Session 85 PD, ACA Implementation and Strategies in 2017 and Beyond: Light at the End of the Tunnel, or Oncoming Train?

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Society of Actuaries 2014 Annual Meeting & Exhibit

ACA Implementation—Health Plan Perspective on Open Enrollment and Looking Ahead to 2016 and Beyond

Rosen Shingle Creek Resort, Orlando, FL
October 28, 2014

Gregory Gierer
Vice President, Policy & Regulatory Affairs
Overview

- Launch of the new exchange marketplaces and 2015 open enrollment issues and challenges

- Looking ahead to 2016 and beyond—longer-term implementation issues and opportunities for promoting health system change
  - Expected regulatory action and activity
  - Factors affecting coverage and affordability in the marketplace
  - Changing electoral landscape and potential for legislative changes
ACA Implementation—Launch of Exchanges and 2015 Open Enrollment
## Marketplace Choice and Competition; Subsidies Lower Costs for Many

<table>
<thead>
<tr>
<th></th>
<th>Number of QHPs</th>
<th>Number of Issuers</th>
<th>2nd Lowest Cost Silver Plan</th>
<th>Lowest Cost Bronze</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>53*</td>
<td>8*</td>
<td>$328</td>
<td>$249</td>
</tr>
</tbody>
</table>

**Exchange plan premiums are 16% below official projections (HHS-ASPE)**

**17 million individuals eligible for tax credits for exchange coverage in 2014 (KFF)**

**Nearly 7-in-10 uninsured will qualify for coverage for less than $100 per month (HHS-ASPE)**

* Average number of QHPs/issuers per state in 36 FFM states; ASPE/HHS Issue Brief
2014 Open Enrollment--Highlights

- 8 million people enrolled in exchange plan coverage during the 2014 initial open enrollment period
  - More than 8-in-10 (85%) qualified for subsidized coverage
  - 4.8 million enrolled in Medicaid/CHIP through March 2014
- 2.2 million (28%) of the people who selected a marketplace plan were young adults (18-34)
  - 2.7 million (34%) were under the age of 35 (includes children)
- 3.8 million selected a plan during the March enrollment surge
  - Includes 1.2 million young adults who signed up during March 2014
- Nearly two-thirds (65%) of marketplace plan selections were “silver” plans
  - Premium subsidies tied to 2nd lowest cost silver plan; cost-sharing subsidies only available under silver-plan variations
### ACA Exchange Enrollment—Early Evidence on Expanding Coverage to the Uninsured

<table>
<thead>
<tr>
<th>Study</th>
<th>Enrollment Estimates/Impact on the Uninsured</th>
</tr>
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<tbody>
<tr>
<td>Commonwealth Fund</td>
<td>9.5 million gained coverage as of June 1, 2014</td>
</tr>
<tr>
<td>CBO</td>
<td>12 million newly-insured in FY 2014; 6 million in exchange and 7 million in Medicaid/CHIP</td>
</tr>
<tr>
<td>Los Angeles Times</td>
<td>9.5 million newly insured since September 2013</td>
</tr>
<tr>
<td>HHS/ASPE</td>
<td>7.3 million enrolled in exchange plans; 8 million enrolled in Medicaid/CHIP</td>
</tr>
<tr>
<td>RAND Corp.</td>
<td>9.3 million newly insured since September 2013</td>
</tr>
<tr>
<td>Urban Institute</td>
<td>8.0 million newly insured since September 2013</td>
</tr>
</tbody>
</table>
“The uninsured rate in the U.S. fell 2.2 percentage points to 13.4% in the second quarter of 2014. This is the lowest quarterly average recorded since Gallup and Healthways began tracking the percentage of uninsured Americans in 2008. The previous low point was 14.4% in the third quarter of 2008.”

Gallup Poll, July 10, 2014

“The Centers for Disease Control (CDC) has spent 17 years measuring the number of people without health insurance. In new 2014 data, the federal agency found that number hit a new low. The survey found that 13.1 percent of Americans lacked health insurance at the time of their interview with the CDC.”

