risk pool will base their decisions on the rate change shown in the table below.

Table 7
Changes in Average 2017 Premiums – 3:1 After FIHRP vs. 5:1 After FIHRP

Age Band	Before FIHRP 3:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$250	$151	-$99	-39.7%
20-29	$320	$199	-$121	-37.8%
30-39	$375	$265	-$110	-29.3%
40-49	$453	$360	-$94	-20.7%
50-59	$684	$638	-$46	-6.7%
60+	$898	$896	-$2	-0.2%

SCENARIO 2 – FIHRP IN EXISTING RISK POOL

In this scenario, we assume there is no new risk pool. The current ACA risk pool is the only mechanism for purchasing individual health insurance. We also assume that the provisions of the current ACA single risk pool for the individual marketplace remain the same. This includes Advance Premium Tax Credits (APTCs) and cost-sharing reductions (CSRs), along with a 3:1 age curve. The marketplace that provides insurance in this risk pool has several carriers in each marketplace, each one offering its own plans of benefits. Open enrollment occurs annually, during which time eligible persons can change plans within a carrier, switch carriers, become uninsured or, for the currently uninsured, purchase insurance.

We have evaluated the effect of the FIHRP on the existing risk pool based on two different eligibility conditions. One assumes that only persons who are newly insured with a carrier, either by changing carriers or by entering the insurance market, are eligible to participate in the FIHRP. The other assumes that a carrier can cede to the FIHRP any of its members, including those that have been and remain insured with the carrier.

Effect of the FIHRP on Individual Marketplace Premium Rates

Table 8
Effect of FIHRP on Marketplace Rates in Current Risk Pool

FIHRP Premium as % of Direct Premium	FIHRP Reimbursement Basis	Include Closed Block?	Rate Reduction
90%	Commercial	No	1-2%
90%	Commercial	Yes	2-4%
90%	Medicare	No	4-7%
90%	Medicare	Yes	7-14%
45%	Medicare	No	6-10%

We estimate that the existence of the FIHRP with its premiums fully adjusted to reflect FIHRP claim payments at 100% of Medicare will reduce average premiums in the individual marketplace by about 4% to 7%. The range of possible rate reductions is largely influenced by the proportion of insured lives that are voluntarily ceded to FIHRP; the calculations used a range from 5% to 15% of the individual marketplace as becoming reinsured. That range is a blend of judgment and experience under MGARA in 2012 and 2013. In addition, 7% of the individual marketplace lives are ceded to the FIHRP because they have one of the automatic ceding medical conditions or because they are part of a contract covering someone with one of those conditions. The potential magnitude of rate decrease is dampened by the

requirement that existing insured lives who remain with their current insurers are not eligible for participation in the FIHRP. We estimate the segment of the marketplace that will be eligible for participation in the FIHRP represents about 57% of the total individually insured population[4]; that percentage will increase over time as more people change carriers.

We assume that 57% of the total individual market will be eligible for the FIHRP. We derived the 57% assumption as the ratio of individuals who switched plans to all individual who reenrolled plus the percent of new individuals from 2017 Open Enrollment.[5] There are two unknown dynamics that may affect this assumption. Each dynamic has a directionally opposite effect on this assumption. As a result, we relied on the 57% estimate derived from CMS data.

Individuals who change carriers are eligible for the FIHRP. The 57% percent assumption is based on the number of individuals who selected a different plan. A portion of the individuals who changed plans did not necessarily change carriers. Individuals who change plans but remain with a single carrier are not eligible for voluntary FIHRP enrollment. This dynamic would reduce the FIHRP eligibility assumption.

Carriers may elect to no longer offer products in the individual marketplace in 2018. When a carrier exits a market, the individuals who were previously insured are disrupted and are forced to either select a plan with a new carrier or become uninsured. The extent to which carriers exit the individual market in 2018 is uncertain at this time. This dynamic would increase the FIHRP eligibility assumption, and will affect other assumptions as well.

Because the single risk pool concept requires a consistent morbidity assumption for the entire individual marketplace, the reduction in claims arising from the portion of the population that is eligible to participate in the FIHRP must be spread across the entire individual population, diminishing the average rate decrease. If this restriction were not in place, such that persons remaining with their current insurers could be ceded to the FIHRP, we estimate that the premium reduction would be 7% to 14%; the range is influenced by the same 5% to 15% of persons being voluntarily ceded to the FIHRP described above.

