Session 042 PD - Health Care Under Trump

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2017 SOA Annual Meeting & Exhibit

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42 – Health Care Under Trump

October 16, 2017

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Today's Agenda

- Overview of Potential Changes to ACA
- Case Study – States' Reactions to Uncertainty

Potential Changes to the ACA

Individual and Small Group

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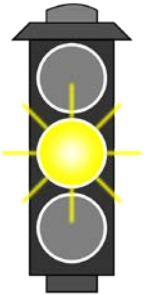
Individual Mandate

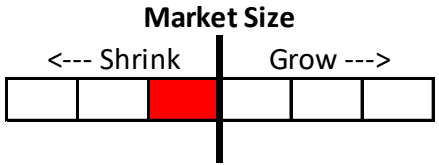
Key Considerations

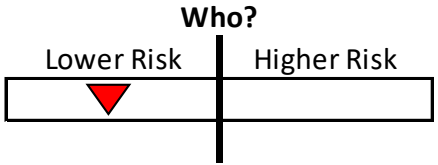
- Is the mandate removed?
- How is it removed?
- How effective was current mandate?

Risk Adj Implications



Potential Impact Snapshot



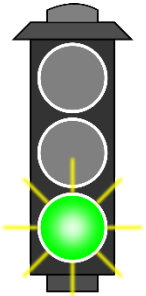


Guarantee Issue

Key Considerations

- Does guarantee issue remain?
- Open vs special enrollment?
- Any changes to rating factors or EHB?

Risk Adj Implications



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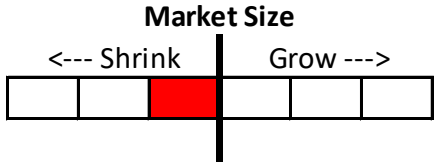
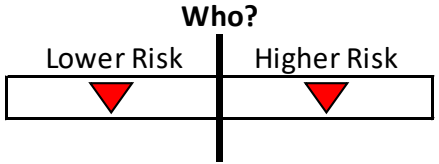


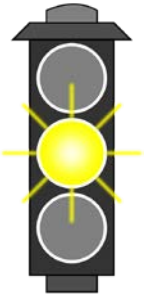


Cost Sharing Reduction Payments

Key Considerations

- Do CSR remain?
- Are carriers required to offer?
- Coordination with APTC?

Risk Adj Implications



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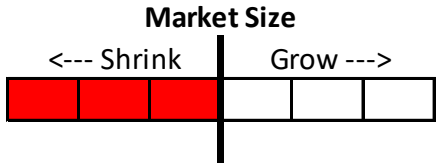
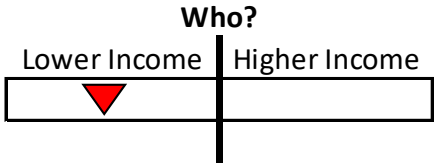


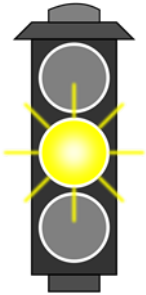


Advance Payment Tax Credits

Key Considerations

- Do subsides remain?
- What's the basis?
  - Age, Income, Area, other?

Risk Adj Implications



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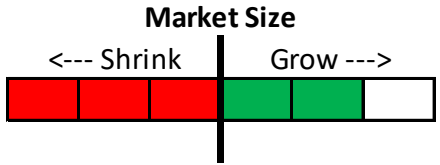
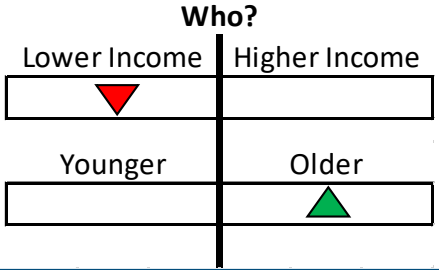


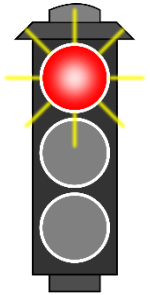


Rating Factors

Key Considerations

- Age factor expansion?
- Health status rating?

