Session 90 L, Learning From the First Two Years of the ACA

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2016 SOA
Annual Meeting & Exhibit

Session 90, Learning From the First Two Years of the ACA

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America's Health Insurance Plans

The Future of the Exchange Marketplace

Learning from the First Two Years of the ACA

Society of Actuaries 2016 Annual Meeting and Exhibit

Las Vegas, Nevada

October 25, 2016

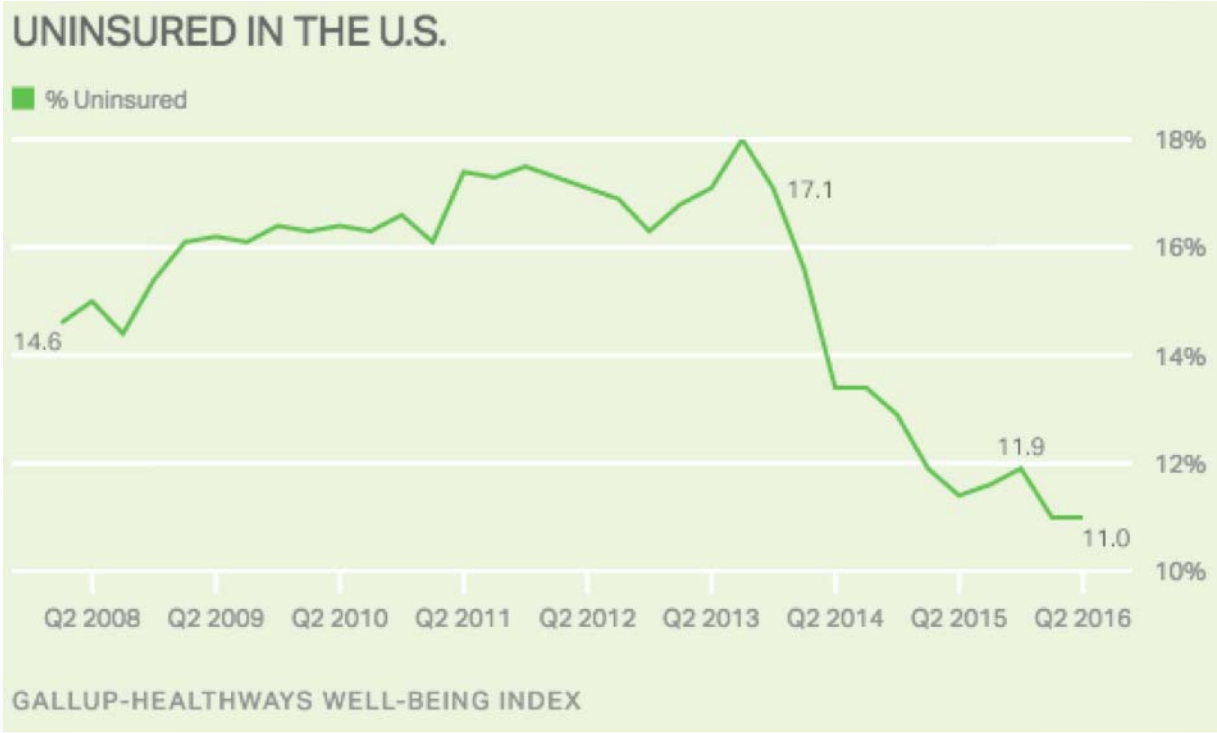
Gregory Gierer
Vice President, Policy & Regulatory Affairs

Agenda

- Expanding Access - Early Successes
- Ongoing Challenges
- Policy Options to Promote a Stable Market

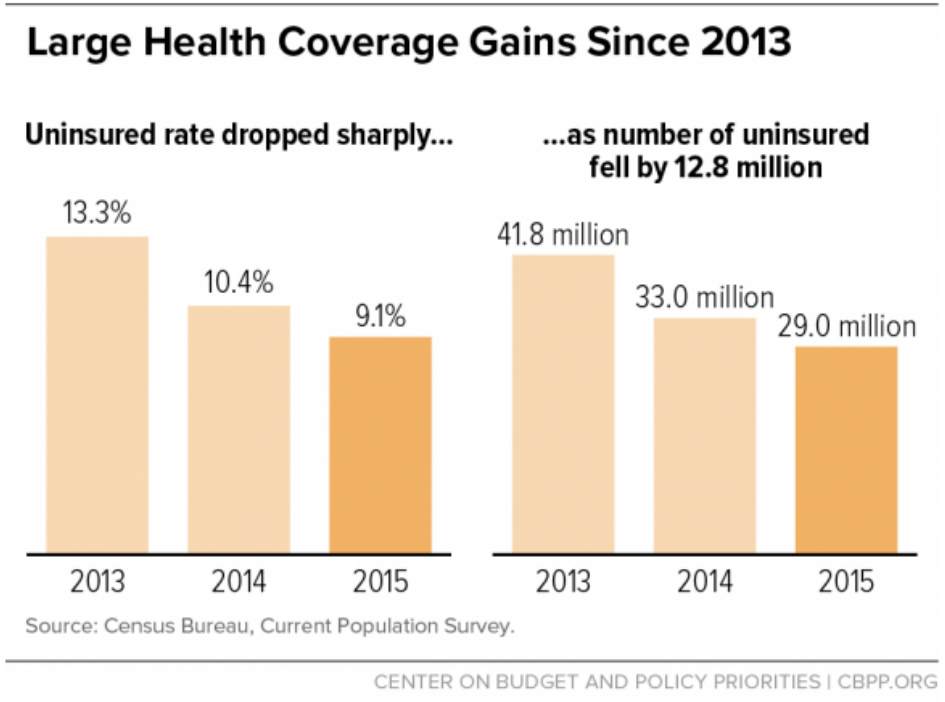
Expanding Access – Early Successes

Gallup Survey Finds Uninsured Rate Dropping to Historic Lows



Census Bureau Shows Large Coverage Gains Continued in 2015

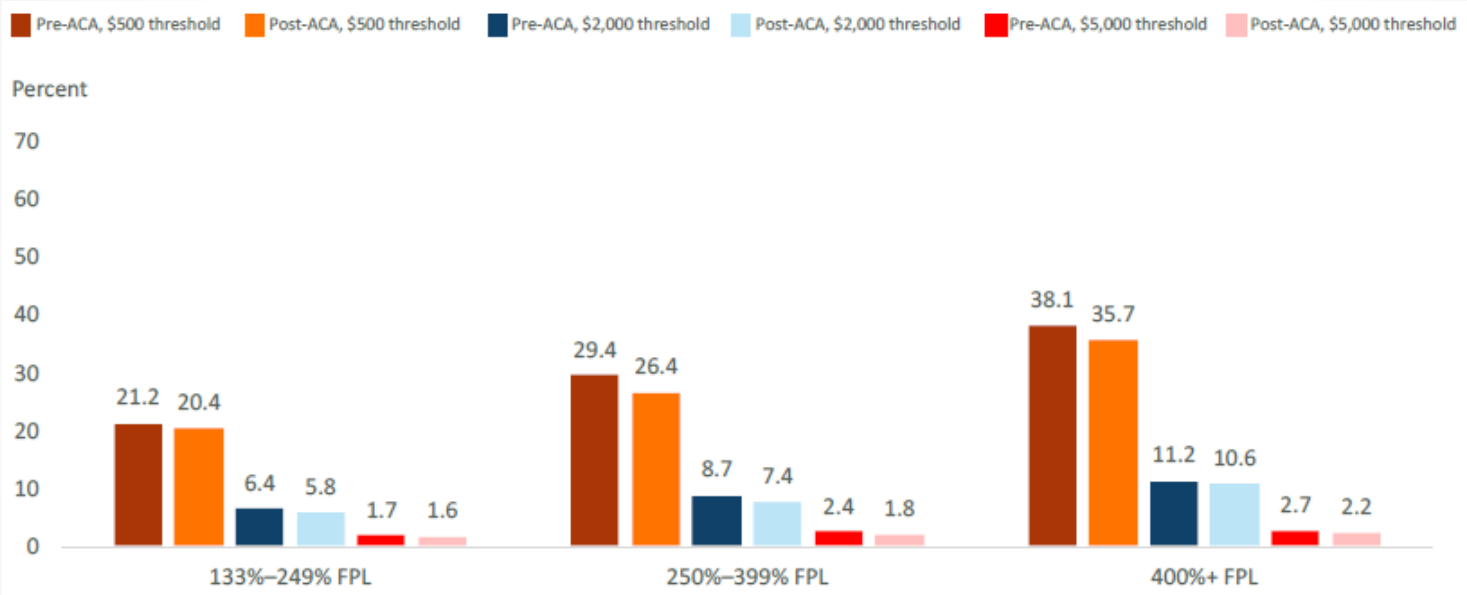
FIGURE 1



Non-Partisan Studies Find Coverage Gains as a Result of the ACA

Study	Coverage Gains as a Result of the ACA
HHS/ASPE	20 million
Urban Institute	15.5 million
Commonwealth Fund	13 million
RAND Corp.	16.9 million (through Feb. 2015)

Coverage Gains Reduce Out-Of-Pocket Spending



Notes: Average marketplace enrollment in June 2014 was 2.6 percent of the adult population. Regression models adjust for marketplace enrollment rate (the number of individuals enrolled divided by the total adult population), state Medicaid expansion status (year interacted with whether a state had expanded Medicaid), and year, and control for age, work status, gender, education level, marital status, and state dummies.
Data: Current Population Surveys, 2010–2014, and Charles Gaba, 2016.