The payment rate for claims ceded to the FIHRP can have a material effect on the rate reduction. Medicare provider reimbursement levels are lower than commercial. If FIHRP benefits were paid based on regular commercial insurance negotiated fees and not 100% of Medicare, or if the premium insurers pay to the FIHRP did not reflect the Medicare reimbursement rate, we estimate that the rate reduction would be only 1% to 2%, versus the 4% to 7% mentioned above.

The concept of the FIHRP premium rate being set at 90% of the policy premium is one answer to the balance between the reduction in the individual marketplace rates and the spread of the cost of FIHRP between the carriers and the PSSF or similar fund. For example, if the FIHRP premium were set at 45% of the policy premium and could reflect Medicare reimbursement, the rate reduction would be around 6% to 10% of premium if only newly enrolled or those switching carriers can be ceded and no additional lives are ceded to FIFRP, compared with the 4% to 7% illustrated above. The lower the FIHRP premium the insurer pays, the more the cost of the FIHRP needs to be borne by PSSF. The section below that deals with the cost of FIHRP addresses this subject in more depth using some examples.

To summarize the points above, for the FIHRP to be appropriately funded, the following equation needs to hold true:

$$(90\%\ Reinsurance\ Premium) \geq Reinsured\ Claims - PSSF\ Contribution + Cost\ to\ Administer\ FIHRP$$

In addition to the factors described above, the following are among the major items that affect the change in the marketplace rates:

[4] Derived from: Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight: Health Insurance Marketplace Public Use Files. OE2017_STATE_PUF_FINAL.xlsx, available at https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html plus actuarial judgment.
[5] Derived from CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid., plus actuarial judgment.

- Based on nationwide data from Milliman's 2014 databases, fewer than 5% of the persons insured in the individual marketplace have one of the eight conditions that require automatic ceding to the high risk pool.
- Claims for persons with one of the eight automatic ceding conditions are more than five times that of the average person in the individual marketplace, based on the same 2014 Milliman databases. People with these conditions represent around 30% of the total claims in the individual marketplace.
- When adding in family members on the policy that includes a person with one of the eight automatic ceding conditions, the average claim cost is about three times the claim cost for the average person in the individual marketplace. About 7% of the individual marketplace membership is represented by the persons with any of the eight conditions together with the other family members covered by an individual insurance policy.
- We estimate that 5% to 15% of lives in the individual marketplace will be ceded to FIHRP on a voluntary basis by carriers. This estimate is based on consultant judgment, with reference to the MGARA experience in 2012 and 2013 when Maine's reinsurance program was in operation.

Effect on the Number of Lives Insured in the Individual Marketplace

In this section of the report, we estimate the number of lives that will be covered in the individual marketplace. The estimates vary considerably based on assumptions about the likelihood that persons who are presently uninsured will become insured because the premium rates in the marketplace have been reduced. We strongly encourage the reader to review the estimates in context with the assumptions underlying their development.

We estimate that, as a result of the rate reduction resulting from FIHRP, the number of uninsured lives eligible for qualified health plans (QHPs) will drop by about 8% to 13% or 800 thousand to 1.4 million people nationwide; these figures are based on the FIHRP reducing rates by 4% to 7% as described earlier. Persons who are currently insured and pay 100% of the individual marketplace premium will remain insured; the reduction in premium rates will support their decisions to continue to purchase individual insurance. Similarly, persons receiving premium subsidies in the APTC program under the ACA will likely retain their coverage. Many of the people receiving APTCs already have their premiums capped at a percentage of household income; some will see a modest reduction in their costs as the lower premiums drop below the cap, while others will continue to have their premium contributions capped and will see no change in their premium costs.

Table 9 illustrates the distribution of the nationwide individual insurance marketplace by insured status. It shows the number of persons in each of the cohorts described above, along with the changes in their enrollment status arising from the rate reduction generated by the FIHRP.

