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ACA health insurer fee

Estimated impact on the U.S. health insurance industry



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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA), along with the Health Care and Education Reconciliation Act of 2010, represent a historic effort by the U.S. government to reform and overhaul the American healthcare system. One of the notable revenue provisions included in the ACA is a fee imposed on health insurers. This fee is an excise tax on the health insurance industry that will be assessed annually starting in 2014.

Milliman created this report to provide an independent analysis of the impact of the ACA health insurer fee provision on the United States health insurance industry.

SUMMARY OF ACA HEALTH INSURER FEE

Section 9010 of the ACA and Section 1406 of the Reconciliation Act impose an annual fee on the health insurance industry starting at \$8 billion in 2014. The health insurer fee will increase gradually to \$14.3 billion in 2018 and will be indexed to the rate of premium growth thereafter. *The health insurer fee is considered an excise tax and thus is nondeductible for income tax purposes.*

The fee will be allocated to qualifying health insurers based on their premium in the previous year (e.g., the 2014 health insurer fee will be based on 2013 premium revenue). Each health insurer's fee is calculated as its market share multiplied by the annual fee. *Market share is based on commercial, Medicare, and Medicaid premium revenue after applying prescribed dollar thresholds, which effectively reduces the market share used in the insurer fee calculation for smaller insurers.*

Actual results for any given carrier will depend on its take-up rates in the Medicaid and uninsured markets (e.g., a carrier that does not grow its commercial and/or Medicaid business as fast as another carrier in 2014 and beyond will pay a lesser portion of the fee each year). In addition, market growth will serve to reduce the health insurer fee for all carriers. We produced two scenarios in this report, Status Quo and Full Medicaid Expansion. The appendices contain other market population growth scenarios.

Not-for-profit insurers receive preferential treatment under the health insurer fee rules. Not-for-profit insurers that receive more than 80% of their premium revenue from Medicare, Medicaid, and SCHIP are exempt from the fee. Other not-for-profit insurers exclude 50% of their premium revenue from the health insurer fee calculation.

SUMMARY OF RESULTS

We believe carriers will pass on the ACA health insurer fee to consumers through the form of higher member premiums (or reduced benefits) in the same manner that they pass on premium taxes and other fees and assessments.

However, unlike many other fees, the health insurer fee is not deductible for federal corporate income tax purposes. Therefore, a carrier needs to load its premium for (a) the health insurer fee, and (b) an allowance to reflect the federal income tax the carrier will be charged on profits related to the health insurer fee, in order to fully pass on these costs to its members. Assuming a 35% marginal federal corporate income tax rate, premium rates would need to increase by the estimated ACA health insurer fee divided by 0.65 ($1 - 0.35$). Each for-profit insurer, all else equal, will have to raise premiums by its health insurer fee multiplied by 1.54 (i.e., $1 / 0.65$) in order to maintain profit levels.

Figure 1 shows the estimated impact of the health insurer fee by line of business over the next 10 years. We estimate the federal government will collect \$152 billion in health insurer fees over the next 10 years and an additional \$61 billion from increased corporate taxes related to the fee's implementation for a total revenue increase of approximately \$213 billion.

Note that the effective multiplier to the fee of \$152 billion is less than the 1.54 mentioned previously, because not all carriers that pay the health insurer fee pay federal income tax. Many not-for-profit carriers will still pay the fee, but not any tax.

**FIGURE 1: ACA HEALTH INSURER FEE
ESTIMATED FEE ALLOCATION BY LINE OF BUSINESS FOR ALL HEALTH INSURERS FROM 2014 TO 2023
STATUS QUO MARKET GROWTH SCENARIO (BILLIONS)**

	COMMERCIAL	MEDICARE	MEDICAID	TOTAL
FEE ALLOCATION	61.0%	24.6%	14.4%	100.0%
HEALTH INSURER FEE IMPOSED	\$92.7	\$37.4	\$21.8	\$151.9
EFFECTIVE MULTIPLIER	1.355	1.460	1.482	1.399
TOTAL FEE INCLUDING ESTIMATE OF FEDERAL INCOME TAX NEEDED TO BE COLLECTED	\$125.6	\$54.6	\$32.3	\$212.5

The health insurer fee provision gives a competitive advantage to not-for-profit health insurers because:

- They are exempt from paying the fee if they receive at least 80% of their revenue from government programs.
- Only 50% of their premiums count toward their shares of the fee (assuming they do not qualify for the aforementioned exemption).

We estimate the premium increase that is due to the health insurer fee will be approximately 1.7% to 2.4% in 2014, growing to about 2.0% to 2.9% in later years. Figure 2 displays our estimates of the average premium load by year with and without the additional corporate taxes.

**FIGURE 2: ACA HEALTH INSURER FEE
BEST ESTIMATE AND RANGE OF PREMIUM INCREASES BY YEAR WITH AND WITHOUT CORPORATE TAXES**

YEAR	BEST ESTIMATE OF PREMIUM INCREASES		RANGE WITH CORPORATE TAXES*
	WITHOUT CORPORATE TAXES	WITH CORPORATE TAXES	
2014	1.2%	1.7%	0.0% – 2.4%
2015	1.5%	2.1%	0.0% – 3.0%
2016	1.4%	1.9%	0.0% – 2.7%
2017	1.5%	2.1%	0.0% – 3.0%
2018	1.4%	2.0%	0.0% – 2.8%
2019	1.4%	2.0%	0.0% – 2.8%
2020	1.4%	2.0%	0.0% – 2.8%
2021	1.4%	2.0%	0.1% – 2.9%
2022	1.5%	2.0%	0.0% – 2.9%
2023	1.5%	2.0%	0.0% – 2.9%

* Certain not-for-profit health insurers will be exempt from the fee. Also, small health insurers will be assigned a very small portion of the fee, which is due to their extremely small market share.