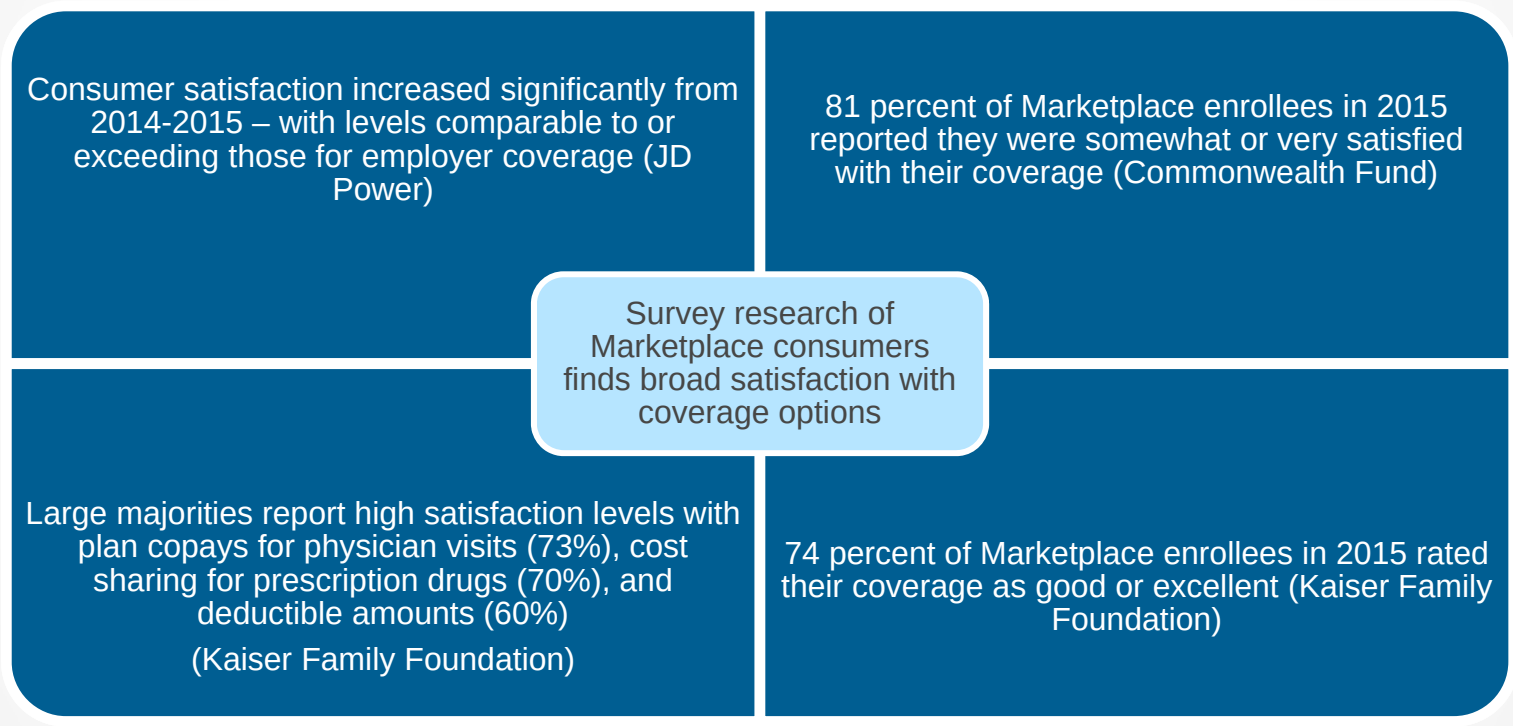
Source: "How the ACA's Health Insurance Expansion Have Affected Out-of-Pocket Cost-Sharing and Spending on Premiums," September 2016. The Commonwealth Fund. Exhibit 3 – Change in Probability That Out-of-Pocket Spending Equals or Exceeds Thresholds as Marketplace Enrollment Increases.

Consumer Satisfaction with Marketplace Coverage

Survey	QHP enrollees reporting satisfaction with their plan
Commonwealth Fund	2016 – 77% 2015 – 81% 2014 – 65%
Deloitte	2016 – 85% 2015 – 86%
RWJF/GMMB	2015 – 74%

Source: Adapted from Table 1: National Survey Data on Enrollee Satisfaction with Qualified Health Plans (QHP) Obtained through the Exchanges, 2014 through 2016. Health Insurance Exchange Enrollee Experiences. Government Accountability Office. September 12, 2016.

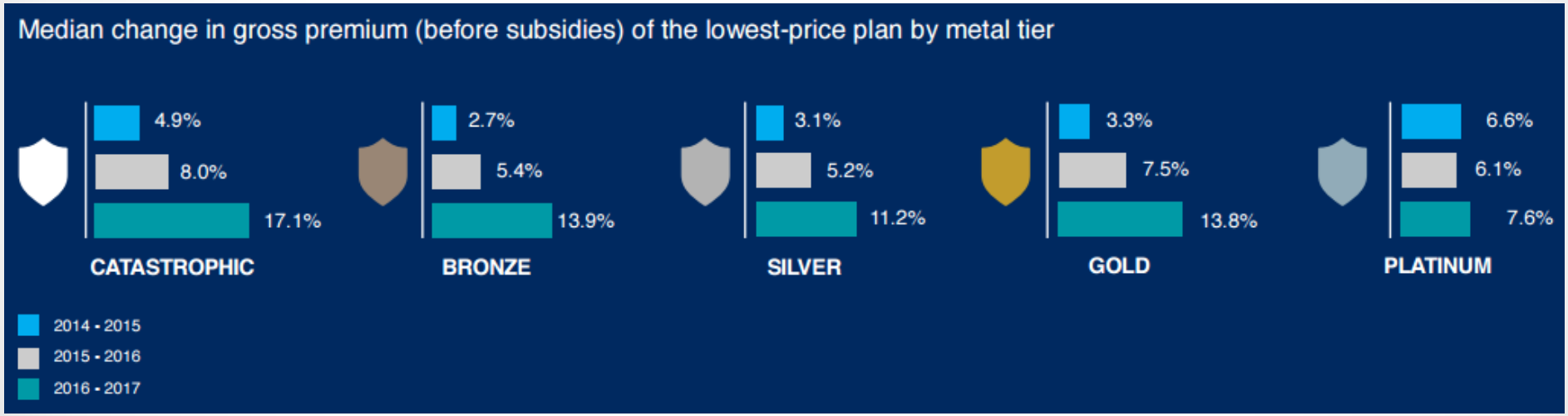
Satisfaction Levels Are High Across a Broad Range of Plan Features



Ongoing Challenges

Affordability

Requested premiums for most metal levels are trending higher than in past years:

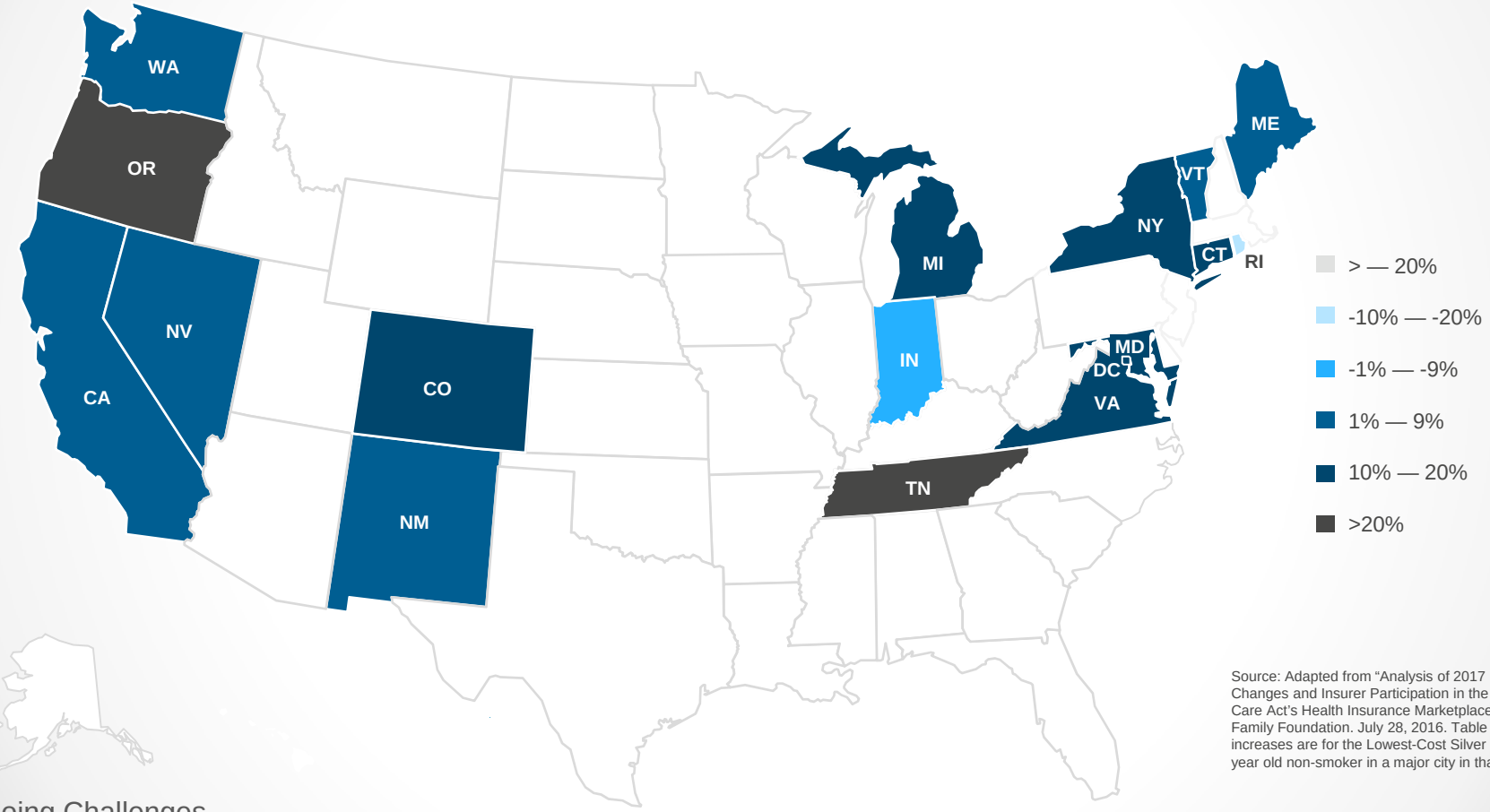


Source: "2017 exchange market: Emerging pricing trends," McKinsey Center for U.S. Health System Reform. September 2017.

Affordability

	Average Premium Increase for 2017
Avalere	8% (2nd Lowest Cost Silver)
KFF	9% (2nd Lowest Cost Silver)
McKinsey	11.2% (All Silver)

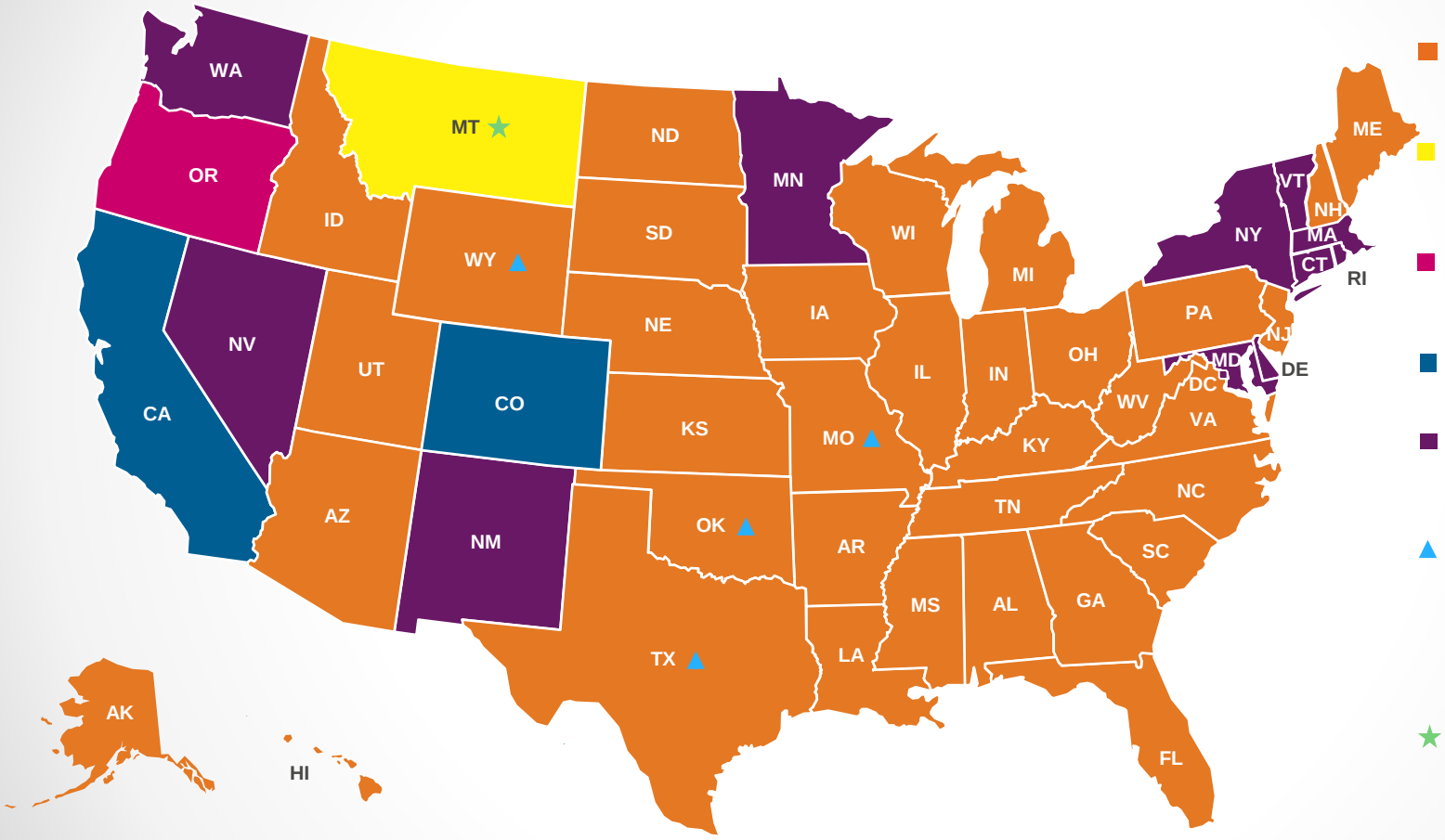
Significant Variation in Rate Increases by State



Source: Adapted from "Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces," Kasier Family Foundation. July 28, 2016. Table 1. Premium increases are for the Lowest-Cost Silver Plan for a 40-year old non-smoker in a major city in that state.

Factors Affecting Premiums

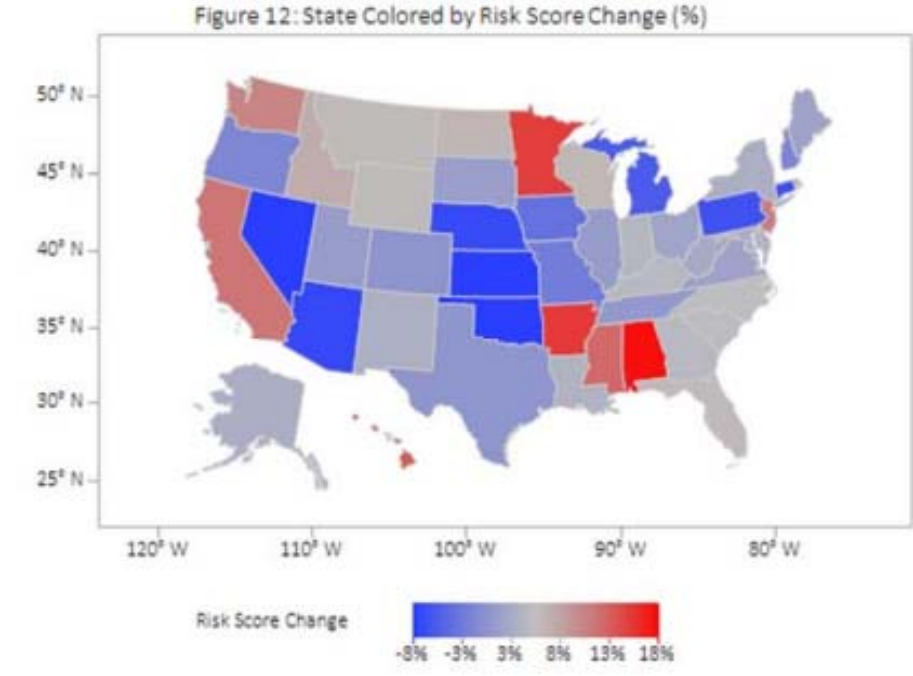
Transitional Policies



- Permits additional 3 month extension through December 31, 2017 (35)
- Permits individual and small group three year extensions (1)
- Transitional plans for Small Group only permitted through November 2017 (1).
- Permitted individual and small group one year extensions (2)
- Did not permit individual and small group extensions (11 + DC)

- ▲ Direct enforcement state where CMS, rather than the state, is enforcing the ACA's market reforms. We assume transitional policies permitted by state.
- ★ State has announced they will NOT adopt the 3 month extension (MT).