Risk Adj Implications



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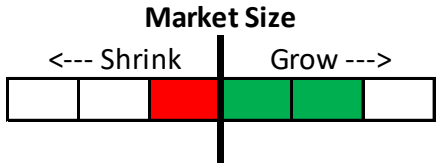
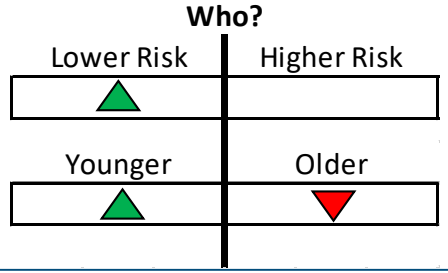


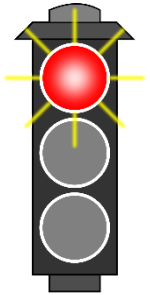


Essential Health Benefits

Key Considerations

- Changes to broader categories?
- Flexibility within each category?
- Coordination with rating factors?

Risk Adj Implications



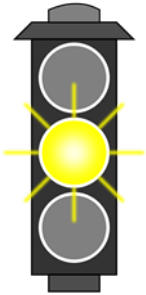
Potential Impact Snapshot

Metallic Tiers

Key Considerations

- Changes to metal ranges?
- New metal tiers?

Risk Adj Implications



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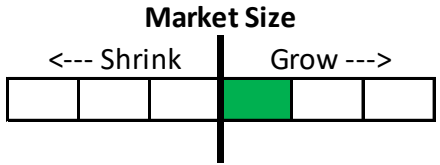

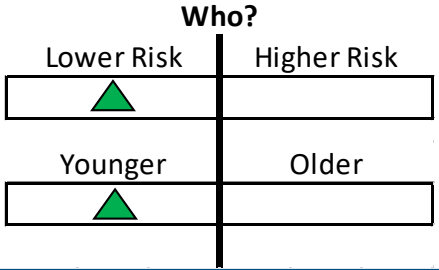

Small Group Considerations

- Employer Mandate
- Interaction with Individual market

Dealing with Uncertainty – State Actions

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Setting the stage…

- Spring 2017
  - 2018 rate filings due
  - Future of ACA unknown
  - CSR funding unknown (current or future)

- Goal: Maintain stability in marketplace

State Constraints

- Funding, funding, funding, funding, funding, funding, funding, funding, funding, funding, funding
- Legislative session timing
- Budget cycles
- Current state law
- Politics

- Uncertain “problem” to fix

Utah

- "Wait and see"
- Address the most immediate issue
- Stay in contact with carriers

Washington

- "Plan for the future"
- Current stability
- Get things in place to keep it that way

Idaho

- "Little bit of everything"
- Short-term steps
- Longer term solutions

Oregon

- "Comprehensive approach"
- Immediate market impacts
- Additional regulatory flexibility
- Long term planning

Case Study Wrap-up

- CSR flexibility – did it work?

- Market stability (mostly) achieved

Individual Potpourri

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Topics: Individual Potpourri

- This Week: In the News
- Summary of 2018 Premium Changes
- Market Instability
- Rating Impact for CSR Defunding
- Waivers
- High Risk Pools
- Nevada Findings

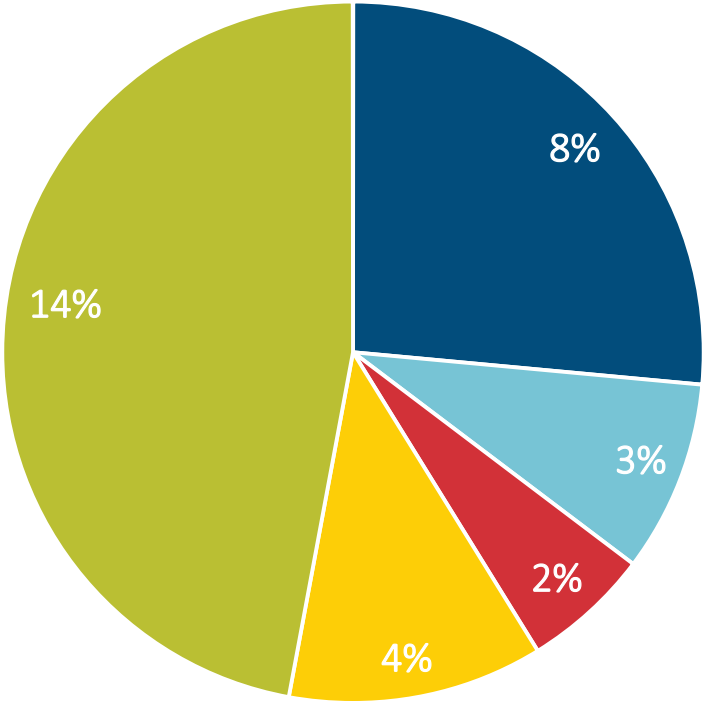
This Week: In the News

- What is an Executive Order?
- Short duration plans
- Associations
- Health Reimbursement Arrangements (HRAs)
- CSR Defunding: What happens to APTCs?