Commercial considerations

Insured commercial premiums will increase over what they would otherwise be absent the fee. As a result, plan sponsor contributions or plan beneficiary contributions will increase or benefits will decrease. *The effective net result is a tax, realized as increased premiums and/or decreased benefits, on plan sponsors and/or beneficiaries. The application of the tax will encourage larger employers to consider self-insurance over fully insured products.*

Medicare considerations

Guidance issued by the Centers for Medicare and Medicaid Services (CMS) requires insurer fees to be included in Medicare Advantage and Part D bids. Thus, Medicare Advantage and Part D bids will increase over what they would otherwise be absent the fee. As a result, Medicare Advantage and Part D beneficiary premiums will increase or benefits will decrease for Medicare beneficiaries participating in those programs. Also, federal government payments to Medicare Advantage and Part D insurers will increase modestly but not as much as the fee. *The effective net result is a tax, realized as decreased benefits and/or increased premiums, on Medicare beneficiaries participating in the Medicare Advantage and/or Part D programs.*

Medicaid considerations¹

Regulations issued by CMS require Medicaid managed care premiums to be actuarially sound and that states obtain an actuarial certification from a qualified actuary. While CMS does not have set criteria to determine actuarial soundness, taxes are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid managed care organizations (MCOs) and are included in Medicaid managed care premiums.

Because the ACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Both state and federal governments will share in funding the health insurer fee because Medicaid managed care premiums are funded by both the state and federal governments. This situation results in the federal government taxing both itself and state governments with no net financial impact to Medicaid MCOs. *The net result is a transfer from state governments to the federal government.*

¹ Meerschaert, J. & Doucet, M. (January 2012). PPACA Health Insurer Fee: Estimated Impact on State Medicaid Programs and Medicaid Health Plans, Medicaid Health Plans of America.

BACKGROUND

On March 1, 2013, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) issued proposed regulations on the health insurer fee provision of the ACA. The published regulations did not deviate from the original rules found in Section 9010 of the ACA and Section 1406 of the Reconciliation Act, but rather confirmed what the industry already assumed about the health insurer fee. The regulations did provide more detailed guidance on how the IRS will collect the controversial health insurer fee, as follows:

- The fee is calculated at the corporate entity level.
- Life and property and casualty insurance companies with U.S. health risk business are also subject to the health insurer fee.
- Retiree-only health plans are included in the calculation.

HOW MUCH IS THE FEE?

The ACA places an annual fee on health insurance providers, which starts at \$8 billion in 2014. The annual fee increases according to the schedule in Figure 3.

FIGURE 3: ANNUAL FEE ON HEALTH INSURANCE PROVIDERS, APPLICABLE FEE BY CALENDAR YEAR

CALENDAR YEAR	APPLICABLE FEE
2014	\$ 8.0 BILLION
2015	\$11.3 BILLION
2016	\$11.3 BILLION
2017	\$13.9 BILLION
2018	\$14.3 BILLION
2019+	GROWTH OF FEE INDEXED TO RATE OF PREMIUM GROWTH

As stated previously, the health insurer fee is considered an excise tax and is nondeductible for income tax purposes.

WHAT ENTITIES ARE SUBJECT TO THE FEE?

The health insurer fee applies to any covered entity engaged in the business of providing health insurance with respect to U.S. health risks and includes health maintenance organizations (HMOs) and other insurance companies and encompasses commercial insurance, Medicare Advantage, Medicare Part D, and Medicaid. Covered entities specifically exclude the following organizations:

- Employers that self-insure the health risks of their employees
- Government entities, including independent not-for-profit county-organized health system entities that contract with state Medicaid agencies
- Not-for-profit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations, including Medicare, Medicaid, State Children's Health Insurance Plan (SCHIP), and dual eligible plans
- Organizations that qualify as voluntary employees' beneficiary associations (VEBAs) established by entities other than employers
- Educational institutions that establish or administer programs to provide students with access to health insurance

HOW IS THE FEE CALCULATED?

The fee will be allocated to health insurers based on the respective market share of premium revenue in the previous year (e.g., the 2014 health insurer fee will be based on 2013 premium revenue). Each entity's fee is calculated as their market share multiplied by the annual fee shown in Figure 3.

Each insurer's market share is based on commercial, Medicare, and Medicaid (including SCHIP) premium revenue, excluding the following coverages:

- Accident and disability insurance
- Coverage for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Long-term care insurance
- Educational institutions that provide students with access to health insurance
- Medicare supplement and Medigap insurance
- Stop-loss insurance

The amount of net premiums that are taken into account for the purposes of determining a covered entity's market share is subject to the dollar thresholds shown in Figure 4. The dollar thresholds serve to lower the market share (and therefore the corresponding health insurer fee) for smaller insurers.

FIGURE 4: DOLLAR THRESHOLDS FOR DETERMINING PREMIUMS TAKEN INTO ACCOUNT

NET PREMIUMS WRITTEN	PERCENTAGE TAKEN INTO ACCOUNT
NOT MORE THAN \$25 MILLION	0%
\$25 MILLION-\$50 MILLION	50%
MORE THAN \$50 MILLION	100%

For example, a covered entity with:

- \$15 million of net premiums would have \$0 in net premiums taken into account for purposes of calculating its share of the fee (and, therefore, pay no fee)
- \$45 million of net premiums would have \$10 million in net premiums taken into account for purposes of calculating its share of the fee (0% of \$25 million + 50% of \$20 million)
- \$150 million of net premiums would have \$112.5 million in net premiums taken into account for purposes of calculating its share of the fee (0% of \$25 million + 50% of \$25 million + 100% of \$100 million)

Not-for-profit entities can exclude an additional 50% of their net premium because of their status as a public charity, social welfare organization, high-risk health insurance pool, or a consumer operated and oriented plan (CO-OP). For example, a qualifying organization with \$60 million of net premiums would have \$11.25 million taken into account (50% × [0% of \$25 million + 50% of \$25 million + 100% of \$10 million]).