Table 9

	Estimated 2017 Lives by Insured Status, Before FIHRP	2017 Lives After FIHRP, Newly Enrolled Lives Only	2017 Lives After FIHRP, Including Existing Block
Insured On Exchange:			
No Subsidy	1,601,000		
With Subsidy	9,073,000[6]		
Insured On Exchange Total	10,674,000[7]		
Insured Off Exchange	5,100,000[8]		
Total Insured	**15,774,000**	16,889,000	17,039,000
Uninsured but Eligible for QHP	**10,700,000[9]**	9,585,000	9,435,000
Total QHP Eligible Individual Market	26,474,000	26,474,000	26,474,000

The first column of Table 9 shows the number of persons covered by the individual insurance marketplace in 2017 or who are uninsured and would be eligible to be covered by a QHP in the individual marketplace. The second column illustrates the increase in the number of insured, offset by a corresponding decrease in the number of uninsured, if the individual insurance premium rates decreased by 5.5%, which corresponds to the midpoint of the range of rate decreases we estimated if eligibility for participation is limited to persons who become newly insured or who change carriers. We estimate that the number of uninsured would decrease by 1.1 million under this scenario. The last column shows that, if the eligibility for participation in the FIHRP were expanded to all persons presently insured in the individual marketplace or who become insured, the rate reduction becomes 10.5%, the midpoint of the range of rate decreases of 7% to 14% we estimated under this scenario. We estimate that the number of uninsured lives decreases by about 1.25 million persons. Table 10 compares the reduction in number of uninsured when FIHRP eligibility includes or excludes the persons who remain covered by their current insurer (i.e. the closed block).

Table 10
Effect of FIHRP on # of Uninsured Lives

FIHRP Premium as % of Direct Premium	FIHRP Payment Basis	Include Closed Block?	Reduction in Uninsured	% Reduction in Uninsured eligible for QHP
90%	Medicare	No	800k-1.4 mil	8-13%
90%	Medicare	Yes	900k-1.6 mill	9-15%

Though the rate reduction will primarily benefit those persons who are paying most or all of their individual premium, the federal government will see a reduction in its APTC expenses because the marketplace premium, which is the foundation for the APTC payments, has reduced. We estimate that this reduction in the federal government's annual payment for APTCs will be approximately $2.2 billion in 2017, using the 5.5% rate reduction described above. The actual amount will vary based on the actual premium reductions, the change in the number of lives in the individual marketplace, and the mix of persons whose premiums are and remain limited by their income cap and those whose premiums drop below the income cap.

[6] Derived from CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid., plus actuarial judgment, and CMS 2016 Effectuated Enrollment Snapshot, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.
[7] Derived from CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid., and marketplacestatefinal2016 (1).xlsx, plus actuarial judgment.
[8] Derived from ASPE Issue Brief (October 19, 2016). Health Insurance Marketplace Enrollment Projections for 2017 at http://www.aspe.hhs.gov/.
[9] ASPE Issue Brief (October 19, 2016), Ibid.

PSSF or Similar Proceeds from State or Federal Agencies Required to Fund the FIHRP

Table 11
Cost of FIHRP measured by additional funding needed to supplement Premiums paid to FIHRP

FIHRP Premium as % of Direct Premium	FIHRP Payment Basis	Include Closed Block?	Additional Annual Funding Needed
90%	Medicare	No	$5.4 billion
90%	Medicare	Yes	$9.9 billion

On a nationwide basis, we estimate that the FIHRP premiums, if adjusted for Medicare reimbursement, will need to be supplemented by at least $5.4 billion per year in PSSF or other funds provided by the federal government and/or states. This amount assumes a rate reduction of 5.5%, 10% of the individually insured lives are voluntarily ceded, and ceding is allowed only for a carrier's new enrollees and enrollees changing carriers. The sum of the premiums charged plus these additional funds are needed to cover all of the FIHRP claims for the lives that have been covered by the FIHRP. Note that we have not included any provision for expenses to operate the FIHRP; such expenses would add to the amount that needs to be covered by funds in excess of the FIHRP premium rate.

If FIHRP eligibility is expanded to include those persons who remain insured with their current carrier, if the rate reduction is 10.5%, and if that 10% of lives are voluntarily ceded, the supplemental dollar amount increases to $9.9 billion per year, exclusive of funds to administer the program.

