The Operation of Pennsylvania's Health Insurance Exchange and the Impact of Federal Regulations

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1/30/2015

I. Introduction

The goal of this paper is to conduct a limited evaluation of the first year (2014) operation of the Affordable Care Act in Pennsylvania, in particular, the performance of the health insurance marketplace known as the Exchange. While we will make recommendations for improving the operation of the Pennsylvania Exchange, Citizen Power continues to believe that implementation of a single payer health care financing system is the only remedy that will solve a myriad of problems with the current US health insurance system.

Under the Affordable Care Act as well as the related Health Care and Education Reconciliation Act (collectively referred to as the "ACA"), each state is required to open a health insurance marketplace, established in accordance with federal regulations, in order to facilitate the ability of consumers to purchase health insurance. The operation of a state's Exchange has a significant impact on both the cost and quality of healthcare available to consumers. As explained in more detail below, the Exchange can be state or federally managed, or a combination of the two. Pennsylvania's Exchange is Federally-facilitated, and therefore the functioning of the Exchange is dependent upon federal interpretations of the ACA's regulations. Additionally, as a Federally-facilitated Exchange, Pennsylvania has less latitude than other states regarding the development of the Exchange moving into the future.

The functioning of the Exchange, as evidenced by the plans available in Western Pennsylvania during 2014, provides evidence that a laissez fare application of the ACA's regulations may result in a less than optimal result from a consumer standpoint. However, there is a marked increase in the number of provider plan offerings for 2015. Despite the evidence that competition on the Exchange in 2015 could result in quality health insurance at relatively lower premiums, Citizen Power believes that, at the very least, Pennsylvania should move toward a more active regulation of the Exchanges as allowed under the ACA, because it is unclear whether the current competitive environment will continue to benefit consumers in the future.

II. Background

In March of 2010, the ACA was signed into law. The main goals of the ACA were to improve the quality and affordability of health insurance, reduce the number of the uninsured, and lower the overall cost of healthcare. The ACA was an extremely complex law which marked a significant change in the regulation of the healthcare and health insurance industries. The 906 page document included numerous provisions[1] including:

- Guaranteed issue which requires that policies do not deny coverage for persons with pre-existing conditions.
- Community rating which does not allow plans to base the premium amount upon anything other than age, location, and smoking status of the applicant and limits the degree to which premiums can vary from each other.
- An expanded list of essential health benefits that are required to be covered by all policies.
- An individual mandate requiring most citizens to have health insurance or face a tax penalty.
- The elimination of lifetime and annual policy benefit limits.
- Allowing dependent children to stay on their parent's insurance until they are 26.
- Rescissions for unintentional mistakes in applications have been banned.
- Allowing plan participants to designate a primary care physician as their provider.
- Expanding Medicaid to individuals and families up to 138% of the poverty level. [2]
- An employer mandate requiring larger employers (in 2015 those with 100 or more employees and in 2016 those with 50 or more employees) to provide coverage to their employees or pay a tax penalty.
- Minimum medical loss ratios which require policies to pay a certain percentage of the premium revenue towards health expenditures (80% for small group and individual plans).
- The creation of health insurance Exchanges through which some individuals and families could qualify for subsidies on premiums and out-of-pocket expenses.
- The elimination of higher copayments or coinsurance for emergency services that are out of network.
- The reduction of the Medicare Part D coverage gap until it is eliminated by January 1, 2020.

The successful implementation of the ACA depends heavily on the establishment of Exchanges which allow consumers to compare and purchase qualified health plans (QHPs) on an apples-to-apples basis. There are three main models for setting up an Exchange: a State-based Exchange, a Federally-Facilitated Exchange, or a Partnership Exchange. In a State-based Exchange the state is responsible for all of the central functions of the Exchange, though there are options available for some assistance from the Federal Government. For example, a state can avail itself of federal assistance in determining the eligibility of applicants for federal financial assistance. If a state does not establish a State-based Exchange, the Exchange would then default to a Federally-Facilitated Exchange model where all the core

[1] Some of these provisions only apply to policies purchased after March 22, 2010.
[2] As a result of the Supreme Court decision in *National Federation of Independent Business v. Sebelius*, states are allowed to opt-out of the expansion of Medicaid. Pennsylvania is one of the states that did so, though they began "Healthy PA," a customized expansion program, on January 1, 2015.