Sarah Kliff, Vox September 16, 2014,
## 2015 Open Enrollment Timelines

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dates/Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial FFM QHP Application Submission Window</td>
<td>5/27 - 6/27</td>
</tr>
<tr>
<td>FFM Review of QHP Application Submissions</td>
<td>6/30-7/25</td>
</tr>
<tr>
<td>Deadline for Final Submission of QHP Application Data</td>
<td>9/4/14</td>
</tr>
<tr>
<td>FFM Completes Review of Application Data</td>
<td>9/22/14</td>
</tr>
<tr>
<td>Certification Notices and QHP Agreements Sent to Issuers; Agreements Signed</td>
<td>10/14 - 11/03</td>
</tr>
<tr>
<td>2015 Open Enrollment Begins</td>
<td>11/15/14</td>
</tr>
<tr>
<td>2015 Open Enrollment Ends</td>
<td>2/15/15</td>
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2015 Open Enrollment—Progress and Challenges Ahead

**Operations**
- Considerable progress on front-end functionality and consumer experience
- Need to focus on improving critical back-end functions and away from manual work-arounds to build on early success and continue to make improvements

**Regulatory**
- Major regulatory actions expected in the fall—including updated policy and payment parameters for the ACA premium stabilization programs
- New regulatory requirement for plans are possible for 2016—e.g. annual letter to issuers and potential updates to EHB

**Legislative**
- 2014 Mid-term election has important consequences—including control of the Senate and potentially action on major national issues
- Potential for legislative action on health care and changes to the ACA—although prospects for major changes are uncertain
Factors Affecting 2015 Marketplace Premiums

- Medical trend
- Covered population
- ACA taxes and fees
- Benefit requirements
- Premium subsidies and other factors
### 2015 Premiums—Studies Show
Premiums Largely Stable but Considerable Variation

<table>
<thead>
<tr>
<th>Study</th>
<th>Main Findings</th>
<th>Study design/limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avalere Health</strong></td>
<td>Average monthly premiums for silver plan coverage will increase by 8%--with an average monthly premiums increasing from $324 in 2014 to $350 in 2015</td>
<td>Based on initial rate filings in 8 states</td>
</tr>
<tr>
<td><strong>PwC Health Research Institute</strong></td>
<td>Average increase across all states is 7% and the average monthly premium across all metal tiers (without subsidies) at $379 per month</td>
<td>Based on analysis of rate filings in 33 states</td>
</tr>
<tr>
<td><strong>McKinsey/New York Times</strong></td>
<td>Average increase of 8.4% for the lowest cost silver plan in 2014</td>
<td>Based on analysis of rates in 18 states</td>
</tr>
<tr>
<td><strong>Kaiser Family Foundation</strong></td>
<td>Premiums for the second-lowest cost silver plan in the marketplace is decreasing by an average of -0.8% (ranges from an increase of 8.7% to a decrease of -15.6%)</td>
<td>Based on premiums for second lowest cost silver plan in largest city in 15 states</td>
</tr>
</tbody>
</table>
## Elements Necessary for Successful 2015 Open Enrollment

### Affordable premiums
- Premiums largely stable although considerable state-by-state variation
- Plan design and related innovations a key factor
- Subsidies and cost-sharing reductions improve affordability

### Choice and competition
- Health plan participation in exchanges increased by 25% in 2015—57 new issuers in the FFM alone

### Improved functionality and consumer experience
- Continued improvement is exchange functionality is key to success—especially critical back-office functions that are critical to a workable and consumer-friendly experience
- Need to assure stability in enrollment process to build on early success (e.g. simplifying renewal process, early access for renewing members, direct enrollment capabilities)
Looking Ahead to 2016 and Beyond—Longer-Term ACA Implementation Issues
ACA Timeline

2014
- Comprehensive insurance market reforms
- Coverage expansions

2015
- CHIP expires
- Employer mandate in effect (after 1 year delay)
- Exchanges must be self-sustainable
- Individual mandate penalty increases ($325 or 2% of income)