Effect That the Rate Reduction Will Have on the Change in Rate Slope From 3:1 to 5:1

Under the ACA, individual market premium rates for persons age 64 and higher can be no more than three times the rate for a person age 21 covered by the same plan of benefits. A proposal to increase that rate slope from three times to five times has been under consideration. A reduction in the average rate level that is due to introduction of the FIHRP or a comparable program would reduce rates at all ages, moderating the impact of a change in age curve; in particular, it would dampen the increase in rates at older ages, and would create a larger decrease at younger ages.

The following tables illustrate relative rate levels under the current 3:1 age curve and an illustrative 5:1 age curve (Table 12), and the 5:1 age curve with rates reduced by 10.5% due to FIHRP (Table 13). The amount of the actual rate reduction between current rates on a 3:1 age curve and the reduced rates reduced due to FIHRP is presented in Table 14. A 10.5% rate reduction used in the illustration is with the same as the reduction described earlier if FIHRP eligibility is extended to the entire current risk pool. The results presented below will vary based on the rate decrease assumed.

Table 12 below shows the isolated effect on rates that results from changing the 3:1 age-curve to a 5:1 curve to 2017, with no premium reduction due to the FIHRP.

Table 12
Changes in Average 2017 Premiums – 3:1 Age Curve vs. 5:1 Age Curve

	2017 Average Premium			
Age Band	3:1 Age Curve	5:1 Age Curve	$ Difference	% Difference
<20	$265	$199	-$66	-25.0%
20-29	$339	$262	-$77	-22.7%
30-39	$397	$348	-$48	-12.2%
40-49	$480	$473	-$7	-1.4%
50-59	$724	$838	$115	15.9%
60+	$950	$1,178	$228	24.0%

The values in Table 12 include the monthly premium rate and the dollar and percent change in the premium by age-band due only to the change in age curve from 3:1 to 5:1. These values do not reflect how the premiums by age might change due to subsequent enrollment shifts in reaction to the change in age curve. Average premium changes range from -25% for enrollees under age 20, to 24% for members over age 60. The rates in Table 12 were calibrated so that the total dollars of premium revenue would remain unchanged for a nationwide average distribution of individual marketplace membership by age.

Table 13 below isolates the effect of implementing the FIHRP on premiums that are already under the 5:1 age-curve.

Table 13
Changes in Average 2017 Premiums – Before and After FIHRP

Age Band	Before FIHRP 5:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$199	$178	-$21	-10.5%
20-29	$262	$234	-$27	-10.5%
30-39	$348	$312	-$37	-10.5%
40-49	$473	$423	-$50	-10.5%
50-59	$838	$750	-$88	-10.5%
60+	$1,178	$1,054	-$124	-10.5%

Note that the percentage reduction in premium by age is constant and is equal to the rate reduction that is assumed to result from FIHRP. The effect on costs of the claims ceded under the FIHRP will be spread across the entire individual risk pool as a percent of premium under single-risk-pool rating requirements. The percent difference is consistent across all ages due to the requirement of a single marketplace rate for a given plan of benefits that can be adjusted only for age, geographic area and smoking status.

However, the absolute effect of premium decreases differ by age. The decreases range from $21 per member per month for members under age 20, to $124 per member per month for members 60 and over.

Table 14 below shows the combined effect of changing the age-curve from 3:1 to 5:1, along with an assumed 10.5% rate reduction arising from implementing the FIHRP.