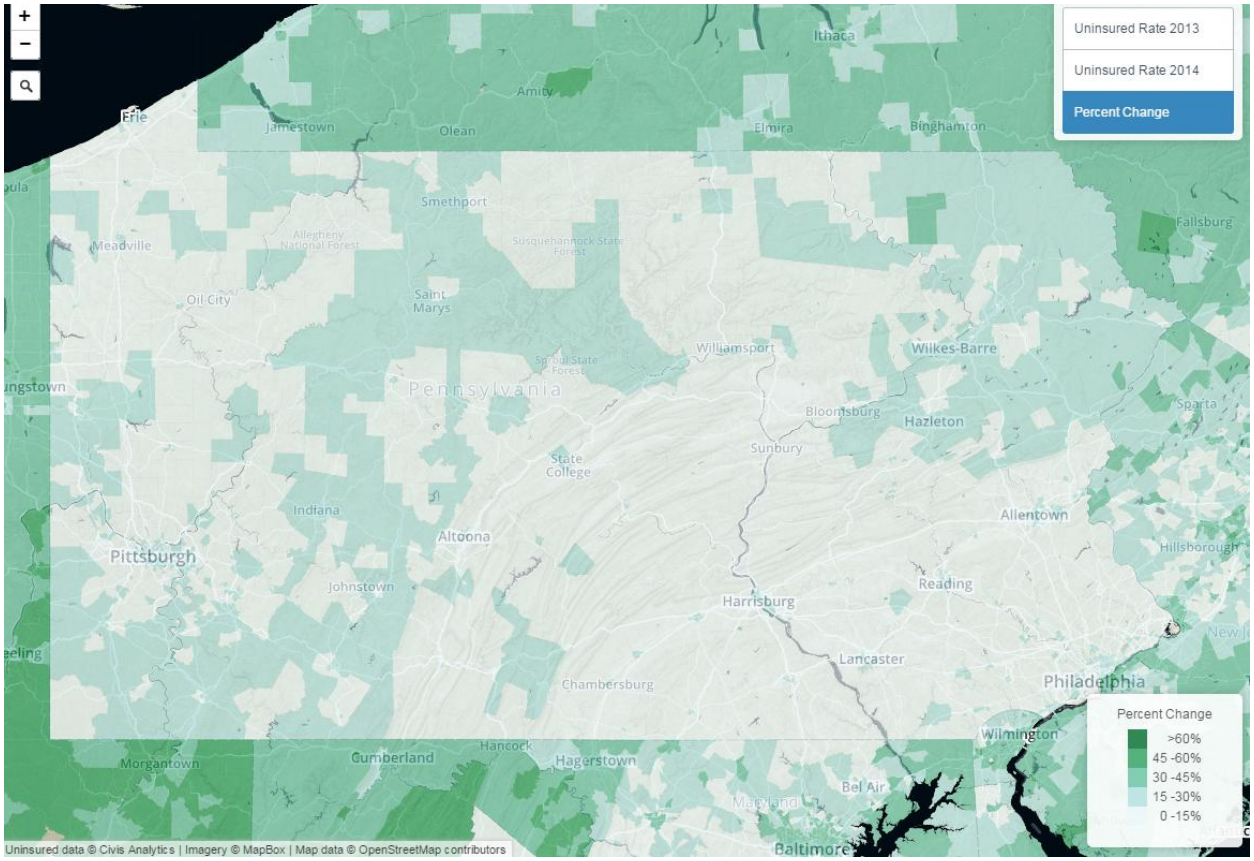
functions would be performed under the authority of the US Department of Health and Human Services (HHS). Under this model, the state has reduced involvement in the regulation of the Exchange, though in Pennsylvania, as in other states, HHS will depend upon the traditional rate review functions of the insurance department. The third model, a State Partnership Exchange, is technically a variant of the Federally-Facilitated Exchange model. Under a State Partnership Exchange, the state can elect to perform plan management functions such as certifying plans available in the Exchange or managing certain consumer assistance functions. Any functions not performed by the state default to the federal government.[3]

Early indications concerning the impact of the ACA have been mixed. It may be too early to determine the impact of the ACA on the quality and cost of health insurance for individuals, as well as the overall cost of healthcare as a percentage of the GNP. It is known that of the 7.3 million people enrolled in the Exchanges during the first enrollment period, 85% were eligible for federal subsidies to help pay premiums. The average premium reduction among this group was 76%.[4] However, these premium reductions do not tell the whole story. The cost to the Federal Government for Exchange subsidies and related spending is estimated to be more than a trillion dollars between 2014 and 2025.[5] In Pennsylvania, the average premium on the Exchange increased 10.5% from 2014 to 2015, one of the highest increases in the United States.[6]

One area where the ACA has been clearly successful is in reducing the number of uninsured. However, it has been notably less successful in achieving this goal in Pennsylvania, because of a number of factors including the refusal, until recently, to expand Medicaid. An analysis of the data collected by Civis Analytics and Enroll America indicates that the average uninsured rate for a county in the United States in 2013 was 18.8%. In 2014, that number had been reduced to 12.7%, a decrease of over 32%. However, in Pennsylvania, the comparable numbers were 14.9% uninsured in 2013 and

[3] A fourth type of exchange, known as a Bifurcated Exchange, has been approved for the state of Utah. This type of exchange allows the state to run the small-business exchange while the federal government runs the individual exchange.
[4] http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?_r=0#/
[5] https://www.cbo.gov/publication/45231; https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf
[6] http://www.pwc.com/us/en/health-industries/health-research-institute/aca-state-exchanges.jhtml

12.9% in 2014, a decrease of a bit over 13%. As seen in the map below, our neighboring states have seen a bigger reduction in the number of uninsured.[7]



As discovered by a Gallup study, the drop in uninsured can be tied to two main factors, whether the state expanded Medicaid and if the Exchange was a State-based or State Partnership Marketplace.[8] In 2014, Pennsylvania did not have an expanded Medicaid program and had a Federally-facilitated marketplace. The decision to not expand Medicaid resulted in an estimated 500,000 people who were not eligible for coverage.[9] Pennsylvania has decided to expand Medicaid in 2015 under the Healthy PA program. This program offers coverage from a select list of commercial insurance providers to low-income Pennsylvanians not eligible for Medicaid but who fall below 133% of the poverty level at a premium not to exceed 2% of their household income. Furthermore, these premiums can be reduced by the participation in "healthy behaviors", which will include a wellness exam. The main difference between Healthy PA and the Exchange is that the state has directly contracted with the providers to participate in Healthy PA. The new governor

[7] http://www.enrollamerica.org/state-maps-and-info/changes-in-uninsured-rates-by-county/
[8] http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx
[9] http://articles.philly.com/2014-09-04/news/53527717_1_healthy-pa-health-coverage-most-medicaid-recipients

Tom Wolfe has recently announced that he would be working to transition from Healthy PA to a full Medicaid expansion during 2015.

