Exhibit B-3:

Patient Cost Sharing Under the Affordable Healthcare Act

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THE HENRY J. KAISER FAMILY FOUNDATION

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Patient Cost-Sharing Under the Affordable Care Act

There has been heated public debate over the requirement in the Affordable Care Act (ACA) that most people have health insurance or pay a penalty to the federal government. Yet, there has been relatively little attention focused on the type of coverage that people would have to buy and how much it would cost individuals to satisfy the so-called "individual mandate."

This data note provides estimates of the potential cost-sharing levels for plans that will be available in the non-group market (including in new health insurance exchanges) when the ACA is fully implemented in 2014. It builds on previous work from Kaiser[1] and reflects recent guidance from the federal government on benefits and cost-sharing for plans offered in those markets.

ACA Rules for Benefits and Cost-Sharing

The ACA changes the structure of the non-group market to provide participants with a defined set of "essential health benefits" with standardized tiers of cost-sharing. The law specifies 10 categories of benefits to be included in the essential health benefit package, and provides that the scope of the package be equal to the scope of benefits in a typical employer-sponsored plan.

In recent proposed guidance[2], the federal government indicated that it plans to give states the option to choose an essential benefits package from among one of the following options: one of the three largest products in the small group market in the state, one of the three largest health plans offered to federal or state employees, or the Health Maintenance Organization (HMO) with the largest commercial enrollment in the state. States will need to fill in certain benefits specified by the ACA that are often not included in benefit plans today, such as habilitation and pediatric dental services. The guidance suggests that benefits are not expected to vary significantly across the different options. Under the guidance, health plans would be permitted to adjust the scope of benefits as long as the average benefit amount remains the same, as measured for a standard population.

In separate proposed guidance[3], the federal government described an intended approach for how "actuarial value" will be determined for the purpose of establishing the different cost-sharing tiers. The actuarial value of a plan is the percentage of covered heath care costs expected to be paid by the plan for a broad population. Under the ACA, plans in the non-group and small group markets must have an actuarial value of 60 percent (bronze plans), 70 percent (silver plans), 80

[1] http://www.kff.org/healthreform/8177.cfm
[2] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
[3] http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf

percent (gold plans), or 90 percent, (platinum plans). For example, a bronze plan on average would pay for 60 percent of the costs for covered benefits and enrollees on average would pay the remaining 40 percent through cost-sharing such as deductibles, copayments and coinsurance.

The guidance states that actuarial values will be calculated using a publically-available actuarial value calculator based on claims data that will be weighted to reflect the expected population in the individual and small group markets. The calculator will reflect standard prices and use of services reflecting the population. Although essential benefits will vary somewhat from state to state, the guidance states that the variation is very small relative to the total amount of covered expenses and that the "variation is expected to have limited impact on the plan [actuarial value]." Insurers using straightforward designs will be able to calculate an actuarial value directly from the calculator; insurers with more complex cost-sharing or network designs may need to submit a separate actuarial analysis estimating the impact of their design on the plan's actuarial value.

All plans are required to cap patient out-of-pocket costs at a specified level. Lower-income enrollees are eligible for lower out-of-pocket limits and higher actuarial value coverage.

Estimates of Patient Cost-Sharing

Because actuarial value is stated as a percentage, it is hard for most people to understand what cost-sharing in health plans will look like when the new rules take effect. To provide a more tangible picture of what coverage people would be required to buy, the Kaiser Family Foundation commissioned Aon Hewitt, a prominent benefit consultant, to estimate dollar values for several illustrative cost-sharing structures for non-group bronze and silver level plans when the ACA is fully implemented in 2014. Bronze plans are the least comprehensive of the four tiers, and represent the minimum coverage people purchasing non-group coverage could buy to satisfy the individual mandate. Silver plans are likely to be the most common level of coverage because premium tax credits are based on silver plan premiums and only people enrolled in silver plans will be eligible for cost-sharing subsidies.

These estimates update previous work and better reflect the federal guidance on essential health benefits and actuarial value. A detailed description of the methodology is provided at the conclusion of the brief.

We present two illustrative cost-sharing designs that were applied to each tier: one with a deductible and 20 percent patient coinsurance up to an out-of-pocket limit of $6,350 for an individual, and a second with a smaller deductible and higher patient coinsurance of 40 percent up to the same out-of-pocket limit. The deductible and coinsurance were assumed to apply to all services except preventive services, which are available under the ACA without patient cost-sharing. This means that for most services covered by the plan under these designs, the patient would pay all of the

cost until the deductible is reached, and either 20 percent or 40 percent (depending on the option) of any additional costs until total patient cost-sharing reaches the out-of-pocket limit. Under the ACA, out-of-pocket limits for health plans are subject to the limit that currently applies to health savings account-qualified health plans, which is $6,050 for single coverage in 2012, and we estimate it to be $6,350 in 2014.

The results are shown in Table 1. All amounts are for coverage of a single individual under a preferred provider organization (PPO) plan. Deductibles and out-of-pocket limits would be double these amounts for families.