2018 National Premium Rate Changes Average is 30%

Unsubsidized Enrollees

- Medical inflation
- Morbidity correction from 2017
- Issuer fee
- Individual mandate uncertainty
- CSR funding uncertainty



Source: http://acasignups.net/2018-rate-hikes as of 10/4/2017 - 23 States, assuming enrollees select same plan in 2018 as existing plan

2018 Premium Rate Changes (Approved)

Unsubsidized Enrollees

State	% of Nation	Approved Rate Change	Requested Rate Change
Alaska	***0.2%***	***-22.0%***	***Rates Dropped***
Arizona	2.1%	11.2%	
Arkansas	0.9%	17.5%	
Colorado	1.7%	36.7%	
Connecticut	1.1%	28.4%	
Florida	6.3%	44.7%	
Georgia	3.2%	54.2%	
Idaho	**0.5%**	**27.0%**	**Decreased 11%**
Louisiana	1.5%	21.4%	
Maine	**0.4%**	**24.7%**	**Decreased 7.2%**
Maryland	**1.9%**	**43.8%**	**Decreased 13.2%**
Michigan	3.1%	26.8%	

State	% of Nation	Approved Rate Change	Requested Rate Change
Minnesota	***1.7%***	***-5.3%***	***Rates Dropped***
Mississippi	0.9%	38.0%	
New Mexico	**0.6%**	**30.0%**	**Decreased 7.2%**
New York	**6.2%**	**13.4%**	**Decreased 36.9%**
North Dakota	0.2%	28.2%	
Oregon	1.3%	15.7%	
South Carolina	1.5%	30.7%	
Tennessee	2.1%	28.5%	
Vermont	**0.2%**	**10.5%**	**Decreased 11.1%**
Virginia	2.6%	57.7%	
Washington	**2.2%**	**33.0%**	**Increased 10.7%**
Total	42.4%	30.4%	

Highlighted: largest percentage of rate changes from requested to approved

Source: http://acasignups.net/2018-rate-hikes as of 10/4/2017

Market Instability – Historical View

- Issuers leaving the market
- Issuers restricting regional footprint (e.g., leaving rural rating areas)
- Less provider choice
- Less choice in plans – fewer platinum, gold
- Large premium increases
- Significant changes in number of enrollees or significant churn
- Difficult for issuers to rate accurately due to uncertainty
  - Federal policy uncertainty
  - Change in market morbidity
  - Rules continue to change after rates filed

Market Instability – Additional New Concerns

- Things previously mentioned
  - Subsidy structure
  - Changes in rating rules: 5:1 age rating, ability to rate on health, etc.
  - Changing actuarial value or EHB requirements
  - Individual Mandate

Market Instability – Additional New Concerns

- Impact of any new risk adjustment changes
- Potential for reduced Medicaid funding and eligibility
- Open enrollment period shortened for Healthcare.gov states: 90 days to 45 (now Dec 15)
  - In 2015, 60% of new enrollees and 33% of switchers enrolled in second half of OEP
- Less advertising at the federal level
- SEP verification
- Executive Orders: Associations?
- Bare counties

CSR Defunding

- What does this mean?
- State variation
  - Apply adjustment to
    - No plans (at risk next year?)
    - Only Silver
    - Spread across all plans (Colorado)
  - Off-exchange considerations
  - BHP in MN and NY at risk?
- Variables
  - % of each CSR variant
  - Relative movement of standard Silver
  - Auto enrollment?
- Risk adjustment changes (chia.chin@wakely.com)