Table 14
Changes in Average 2017 Premiums – 3:1 Before FIHRP vs. 5:1 After FIHRP

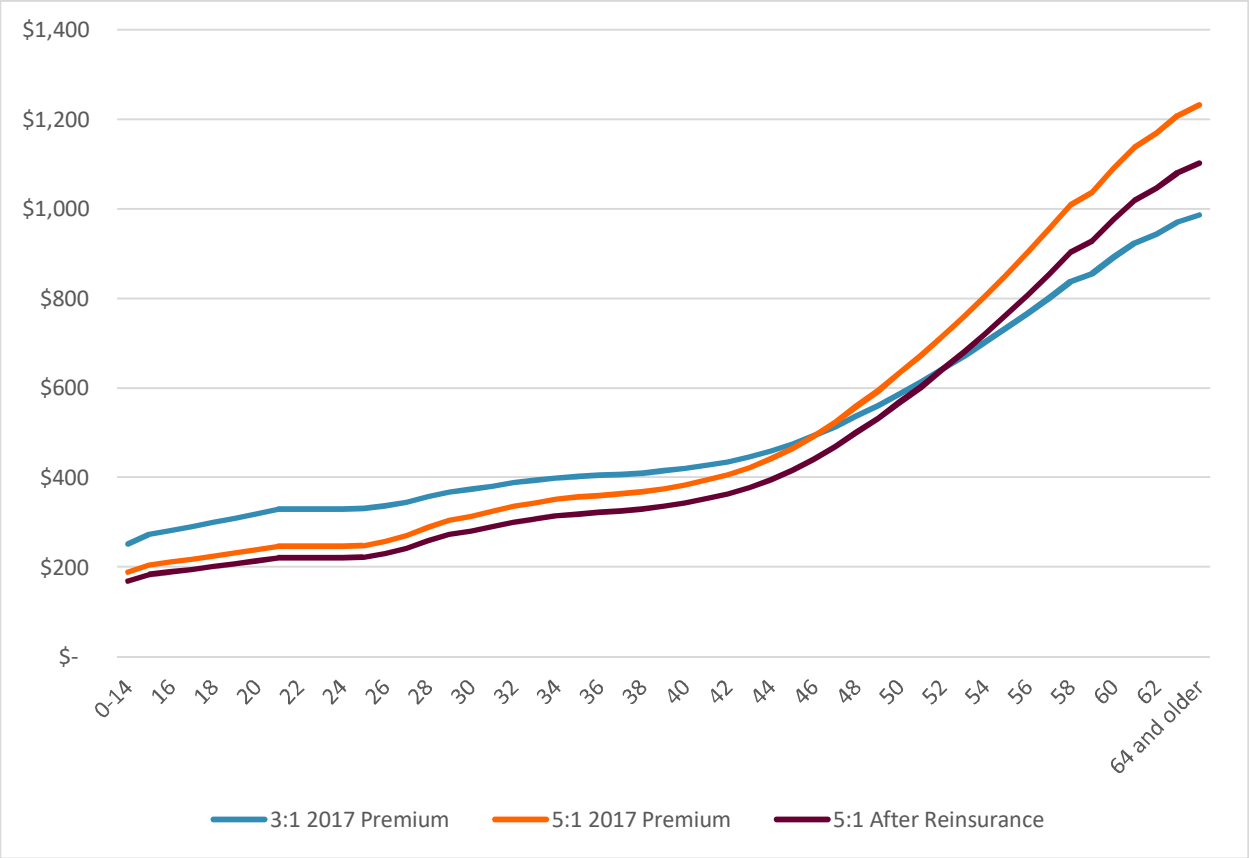
Age Band	Before FIHRP 3:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$265	$178	-$87	-32.9%
20-29	$339	$234	-$104	-30.8%
30-39	$397	$312	-$85	-21.4%
40-49	$480	$423	-$57	-11.8%
50-59	$724	$750	$27	3.7%
60+	$950	$1,054	$104	11.0%

After considering the effect on premiums due to both the change in age-curve and the reduction in premium from the FIHRP, the change in premiums ranges from a 32.9% decrease for members under age 20, to a 11.0% increase to members over age 60.

Figure 2 below graphs the premiums by age under the 3:1 and 5:1 age curves before the FIHRP, and the 5:1 age-curve after the FIHRP.

Figure 2

Premiums by Age in 3:1 Age Band Before FIHRP, 5:1 Age Band Before FIHRP, 5:1 Age Band After FIHRP



The change in age curve causes the premium slope to steepen; as a result, younger members see decreases in premiums while older members see increases. Premiums for members around age 46 will remain unchanged before FIHRP. The change that is due to the introduction of FIHRP will cause the premium to shift uniformly downward on a percentage of premium basis. The premiums after FIHRP with the 5:1 age-curve compared with the premiums before the FIHRP under the 3:1 curve remain roughly the same at age 52.

Different age distributions of the covered population and/or different rate decreases that are due to the FIHRP will produce different results from those illustrated above.