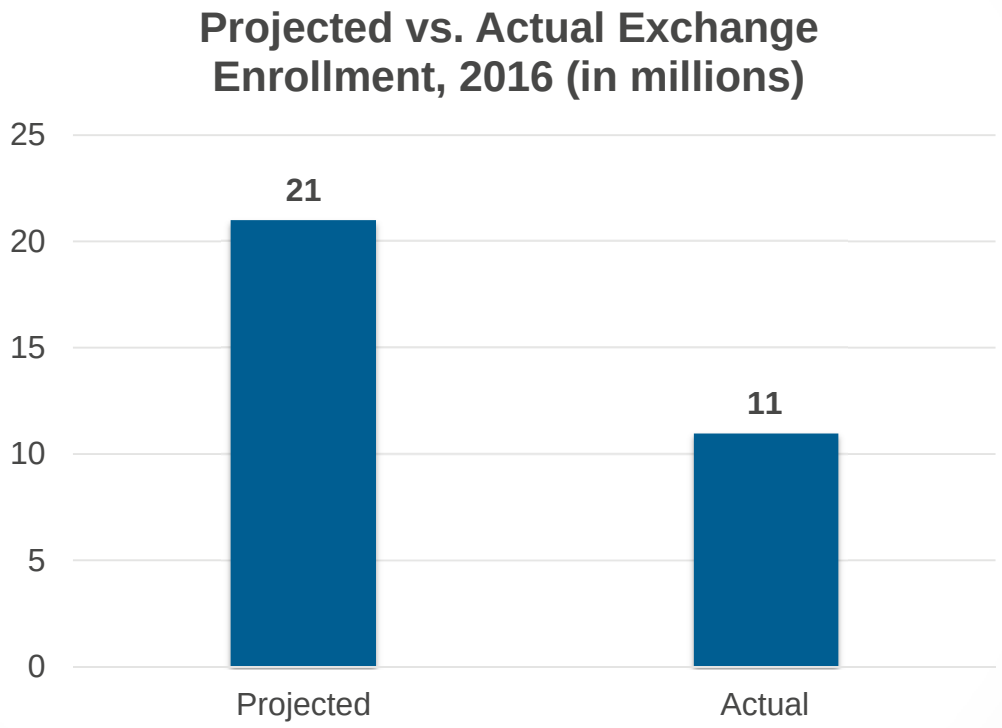
Risk Pool



	2015	2014	% change
Average Risk Score	2.31	2.20	5.2%
Maximum	2.96	2.78	6.3%
Minimum	1.84	1.72	6.9%

Source: "An Examination of Relative Risk in the ACA Individual Market," Society of Actuaries. August 2016.

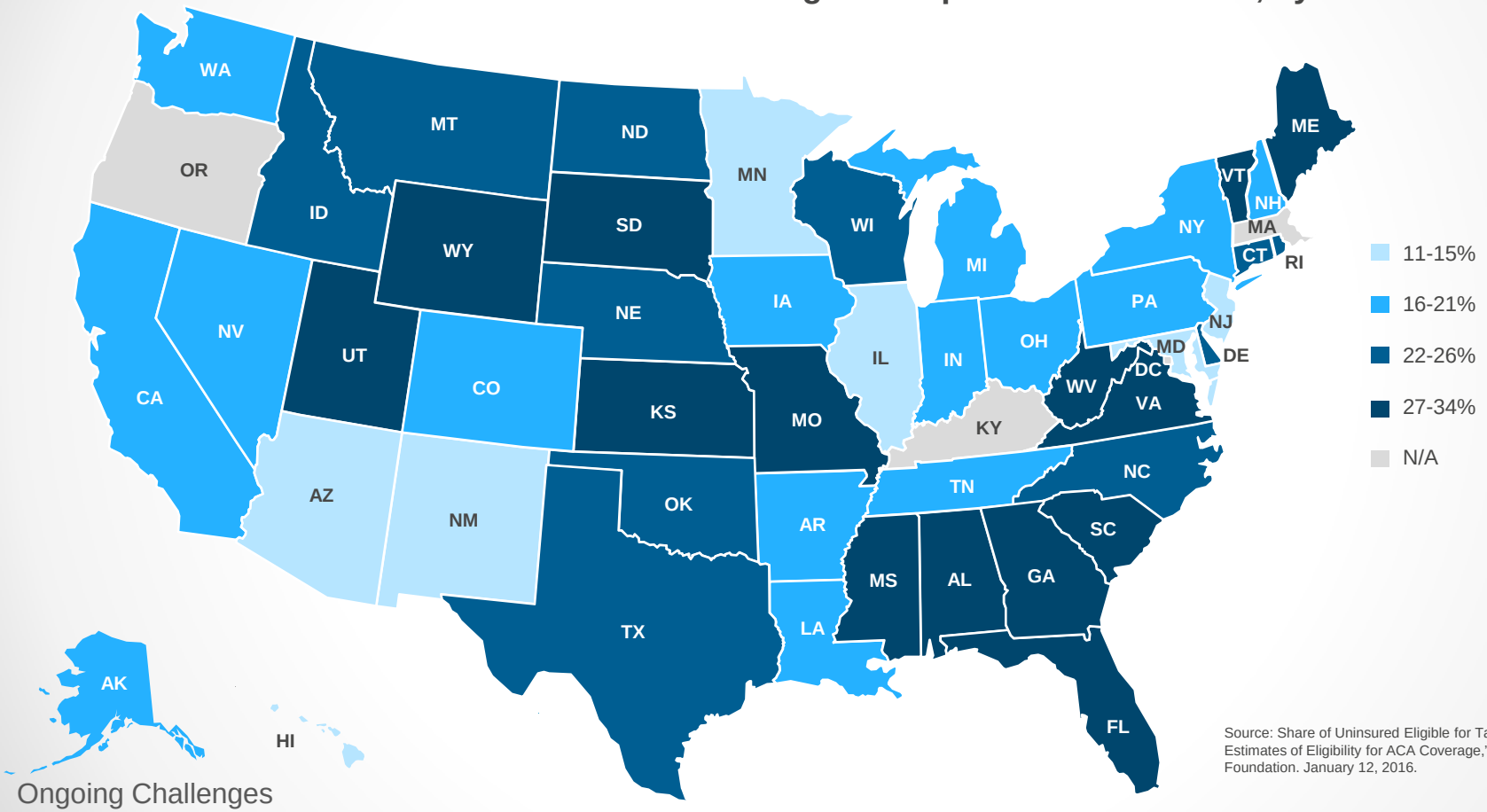
Lower than Projected Enrollment



Source: "The Budget and Economic Outlook: 2016 to 2026," CBO. January 2016.

Reaching the Remaining Uninsured

Share of the uninsured who are eligible for premium tax credits, by state:



Source: Share of Uninsured Eligible for Tax Credits. "New Estimates of Eligibility for ACA Coverage," Kaiser Family Foundation. January 12, 2016.

Additional Challenges

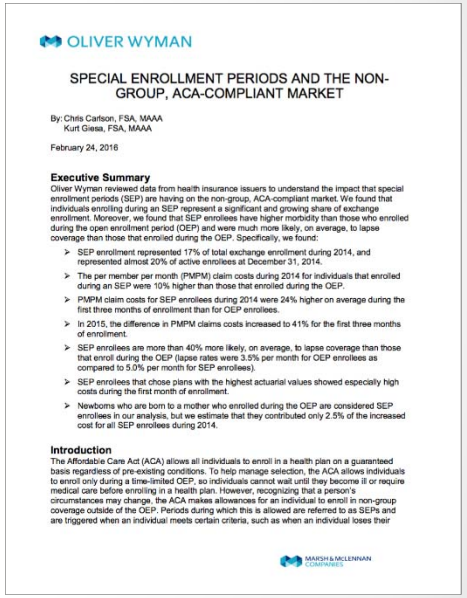
- Special Enrollment Periods (SEPs)
- Unsustainable price increases for prescription drugs
- Third Party Payments

Policy Options to Promote a Stable Market

Policy Solutions

Special Enrollment Periods (SEPs)

- Enrollees who accessed coverage through an SEP made up one-fifth of all Exchange enrollees by the end of 2014*
- SEP enrollees had claims costs that were 10% higher than enrollees that accessed coverage through the traditional open enrollment period*
- SEP enrollees are 40% more likely to allow their coverage to lapse*
- The administration has taken steps to reduce inappropriate use of SEPs – by eliminating unnecessary categories of SEPs, confirming documentation of paperwork related to SEPs, and implementing a pilot program that would verify eligibility for an SEP prior to enrollment



OLIVER WYMAN

SPECIAL ENROLLMENT PERIODS AND THE NON-GROUP, ACA-COMPLIANT MARKET

By: Chris Carlson, FSA, MAAA
Kurt Giesa, FSA, MAAA

February 24, 2016

Executive Summary

Oliver Wyman reviewed data from health insurance issuers to understand the impact that special enrollment periods (SEP) are having on the non-group, ACA-compliant market. We found that individuals enrolling during an SEP represent a significant and growing share of exchange enrollment. Moreover, we found that SEP enrollees have higher morbidity than those who enrolled during the open enrollment period (OEP) and were much more likely, on average, to lapse coverage than those that enrolled during the OEP. Specifically, we found:

- SEP enrollment represented 17% of total exchange enrollment during 2014, and represented almost 20% of active enrollees at December 31, 2014.
- The per member per month (PMPM) claim costs during 2014 for individuals that enrolled during an SEP were 10% higher than those that enrolled during the OEP.
- PMPM claim costs for SEP enrollees during 2014 were 24% higher on average during the first three months of enrollment than for OEP enrollees.
- In 2015, the difference in PMPM claims costs increased to 41% for the first three months of enrollment.
- SEP enrollees are more than 40% more likely, on average, to lapse coverage than those that enroll during the OEP (lapse rates were 3.5% per month for OEP enrollees as compared to 5.0% per month for SEP enrollees).
- SEP enrollees that chose plans with the highest actuarial values showed especially high costs during the first month of enrollment.
- Newborns who are born to a mother who enrolled during the OEP are considered SEP enrollees in our analysis, but we estimate that they contributed only 2.5% of the increased cost for all SEP enrollees during 2014.

