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Ideas to Consider for the Individual Health Market in 2016

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Rating for individual health plans in calendar year 2016 will have many details to be considered for the first time. To highlight this, an April 2014 Congressional Budget Office (CBO) report projected several significant shifts: a) exchange enrollment is expected to grow from 13 million in 2015 to 25 million in 2016; b) the annual, national average benchmark premium is expected to increase by over 10 percent (from $3,900 to $4,400 per year); and c) exchange plans are expected to have broader provider networks than in years past. These all are interrelated, as will be explained later in this article. In the meantime, off-exchange, nongroup plan enrollment is projected to be flat from 2015 to 2016.[1]

As indicated by this projected climb in enrollment and premium, there is much to consider. In broad terms, actuaries will have to monitor the regulatory environment for expected as well as unexpected guidance. They will have to try to make sense of newly available information. Most importantly, they will need to anticipate how the newly insureds will access the health care system differently over time, compared to what was observed in 2014.

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As in years past, regulatory guidance may bring delays to scheduled guidance, or bring modifications to guidance already released. As a result, the discussion below of scheduled, effective regulations should be treated as preliminary. Here is some of the regulatory guidance that could occur for 2016:

1. **Updated actuarial value (AV) calculator, or underlying continuance data.** This is important because plan designs are required to have benefits that cover 60 percent, 70 percent, 80 percent or 90 percent of total expected essential health benefit (EHB) costs +/- 2 percent. When costs are trended forward and utilization data is updated, it is likely that the updated AV calculator will show AV results with values that fall outside of the de minimis range. Existing plan benefits will have to be modified accordingly.

   In the final rule for the 2015 Notice of Benefit and Payment Parameters,[2] they note that "where the trend factor is cumulatively more than 5 percent different from the previous time the AV calculator was updated, we would implement the trend factor." The AV calculator was not updated for 2015 due to trend, so it is likely that this threshold will be reached in 2016 and, at the least, trend will be applied to the underlying continuance data.

2. **States may be allowed to revisit their EHB benchmark plans.** In the Final Rule for 2013 Standards Related to Essential Health Benefits,[3] the Centers for Medicare & Medicaid Services (CMS) relate that they are "currently reviewing all options for updating EHB in 2016 and anticipating additional guidance in the future on enforcement of EHB requirements and updating EHB." As with the AV calculator update, an update to one's respective EHB benchmark plan may require change to plan designs of existing plans in order to continue to comply with EHB requirements.

3. **Small employer rating requirements apply to groups up to size 100 in 2016.** Previously, most states applied small group rating requirements only to groups up to size 50. The rating rules specific to small group that would now apply to groups up to size 100 are many and varied. No comprehensive list is presented here, but some examples include rating by state-specific rating areas or prescribed age factors, and benefit designs that conform to metal level.[4]

4. **Employer mandate delayed until 2015.** Currently a phase-in year is prescribed for 2015, and full requirements are scheduled to be in place for 2016.[5] As scheduled employer reporting rules strengthen, many employers may question their role in providing health insurance to their employees.

Any impacts to the employer market should be evaluated with possible implications for the individual market. Will more employers pay the penalty or continue to provide coverage? Will more employers move to provide self-insured coverage instead?

In addition to the emerging regulatory requirements in the backdrop, there will also be much newly available information to consider. Information such as renewal enrollment data, new enrollment in 2015, the data collection reports, and 2014 claim experience will potentially aid actuaries in determining effective rating actions for 2016.

By the time we price for 2016, the open enrollment period for 2015 is slated to be completed.[6] This enrollment period will be invaluable to observe market forces in action that pertain to this newly developed market. Questions that will be answered include:

- How much do renewal rate increases, as opposed to rate levels, impact enrollment?[7]
- Is there an increasing awareness of provider networks evident in marketing results?
- What renewal (outreach) activities appear to be most effective?

Besides renewal activities, carriers will be interested to know what was most effective in attracting the newly insured (as of 2015), as well as the members migrating from group health coverage.

Besides renewal enrollment data, financial results pertaining to the 3Rs are beginning to become clear. Issuers are supposed to have completed their 2014 edge server submissions of reinsurance and risk adjustment data and submitted by April 30.[2] However, earlier submissions and reports by CMS are intended to be available by then.

With regard to risk adjustment, the importance of market-wide information that will allow insurers to adequately understand the impact of the payment transfers when pricing for 2016 and beyond cannot be overstated. This information will be available for the first time, and will inevitably lead many insurers to substantially revisit their pricing and enrollment results. These comments were recognized in the Final Notice of 2015 Benefit and Payment Parameters, with CMS noting that they will provide more details on this content in future guidance or future rules, where appropriate.[2]

With regard to reinsurance, the impact to one's own financial results is self-evident. Unlike the risk adjustment program, the reinsurance program is phasing out. 2016 is the last year intended for the reinsurance program to stabilize premiums in this still-developing market. This is true for the risk corridor program as well (though the risk corridor program is more of a "backstop" against adverse events and not an allowable rating factor). Insurers should be considering the impact that the absence of these stabilizing programs will have on their 2017 rate levels, when setting their 2016 rates.