Related entities under common control (e.g., under the financial umbrella of a parent organization) will be considered a single entity for the calculation of the health insurer fee. That is, the parent organization must pool the premiums for all its subsidiaries to calculate its premium for purposes of determining its share of the health insurer fee.

WHAT ARE THE TAX IMPLICATIONS?

Because the ACA health insurer fee is nondeductible for income tax purposes, any attempts by insurers to pass on the fee to its consumers will result in increased premium revenue, which will be subject to corporate income taxes and will also need to be taken into account when adjusting premium rates for the health insurer fee. In other words, any corporate income tax paid by the insurer will leverage the impact of the health insurer fee by an additional 54% (assuming a 35% marginal corporate income tax rate).

RESULTS

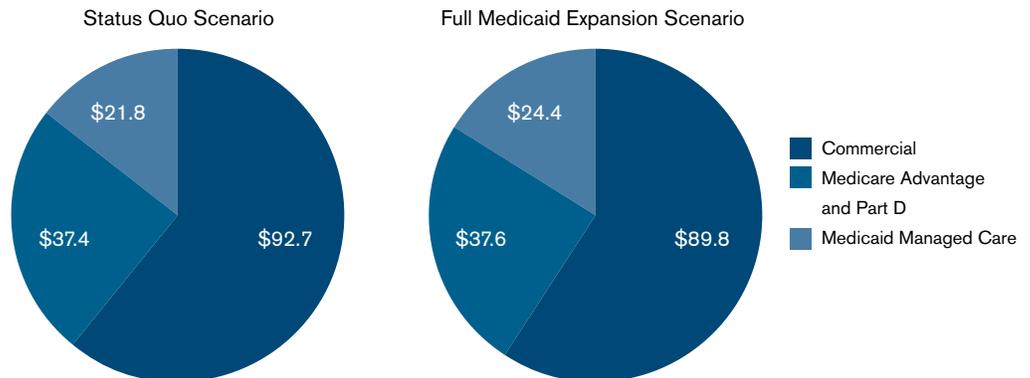
This section of our report presents our estimates of the financial impact of the health insurer fee on the U.S. healthcare industry under two scenarios.

In its decision of June 28, 2012, the U.S. Supreme Court upheld most of the ACA, but gave states the flexibility to decide whether to expand Medicaid program eligibility to 133% of the federal poverty level (FPL). Even though several states have already voiced their intentions for or against the Medicaid expansion, the two scenarios modeled in this report take an all-or-nothing approach. We present the results of our analysis under first a status quo scenario and then a second scenario under which all states expand their Medicaid programs to 133% of FPL (138% of FPL with the 5% income disregard).

HEALTH INSURER FEE SHARE BY MARKET SEGMENT UNDER STATUS QUO AND FULL MEDICAID EXPANSION SCENARIOS

Figure 5 below shows the share of the total ACA health insurer fee paid by line of business. Over a 10-year period from 2014 to 2023, we project that commercial plans will bear about 61% of the total health insurer fee, or about \$92.7 billion, with Medicare and Medicaid paying about 25% and 14% respectively under a *Status Quo* scenario. Under a nationwide *Full Medicaid Expansion* scenario, the Medicaid portion of the health insurer fee increases by about 12% or \$2.6 billion, with corresponding reductions to the fee paid by other markets.

**FIGURE 5: ACA HEALTH INSURER FEE PAID BY MARKET
TOTAL FOR 10-YEAR PROJECTION FROM 2014 TO 2023 (BILLIONS)**



Figures 6 and 7 show the portion of the ACA health insurer fee paid by line of business in each year under the *Status Quo* and *Full Medicaid Expansion* scenarios, respectively.

FIGURE 6: ESTIMATED ACA HEALTH INSURER FEE PAID BY LINE OF BUSINESS AND YEAR UNDER THE “STATUS QUO” AND “FULL MEDICAID EXPANSION” SCENARIOS (BILLIONS)

HEALTH INSURER FEE PAID BY LINE OF BUSINESS							
YEAR	TOTAL HEALTH INSURER FEE	STATUS QUO SCENARIO			FULL MEDICAID EXPANSION SCENARIO		
		COMMERCIAL	MEDICARE	MEDICAID	COMMERCIAL	MEDICARE	MEDICAID
2014	\$8.00	\$4.62	\$2.18	\$1.20	\$4.57	\$2.19	\$1.24
2015	11.30	6.56	2.98	1.76	6.37	2.97	1.95
2016	11.30	6.69	2.89	1.73	6.48	2.89	1.93
2017	13.90	8.37	3.48	2.05	8.11	3.48	2.31
2018	14.30	8.75	3.50	2.05	8.47	3.52	2.31
2019	15.6*	9.59	3.80	2.22	9.28	3.82	2.50
2020	17.0*	10.48	4.10	2.39	10.13	4.13	2.69
2021	18.5*	11.44	4.44	2.58	11.06	4.47	2.90
2022	20.2*	12.53	4.82	2.80	12.11	4.85	3.16
2023	21.9*	13.69	5.23	3.04	13.22	5.26	3.42

* Estimated based on growth in premiums.
The *Full Medicaid Expansion* scenario generates lower overall premium growth than the *Status Quo* scenario.