Introduction

The Affordable Care Act (ACA) allows all individuals to enroll in a health plan on a guaranteed basis regardless of pre-existing conditions. To help manage selection, the ACA allows individuals to enroll only during a time-limited OEP, so individuals cannot wait until they become ill or require medical care before enrolling in a health plan. However, recognizing that a person's circumstances may change, the ACA makes allowances for an individual to enroll in non-group coverage outside of the OEP. Periods during which this is allowed are referred to as SEPs and are triggered when an individual meets certain criteria, such as when an individual loses their

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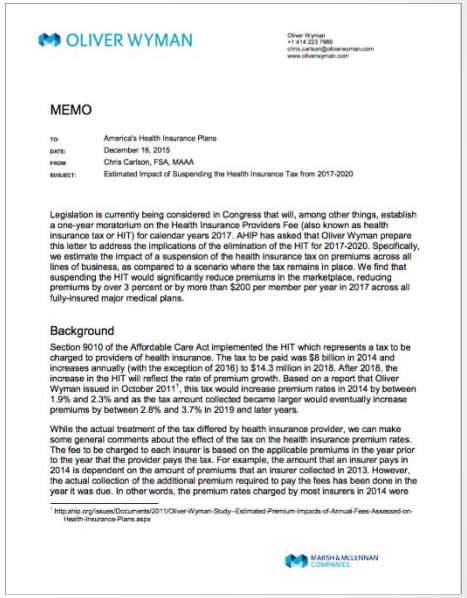
*Source: "Special Enrollment Periods and the Non-Group, ACA-Compliant Market," Oliver Wyman. February 2016.

Health Insurance Tax

- The ACA included a tax on health insurance plans that directly increases the cost of coverage
- A budget deal signed into law at the end of 2015 suspended the health insurance tax for 2017
- An analysis by Oliver Wyman found that this moratorium on the HIT reduced premiums by more than $200 on average for fully-insured major medical health plans in 2017



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MEMO

TO: America's Health Insurance Plans
DATE: December 16, 2015
FROM: Chris Carlson, FSA, MAAA
SUBJECT: Estimated Impact of Suspending the Health Insurance Tax from 2017-2020

Legislation is currently being considered in Congress that will, among other things, establish a one-year moratorium on the Health Insurance Providers Fee (also known as health insurance tax or HIT) for calendar years 2017. AHIP has asked that Oliver Wyman prepare this letter to address the implications of the elimination of the HIT for 2017-2020. Specifically, we estimate the impact of a suspension of the health insurance tax on premiums across all lines of business, as compared to a scenario where the tax remains in place. We find that suspending the HIT would significantly reduce premiums in the marketplace, reducing premiums by over 3 percent or by more than $200 per member per year in 2017 across all fully-insured major medical plans.

Background

Section 9010 of the Affordable Care Act implemented the HIT which represents a tax to be charged to providers of health insurance. The tax to be paid was $8 billion in 2014 and increases annually (with the exception of 2016) to $14.3 million in 2018. After 2018, the increase in the HIT will reflect the rate of premium growth. Based on a report that Oliver Wyman issued in October 2011[1], this tax would increase premium rates in 2014 by between 1.9% and 2.3% and as the tax amount collected became larger would eventually increase premiums by between 2.8% and 3.7% in 2019 and later years.

While the actual treatment of the tax differed by health insurance provider, we can make some general comments about the effect of the tax on the health insurance premium rates. The fee to be charged to each insurer is based on the applicable premiums in the year prior to the year that the provider pays the tax. For example, the amount that an insurer pays in 2014 is dependent on the amount of premiums that an insurer collected in 2013. However, the actual collection of the additional premium required to pay the fees has been done in the year it was due. In other words, the premium rates charged by most insurers in 2014 were

[1] http:ahip.org/issues/Documents/2011/Oliver-Wyman-Study--Estimated-Premium-Impacts-of-Annual-Fees-Assessed-on-Health-Insurance-Plans.aspx

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Improving Risk Adjustment

- The ACA's permanent risk adjustment program guards against adverse selection by transferring funds from those plans that enroll disproportionately low-risk individuals to plans that enroll higher-risk individuals
- Although the program generally worked as-expected in 2014 and 2015, targeted changes could be made to improve the accuracy of the model
- The administration has proposed adjustments for partial year enrollment, incorporating prescription drug data, and recalibrating the model to a more representative data set in future years


The Actuary

ACA Exchange Initiatives Program | Web Exclusives

The ACA Risk Adjustment Program—A Critical Element in Assuring Market Stability and Affordability

Targeted and incremental changes hold promise in strengthening the program to better fulfill its goals Gregory Glazer Web Exclusive

Share:

Since the ACA was enacted six years ago, 20 million Americans have gained health insurance coverage through the exchange marketplace, expanded Medicaid and related coverage expansions in the law.[1] While the expanded access to coverage represents important progress, policymakers and stakeholders must work to advance real reforms to address stability and affordability in the exchange marketplace.

The ACA risk adjustment program plays a critical role in the future of the market. By reducing the potential for adverse selection and encouraging a level playing field, the risk adjustment program plays a crucial role in promoting stability and affordability for consumers.

Background on ACA Risk Adjustment Program

The ACA risk adjustment program is part of an interconnected set of programs—the ACA premium stabilization programs or 3Rs—that work to protect consumers from market volatility and keep coverage affordable. The premium stabilization programs include:

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Five Areas of Concern

Market Dynamics Under ACA Risk Adjustment

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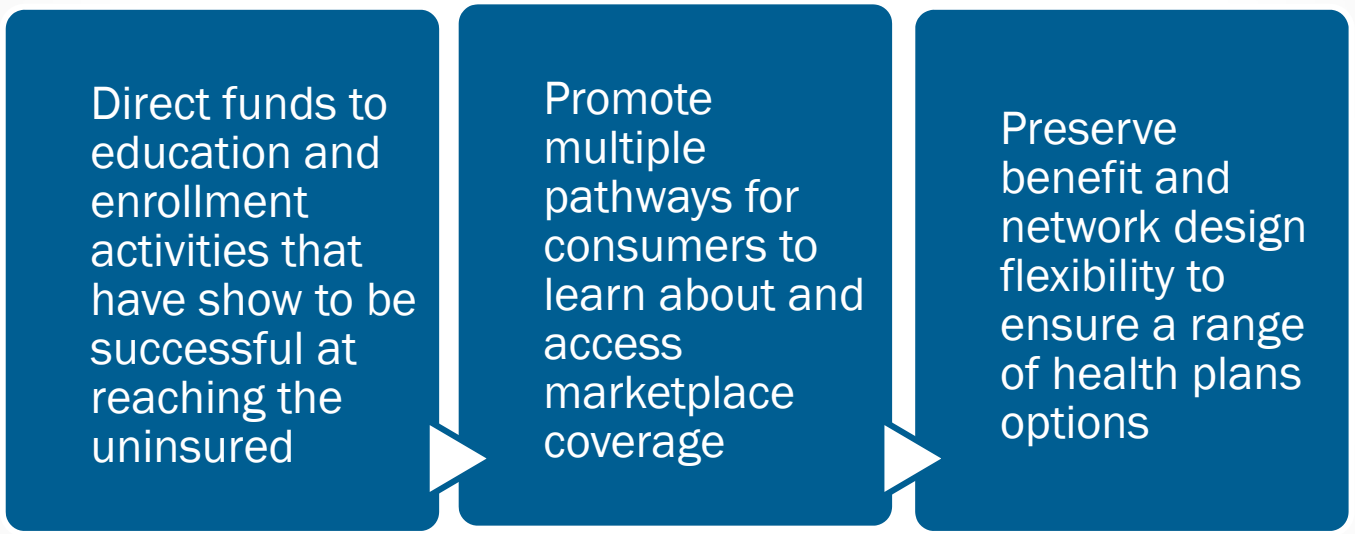
Improving Outreach and Enrollment



Congressional Interest in Stabilizing the Market

Issue	Introduced by	Bill Number
SEP pre-enrollment verification	Rep. Blackburn	H.R. 5589
Wider age bands (5:1)	Rep. Bucshon	H.R. 5921
Equalizes treatment of stand-alone dental plans inside and outside of the exchanges	Reps. Griffith & DeGette	H.R. 3463
Aligning APTC grace periods with state law	Rep. Flores	H.R. 5410
Repeals the ACA's health insurance tax	Sens. Barrasso & Hatch, Reps. Boustany and Sinema	S. 183 and H.R. 928

Resources

@ahipcoverage

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America’s Health Insurance Plans (AHIP)

Learning from the First Two Years of the ACA

Society of Actuaries 2016 Annual Meeting and Exhibit
Las Vegas, Nevada
October 25, 2016

Karan Rustagi, ASA, MAAA
Consulting Actuary

Agenda

- Financial results by state
- Market share determinants
- Platinum loss ratios
- Facility discounts: case study
- Key determinants of success with risk adjustment