V. METHODOLOGY AND ASSUMPTIONS

DEVELOPMENT OF 2017 INDIVIDUAL MARKETPLACE ENROLLMENT BASELINE

We used publicly available data to develop assumptions regarding the size of the 2017 individual insurance market. To assess on-exchange plan selections for 2017, we utilized data from CMS's 2017 Health Insurance Marketplace Public Use files[10] and then applied an assumed effectuation percent of 87.4% which was derived from CMS estimates[11]. Off-exchange enrollment and uninsureds eligible for QHP purchase are based on Office of the Assistant Secretary for Planning and Evaluation (ASPE) 2017 marketplace projections[12] a report from the U.S. Department of Health and Human Services (HHS).

Using the data and assumptions just described, Table 2 above presents the 2017 individual marketplace baseline used in our analysis.

DEVELOPMENT OF ESTIMATED IMPACT OF THE FIHRP ON PREMIUMS

The CMS Public Use files indicate a 2017 on-exchange average per member per month (PMPM) premium of $473[13] which we assumed was appropriate for the entire individual market. Assuming an average loss ratio of 80%, this produces an average claim cost for the individual market of $378.40 PMPM.

We developed an illustrative benefit plan design that would produce an expected 2017 claim cost consistent with the average market claim cost described above when input into Milliman's Managed Care Rating Model (MCRM). The MCRM was calibrated for nationwide allowed charges based on average commercial provider reimbursement levels. We determined those reimbursement levels using Milliman's proprietary benchmarking discount model.

The FIHRP reimburses claims in excess of $10,000 for ceded lives at 100% of Medicare for medical services. Pharmacy claims are assumed to be reimbursed at commercial payment rates. In order to estimate the impact on the expected claim costs of the reduced reimbursement levels for claims that are ceded to FIHRP, we developed a claim probability distribution (CPD) for the illustrative benefit plan in the MCRM. Using this CPD, we estimated the cost of claims paid at commercial reimbursement levels for the first $10,000 in benefits. We then estimated the cost of claims above that attachment point for claims reimbursed at 100% of Medicare. We compared the total of these two amounts with the total cost of claims at commercial reimbursements to determine that if all lives in the individual marketplace had their medical claims in excess of $10,000 adjudicated based on 100% of Medicare fees, claim costs would drop by about 29% to 31%.

Because only newly insured enrollees or those enrollees who change carriers are eligible to be ceded to the FIHRP, the expected impact on marketplace claim costs is less than the 29% - 31% we developed based on 100% of the market being eligible.

We used the following assumptions to estimate the reduction to the average market premiums resulting from the introduction of the FIHRP:

[10] CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid.
[11] March 31, 2016 Effectuated Enrollment Snapshot https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html
[12] ASPE Issue Brief (October 19, 2016), ibid.
[13] CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid.

- 57% of the total individual market will be eligible for ceding to the FIHRP. As described earlier in this paper, this estimate was developed from CMS Health Insurance Marketplace Public Use Files.
- 7% of individuals will be ceded based on the presence of one of the eight auto-cede conditions. This estimate was developed from Milliman's 2014 consolidated database.
- 5% to 15% of individuals will be voluntarily ceded by carriers.

Based on these assumptions, we estimate that the total lives ceded to the FIHRP are 7% to 13% of the individual market (7% = 57% * [7% + 5%]; 13% = 57% * [7% + 15%]).

We also estimated that when adding in family members on the contract that includes a person with one of the eight automatic ceding conditions, the average claim cost is about three times the claim cost for the average person in the individual marketplace.

The reduction in average market claim cost was developed by first estimating the PMPM value of the ceded claims for the portion of the market that might be ceded to the FIHRP (7% to 13%), based on 300% morbidity for those lives. That amount was subtracted from the starting market claim cost for the total individual market to produce the adjusted claim cost for benefits ceded to FIHRP. We assumed that the expenses on a PMPM basis are unchanged. Finally, we solved for the premium payable to FIHRP for the portion of the market that might be ceded, under the various scenarios described earlier:

1. The FIHRP premium is 90% of the average premium, with no adjustment for Medicare reimbursement.
2. The FIHRP premium is 90% of the average premium, with a downward adjustment to account for ceded claims being reimbursed at Medicare levels.
3. The FIHRP premium is 45% of the average premium and is adjusted for the Medicare reimbursement of ceded claims.