FIGURE 7: ACA HEALTH INSURER FEE PAID BY LINE OF BUSINESS AND YEAR PERCENTAGE ALLOCATION

HEALTH INSURER FEE PAID BY LINE OF BUSINESS							
YEAR	TOTAL HEALTH INSURER FEE	STATUS QUO SCENARIO			FULL MEDICAID EXPANSION SCENARIO		
		COMMERCIAL	MEDICARE	MEDICAID	COMMERCIAL	MEDICARE	MEDICAID
2014	\$8.0	57.8%	27.2%	15.0%	57.2%	27.3%	15.5%
2015	11.3	58.0%	26.4%	15.6%	56.4%	26.3%	17.3%
2016	11.3	59.2%	25.6%	15.3%	57.3%	25.5%	17.1%
2017	13.9	60.2%	25.0%	14.8%	58.3%	25.1%	16.6%
2018	14.3	61.2%	24.5%	14.3%	59.2%	24.6%	16.2%
2019	15.6*	61.4%	24.3%	14.2%	59.5%	24.5%	16.0%
2020	17.0*	61.7%	24.2%	14.1%	59.7%	24.3%	15.8%
2021	18.5*	62.0%	24.0%	14.0%	59.9%	24.2%	15.7%
2022	20.2*	62.2%	23.9%	13.9%	60.1%	24.1%	15.7%
2023	21.9*	62.4%	23.8%	13.8%	60.2%	24.0%	15.6%

* Estimated based on growth in premiums.
The *Full Medicaid Expansion* scenario generates lower overall premium growth than the *Status Quo* scenario.

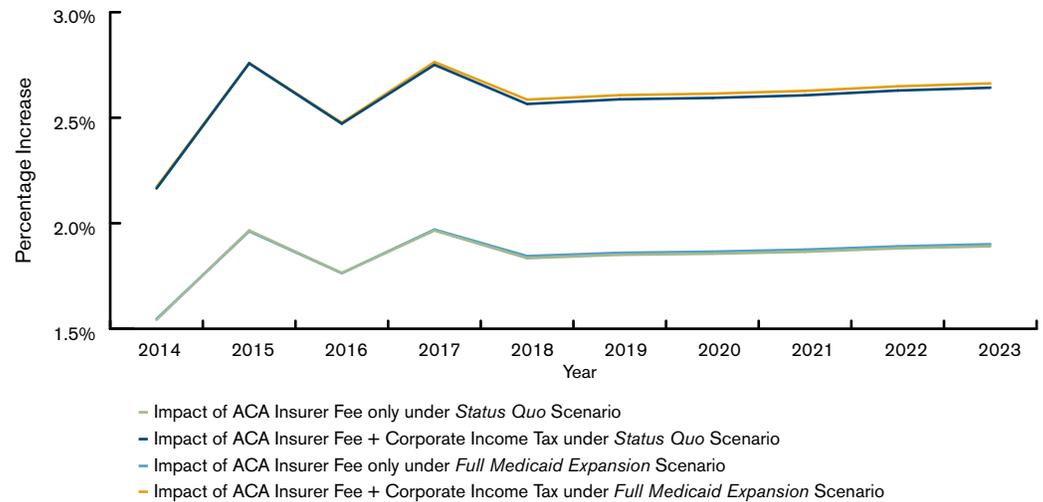
The share paid by Medicaid MCOs drops after 2015 as the projected growth in commercial and Medicare Advantage premiums outpaces the projected growth in Medicaid MCO premiums.

The share paid by Medicare Advantage plans increases under the *Full Medicaid Expansion* scenario, which is due to the expected migration of higher-cost individuals from the commercial market to the Medicaid market. Medicaid reimburses at a lower rate, resulting in overall lower premium revenue nationwide.

HEALTH INSURER FEE IMPACT ON PREMIUMS

Figure 8 shows the nationwide average percentage increase to health premiums related to the ACA health insurer fee. For each scenario, the lower line shows the impact of only the health insurer fee. The upper line shows the impact of the health insurer fee plus an allocation for corporate income tax due to the non-deductibility of the health insurer fee.

FIGURE 8: NATIONWIDE PERCENTAGE INCREASE TO OVERALL PREMIUM DUE TO ACA HEALTH INSURER FEE



On average, health plans can expect that their premiums will increase 1.7% because of the ACA health insurer fee (combined for-profit and not-for-profit companies subject to fee). Increases of this magnitude are meaningful; given that commercial health plans are subject to annual premium rate increase reviews, Medicare Advantage plans need to comply with total beneficiary cost (TBC) requirements, and state budgets for Medicaid expenditures are under pressure.

The insurer fee's premium impact varies greatly by insurer size as shown in Figure 9.

FIGURE 9: ESTIMATED 2014 PREMIUM IMPACT OF HEALTH INSURER FEE BY PREMIUM VOLUME FOR-PROFIT HEALTH INSURER

PREMIUM VOLUME	WITHOUT INCOME TAX ALLOCATION	WITH INCOME TAX ALLOCATION
< \$100 MILLION	0.64%	0.95%
\$100 MILLION-\$250 MILLION	1.09%	1.60%
\$250 MILLION-\$500 MILLION	1.30%	1.94%
\$500 MILLION-\$750 MILLION	1.34%	1.99%
\$750 MILLION-\$1 BILLION	1.36%	2.03%
\$1 BILLION +	1.18%	1.63%

MEDICAID-SPECIFIC CONSIDERATIONS

Because the ACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Medicaid is funded by the state and federal governments, which means that both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund the higher Medicaid managed care premiums required to fund the ACA health insurer fee, with no net financial impact to Medicaid MCOs.