2016
- Small group expands to 100 (all states)
- Individual mandate penalty increases ($695 or 2.5% of income)
- Authorized health care choice compacts (insurance across state lines)
- Employer reporting of insurance coverage

2017
- State innovation waivers in effect
- Large employers on Exchanges (state may permit)
- Reinsurance and Risk Corridors phased out

2018
- Tax on high cost health plans
### ACA Coverage and Exchange Premium Estimates for 2017

<table>
<thead>
<tr>
<th>Study</th>
<th>Uninsured</th>
<th>Exchanges</th>
<th>Medicaid/CHIP</th>
<th>ESI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBO*</td>
<td>-26 million</td>
<td>+25 million</td>
<td>+12 million</td>
<td>-7 million</td>
</tr>
</tbody>
</table>

“The benchmark premium is projected to rise slightly in 2015, to about $3,900, and then rise more rapidly thereafter, reaching about $4,400 in 2016 and about $6,900 in 2024. Thus, premiums are projected to increase by about 6 percent per year, on average, from 2016 to 2024.”

* CBO Updated Estimates of the Effects of the Health Insurance Coverage Provisions of the Affordable Care Act; April 2014
## Factors affecting premiums in 2016 and beyond

<table>
<thead>
<tr>
<th>Medical trend</th>
<th>Private market competition</th>
<th>Phase out of key ACA premium stabilization programs (reinsurance and risk corridors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases in ACA taxes and fees</td>
<td>Phase out of transitional policy and risk pool effects</td>
<td>Increased penalties under individual coverage requirement; greater consumer awareness</td>
</tr>
<tr>
<td>Changes in legislative and/or regulatory environment (including provisions not yet in effect)</td>
<td>Medicaid expansion and extension of CHIP</td>
<td>Factors affecting employers decisions to offer coverage</td>
</tr>
</tbody>
</table>
Future of CHIP—Background and Implications

- **8 million low-income children currently receive coverage under state CHIP programs (CBO/KFF)**
  - Program has been a success—reducing the uninsured rate for children in half—from 14% (1997) to 7% (2012)

- **CHIP funding is set to expire on September 2015**
  - CHIPRA—enacted in 2009—expanded funding for CHIP and provides states additional resources and incentives to enroll uninsured children
  - Without additional funding, coverage for nearly 2 million children at-risk (Urban Institute)

- **CHIP traditionally has enjoyed bipartisan support and remains popular in the States**

- **Legislation to extend CHIP introduced this Congress**
  - Legislation introduced in the Senate by Senator Rockefeller (D-WV) and the House by Representatives Waxman (D-CA) and Pallone (D-NJ) extends funding through 2019 and improves access to coverage and care for low-income children
  - Prospects for extending the program uncertain—could potentially be addressed in the lame-duck session (post-midterm) or (more likely) next year (in the new Congress)
Waiver for State Innovation—Background and Implications

§ 1322 of the ACA establishes waiver for state innovation—state may apply for a waiver of selected ACA requirements effective January 1, 2017

- Requirements that may be waived include requirements for qualified health plans, essential health benefits, cost-sharing limits, exchanges, premium tax credits and cost-sharing reductions, and employer and individual mandates
- States must develop alternative coverage plan that meets the broad goals of the ACA and does not increase the federal deficit

Regulatory activity

- Final rule released on issues on March 27, 2012—addressed process related issues but leaves key issues unresolved (e.g. standards for HHS approval and how HHS will determine state-specific funding amounts)

Legislative activity

- Bi-partisan legislation introduced last Congress (Wyden-Brown)—endorsed by President Obama (2011); no action this Congress

Variety of approaches states could take in the future but unclear how many states will pursue
Other Key Longer-Term ACA issues

- Allow states to enter into Health Care Choice Compacts to permit interstate sale of insurance—effective 2016
- Definition of small group expanded to 100 (states currently have the option to define as 2-50)—effective 2016
- States may permit large employers (over 100 employees) to participate in exchanges—effective 2017
- Imposes a 40% excise tax on high-cost employer-sponsored insurance—effective 2018
Legislative action on the ACA amidst a partisan and uncertain political environment