The second factor, whether a state's Exchange is a Federally-facilitated Marketplace, a State Partnership Marketplace, or a State-based Marketplace also has significant impacts upon the operation of the Exchange. Although HHS has indicated in its November 29, 2011 guidance that it intends to work with states that have Federally-facilitated Marketplaces in order to preserve the traditional responsibilities of the State insurance departments, states that have a greater role in managing the Marketplace have more flexibility in interpreting the regulations related to the operation of the Exchange. This may explain why states that have a role in managing their Exchange have greater reductions in the number of uninsured. However, the management of the Exchange does not come without costs. Some states that initially elected to have a State-based Marketplace have had problems managing the Exchange and are considering moving to either a State Partnership Marketplace or a Federally-facilitated Marketplace.

III. Operation of the Exchange

Each state's Exchange is divided into one or more geographic rating areas, which essentially operate as independent Exchanges; Pennsylvania has nine such geographic rating areas.[10] The plans in the Exchange are then categorized into four different classes (Platinum, Gold, Silver, and Bronze) which correspond to the percentage that the plan pays of the cost of providing "Essential Health Benefits". On average, a Platinum plan pays 90% of healthcare costs, Gold 80%, Silver 70%, and Bronze 60%. From a consumer perspective, the most important of these categories is Silver because the amount of premium subsidies an individual qualifies for is based upon the second-lowest priced Silver plan available in the Exchange. In addition, *an income qualified individual can only receive a cost sharing subsidy if they purchase a Silver plan*.

The composition of the plans available through the Exchange in Western Pennsylvania has changed dramatically from the 2014 coverage year. Consumer selection on the Exchange for the 2014 coverage year was dominated by the existence of one or two low-cost "Community Blue" plans offered by Highmark in the Silver category. These plans, which were eligible for government subsidies, made up 40% of the total statewide Exchange market, even though they did not

[10] The number of plans available within a geographic rating area may vary as plans do not necessarily cover the entire rating area.

include most of the University of Pittsburgh Medical Center (UPMC) network.[11] The 2015 coverage year is very different, with both UPMC and Highmark having competitively priced Silver plans in the Exchange, along with plans from UnitedHealthcare, Assurant, and Coventry. For example, in Allegheny County, there are 25 plans available at the Silver level, many of which have competitive premiums. The ten cheapest Silver plan premiums for a 45 year old non-smoker that does not qualify for subsidies range from $193 to $211. Of these ten policies, eight are offered by UPMC and two are offered by Highmark. In general, the price for the lowest cost silver plans in Western Pennsylvania increased by a little over 10% from the 2014 plan year for individual plans.[12]

The fact that there is more competition in the Exchange this year compared to last year does not guarantee that there will be vigorous competition in future years. The inclusion of plans in the Exchange by UPMC and Highmark and their associated premiums is not simply based upon the costs of providing insurance. Since both UPMC and Highmark are vertically integrated healthcare and insurance non-profits, the decision to offer a plan into the Exchange has to make financial sense from the perspective of the overall entity, including both the healthcare side as well as the insurer side of the equation. While the competition between UPMC and Highmark should initially keep premiums low, it is in the interest of a vertically integrated company to shift profits from the insurance operations to the healthcare side for two reasons: first, under the ACA, 80% of total premiums collected must be used toward health care claims and quality improvements (essentially a 20% cap on administrative costs). This is called the Medical Loss Ratio. Any profits earned on the issuance of a plan increase the likelihood that the plan does not meet the 80% benchmark. If an insurer does not meet the 80% target, the insurer must issue rebates to their customers. Second, the federal government has created a "risk corridor" program which partially reimburses insurers on plans that lose 3% or more than expected by collecting money from plans that gain 3% or more than expected. This provides an incentive to under price premiums in the Exchange which increases market share of a plan and increases the utilization of the associated healthcare facilities. Not only are any losses partially compensated by the risk corridor program, but the increased use of the healthcare facilities

[11] http://insurancenewsnet.com/oarticle/2014/11/11/upmc-health-plan-slashes-insurance-marketplace-premiums-a-572430.html#.VIIQKNLF92A

[12] http://triblive.com/business/headlines/7010194-74/highmark-health-percent#axzz3MkEEqkJp. The rate hikes for Highmark plans were between an average of 13.4% and 15%. The actual increase was lower than this because the new UPMC plans are slightly less expensive than the Highmark plans.

spreads any fixed costs over a greater number of patients, increasing the overall profitability. Similarly, it is also in the interest of these insurers to narrow healthcare networks to promote the use of affiliated healthcare facilities.

As an example, imagine two different vertically integrated insurance and healthcare provider organizations, Organization A and Organization B. Organization A processes claims mostly through work performed on the insurer's side of the operation while Organization B requires that the bulk of the administrative claims work be performed by the healthcare provider. For both organizations, the amount of work is similar. However, the administrative costs for Organization A count toward the 20% cap on administrative expenses while the administrative costs for Organization B would not.