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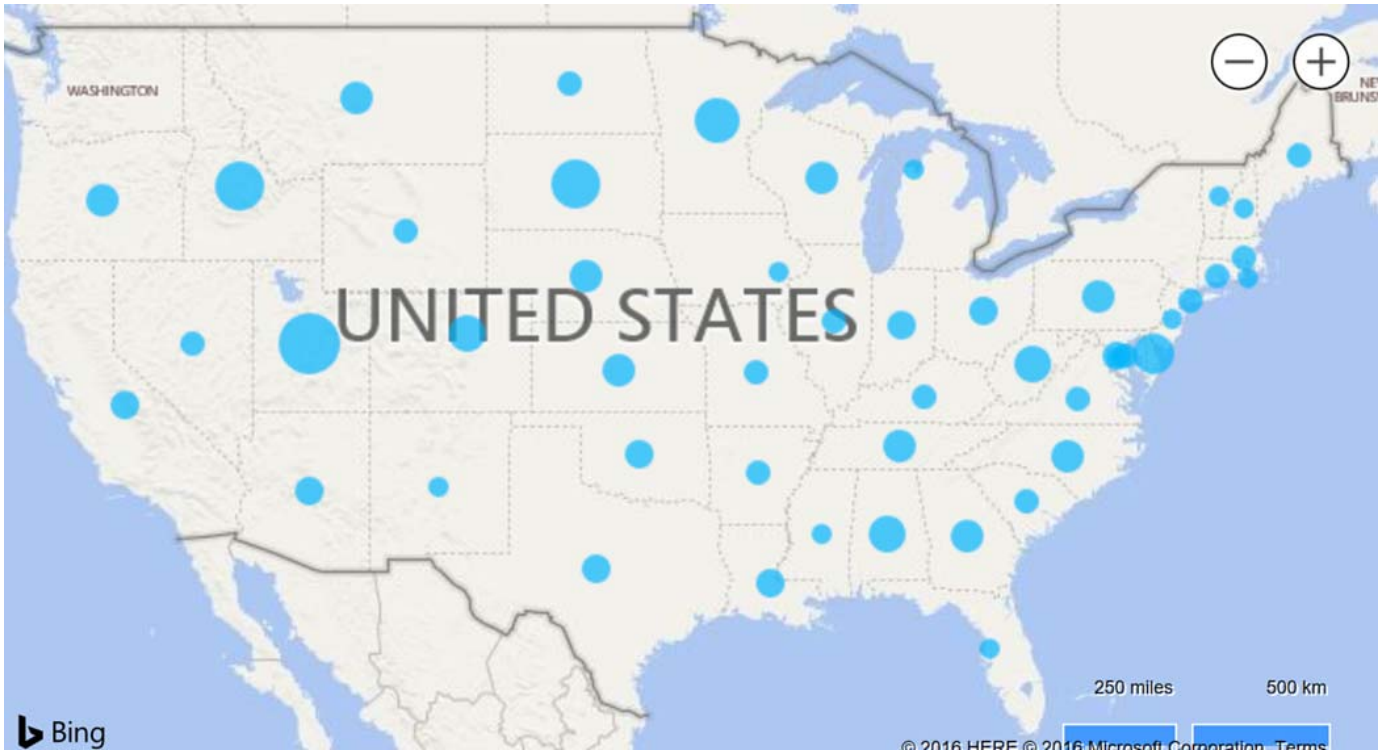
Loss Ratio at the State Level



Source: SNL Financial Data 2015

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2014 Market Share Study

- Individual ACA, On- & off- exchange, Silver plans in 2014, by rating area
- Brand recognition is important
  - Brand: significant market share (15%+) even if 4th highest premium rank
  - No Brand: need to be lowest or second lowest for any significant market share (10%+)
- Network size is important
  - Broad network plans typically only offered by brand name plans and got significant market share (30-50% in some cases) even when 4th highest in the premium ranking.
  - Plans without brand had higher market share when they offered mid-sized network than limited networks.

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Net Income by Metal

Net Income by Metal (2014, with 1R)		
Metal	**Net Income PMPM (1R)**	**Net Income PMPM (2R)**
Bronze	($39.52)	$6.36
Silver	$5.16	$56.69
Gold	($115.95)	($14.81)
Platinum	($235.51)	($89.23)

Source: Wakely National WRI Study Data 2014
Caveat: Results vary significantly from plan to plan

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Induced Demand Adjustment (with Risk Adjustment Only)

Inequities in Rating by Metal (Individual ACA 2014, with 1R)							
		Expense		Revenue		Desired Induced Demand	
Metal	**Federal I.D.**	**Paid - CSR PMPM**	**Ratio**	**Premium + RA Transfer**		**Implied Adjustment**	**Desired I.D.**
Bronze	1.00	$189	1.00	$189	1.00	1.00	1.00
Silver	1.03	$316	1.67	$367	1.94	0.86	0.89
Gold	1.08	$508	2.68	$437	2.31	1.16	1.25
Platinum	1.15	$787	4.16	$613	3.24	1.28	1.48

Source: Wakely National WRI Study Data 2014
Caveat: Results vary significantly from plan to plan
We do not recommend using these ID factors.
Data does not provide justification for higher ID factors as results vary by plan

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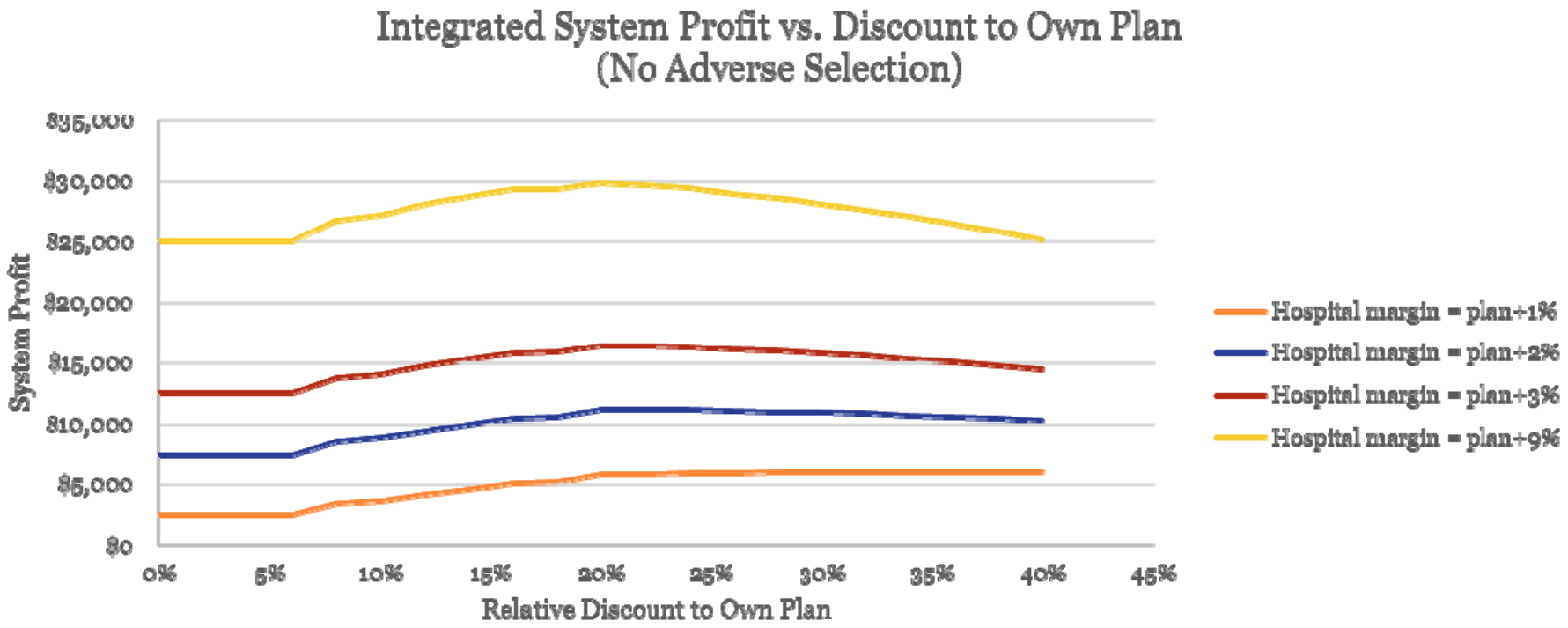
Integrated Provider-Payer System Value