Also newly available during the pricing process for 2016 will be the 2014 experience data for the newly insured. It is estimated that at least 8 million enrolled in the exchange (not considering who paid or not), and millions more enrolled in plans off the exchange.[8] Obviously, many of these are newly insured, and are embedded in your population. However, it will not be straightforward in projecting this experience to expected 2016 circumstances. When considering 2014 data, one should consider this is merely the initial year in a new marketplace. There are many reasons to assume that 2014 experience will not resemble the marketplace in future years. Differences may include:

- Pent-up demand of previously uninsured members will have been addressed in earlier years.
- Suppressed demand of previously uninsured members will have been addressed with an increasing awareness of how to optimally access the health care system.
- The impact of transitional policies.
- Varying impact of members insured for part of the year.
- First enrollment opportunity that many will have beyond their 2014 tax returns.
- Accounting for the predicted CBO shift of insureds if it were to happen.

For those newly insured members in 2014, we would have expected pent-up demand reflected in those results. Where that occurs, we would expect the initial intensity of utilization of services to subside, certainly by 2016. On the other hand, we could have expected suppressed demand reflected for other newly insureds. For example, confusion around the enrollment and eligibility processes for some exchanges[9] could have inhibited usage in the early days of their enrollment. Additionally, many others who had never before had insurance likely had a learning process in their early days in a plan. One might expect their utilization levels would increase to reflect optimal understanding of how to access the health care system by 2016.

For transitional plans, their experience is reflected in 2014 as non-ACA compliant plans. For those states that adopted a transitional policy, most are allowing them to continue through 2017. However, several of them may permit them to continue only into 2015 or 2016.[10]

As for members insured for part of 2014, there are several reasons why they may not have been covered for the entirety of 2014. There are those

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who enrolled, then curtailed enrollment for the remainder of the year upon utilizing their intended services for the year.[11] There are those who waited until the end of the enrollment period, to minimize the amount of time to be enrolled in a health plan without incurring an individual mandate penalty. On the other hand, there are those who enrolled later in the year due to changing personal circumstances, such as a change in Medicaid eligibility. Lastly, there are many who encountered technical difficulties in enrolling for 2014. These people may have wanted 12 months of coverage, but were unable to do so.

It is recommended to consider those assumptions that seem reasonable for your particular state and your particular marketplace as you project your 2014 experience into the 2016 rating period.

The timing of 2014 tax returns could play a significant role in 2016 enrollment in a number of ways. First, the 2014 tax returns are the first time that people are scheduled to pay a penalty to the Internal Revenue Service (IRS) because of a lack of qualifying coverage in 2014. In conjunction with paying the penalty, many may realize that the penalty for 2016 is intended to be much larger than it was in 2014. In 2014, the penalty is max (1 percent of your taxable income or $90 per person per household). In 2016, the penalty is max (2.5 percent of your taxable income, or $695 per person per household).[12]

Additionally, for those receiving premium subsidies in 2014, the reconciliation of their premium subsidies that they received, to what the IRS calculates they should have received, will result in additional payment either to or from the IRS upon filing their 2014 returns. Perhaps by 2016, we could see significant shifts in how the premium subsidies are determined and in how they are administered as a result of any necessary regulatory responses after this initial tax year cycle.

Lastly, there are those enrollment scenarios projected by the CBO, as described at the outset of this article. The CBO predicts that exchange plans will begin to become closer in price to employer plans. They predict that "many plans will not be able to sustain provider payment rates that are as low or networks that are as narrow as they appear to be in 2014." While still lower than employer plans, they expect the gap to narrow in 2016. As a result, premium costs would then rise. The benchmark premium would rise by over 10 percent. (Note that this doesn't necessarily equate to 10 percent average premium increases: The benchmark plan is the second-lowest silver plan on the market, so it's more a reflection of what plans are available for purchase at a lower cost in the market.) This increase in premium will lead to a significant increase in subsidies available to people who enroll in exchange plans. The CBO projects an annual subsidy increase of almost 14 percent from 2014 to 2015, for those who will receive a premium subsidy. This increased attractiveness in plans with premium subsidies (as well as the awareness of the penalties) the report explains, will lead to exchange enrollment to grow substantially in 2016.[1]

There are certainly other possible reasons for dissimilar experience for 2016, such as changes in provider delivery models to meet demands of a changing insured population (more evening and weekend clinic hours, perhaps?), or a changing face of insurer marketplaces (insurers coming and going). It is recommended to consider those assumptions that seem reasonable for your particular state and your particular marketplace as you project your 2014 experience into the 2016 rating period.

In many ways, 2016 marks the end of the initial phase of the ACA. As noted in the oft-cited CBO report, they project that plans' characteristics will stabilize after 2016, as well as the numbers of subsidized insureds on the exchange. If that turns out to be the case, then 2016 is of the utmost importance for determining the market position of your plans in your respective market as the ACA enters a more stable phase in future years.

In the meantime, there is much that is yet to unfold. There is significant regulatory guidance that could impact the insured population for 2016 and which plans they can buy. There is much new information that will prove insightful when developing rates reasonable in relation to the benefits provided. However, it will be important to realize that the experience for 2016 will not necessarily just be an extension of what we have seen so far.

ENDNOTES

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