It is unclear what impact the UPMC/Highmark duopoly will have upon the operation of the healthcare markets.[13] "Vertical acquisitions and affiliations between health insurers and hospitals with market power can potentially reduce competition."[14] In the shorter term, the structure of the Exchange may, in any particular year, encourage insurers to withhold competitive products to increase revenue, or price products below cost to gain market share. In the longer term, competition may be reduced through the reduction of market share and financial viability of either UPMC or Highmark, leaving the region with one dominant vertical monopoly, or, in the alternative, UPMC and Highmark may end up in a mutually beneficial arrangement where they both charge above market prices and split the market between themselves.[15]

Active management of the Exchange can combat situations where the lack of traditional competition may fail to promote consumer interests. Whether an Exchange is operated by the Federal government, the state, or a combination of the two, there are certain required functions under the ACA that fall broadly into the following five categories: (1) determining individuals' eligibility for federal subsidies through the Exchange or public coverage such as Medicaid, (2) assisting consumers with choosing between plans for which they are eligible, (3) performing plan management including

[13] Although there are several insurers participating in the Western Pennsylvania market, only UPMC and Highmark are vertically integrated. Both UPMC and Highmark have disproportionate control over the operation of the health insurance market through their relatively stronger position in setting of reimbursement rates.

[14] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3474455/

[15] There does not have to be explicit collusion between two competitors to result in price increases for consumers. Specifically, UPMC and Highmark may reach a "Nash Equilibrium" in the pricing of their insurance policies. Under this theory, a company does not have an incentive to lower prices in order to gain market share if they know their competitors will respond by lowering prices, which results in no change in market share and a lower margin for both companies.

determining which plans will be offered in the Exchange, (4) conducting financial management of the Exchange, and finally, (5) providing customers with coverage through the Exchange or public coverage. Although some aspects regarding the operation of an Exchange are mandatory under the ACA, such as the use of a website to allow customers to compare qualified health plans, others involve a degree of flexibility. Many of these flexible functions fall under the category of plan management which includes: the qualification of QHPs, the review of rates and benefits, monitoring plans for ongoing compliance with current regulations, and recertifying and decertifying plans as necessary. The prudent use of this authority can have significant impacts upon the functioning of the Exchange. As an example, Massachusetts' state Exchange has had much more success expanding affordable coverage using an active purchaser model which selectively allows plans to participate in their Exchange as compared to Utah, which uses an open marketplace Exchange.[16] Under the active purchaser model, Massachusetts limited the plans available on their pre-ACA state Exchange (known as the "Connector") by establishing criteria regarding cost and quality that plans had to meet in order to participate. In addition, Massachusetts allowed the Connector to directly negotiate with insurers regarding the subsidized portion of the market. On the other hand, Utah did not limit the plans participating in its Utah Health Exchange. The active purchasing model was more successful as Massachusetts saw higher participation rates and lower premium growth than Utah.

An example of how an interpretation of the ACA can impact an Exchange can be found in the different interpretations of ACA §1311(e)(1)(B), which requires an Exchange to determine if qualifying a health plan is in the interest of qualified individuals and qualified employers. The Center for Medicare Services (CMS) has indicated that a state operated Exchange has great discretion in how to interpret this "best interest" standard. However, in the Federally-facilitated Exchanges, CMS typically allows any eligible plan to participate in an Exchange as long as it meets the "meaningfully different" standard. During the 2014 coverage year, in many of the geographic service areas of the Exchange in Western Pennsylvania, there were two very similar plans being offered at a low price in the Silver category by the same insurer (i.e., Highmark). However, the plans were different enough to both be certified under the "identifiably different" standard used by CMS. As described later in this report, a more narrow interpretation of "best

[16] Solomon, Sam. *Health Exchange Federalism: Striking the Balance between State Flexibility and Consumer Protection in ACA Implementation*. Cardozo Law Review, Vol. 34, 2086-2089.

interest" could have significantly increased the amount of subsidies that many consumers in Western Pennsylvania would have qualified for.

In fact, the ACA allows optional functions that an Exchange may, at its discretion, choose to pursue. Many of these functions can be used to promote consumer interests. For example, the Exchange may negotiate with insurers regarding policy terms and premiums, require that insurers provide supplemental information to consumers, or limit which plans participate in the Exchange based upon consumer feedback. Given the importance of a properly functioning Exchange within a state, it would be a benefit to Pennsylvanians if the state would, at the very least, implement a State Partnership Exchange which would allow Pennsylvania to designate the Pennsylvania Insurance Department (PID) as the organization that certifies QHPs.

IV. Regulations related to the operation of the Exchange

The Pittsburgh Foundation, in its response to our proposal, identified three aspects related to the operation of the Exchange that should be examined in greater detail: the §1311(e)(1)(B) "public interest" standard, the related "meaningfully different" standard, and the identification of "outlier insurance plans".

a. Public Interest Standard

ACA's §1311(e)(1)(B) public interest standard requires that an Exchange may certify a health plan if "the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates." Although the determination of whether certifying a health plan is in the interests of consumers is mandatory under the ACA, the interpretation of exactly what is in the interests of consumers is open to interpretation. In Pennsylvania, this interpretation was conducted by CMS since Pennsylvania is a Federally-facilitated Marketplace. Unfortunately, CMS used the "any willing insurer" interpretation, which means that as long as a plan meets all the other certification requirements under the ACA, it will be included in the Exchange, even if it may not be in the best interest of consumers.