The resulting premium reductions range from 1% to 14% and are dependent on the assumed portion of the market that will be ceded as well as the basis for determining the FIHRP premium.

DEVELOPMENT OF 5:1 AGE CURVE

We developed an age curve that can be used to build a 5:1 rating scheme where a person aged 64 or older would have premium levels five times the premium of a 21-year-old for the same plan. To create this 5:1 age rating curve we utilized a linear transformation of the existing federal 3:1 age curve in use illustrated by the following formula:

$$\text{5:1 Age Curve Factor} = \{\text{3:1 Age Curve Factor} * 2.0\} - 1.0$$

The exact age factors to be used have not been released along with the proposals being considered that would change the age rating to a 5:1 ratio. However, the methodology above is consistent with the equation developed by Saltzman and Eibner of the Commonwealth Fund Study.[14] This linear transformation causes a greater increase of the age factors of older ages because the differential between age factors is greatest at older ages.

Computing the corresponding premiums by age under the 5:1 age-curve requires computing the appropriate base premium and applying this rate to the age-factors. This base rate would result in premiums by age such that total aggregate revenues remain budget-neutral between the 3:1 and 5:1 age curve scenarios for a given population. We relied on the actual on-exchange 2016 individual market

[14] Saltzman, E. & Eibner, C. (September 2015). Technical Appendix: Rate Banding Analysis. The Commonwealth Fund. Retrieved April 6, 2017, from http://www.commonwealthfund.org/~/media/files/publications/blog/2015/eibner_rate_banding_tech_append_090215_clean_pf.pdf?la=en.

enrollment distribution by age from a report produced by ASPE. We assume that enrollment levels and distributions by age do not change under the 5:1 age curve when compared with the 3:1 scenario when illustrating the premiums by age. We also assume no further changes in population morbidity to illustrate the isolated impact of changing the age curve and implementing the FIHRP.

Potential member migration was estimated after the rate change by age was computed for the impact of moving to the 5:1 age curve and the introduction of the FIHRP. The existing individual market enrollment was segmented into separate cohorts by their household income in relation to the federal poverty level (FPL). This was done to model potential policyholder behavior separately because behavior is expected to be dependent on income level. No migration was assumed for those under 250% of the FPL.

Individuals in this income range qualify for advance Advance premium Premium tax Tax credits Credits (APTCs) as well as cost Cost-sharing Sharing reduction Reduction (CSR) subsidies. Introducing the FIHRP should lower premiums in the market. If members in this cohort are currently insured they will likely remain insured in the market where they have access to the same level of subsidization. If individuals in this cohort are uninsured despite the access to subsidies and CSR plans, they will likely remain uninsured. Therefore, it was assumed that no migration would take place for this cohort.

Individuals with incomes greater than 400% of the FPL do not qualify for any subsidization. They may be motivated to switch plans if the potential savings is great enough. To model the migration of this group, rate changes by age band were estimated. For each age band, a factor was used to estimate how many individuals would migrate to the new pool. The table below illustrates the assumed likelihood of migration by rate decrease. The likelihood of moving when the rate decrease is less than 5% is assumed to be 20%. It was assumed that all individuals would migrate at rate decreases over 40%.

Table 15
Migration Factors by Rate Decrease

Rate Decrease	Likelihood of Migration
0% -5%	20%
5% -10%	40%
10% -15%	55%
15% -20%	70%
20% -25%	80%
25% -30%	90%
30% -35%	95%
35% -40%	100%

Individuals with household income between 250% and 400% of the FPL qualify for lower levels of APTCs, and do not qualify for CSR subsidies. The impact of the tax credits that offset the premiums paid need to be considered when modeling behavior for this cohort. Tax credits by age band from the Milliman Health Care Reform Financial Model were used to estimate current net premiums under the existing risk pool. These net premiums were then compared with the projected premiums in the alternate risk pool to create a rate change. The same migration factors used in the table shown above were then used with these rate changes to estimate the number of members that would migrate.