Source: Wakely Simulation Model, Hypothetical Data

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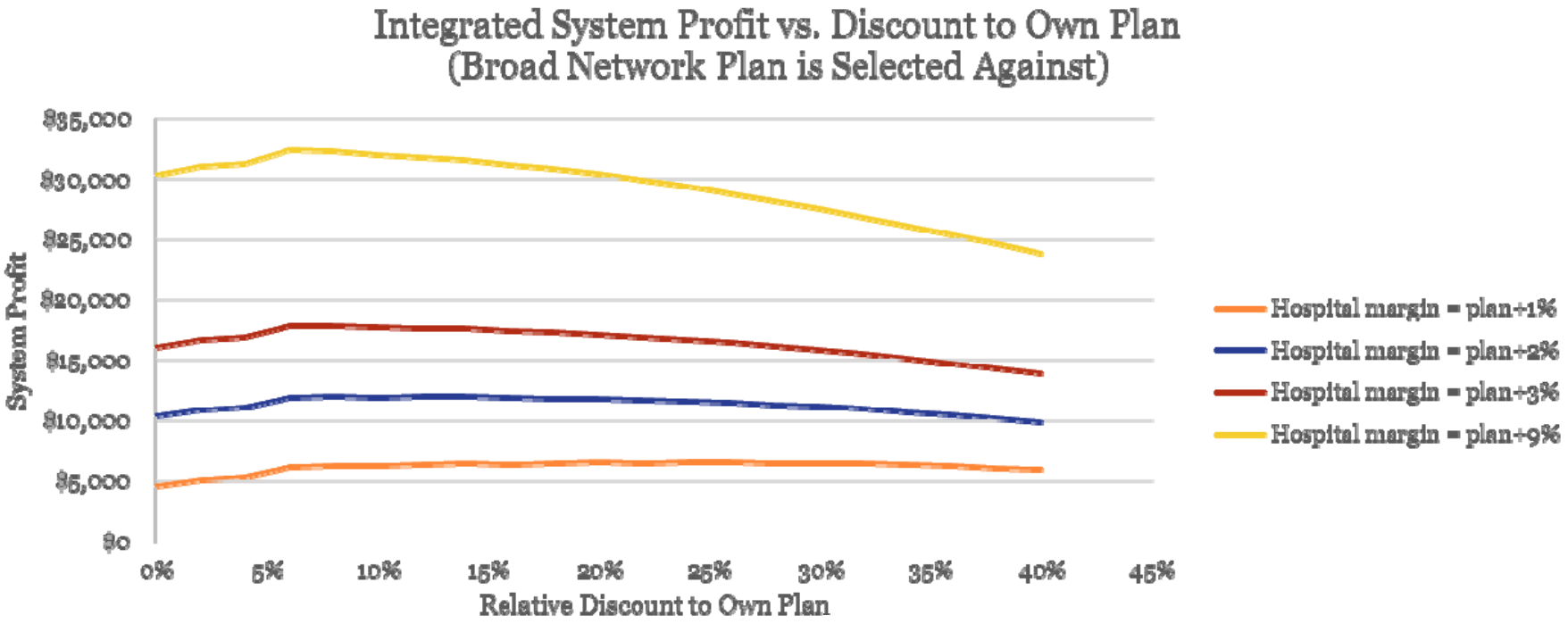
Integrated Provider-Payer System Value



Source: Wakely Simulation Model, Hypothetical Data

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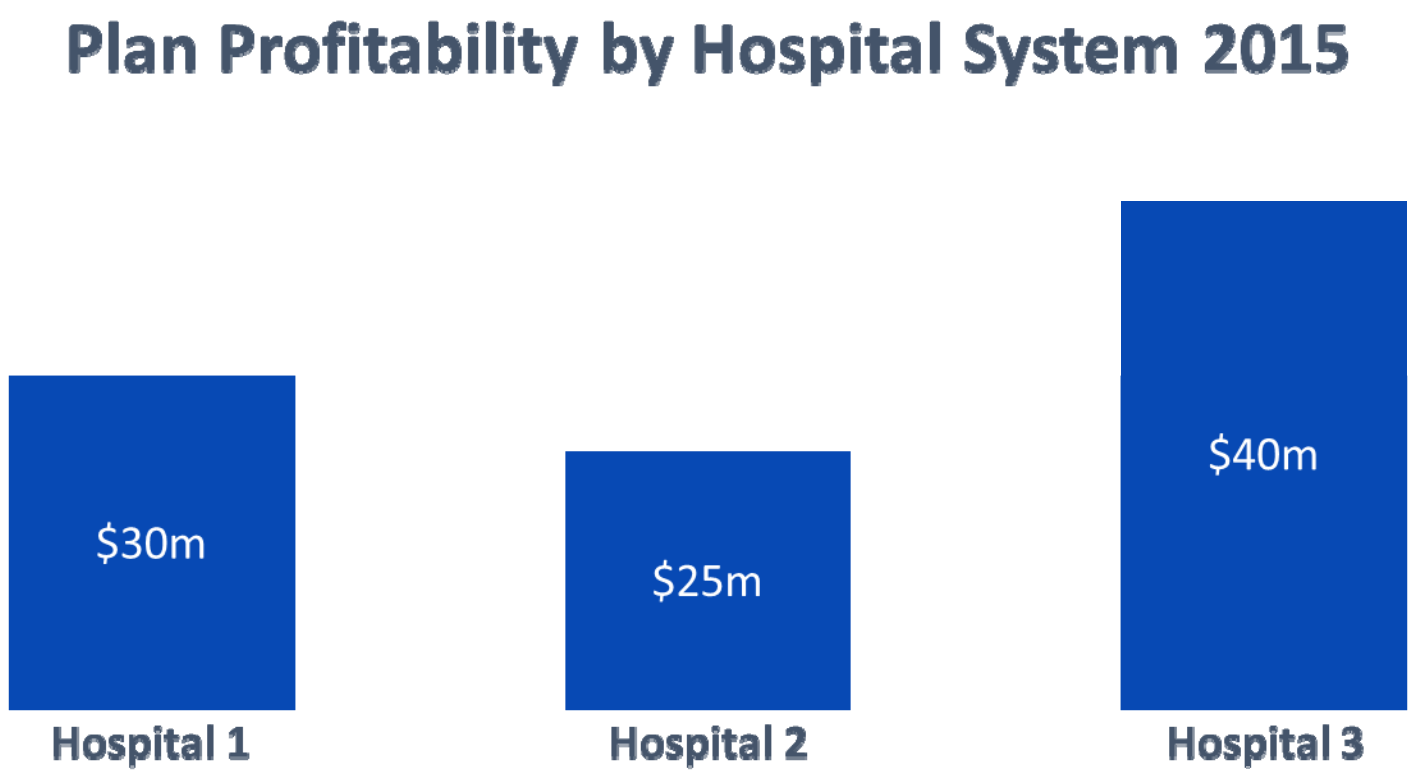
Profitability by Provider



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Risk Adjustment vs. Claim Cost by HCC

Comparison of Cost and Risk Score by HCC in the Individual Market (2014/2015 model)					
HCC	**HCC Description**	**Relative Risk Score**	**Relative Cost**	**Cost Relative to Risk Score**	**Cost Relative to Transfers**
G01	Diabetes	3.25	2.48	-24%	45%
HCC008	Metastatic Cancer	27.39	20.95	-24%	-14%
HCC130	Congestive Heart Failure	11.04	8.09	-27%	-9%
INT_GROUP_H	Adult has at least 1 of the 9 high-cost interactions	39.13	27.20	-30%	-21%
G18	Completed Pregnancy	2.72	2.86	5%	60%
HCC037	Chronic Hepatitis	3.76	4.57	22%	100%
HCC001	HIV/AIDS	5.10	5.88	15%	56%
NOHCC	Not grouped in any HHS HCC category	0.29	0.32	9%	-150%

Source: Wakely National WRI Study Data 2014

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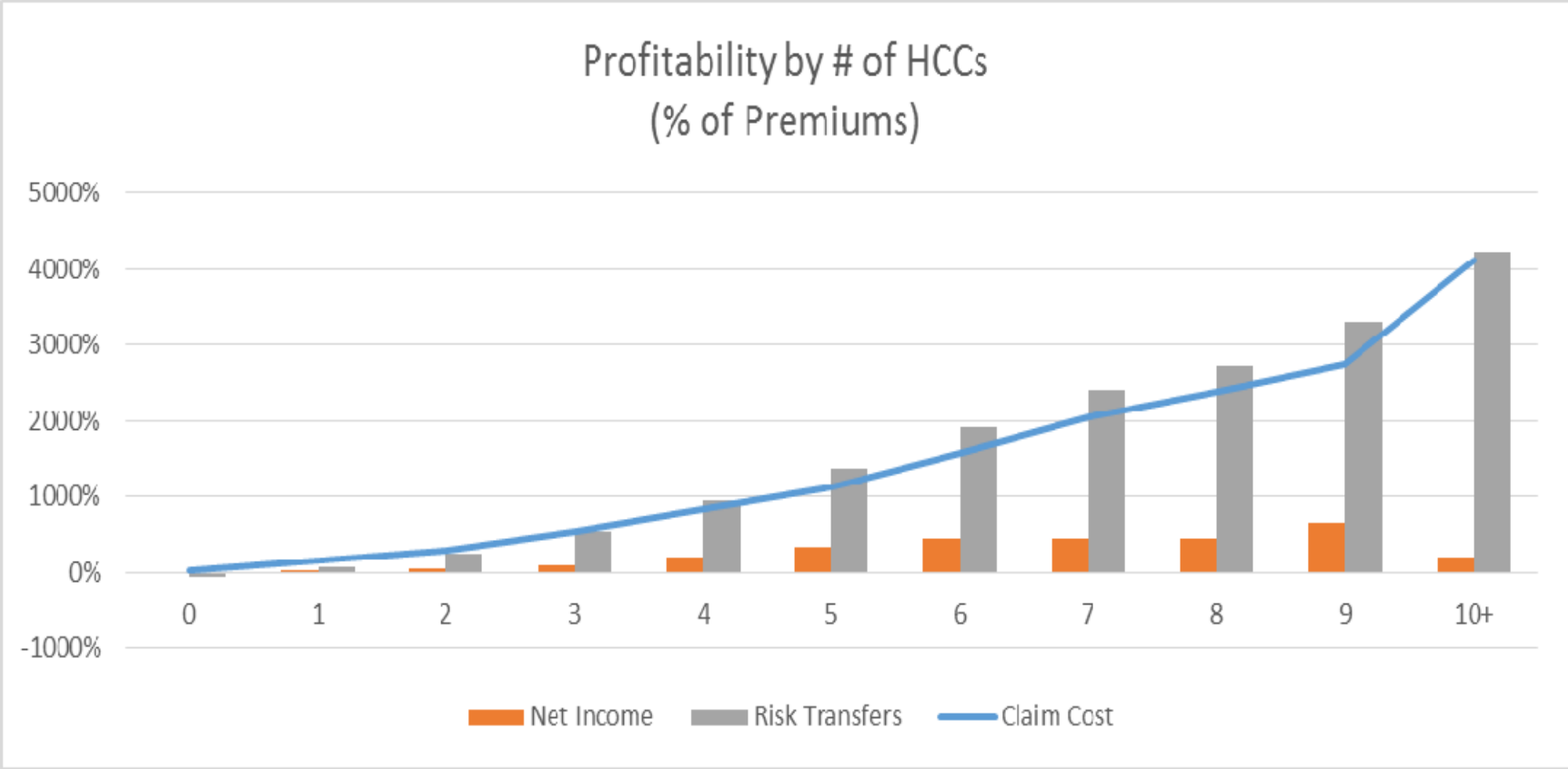
Profitability by # of HCCs