An example of how the CMS' "any willing insurer" interpretation can have negative consumer impacts occurred during the 2014 coverage year, when many of the Exchange's geographic rating areas in Western Pennsylvania had two

very similar Highmark Community Blue plans available in the Silver category. Since the amount of subsidy that an individual receives from the government under the ACA is based upon the second least expensive policy available in the Silver category, the existence of two inexpensive policies had a major impact on Pennsylvania's subsidies. It could be argued that the existence of the second Community Blue plan was not in the interest of consumers under 1311(e)(1)(B) because of the negative impact on subsidies as explained in the next several paragraphs; and it should not have been certified by the Exchange.

One of the central tenets of the ACA is that healthcare policies in the Exchange should be affordable. In order to make premiums affordable, the ACA provides subsidies to consumers shopping in an Exchange in the form of premium credits, which are tax credits that can be used either in advance to defray premium costs or credited at the end of the year on the consumer's tax return. The value of these credits is the difference between what health insurance premiums cost and what the consumer should be able to afford. For example, if an individual could afford $200 a month to pay for insurance premiums and health care premiums cost $300 a month in the Exchange, s/he would receive a tax credit of $100 a month which s/he could either use towards their monthly premium or apply at the end of the year towards their tax return.

The ACA has very specific rules to determine what consumers should be able to afford in premiums. For those that live in households between 100 and 400% of the Federal Poverty Level (FPL), the ACA sets what a consumer should be able to afford on a formula that slides between 2% and 9.5% of income. The greater the income (as a percentage of the FPL) the greater the percentage the consumer is expected to pay toward their monthly premium. Consumers below 100% of the FPL are not eligible for premium credits because it was anticipated that they would be eligible for Medicaid. However, the Supreme Court made expanded Medicaid optional for the states, which has created a situation where low-income consumers may not qualify for Medicaid and are also not eligible for premium credits. Consumers in households with income greater than 400% of the FPL are also not eligible for premium credits. As an example, under the ACA the following are considered affordable premiums:

Household Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium
1	$10,000	87%	N/a – below 100% threshold	N/a
1	$15,000	131%	2% of income	$25
1	$20,000	174%	5.1% of income	$85
1	$25,000	218%	6.9% of income	$144
1	$30,000	261%	8.4% of income	$210
1	$40,000	348%	9.5% of income	$317
1	$50,000	435%	N/a – over 400% threshold	N/a

The credit pays for the monthly cost of the insurance premium above the affordable monthly premium for a customer. However, they will not pay this difference for all insurance policies because some policies are more expensive than others. The ACA was not set up to make expensive insurance affordable, but was established to make ordinary insurance affordable. As mentioned earlier, in order to determine the quality of insurance in an Exchange, the ACA set up four different categories based upon the average amount of out-of-pocket costs that the consumer should expect to pay for any claims: Platinum, Gold, Silver, and Bronze. The expected out-of-pocket costs for Platinum policies is less than 10%, for Gold is less than 20%, for Silver is less than 30%, and for Bronze is less than 40%. For example, a consumer who has a Gold plan will on average pay less than $20 in co-pays, co-insurance, and deductibles for every $100 in claims. These out-of-pocket costs are capped for all policies at $6,350 for an individual and $12,700 for a family (lower for households under 200% of the FPL). In order to determine the premium credit, the benchmark used is the second cheapest monthly premium Silver plan available on the Exchange. For example, in Allegheny County, a sixty year old individual had the option to buy 13 different Silver plans on the Exchange for 2014, ranging in price from $347-$655 per month. The second least expensive of these plans set the benchmark and had a premium of $361 per month. Therefore, for the following income levels, a sixty year old individual would have received the following premium credit:

Household Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a
1	$15,000	131%	2% of income	$25	$336
1	$20,000	174%	5.1% of income	$85	$276
1	$25,000	218%	6.9% of income	$144	$217
1	$30,000	261%	8.4% of income	$210	$151
1	$40,000	348%	9.5% of income	$317	$44
1	$50,000	435%	N/a – over 400%	N/a	N/a

The cost of the monthly premium for each plan changes depending upon the age of the individual. If the person mentioned above was thirty years old, the premiums for Silver plans would range from $145-$274 per month. The second least expensive of these plans sets the benchmark and has a premium of $151. The thirty year old would receive the following premium credit:

Household Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a
1	$15,000	131%	2% of income	$25	$126
1	$20,000	174%	5.1% of income	$85	$66
1	$25,000	218%	6.9% of income	$144	$7
1	$30,000	261%	8.4% of income	$210	$0
1	$40,000	348%	9.5% of income	$317	$0
1	$50,000	435%	N/a – over 400%	N/a	N/a

Since the premium credit is based upon what the cost of insurance is for a consumer (based on the cost of the second cheapest Silver plan) minus what is affordable for a consumer (based on income), the available premium credit is highly dependent upon which policies are offered into the Silver Exchange, and most specifically the premium of the second cheapest Silver plan. For the 2014 coverage year in Allegheny County, Highmark offered two similar "Community Blue" plans (Health Savings Blue PPO 2750 and Shared Cost Blue PPO 2650) into the Exchange at the Silver level at a much lower price than any other policy. These plans had limited access to UPMC facilities. For a sixty year old individual, the Community Blue plans had premiums of $347 and $361, while the eleven other plans ranged in cost from $501-$655. If Highmark had offered only one of the Community Blue plans into the Silver exchange, the benchmark plan premium would have increased from $361 to $501, resulting in increased monthly premium credits:

HH Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit	Monthly Premium Credit Increase
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a	N/a
1	$15,000	131%	2% of income	$25	$476	$140
1	$20,000	174%	5.1% of income	$85	$416	$140
1	$25,000	218%	6.9% of income	$144	$357	$140
1	$30,000	261%	8.4% of income	$210	$291	$140
1	$40,000	348%	9.5% of income	$317	$184	$140
1	$50,000	435%	N/a – over 400% threshold	N/a	N/a	N/a

Similarly, for a thirty year old individual, if only one Community Blue plan had been offered into the Silver Exchange, the benchmark premium would have been $210 and there would be an increase in the monthly premium credits:

HH Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit	Monthly Premium Credit Increase
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a	N/a
1	$15,000	131%	2% of income	$25	$185	$59
1	$20,000	174%	5.1% of income	$85	$125	$59
1	$25,000	218%	6.9% of income	$144	$66	$59
1	$30,000	261%	8.4% of income	$210	$0	$0
1	$40,000	348%	9.5% of income	$317	$0	$0
1	$50,000	435%	N/a – over 400% threshold	N/a	N/a	N/a

The impact of two Community Blue offerings in the Silver Exchange reduced the benchmark premium impacts to consumers whether they chose Community Blue or another product. For instance, these were the costs for a sixty year old individual to purchase the cheapest Silver Community Blue offering versus the cheapest Silver offering that includes UPMC facilities:

HH Size	HH Income	Affordable Monthly Premium	With 2 Community Blue Plans - $361 Benchmark			With 1 Community Blue Plan – $501 Benchmark		
			Monthly Credit	Net Cost of $347 CB Plan	Net Cost of $501 Highmark Plan	Monthly Credit	Net Cost of $347 CB Plan	Net Cost of $501 Highmark Plan
1	$10,000	N/a	N/a	$347	$501	N/a	$347	$501
1	$15,000	$25	$336	$11	$165	$476	-$129	$25
1	$20,000	$85	$276	$71	$225	$416	-$69	$85
1	$25,000	$144	$217	$130	$284	$357	-$10	$144
1	$30,000	$210	$151	$196	$350	$291	$56	$210
1	$40,000	$317	$44	$303	$457	$184	$163	$317
1	$50,000	N/a	N/a	$347	$501	N/a	$347	$501

It should be noted that a negative net cost is not refunded to the consumer. However, the consumer can use a negative monthly balance to pay for supplemental insurance such as vision or dental.

Applying the same analysis as above to a thirty year old individual yields the following results:

HH Size	HH Income	Affordable Monthly Premium	With 2 Community Blue Plans - $151 Benchmark			With 1 Community Blue Plan – $210Benchmark		
			Monthly Credit	Net Cost of $145 CB Plan	Net Cost of $210 Highmark Plan	Monthly Credit	Net Cost of $145 CB Plan	Net Cost of $210 Highmark Plan
1	$10,000	N/a	N/a	$145	$210	N/a	$145	$210
1	$15,000	$25	$126	$19	$84	$185	-$40	$25
1	$20,000	$85	$66	$79	$144	$125	$20	$85
1	$25,000	$144	$7	$138	$203	$66	$79	$144
1	$30,000	$210	$0	$145	$210	$0	$145	$210
1	$40,000	$317	$0	$145	$210	$0	$145	$210
1	$50,000	N/a	N/a	$145	$210	N/a	$145	$210

An additional question is, if the Community Blue Plans were priced below cost wouldn't the savings from paying below market fees cancel out the benefit of having a higher benchmark? First, the issue of the benchmark should be separated from the issue of below cost premiums. If there was one Community Blue Plan offered in the Silver Exchange, the benchmark would not be impacted, even if the cheapest plan was below market cost, because the benchmark is based upon the cost of the second cheapest plan. Second, having a plan that has a limited network as the benchmark has the effect of making an inferior product the status quo. Both Highmark and UPMC are nonprofit organizations that the people of Western Pennsylvania have paid for both through direct support and through tax breaks. By segmenting

the market into products that have access to UPMC facilities and products that do not have access to UPMC, the benefits provided by the services of UPMC were not available to citizens who could not afford to pay the higher UPMC premiums. These services have been paid by all the citizens of Western Pennsylvania through tax breaks and should have been available to everyone. Third, assuming that the Community Blue Plans were underpriced, (Highmark did lose $2.9 million on its Pennsylvania Exchange plans in 2014), it is likely that any savings from some consumers paying less than the fair market value of the Community Blue Plan were more than offset by the overall regional reduction in premium credits. The only consumers that would have benefited from underpriced Community Blue Plans are those people who purchased a Community Blue Plan and had an income more than 400% of the FPL. Everyone else participating in the Exchange was faced with a reduction in premium credits because of below market pricing, making the other potential plans less affordable.