Migration into the risk pool from the currently uninsured population was handled in a similar fashion. Members who are currently uninsured and have household incomes less than 400% of the FPL were assumed to remain uninsured. Uninsured individuals with income greater than 400% of the FPL were assumed to migrate into the alternate risk pool at 25% of the likelihood assumed for insured individuals in the same age-band. For example, if it was determined that the rate decrease for individuals in a particular age-band was -8%, we assumed 40% of the insured population and 10% of the uninsured population over 400% of FPL would migrate.

VI. CAVEATS, LIMITATIONS AND QUALIFICATIONS

This Milliman report has been prepared for the specific purpose of estimating the impact of the FIHRP on individual marketplace premium rates and enrollment. This information may not be appropriate, and should not be used, for any other purpose.

Any release of this report to a third party must be in its entirety; in particular, Attachment A should not be released other than in context with the rest of this report.

The information presented in this report is provided for the Foundation for Government Accountability. The Foundation may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work product. Any third party recipient of this work product should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates 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.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views in this report related to the FIHRP, age rating rules, or any other policy.

Milliman does not provide legal advice, and recommends that Foundation for Government Accountability consult with its legal advisors regarding legal matters.

The authors are actuaries for Milliman, are members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

ATTACHMENT A — REVISED April 17, 2017

Scenario 1: New Risk Pool for Newly Insured Lives Alongside Existing ACA Risk Pool

Existing Risk Pool FIHRP Rate Components				New Risk Pool FIHRP Rate Components			Rate Reduction vs. Current Rates		Lives in Risk Pool		Uninsured		APTCs	PSSF
Pool	% of Direct	FIHRP Payment Basis	Include Closed Block?	Pool	% of Direct Premium	FIHRP Payment Basis	Existing Pool	New Pool	Existing Pool	New Pool	Reduction in Uninsured	% QHP-eligible	Annual Reduction in Federal Dollars	Annual PSSF Subsidy to Support FIHRP
Existing	90%	Medicare	No	New	90%	Medicare	4-7%	16-31%	11.5mil	5.9 mil	1.2-2.0 mil	11-19%	$2.2 bil	$6.6 bil
Existing	90%	Medicare	Yes	New	90%	Medicare	7-14%	16-31%	12.0 mil	5.3 mil	1.1-1.8 mil	10-17%	$4.3 bil	$9.6 bil
Existing	No eligible for FIHRP			New	90%	Medicare	0%	16-31%	10.8 mil	6.7 mil	1.3-2.2 mil	13-20%	$0	$3.33 bil
Existing	90%	Commercial	No	New	90%	Commercial	1-2%	12-23%	11.8 mil	5.5 mil	1.1-1.9 mil	10-18%	$610 mil	$11.23 bil
Existing	90%	Commercial	Yes	New	90%	Commercial	2-4%	12-23%	12.0 mil	5.3 mil	1.1-1.8 mil	10-17%	$1.2 bil	$16.7 bil
Existing	No eligible for FIHRP			New	90%	Commercial	0%	12-23%	11.7 mil	5.6 mil	1.1-1.9 mil	10-18%	$0	$4.9 bil

Scenario 2: Current ACA Structure With Single Risk Pool

Existing Risk Pool FIHRP Rate Components					Rate Reduction vs. Current Rates	Uninsured		APTCs	PSSF
Pool	% of Direct	FIHRP Payment Basis	Include Closed Block?	Lives in Existing Risk Pool	Existing Pool	Reduction in Uninsured	% QHP-eligible	Annual Reduction in Federal Dollars	Annual PSSF Subsidy to Support FIHRP
Existing	90%	Commercial	No	16.8 mil	1-2%	740k-1.27 mil	7-12%	$600 million	$9.3 billion
Existing	90%	Commercial	Yes	16.8 mil	2-4%	740k-1.31 mil	7-12%	$1.2 billion	$17.0 billion
Existing	90%	Medicare	No	16.9 mil	4-7%	820k-1.41 mil	8-13%	$2.2 billion	$5.4 billion
Existing	90%	Medicare	Yes	17.0 mil	7-14%	930k-1.6 mill	9-15%	$4.3 billion	$9.9 billion
Existing	45%	Medicare	No	17.0 mil	6-10%	900k-1.52 mil	9-14%	$3.2 billion	$7.6 billion