CSR Defunding Example

If Rate Increase Only Impacts Silver

		Silver								
	Bronze	70% without APTCs	70% with APTCs	73%	87%	94%	Gold	Total Silver	Total All Metals	Silver Premium Impact
Current Membership Distribution	20%	20%	10%	10%	10%	25%	5%	75%	100%	
Silver Movement to Bronze	N/A	50%	40%	30%	0%	0%	N/A			
2018 Membership Distribution	37%	10%	6%	7%	10%	25%	5%	58%	100%	
Estimated Pricing AV	60%	70%	70%	73%	87%	94%	80%			
Claim Impact	0%	0%	0%	3%	17%	24%	0%			**13.6%**

If Rate Change is Spread to All Plans

		Silver								
	Bronze	70% without APTCs	70% with APTCs	73%	87%	94%	Gold	Total Silver	Total All Metals	Total Premium Impact
Current Membership Distribution	20%	20%	10%	10%	10%	25%	5%	75%	100%	
Movement to Bronze	N/A	50%	40%	30%	0%	0%	N/A			
2018 Membership Distribution	37%	10%	6%	7%	10%	25%	5%	58%	100%	
Estimated Pricing AV	60%	70%	70%	73%	87%	94%	80%			
Claim Impact	0%	0%	0%	3%	17%	24%	0%			**8.3%**

Waivers

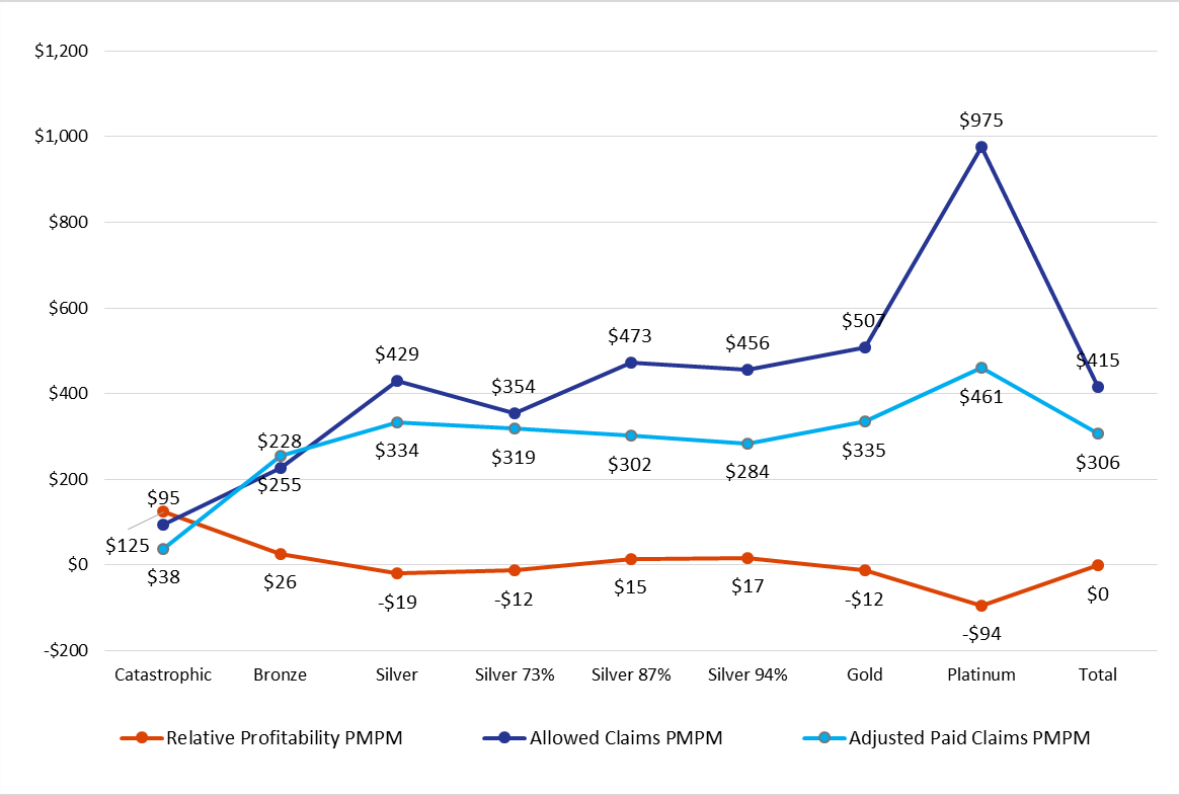
- 1332 Waivers
  - Overview:
    - Must provide at least as many people with similarly comprehensive coverage without increasing the federal deficit in the process
    - State receives federal funds saved through lower APTC amounts
  - Condition-based reinsurance: Alaska
  - Transitional reinsurance program: MN, OR, OK, NH
  - Broadening scope: Iowa
- 1115 Waiver: Medicaid definition change in MA, Arkansas