If Pennsylvania entered into a Partnership Exchange, the state would have the ability to maintain plan management responsibility, which includes the certification of QHPs. In our opinion, **the determination of whether the certification of a QHP is in the best interest of consumers needs to include an analysis of the impact of the inclusion of a plan upon the consumer's eligibility for federal subsidies**.

b. Meaningfully Different Standard

The "meaningfully different" standard allows two plan offerings to participate in the same Exchange as long as they are meaningfully different in one of the following ways: cost sharing; provider networks; covered benefits; plan type; Health Savings Account eligibility; or self-only, non-self-only, or child-only plan offerings.[17] The primary reasoning for the "meaningfully different" standard is to make the shopping experience easier by eliminating similar plans on the Exchanges. CMS has provided guidelines for the degree of difference that is required for two plans to co-exist on an Exchange. Any difference in network, plan type, or HSA eligibility will meet the standard. A difference of $50 or more in both individual and family in-network deductibles, or a $100 or more difference in both individual and family in-network annual limit on cost sharing also meets the standard.[18]

[17] 45 C.F.R. §156.298; 79 FR 13840, Mar. 11, 2014.
[18] March 14, 2014, Center for Consumer Information and Insurance Oversight, Centers for Medicare

Despite this standard, there are a number of similar plans in the 2015 Exchange. For example, there are 60 plans currently available in Allegheny County, 25 are in the Silver category. Of these 25 plans, 12 are offered by UPMC Health Options, 4 by Highmark Health Insurance Company (a for profit subsidiary of Highmark), 3 by Highmark, and 2 apiece by Assurant Health, Coventry, and UnitedHealthcare. The purpose of the meaningfully different standard is to prevent a single insurer from flooding the market with plans and therefore providing too many plans that are similar and thus making consumer choice difficult. A closer look at the offerings of UMPC in the Silver market can give a picture of the types of offerings that are allowed by a single provider in an Exchange. UMPC has four policies offered in the Silver market at very similar prices, all of which are Exclusive Provider Organization (EPO) policies, which is a cross between a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO). The four policies offered are an Advantage Silver plan with a $1,750 deductible, a $30 charge for primary care physician ("PCP") services, and a $6,600 out-of-pocket maximum; an Advantage Silver plan with a $3,250 deductible, a $10 charge for PCP services, and a $6,600 out-of-pocket maximum; an Advantage Silver plan with a $0 deductible, a $50 charge for PCP services, and a $6,600 out-of-pocket maximum; and an Advantage Silver Health Savings Account ("HSA") plan with a $2,000 deductible, a 20% coinsurance charge for PCP services once the deductible is used up, and a $3,500 out-of-pocket maximum. UPMC also offers 3 different networks that increase in size: a basic "partner network", an expanded "select network", and a regional "premium network". Each of the four policy types are offered with the three different networks, resulting in 12 available plans.

It does not appear that for the 2015 coverage year the plans being offered by UMPC in Allegheny's Silver market violate the intent of the regulations, though the question of whether the plans being offered in an Exchange are "meaningfully different" is open to interpretation. The four base policies include three that offer different trade-offs between the deductible and the out-of-pocket charges for services. The HSA policy offers a lower out-of-pocket maximum in exchange for greater costs for utilizing plan services. The 3 networks also represent significant differences in the number and location of the participating physicians. For example, if you look at the number of doctors within the network located within 5 miles of Pittsburgh's 15219 zip code, the partner network has 1881 doctors listed, the select

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& Medicaid Services 2015 Letter to Issuers in the Federally-facilitated Marketplaces, pgs. 30-31. Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

network has 2041 doctors listed, and the premium network also has 2041 doctors listed.[19] However, if you expand the search range to those doctors located within 10 miles of Pittsburgh's 15219 zip code, the partner network has 2576 doctors listed, the select network has 2928 doctors listed, and the premium network has 4696 doctors listed. If you expand the search range even further to those doctors located within 30 miles of Pittsburgh's 15219 zip code, the partner network has 3402 doctors listed, the select network has 4901 doctors listed, and the premium network has 8627 doctors listed. Additionally, each of the networks has 8 in-network hospitals within 5 miles of Pittsburgh's 15219 zip code; though within 30 miles the partner network has 13 hospitals, the select network has 18 hospitals, and the premium network has 22 hospitals.[20] Clearly, the partner network is more Pittsburgh focused while the select and premium networks have greater regional reach. The 12 different policies offered by UPMC seem to be "meaningfully different".

However, the fact that the policies offered in the Allegheny County Exchange are different from one another does not provide evidence that the implementation of CMS' "meaningfully different" standard is rational. Under the existing standard, literally thousands of different plans could be offered by the same insurer in an Exchange just by slightly changing the network, setting plan deductibles $50 apart for the different plans, and setting out-of-pocket maximums $100 apart for the different plans. Though it is unlikely that an insurer would go to this extreme, the current regulations do allow insurers to place very similar plans in the same Exchange which could be used to take up valuable shelf space and crowd out competitors. Since CMS has such lax regulations, it would be in Pennsylvania's interest to take control of the QHP certification process.

c. Outlier analysis

Under 45 C.F.R. §155.1020, an Exchange needs to consider all rate increases when certifying QHPs and must receive justification for the rate increase. Pennsylvania was deemed to have effective rate review authority under 45 C.F.R. 154.301 on March 21, 2012 after the passage of Act 134 of 2011, which expanded the PID's rate review authority

[19] The 15219 zip code was used because it was the most central zip code located in Pittsburgh.
[20] Interestingly, the select network had fewer urgent care centers listed as in-network than the partner network. It is unclear if this is a listing error.

to include for-profit insurers in the small group market.[21] Accordingly, the PID will continue to review the reasonableness of rate increases inside and outside the Exchange for any proposed rate hike of 10% or greater.