With for-profit health insurers, the net result is a transfer of \$0.55 from the state government to the federal government for every \$1.00 of ACA health insurer fee, as shown in Figure 10, assuming a Federal Medical Assistance Percentage (FMAP) of 64%.

FIGURE 10: NET FINANCIAL IMPACT OF MEDICAID MANAGED CARE FLOW OF FUNDS

	FEDERAL GOVERNMENT	STATE GOVERNMENT	MEDICAID MCO
FUNDING OF MANAGED CARE RATE	(\$0.99)	(\$0.55)	\$1.54
CASH FLOW FROM ACA HEALTH INSURER FEE	1.00	0.00	(1.00)
CASH FLOW FROM 35% CORPORATE INCOME TAX	0.54	0.00	(0.54)
NET IMPACT	\$0.55	(\$0.55)	\$0.00

MARKET-SPECIFIC SCENARIOS

We modeled several incremental market-specific scenarios to understand the impact of the health insurer fee in a wide range of situations.

Appendices A through C show the impact of the health insurer fee by line of business assuming annual growth percentages of -5%, -2%, 0%, 2%, and 5% on each market under both the *Status Quo* and *Full Medicaid Expansion* scenarios.

Appendices A1 and A2 show changes in the commercial market that could be represented by movements in and out of the fully insured commercial market segment.

Appendices B1 and B2 show changes in the Medicare market that could be represented by movements in and out of the Medicare Advantage market segment.

Finally, Appendices C1 and C2 show changes in the Medicaid market that could be represented by movements in and out of the Medicaid managed care market segment.

POTENTIAL FEE AVOIDANCE STRATEGY

One logical reaction by a for-profit corporation to a tax like the health insurer fee would be to develop a strategy to avoid the fee in order to gain a competitive edge over competitors in order to increase market share and/or profit. Unfortunately, the fee is unavoidable without important corporate structural changes.

One option to avoid or lessen the impact of the health insurer fee, however feasible, would be for a company to move its business to a not-for-profit business entity. By doing so, a corporation would eliminate some of the health insurer fee impact that would otherwise be attributable to its business.

As an illustration, Figure 11 shows the impact of the health insurer fee assuming that Medicare and Medicaid for-profit business units convert to not-for-profit entities.

FIGURE 11: IMPACT OF HEALTH INSURER FEE ASSUMING THAT MEDICARE AND MEDICAID FOR-PROFIT BUSINESSES CONVERT TO NON-FOR-PROFIT ENTITIES, UNDER THE "STATUS QUO" SCENARIO (BILLIONS)

PERCENT OF FOR-PROFITS CONVERTING TO NOT-FOR-PROFIT ENTITIES	HEALTH INSURER FEE PAID BY LINE OF BUSINESS		
	COMMERCIAL	MEDICARE	MEDICAID
0%	\$92.7	\$37.4	\$21.8
5%	94.3	36.4	21.2
10%	96.0	35.4	20.6
15%	97.7	34.4	19.9
20%	99.4	33.3	19.2

METHODOLOGY

The range of estimates presented in this report illustrates the impact of the ACA health insurer fee on the U.S. health insurance industry based on several assumptions and scenarios. This section of our report documents the methodology and the scenarios used to present the range of estimates.

At a high level, we:

1. Established 2011 base year enrollment, revenue, and expenditures for all insurance market sectors
2. Tested ranges of penetration for the Medicare Advantage market, the Medicaid managed care market, and the fully insured commercial market
3. Projected enrollment, revenue, and expenditures in each market during the period 2013 to 2023 based on the Milliman Healthcare Reform Financing Projection Model
4. Calculated each insurer's market share and allocated the ACA health insurer fee to each insurer and market

STEP 1: ESTABLISH 2011 BASE YEAR FOR ALL INSURANCE MARKET SECTORS

We gathered premium, claims, and enrollment data for the insurers associated with each major market identified below from 2011 National Association of Insurance Commissioners (NAIC) annual statement filings collected and published by SNL Financial (SNL) to establish base year enrollment, expenditures, and premium volume by insurer and market. We included life and property and casualty insurance companies with healthcare-related business.

- Commercial market: Includes comprehensive (hospital and medical), vision, dental, Federal Employee Health Benefit (FEHB), and other health lines of business.
- Medicare market: Title XVIII Medicare line of business and prescription drug plan (PDP) program (excludes Medicare Supplement policies).
- Medicaid market: Title XIX Medicaid line of business.
- We excluded the Medicare supplement, credit, disability, disability income, long-term care (LTC), stop-loss, Medigap, Tricare, and specific disease and other non-health annual statement lines of business to the extent that they could be identified.

We supplemented the SNL data with filings collected and reported by state government sources.

We compared the starting data to various sources showing summaries of the current state of the commercial, Medicare, and Medicaid markets. Our review process used data compiled by CMS, the Kaiser Family Foundation, and other Milliman sources. Using these comparisons, we supplemented or adjusted our financial statement data for any Medicare and Medicaid health plans whose enrollment and premiums were not filed with the NAIC (e.g., the plan is a not-for-profit that is not required to submit a filing).

We recognize data limitations may impact our base year estimates. While we attempted to adjust the base data to create as accurate a starting point as possible, certain insurers may not be fully represented in our 2011 base year data. Given the uncertain nature of 10-year projections, we do not believe any data irregularities would materially impact on our projections.