High Risk Pools

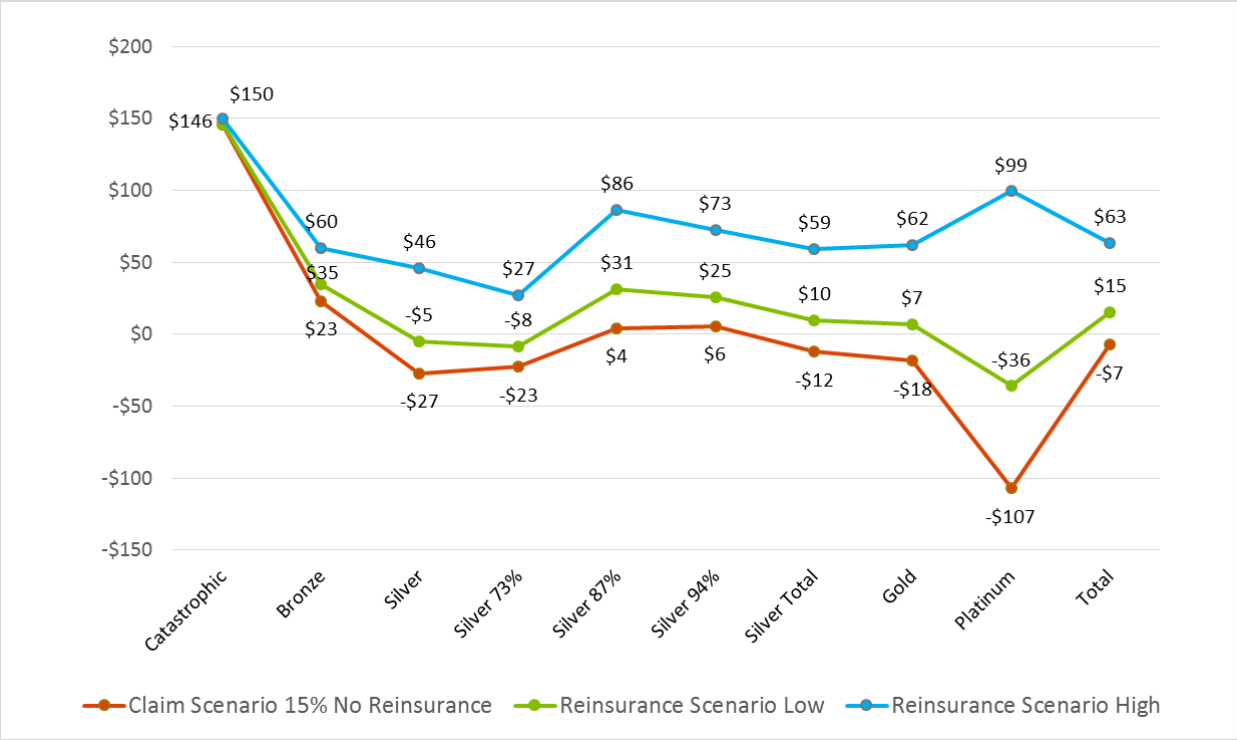
- Stand-alone risk pools versus invisible risk pools
- Alaska: 7.3% rate increase in 2017 rather than 40%
- Nationwide estimate:
  - $11.7B of funding → 10% premium reduction in 2019*
  - 35% to 40% could be from pass-through funding via 1332 waiver
- Considerations
  - Whose claims are eligible?
  - Continued care management if risk is ceded
  - Risk adjustment implications

*Source, including data, methodology, and caveats: https://www.wakely.com/sites/default/files/files/content/white-paper.pdf
suzannagrace.sayre@wakely.com or julie.andrews@wakely.com

Nevada Study: 2015 Claim Cost and Profitability by Metal



Nevada Study: Reinsurance Application on 2015 Profitability (PMPM), Claims at +15%



Medicaid Reform Topics

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Medicaid Reform Topics

- Financing Background
- Potential Legislative Changes
- Funding for Medicaid Expansion Population
- Funding for Traditional Medicaid
- Options for States to Consider