A bronze plan with 20 percent coinsurance – a typical level under coverage today – and an out-of-pocket cost-sharing limit of $6,350 would have a single deductible of $4,375. Increasing the patient coinsurance level to 40 percent would lower the deductible by $900 to $3,475. Under both scenarios the deductibles are significant and would be considered catastrophic plans, particularly for people without significant personal savings. These plans would also meet the requirements for tax-preferred Health Savings Accounts.

The deductibles are more modest for silver plans with the same coinsurance and out-of-pocket limits. A silver plan with 20 percent coinsurance and an out-of-pocket cost-sharing limit of $6,350 would have a deductible of $2,050. Increasing the patient coinsurance level to 40 percent would lower the deductible to $650.

Table 1: Illustrative Plan Designs for Single Coverage

Tier	Actuarial Value	Deductible	Patient Coinsurance	Out-of-Pocket Limit
Bronze 1	60%	$4,375	20%	$6,350
Bronze 2	60%	$3,475	40%	$6,350
Silver 1	70%	$2,050	20%	$6,350
Silver 2	70%	$650	40%	$6,350

Discussion

The ACA seeks to standardize coverage options available in the non-group and small group markets, making it easier for consumers to compare plans and focusing competition on premium levels.

Coverage with cost-sharing levels comparable to current employer-based plans will be available through gold (actuarial value of 80 percent) and platinum (actuarial value of 90 percent) plans. The estimated actuarial value of typical employer-sponsored coverage is over 80 percent[4], with coverage offered by small employers generally less comprehensive.

[4] http://www.kff.org/medicare/7768.cfm

However, the minimum coverage people will be required to buy starting in 2014 will have much higher cost-sharing than typical employer-based coverage and than the average purchased now in the non-group market. With standard 20 percent coinsurance, a bronze plan would have an estimated deductible of $4,375 for a single individual and double that for a family. This compares with an average single deductible of $2,498 in 2010 in the non-group market[5] and an average of $675 in employer-sponsored PPO plans with deductibles in 2011. Deductibles in employer plans paired with tax-preferred savings accounts averaged $1,908 in 2011.[6]

With much of the controversy over the ACA focusing on the individual mandate, it is noteworthy that the minimum coverage requirement is for insurance that is significantly less generous (and with a lower premium) than what most people have today. It is a level of coverage that most would consider catastrophic, providing protection in the event of an expensive illness while subjecting routine expenses (except for preventive care) to a relatively high deductible. While much of the opposition to the individual mandate is likely due to views about the appropriate role of government, a better understanding of how it works and what it requires could moderate some of the resistance to it.

People will have the option of buying more generous coverage than the minimum required, and lower-income enrollees will be eligible for cost-sharing subsidies that decrease their out-of-pocket costs. But, some may still find themselves with insurance that requires substantial cost-sharing. Policymakers will face the challenge over time of finding the right balance between the minimum level of insurance people should be required to have and providing an appropriate level of protection.

[5] http://www.kff.org/kaiserpolls/8077.cfm
[6] http://ehbs.kff.org/

Methodology

This data note was written by Gary Claxton and Larry Levitt of the Kaiser Family Foundation. Actuarial estimates were prepared by Ian Stark, FSA, MAAA of Aon Hewitt.

All estimates are based on the average 2011 premium for a PPO-type plan under employer-sponsored coverage, using an average population of people under age 65 covered by an employer plan. The gross claims distribution of health expenditures was developed based on a single adult premium of $5,584 (from the Kaiser/HRET Employer Health Benefits Survey), as well as assumptions that the typical employer-sponsored PPO plan has an actuarial value of 82 percent and that 10 percent of premiums are related to administration and profit. Additionally, premiums are expected to grow 7.5% annually from 2011 to 2014.

The most recent guidance from the federal government on the definition of actuarial value (AV) for qualified health plans in the individual and small group markets was taken into account as part of this analysis. In brief, the guidance has suggested providing an AV calculator with a limited number of inputs based on a single dataset of health expenditures with the ability to adjust the dataset based on demographic or (limited) geographic variation. While plans were developed to achieve an AV as close to 60% and 70% as possible, the bulletin recommends a +/- 2% corridor in certifying plans for each tier. Finally, it was proposed that employer-funded Health Reimbursement Arrangement (HRA) and Health Savings Account (HSA) contributions could be included as part of the actuarial value but only to the extent that the funds would be expected to be utilized for claims payment during the plan year.

Given the single national dataset proposed for the AV calculator, we did not make any adjustments for non-standard state-mandated essential health benefits (EHB), such as in-vitro fertilization or autism therapy, as the potential cost impact of those additional benefits are likely to be small and within the 2 percent corridor. The bulletin states that "although the benchmark for EHB will vary by state, that variation is expected to have limited impact on plan AV."

The age distribution of the non-group and small group population – including the currently uninsured who would not be eligible for Medicaid – is similar to those who now have employer-sponsored insurance. Basing plan designs on that population would not vary the results significantly, particularly given the 2% corridor proposed in the bulletin.

The estimates do not account for cost-sharing subsidies available for people in silver plans with incomes up to 250 percent of the poverty level, which increase the actuarial value of the coverage.

All results are in 2014 dollars and are national estimates. States estimates may be different if states create an actuarial calculator based on state costs or if the national actuarial value calculator can be adjusted to account for state-specific costs.

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