1. What is adjusted community rating?

Effective Jan. 1, 2014, the ACA changed the way that insurers set rates for coverage in the individual and small group markets. In standards established by the ACA, known as adjusted community rating, insurers are prohibited from considering anything but the following when developing health insurance rates for 2014 and beyond:

- Self-only vs. family coverage
- Age (subject to restrictions)
- Geographic rating area (subject to restrictions)
- Tobacco use (subject to restrictions)

Prior to the ACA, in the majority of states, health insurers offering coverage in the small group market could consider other factors such as health status, industry and gender when developing health insurance rates. In addition, fewer restrictions applied with respect to age, geography and tobacco.

1 In most states, a small employer is defined as one who employs fewer than 51 employees. Effective 2016, the following states define small groups as those with 100 or fewer employees: California, Colorado, New York and Vermont.

2. How do these rating changes affect small groups?

If a group is located in a state that used to allow health status as a rating factor, and its health plan participants were healthier and younger than the average, the group may have seen rate increases in 2014.

A group with health plan participants who are less healthy and older than the average may have seen a rate decrease.

With Starmark’s prior block of fully insured business, these rating changes were expected to drive increases likely ranging from 10 percent to 100 percent for the majority of groups with five or more covered employees.*

*Based on comparison of premiums of 2012 Starmark in-force groups and the estimated rates for similar products and census under an expected 2014 rate manual.
3. How do changes in age band requirements affect the cost of health coverage?

Older individuals generally use costly health services more frequently. Prior to the ACA standards on adjusted community rating becoming effective, their costs for health coverage in the small group market have been higher. In 2013, a total of 42 states had age rating bands that were 5:1 or more. That means the oldest member of a group health plan cannot be charged more than five times the premium dollars charged to the youngest member.

Since Jan. 1, 2014, however, the ACA limits states’ age rating band to 3:1. As a result, older members will pay less while younger members will pay more for health coverage.

The chart to the right demonstrates how participants in groups that are age rated could be affected by the limit on the age rating band.

<table>
<thead>
<tr>
<th>2013</th>
<th>Currently</th>
</tr>
</thead>
<tbody>
<tr>
<td>This 24-year-old employee pays an annual premium of $1,200 for his health plan.</td>
<td>This 60-year-old, who works at the same company, pays an annual premium of $6,000 for health coverage.</td>
</tr>
<tr>
<td>When PPACA standards on community rating took effect</td>
<td>At 12:01 a.m. on Jan. 1, 2014, this 24-year-old employee’s annual premium increased 50 percent to $1,800.</td>
</tr>
<tr>
<td>Meanwhile, this 60-year-old paid $5,400 in annual premium dollars, or 10 percent less.</td>
<td>If the younger employee’s premium becomes unaffordable, he may choose not to participate in his group health plan.</td>
</tr>
<tr>
<td>If young, healthy people drop their group health insurance coverage, premiums for health plans offered by private insurers will rise for everyone.</td>
<td></td>
</tr>
</tbody>
</table>

Source: America’s Health Insurance Plans (AHIP)

4. How do changes in underwriting requirements affect the cost of health coverage?

Less healthy groups are perceived as using costly healthcare services more frequently because of greater health risks. As a result, prior to the ACA standards on adjusted community rating becoming effective, insurance rates have been higher for less healthy groups.

A model law from the National Association of Insurance Commissioners, previously adopted by many states, had allowed for a variance of +/- 25 percent in premium rates to accommodate differences in health status among groups. That means, in a state with this type of variance, a less healthy group in 2013 would pay up to 67 percent more than the premium dollars being paid by a very healthy group, or one perceived as using fewer healthcare services.

The ACA eliminated this variance beginning Jan. 1, 2014. As a result, many very healthy groups may pay more, while unhealthy groups may pay less.

The chart to the right demonstrates how groups could be affected by the elimination of variances allowed for health status.

<table>
<thead>
<tr>
<th>2013 (with a variance of +/-25%)</th>
<th>Currently</th>
</tr>
</thead>
<tbody>
<tr>
<td>This very healthy group’s annual premium is $120,000.</td>
<td>This very healthy group’s annual premium is $120,000.</td>
</tr>
<tr>
<td>Across town, a less healthy group’s annual premium is $200,000.</td>
<td>Across town, a less healthy group’s annual premium is $200,000.</td>
</tr>
<tr>
<td>When the ACA eliminated the variance allowed for health status</td>
<td>At 12:01 a.m. on Jan. 1, 2014, the very healthy group’s annual premium increased 25 percent to $150,000.</td>
</tr>
<tr>
<td>Meanwhile, the less healthy group’s annual premium decreased 25 percent to $150,000.</td>
<td>Meanwhile, the less healthy group’s annual premium decreased 25 percent to $150,000.</td>
</tr>
<tr>
<td>If a very healthy group’s premium becomes unaffordable, the employer may choose not to offer a health plan.</td>
<td>If a very healthy group’s premium becomes unaffordable, the employer may choose not to offer a health plan.</td>
</tr>
<tr>
<td>If very healthy groups do not participate in the small group market, premiums will rise for everyone.</td>
<td>If very healthy groups do not participate in the small group market, premiums will rise for everyone.</td>
</tr>
</tbody>
</table>

PLEASE NOTE: This presentation is designed to provide a high-level overview of aspects of the Affordable Care Act (ACA), as modified by the Health Care and Education Reconciliation Act. It is not comprehensive and does not constitute legal or tax advice for healthcare reform implementation. Please consult a professional benefit adviser or legal counsel regarding how the law may impact your specific benefit plan.
5. Key considerations for savvy employers

Savvy employers who are watching their bottom line should work with their broker or benefits adviser, and may consult their legal counsel, to determine:

- How will their insurance rates be affected by the ACA’s adjusted community rating requirements?
- Is self-funding a good alternative for their employer-sponsored health plan?

Let's take a look at the second question first.

6. Self-funding: Is it right for your organization?

It’s a fact that self-funded plans are not subject to the ACA rating and underwriting requirements that were imposed Jan. 1, 2014, on fully insured health plans in the small group market.

As a result, self-funded employers may have more cost control than employers that offer fully insured health plans, depending on the overall health status and ages of employees in their group, when compared to fully insured rates after Jan. 1, 2014.

7. Self-funding offers many other advantages.

Self-funded plans:

- Offer employers greater flexibility in health plan designs than fully insured group health plans;
- Offer greater control over how premium dollars are spent;
- Have more consideration placed on the history of their own participants, rather than on a pool of employees, as premium rates are set;
- May avoid “premium shock” in 2014 and beyond;
- Face no premium taxes (although stop loss coverage does); and
- Retain the ability to use gender for rating.

Plus, when an employer with a self-funded plan has good claims experience, the employer benefits. When an employer with a fully insured health plan has good claims experience, the insurance company benefits.