STEP 2: INCREASE MEDICAID MANAGED CARE PENETRATION IN STATES THAT HAVE ANNOUNCED NEW OR EXPANDED PROGRAMS

The following states expanded Medicaid managed care enrollment or announced plans to do so within the next several years: California, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Michigan, Mississippi, New Hampshire, New Jersey, New York, Ohio, South Carolina, Texas, Utah, Virginia, and Washington. We increased the Medicaid managed care penetration rates in these states based on high-level estimates of the scope of each state's program expansion because they are not reflected in the 2011 base data from Step 1.

Connecticut is the only state to announce plans to end its full-risk capitated managed care program in favor of an administrative services only (ASO) arrangement. We removed the Connecticut Medicaid managed care enrollment from our analysis.

STEP 3: PROJECT ENROLLMENT, REVENUES, AND EXPENDITURES IN EACH INSURED MARKET DURING 2013-2023 BASED ON THE MILLIMAN HEALTHCARE REFORM FINANCING PROJECTION MODEL

Step 3 projects the enrollment, revenue, and expenditures per member per year (PMPY) by insurer, state, and market for each year from 2013 to 2023 using Milliman's Healthcare Reform Financing Projection Model. We created 14 state groupings based on current Medicaid eligibility standards, uninsured population characteristics, restrictiveness of the individual health insurance market, and selected appropriate assumptions.

We created enrollment, revenue, and expenditure PMPY projection factors for each market and state grouping using projections from Milliman's Healthcare Reform Financing Projection Model. We then summarized total revenues and expenditures and calculated the total premium taken into account for use in calculating each plan's market share for determining the health plan fee allocation after determining enrollment, revenue, and expenditure PMPY for each year from 2013 to 2023.

Medical loss ratio adjustment

Another provision of the ACA is the implementation of a minimum medical loss ratio (MLR) requirement, which goes into effect January 1, 2014. This portion of the law requires that individual and small group lines of business use at least 80% of premium dollars to pay for claims and healthcare quality improvement activity. Large group and Medicare Advantage plans have to achieve at least an 85% MLR. Most states do not require managed Medicaid plans to adhere to a minimum MLR requirement; however, there are a few states that have implemented minimum MLR standards in the 80% to 92% range. Dental and vision lines of business are not subject to minimum MLR requirements. If a plan fails to meet the minimum MLR requirement, they must issue rebates by August of the following year.

We modeled the minimum MLR requirement in each year from 2013 to 2023 by forcing plans to adjust their revenue downward to achieve the specified MLR standard in each respective market, as applicable in their states—commercial, Medicare, and Medicaid—as detailed above. For the commercial market, we were unable to split out individual, small group, and large group lines of business, so we assumed a minimum MLR of 83.5% for the entire market, based on the mix of individual and group business in the commercial market collected from other data sources.

Healthcare Reform Financing Projection Model

The Healthcare Reform Financing Projection Model uses many different data sources and assumptions to develop projection factors for enrollment movements, claim costs, and revenue by lines of business. The data sources at the core of our model consist of the Current Population Survey (CPS) data, the Medical Expenditure Panel Survey (MEPS) data, and medical costs built off of research underlying Milliman's Health Cost Guidelines™. Projection assumptions include:

- Pent-up demand reflecting first-year costs that are 10% higher than normal by age and gender groupings for individuals moving from uninsured to insured status
- Annual medical cost trend rates based on Milliman's ongoing trend research
- Birth rates based on the distribution of newborns in the CPS data
- Mortality rates as reported by the 2008 U.S. mortality tables
- Take-up rates based on Milliman's research of what percentage of people (for each combination of representative age, gender, and health status) will tend to switch markets, including:
 - Formerly dependent children who reach an age where they are emancipated to other markets
 - Adults who reach age 65 and join the Medicare market
 - Individuals in other markets who lapse to the uninsured market because of premium rate increases they can no longer tolerate

STEP 4: CALCULATE EACH INSURER'S MARKET SHARE AND ALLOCATE THE ACA HEALTH INSURER FEE TO INSURER AND MARKETS

Steps 1 through 3 establish projections of each insurer's premium volume by state and market for 2013 to 2023. Step 4 calculates each insurer's ACA health insurer fee based on the rules summarized in Section III of this report. The health insurer fee is allocated to each line of business in proportion to premium volume by insurer. Note that we did not distinguish between 501(c)(3) and 501(c)(4) organizations for the purposes of assigning not-for-profit status.

The corporate income tax impact of the ACA health insurer fee was based on a 35% corporate tax rate for insurers with a for-profit status.

CAVEATS, LIMITATIONS, AND DATA RELIANCE

CAVEATS AND LIMITATIONS

This report was prepared for the specific purpose of analyzing the impact of the ACA health insurer fee on the U.S. health insurance industry. This report should not be used for any other purpose. This report should only be reviewed in its entirety.

Differences between the report projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. The projections in this report are based on our understanding of ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of ACA, necessitating an update to the projections in this report.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

In preparing this information, we relied on information published by SNL, the Kaiser Family Foundation, the Centers for Medicare and Medicaid Services, and other state government data sources. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and did not find material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our research.

This report was not prepared by lawyers or accountants and does not represent legal or accounting professional advice. This analysis is based on our interpretation of the legislation and how the taxation of the fee will work. Please consult your own professionals to determine how it would affect your firm specifically.

UNCERTAINTY OF REPORT PROJECTIONS

Uncertainty surrounds the projections presented in this report. That uncertainty stems from many different sources, including changing legislation and/or regulations, fluctuating economic conditions, state-specific changes to the Medicaid program, imperfect and missing data, and interdependencies of modeling variables, just to name a few. The dynamics of the entire U.S. health insurance system are extremely complex and the impending changes may be unprecedented in the U.S. healthcare system.