Source: Wakely National WRI Study Data 2014
Caveat: Results vary significantly from plan to plan

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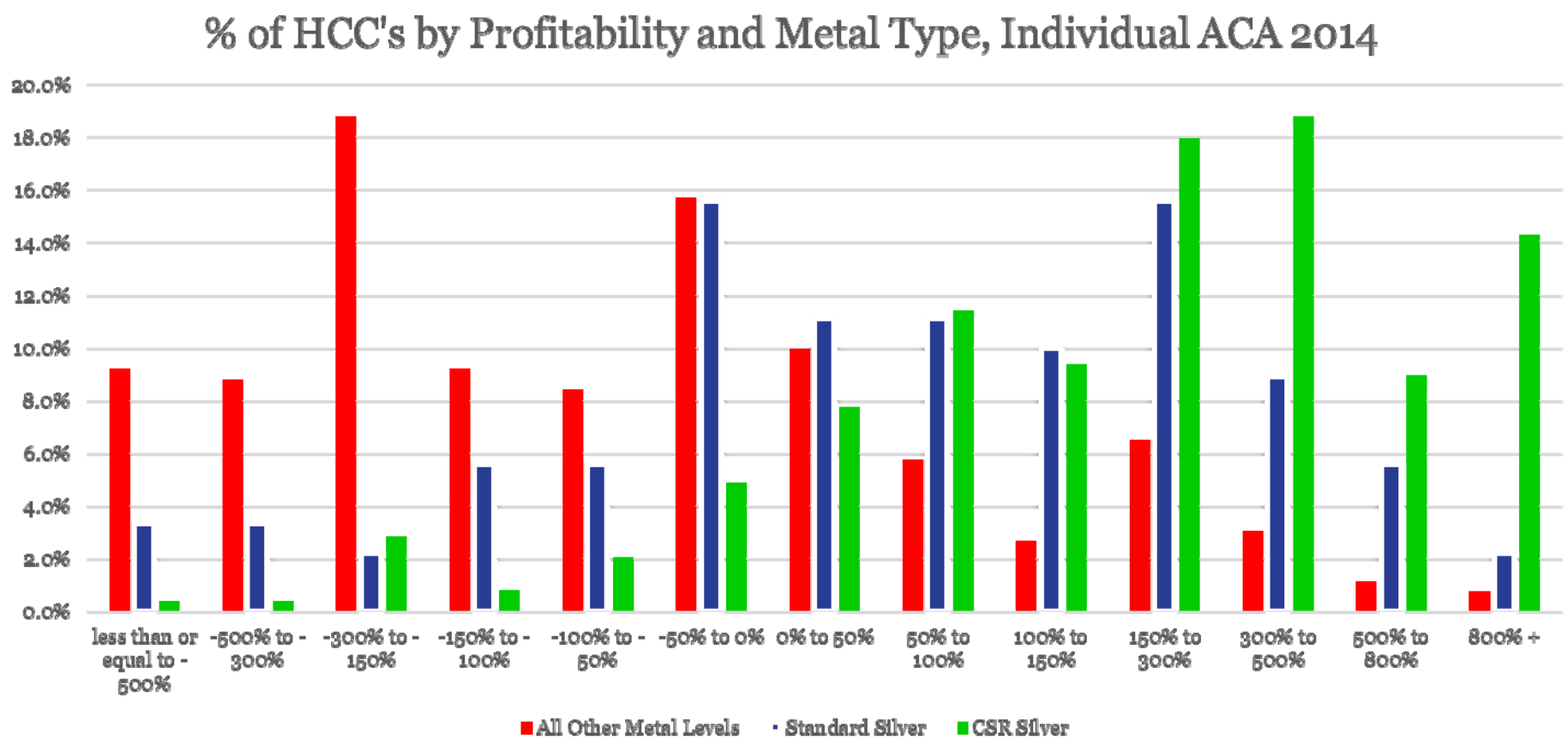
CSRs are Key to Success



Source: Wakely National WRI Study Data 2014
Caveat: Results vary from plan to plan

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Risk Adjustment vs. Claim Cost by Metal

Comparison of Cost and Risk Score by Market and Metal			
Market / Metal	**Relative Risk Score**	**Relative Cost**	**Cost Relative to Risk Score**
Individual			
Catastrophic	0.19	0.21	8%
Bronze	0.55	0.55	0%
Silver Std	0.99	1.06	7%
Silver 73%	0.93	0.87	-7%
Silver 87%	1.09	0.72	-34%
Silver 94%	1.12	0.83	-25%
Gold	1.20	1.50	25%
Platinum	1.63	2.32	43%

Source: Wakely National WRI Study Data 2014
Caveat: Results vary from plan to plan

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Risk Variation by Urban vs. Rural

Year	Relative Risk		
	Urban	Mixed	Rural
2014	-0.006	0.017	-0.002
2015	-0.005	0.014	-0.006

Source: Wakely National WRI Study Data 2014
Caveat: Results vary significantly from market to market

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Relative Risk by Changes in Market Share

Market Share Change	Change in Relative Risk
-200% to -10%	6.5%
-10% to -5%	3.3%
-5% to 0%	2.0%
0% to 5%	-4.4%
5% to 10%	-4.1%
10% to 20%	-14.7%
20% to 200%	-14.1%

Source: Wakely National WRI Study Data 2014
Caveat: Results vary significantly from plan to plan

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Relative Risk by Market Share

Market Share in 2015	0%-5%	5-10%	10-25%	25-50%	50%+
Average Relative Risk	0.11	0.03	-0.10	0.03	0.02
Minimum Relative Risk	-0.53	-0.30	-0.31	-0.27	-0.09
Maximum Relative Risk	1.27	0.73	0.34	0.25	0.24

Source: Wakely National WRI Study Data 2014
Caveat: Results vary significantly from plan to plan

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Narrow vs. Broad Network Plans

Baseline Scenario											
Plan	**MMs**	**PLRS**	**ARF**	**AV**	**IDF**	**GCF**	**Relative Risk**	**Premium**	**Paid PMPM**	**RAF PMPM**	**LR**
Broad Network	10,000	1.72	1.77	70%	1.03	1.00	0.00	$420	$336	$0.00	80%
Narrow Network	10,000	1.72	1.77	70%	1.03	1.00	0.00	$380	$304	$0.00	80%
Market Average	**20,000**						**0.00**	**$400**	**$320**	**$0.00**	**80%**

30 new lives enter the market (0.3% of the market)
PLRS = 19.1 (10x higher)
AV = 97% (38% higher)
Paid PMPM = $4,672 (narrow network) or $5,164 (broad network)
Broad network plan contracts are 10% worse than narrow network plan's contracts

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Narrow vs. Broad Network Plans (Equal Market Share)

Scenario	Market Share		Loss Ratio	
	Narrow Network Carrier	Broad Network Carrier	Narrow Network Carrier	Broad Network Carrier
Baseline	10,000	10,000	80.0%	80.0%
180 Unhealthy Lives go to Narrow Network Plan	10,180	10,000	81.8%	81.4%
180 Unhealthy Lives go to Broad Network Plan	10,000	10,180	81.5%	82.0%
180 Healthy Lives go to Narrow & 180 Unhealthy to Broad Network Carrier	10,180	10,180	81.9%	81.0%
180 Healthy Lives go to Narrow Network Plan	10,180	10,000	79.9%	79.8%
180 Healthy Lives go to Broad Network Plan	10,000	10,180	79.8%	79.9%

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Narrow vs. Broad Network Plans (Broad Network Plan has Large Market Share)

Scenario	Market Share		Loss Ratio	
	Narrow Network Carrier	Broad Network Carrier	Narrow Network Carrier	Broad Network Carrier
Baseline	10,000	30,000	80.0%	80.0%
180 Unhealthy Lives go to Narrow Network Plan	10,180	30,000	86.5%	84.1%
180 Unhealthy Lives go to Broad Network Plan	10,000	30,180	84.6%	85.4%

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Narrow vs. Broad Network Plans (Narrow Network Plan has Large Market Share)

Scenario	Market Share		Loss Ratio	
	Narrow Network Carrier	Broad Network Carrier	Narrow Network Carrier	Broad Network Carrier
Baseline	30,000	10,000	80.0%	80.0%
180 Unhealthy Lives go to Narrow Network Plan	30,180	10,000	85.3%	83.9%
180 Unhealthy Lives go to Broad Network Plan	30,000	10,180	84.3%	88.3%

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Evolution of ACA Risk Adjustment

- Where we have been
- Where we are going

Questions?