Medicaid Financing Background

- Covered populations generally include non-disabled low income children and adults, disabled individuals and dual-eligible individuals

- Medicaid costs are funded using both federal and state dollars
  - Offset by very limited member premiums and cost sharing

- Federal funding varies by state – states with higher income per capita receive a lower relative percentage of total costs funded by the federal government
  - The percentage funded referred to as the Federal Medical Assistance Percentage (FMAP)
  - Lower bound of 50% and upper bound of 82%

Medicaid Financing Background

For $1,000 in Medicaid costs, the FMAP can significantly impact the State's share

- New York: $500 state share

- New Mexico: $289 state share

Fiscal Year 2017 Federal Medical Assistance Percentages (FMAP)	
State	FMAP
Arizona	69.24%
Florida	61.10%
Illinois	51.30%
Massachusetts	50.00%
New York	50.00%
New Mexico	71.13%
Wisconsin	58.51%

Medicaid Financing Background

The ACA allowed states to expand eligibility for low-income adults at an enhanced FMAP

Federal Medical Assistance Percentages (FMAP) for Medicaid Expansion under the ACA	
Year	FMAP
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020+	90%

Potential Legislative Changes

- Reduce or eliminate the funding for the Medicaid expansion population
  - AHCA / BCRA transitioned to standard Medicaid FMAPs

- Create upper bounds for the federal funds provided to each state
  - Block grants
  - Per capita caps

Funding for Medicaid Expansion Population

- 32 states (including DC) adopted some level of Medicaid expansion with roughly 15 million individuals enrolled in Fiscal Year 2016[1]

- In FY2015, this program cost about $68.8 billion in federal funds and $4.2 billion in state funds[1]

- Proposed changes include:
  - Phase out of enhanced federal funding
  - Limit future enrollment of expansion individuals at enhanced FMAP
  - Move current nationwide Expansion funding (along with Exchange funding) to national block grant program spread across all states

1. Source: Kaiser Family Foundation

Funding for Traditional Medicaid Population

- Two proposed mechanisms
  - Block grants: a fixed amount of money provided by CMS
  - Per capita caps: a fixed amount of money *per person* provided by CMS with annual limit increases tied to CPI or CPI-Medical

- Generally coupled with increased flexibility for administering Medicaid programs

- FMAP would likely continue to apply and block grants / per capita caps would serve as maximum funding levels

Funding for Traditional Medicaid Population

- Design considerations
  - Are sub-populations viewed separately or collectively?
  - Are any populations exempt from funding limits?
  - What time period determines the funding level?
  - How does the funding level trend to future years?
  - How much can ‘good years’ offset ‘bad years’?
  - How are medical advancements handled?
- These decisions have potential to shift varying levels of risk to states

Funding for Traditional Medicaid Population

Example of Separate vs. Aggregate Funding Cap				
	Children	Adults	Disabled	Total
Member Months	500	300	200	1,000
Actual Spend PMPM	200	400	1,500	520
Federal Share (50% FMAP) PMPM	100	200	750	260
Funding Limit PMPM	150	250	600	270

- An aggregate funding cap produces no additional state liability ($260 spend vs. $270 limit)

- A population-level funding cap produces additional state liability of $150 for all disabled individuals

Funding for Traditional Medicaid Population

- Base period data selection and inflation trend assumptions will drive future funding limits
- States should evaluate historical trends relative to legislative benchmarks

Historical Trend Rates			
Year	CPI-U	CPI-M	Medicaid*
2010	1.6%	3.4%	-1.0% to 2.4%
2011	3.2%	2.8%	0.7% to 6.9%
2012	2.1%	4.1%	-7.2% to -2.6%
2013	1.5%	2.4%	-0.7% to 7.1%
2014	1.6%	2.0%	-3.3% to 5.7%
2015	0.1%	2.5%	-2.1% to 8.4%
2016	1.3%	4.9%	0.9% to 4.6%

*Based on aged, disabled and child Medicaid expenditures in Table 19 of the CMS *2016 Actuarial Report on the Financial Outlook for Medicaid*

Options for States to Consider

- Reduce costs
- Changes in covered populations
- Reduce optional benefits
- Delivery system reform
- Regular monitoring of the program will become important, as significant changes in a single year will be more difficult under per capita caps and limited trend increases

QUESTIONS?

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