DATA ISSUES

Multiple data limitations arose while compiling the data for this report, including, but not necessarily limited to, those stated below. We attempted to address these limitations to the extent possible to compile an accurate starting data set. We do not believe any data irregularities would have a material impact on our projections, given the uncertain nature of multiyear projections.

We observed the following data issues:

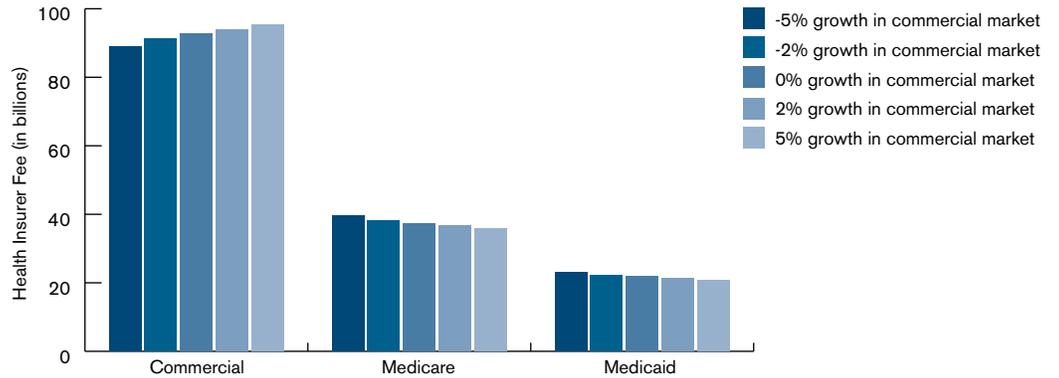
- For states where the NAIC filing requirements are not as pervasive (i.e., Arizona, California, and Maryland), we supplemented the missing data with filings collected and reported by state government sources. These filings may not conform to audited financial standards.

-
- The *Other* category found in the NAIC annual statement can include lines of business such as disability, long-term care (LTC), and stop-loss, along with actual other health dollars, and thus we excluded this category from use in our projections. It appears that many plans reported their prescription drug plan (PDP) dollars in the *Other* category of the health annual statement. Because PDPs are indeed subject to the fee, we compared CMS data to the data from SNL to parse out the companies we could determine were likely reporting only PDP dollars in this category, and added these dollars and enrollments back into the projection.
 - Indemnity companies are specifically excluded from the ACA health insurer fee. Because of how the data from SNL is structured, we had to take some additional steps to ensure that we were excluding companies that offer only health indemnity products. Thus, companies that offer some indemnity products and some non-indemnity products could not be fully excluded from this report because we had no reasonable way of appropriately parsing out the dollars. We do not believe this has a material impact on our projections.
 - We removed dollars and membership that was applicable to *Other Aliens* (i.e., persons covered outside the United States who may or may not be U.S. citizens) for life insurance and property and casualty companies that reported *Other Aliens* business in the states exhibits collected from SNL.
 - There are numerous large healthcare corporations that have many different sub-entities. It is our understanding that the ACA requires that the fee be applied at the parent company level; that is, each subcompany's premium dollars should be rolled up at the parent company level for purpose of the fee calculation. We attempted to group these sub-entities together to the best of our knowledge, but recognize that our groupings may not be complete in all cases.
 - Some insurers pass on some health insurance risk to partners in the form of a sub-capitation. To the extent that these partner entities are licensed health insurers, file financial statements with the NAIC, and report it as health insurance risk, the premiums related to the same health risk may be counted twice. Unfortunately, the IRS guidance published on March 1, 2013, is silent on this issue. We made no adjustment for it.
 - Health insurance premium reported by life and property and casualty insurance companies under the *State Pages* sections of their financial statements may contain non-health risk insurance premium revenue as defined in the ACA.