As a supplement to the review of rate increases, the CMS also conducts an outlier analysis of QHP rates to determine if there are rates that are unusually high or low. The reason for identifying these outlier premium rates is that rates that are unusually high could be a bad deal for consumers while rates that are unusually low are not sustainable over time since the insurer will be losing money. If a premium is identified as being an outlier, it is not automatically interpreted as being indicative of inaccurate pricing. There is a second step, though this step has changed for the 2015 rate year. In the CMS' 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges, the CMS stated that if a plan was determined to be an outlier then the CMS would contact the PID to determine if the rate is justified. If the PID determined that the rate is justified, the CMS would then certify it as a QHP as long as it meets all the other standards, such as having an adequate network.[22] However, the CMS did not actually follow this methodology. Once it determined that there was a plan that was an outlier, it asked the PID to determine if there was evidence that the premium was not justified. Since the PID makes determinations of the reasonableness of rates based upon the past claims of a plans' population, and there was no history or comparable group to examine the proposed rates, the PID could not determine that any of the proposed premiums for the Exchange were unreasonable.

However, in its 2015 Letter to Issuers in the Federally-facilitated Marketplaces, the CMS changed its language to state that the CMS would "consider the state's assessment of the plan's rates" in the determination of certifying the plan to be a QHP.[23] This one change not only removes the requirement that a state affirmatively state that an outlier plan's rate is justified in order for the CMS to certify it, but it allows the CMS to ignore the opinion of a state regarding an outlier plan, as long as it considers the state's opinion.

[21] The PID still does not have rate review authority for small group policies situated outside of the state. CMS retains the authority to review the rate hikes of these polices.

[22] April 5, 2013. Correspondence from the Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services re: Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges. p. 14.

[23] March 14, 201r. Correspondence from the Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services re: Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated Marketplaces. p. 15.

This interpretation of a two-step process makes the outlier analysis ineffective since there is still not enough information to determine the reasonableness of the proposed rates of outliers since the ACA has created a population of insureds that is fundamentally different than those in the past. A larger statistical analysis of rates throughout all of the Federally-facilitated Marketplaces might provide greater insight into the reasonableness of a particular outlier. However, since this is outside what the CMS will do in order to analyze rates, it would be in Pennsylvania's best interest to implement a State-partnership Marketplace in order to allow for greater control over the plans that are certified as QHPs.

IV. Conclusion

The Western Pennsylvania Exchange for the 2015 coverage year provides consumers with a wide choice of plans at comparatively reasonable costs. However, this fact does not assure that the Exchange will always operate efficiently or in the best interest of consumers. For example, the composition of the Exchange in 2014 resulted in sub-optimal federal subsidies because of the existence of two low-cost Silver plans. The artificial (as explained below) competitive environment created by the Exchange, combined with the perverse incentives constructed by the ACA, necessitates greater regulatory oversight than currently being provided. In general, the operation of the Exchange by HHS does not guarantee that the Exchange will act in the best interest of consumers. Although there are regulatory mechanisms in place to correct market failures, such as the outlier analysis, HHS weakly enforces these regulations in the hope that the marketplace will result in low-cost and high-quality options.

As a market, an Exchange can be characterized as having few providers and increasing inelasticity of demand due to the ramp up of penalties for individuals without qualified health insurance. In other words, as the penalties for not having insurance increase under the ACA, the demand for insurance in the Exchange should not only increase but should be less price sensitive as the alternative of not having insurance becomes less attractive. In addition, the entangled nature of the insurance companies and the regional health care providers alters the traditional profit signals that would be present within the Exchange. For example, an unprofitable insurer with reserves may not have the incentive to pressure their own health care service providers to offer lower prices. As a result of the uncertain nature of competition in the Exchange, it is in the best interest of consumers to tightly regulate the premiums and characteristics

of the policies offered through the marketplace. If Pennsylvania became a State Partnership Exchange or a State Based Marketplace, it would have the power to not only regulate the policies that participate in the Exchange, but to also directly negotiate with the providers to make sure the interests of consumers are adequately represented.

Although some of the issues regarding competition in the Exchange can be remedied through the greater regulatory opportunities that are available with a State Partnership Exchange or a State Based Marketplace, the ACA's framework is fundamentally based upon an unsustainable compromise between the goal of expanding affordable coverage and the objective of maintaining a competitive private health insurance system. Unfortunately, these two goals work at cross-purposes. Markets achieve internal efficiency through discriminating between potential customers. Those customers that tend to be healthy end up paying less while those that tend to be sick pay more or are not able to get coverage. However, this goes against the governmental goal of affordable coverage for an expanded number of people. In order to override the tendency of markets to exclude consumers, the ACA has increased the regulation of the markets to a degree where they are extremely complex and confusing to consumers. However, these regulations also impede the operation of the markets, which then require additional regulations in order to function properly. The end result is something that is both market and not market; an inefficient cobweb of regulations that tries to retain the market profit motive but ultimately replaces it with a profit motive based on exploiting the regulations. In the end it would be much less confusing to consumers and more efficient if healthcare was directly financed under a single payer system as is done in many countries around the world.