APPENDICES

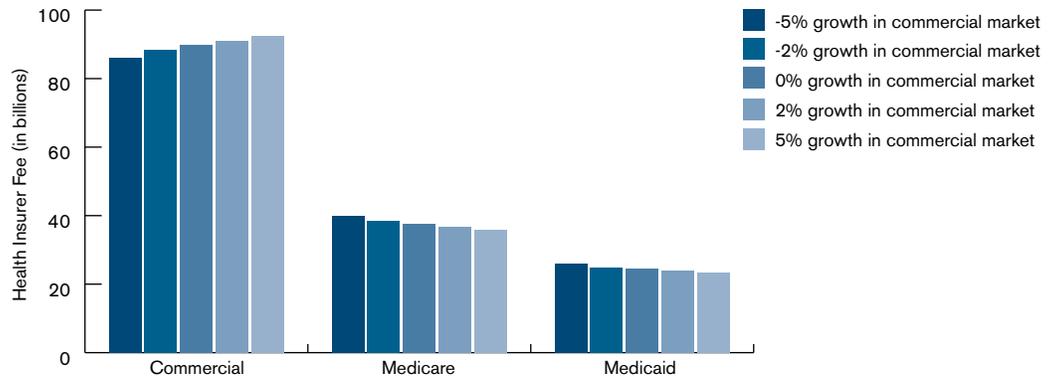
APPENDIX A1

COMMERCIAL MOVEMENT: STATUS QUO



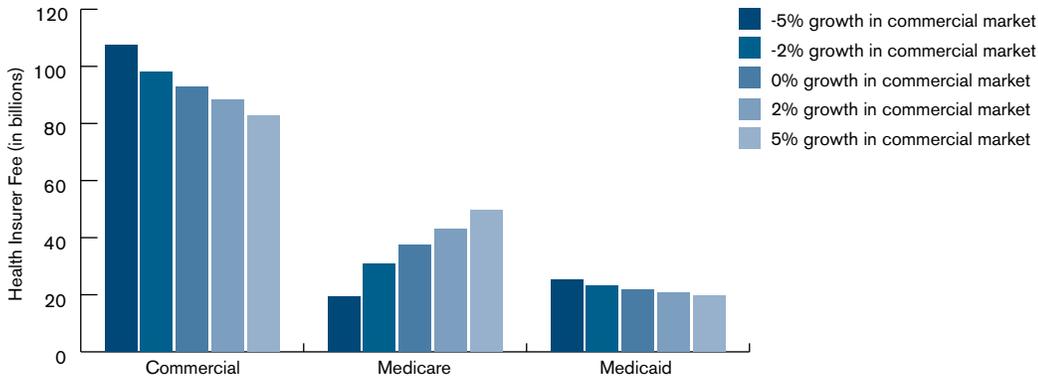
APPENDIX A2

COMMERCIAL MOVEMENT: FULL MEDICAID EXPANSION



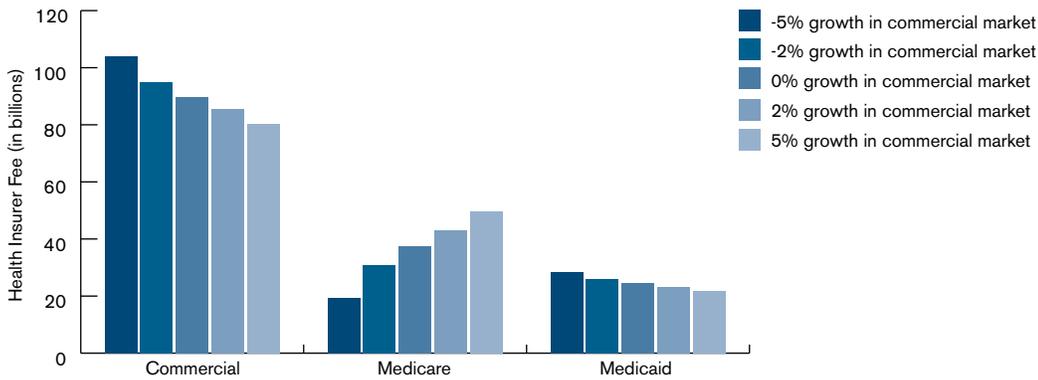
APPENDIX B1

MEDICARE MOVEMENT: STATUS QUO



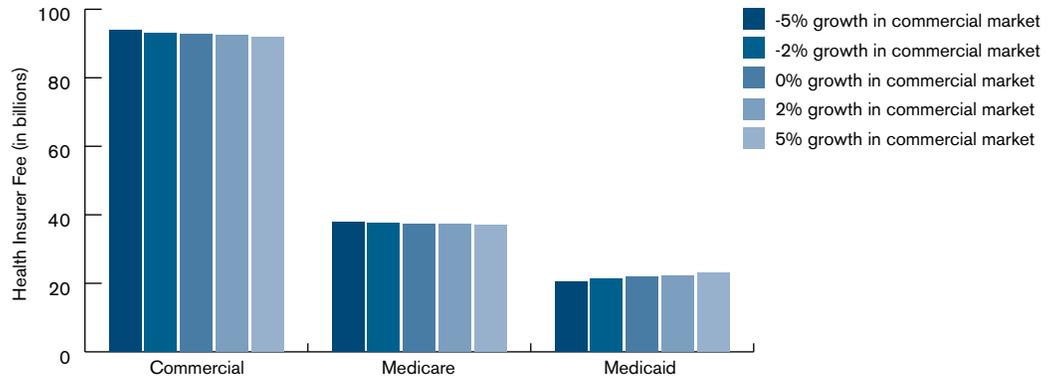
APPENDIX B2

MEDICARE MOVEMENT: FULL MEDICAID EXPANSION



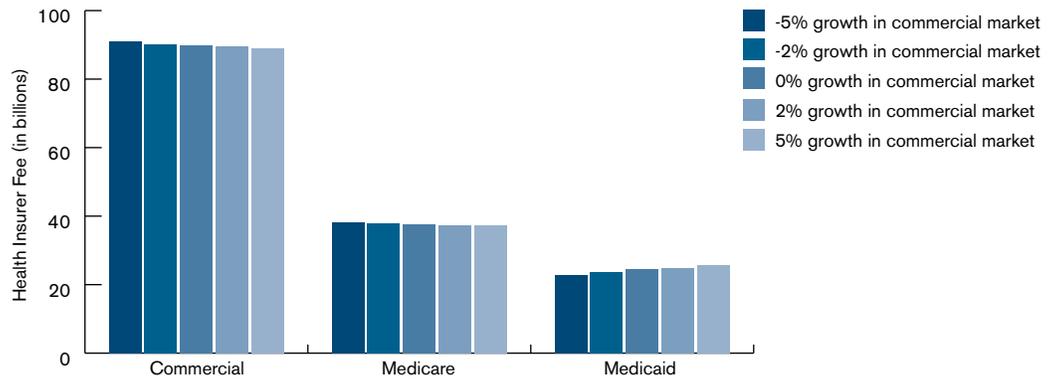
APPENDIX C1

MEDICAID MOVEMENT: STATUS QUO



APPENDIX C2

MEDICAID MOVEMENT: FULL MEDICAID EXPANSION





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