- Repeal and replace v working within the ACA framework

- Changes to the ACA that could attract bi-partisan support

- Changes to the ACA as part of long-term deficit reduction/tax reform (e.g. grand bargain)

- Bipartisan proposals to reduce health care cost growth
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SOCIETY OF ACTUARIES

SOA Annual Meeting
Orlando, FL
Session #85

October 28, 2014

Presented By

James T. O’Connor, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
Topics

Identification of ongoing ACA-related risks
  • Sunset of transitional reinsurance and risk corridor programs
  • Evolution of risk adjustment program
  • Increase in the Insurer fee

Implementation of new phase of ACA
  • The “Cadillac” excise tax

Strategies for addressing risk and opportunities
Sunset of transitional reinsurance program

- 3-year program ending after 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Funding</th>
<th>Individual Marketplace</th>
<th>Group Market Assessments per Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rate Reduction from 2013</td>
<td>Implied Rate Increase</td>
</tr>
<tr>
<td>2013</td>
<td>$0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>$10B</td>
<td>8% to 14%</td>
<td>-8% to -14%</td>
</tr>
<tr>
<td>2015</td>
<td>$6B</td>
<td>4% to 8%</td>
<td>4% to 7%</td>
</tr>
<tr>
<td>2016</td>
<td>$4B</td>
<td>2% to 5%</td>
<td>2% to 3%</td>
</tr>
<tr>
<td>2017**</td>
<td>$0</td>
<td>0%</td>
<td>2% to 5%</td>
</tr>
</tbody>
</table>

* Estimated – assumes 4% growth in membership over which assessment is made
** Residual funding not paid out in 2014-2016, if any, can be used in 2017 and 2018

- Double payments on high-risk claimants goes away
- There is some push to continue the reinsurance program
Sunset of the risk corridor program

3-year program ending after 2016

Purpose is to provide protection to health plans in an uncertain pricing environment

Assumes pricing environment stabilizes by 2017

But did not anticipate various delays in ACA implementation

E.g. transitional program for retaining current coverage through much of 2017

Still not entirely clear how program will be administered

Budget neutral expectations by CMS

CBO projects government will reap payments from health plans

Many health plans believe significant payouts to health plans
Sunset of the risk corridor program

How intertwined is managed competition with the risk corridor program?

- Some health plans have been willing to risk having premium rates lower than those recommended by their actuaries
- Makes the lure of larger market share ever more tempting

Will aggressively priced health plans be able to survive without the risk corridor and reinsurance programs?

- May have challenges to get larger rate increases approved
- Fear of media attention if high rate increases are proposed
- Market compression in health plans offering coverage through exchanges is quite possible
- Survival of the fittest
The ongoing risk adjustment program

- By 2017, risk factor experience should give CMS ability to tweak factors for more balanced results
- Will help shape how health plans operate
  - Influence more accurate coding by healthcare providers
  - Introduce more care management and collaboration with healthcare providers
  - Will influence target marketing approaches – what conditions are most profitable? Least profitable?
- May result in plan design changes
  - Directed drug formularies
  - Services covered
  - Cost-sharing structures
  - Out-of-network coverage
The §9010 health insurer fee

- Increases in the insurer fee

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Fee</th>
<th>% Increase</th>
<th>% of Premium*</th>
<th>Range*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$8.0B</td>
<td>n/a</td>
<td>1.7%</td>
<td>0.0% - 2.4%</td>
</tr>
<tr>
<td>2015</td>
<td>$11.3B</td>
<td>41%</td>
<td>2.1%</td>
<td>0.0% - 3.0%</td>
</tr>
<tr>
<td>2016</td>
<td>$11.3B</td>
<td>0%</td>
<td>1.9%</td>
<td>0.0% - 2.7%</td>
</tr>
<tr>
<td>2017</td>
<td>$13.9B</td>
<td>23%</td>
<td>2.1%</td>
<td>0.0% - 3.0%</td>
</tr>
<tr>
<td>2018</td>
<td>$14.3B</td>
<td>3%</td>
<td>2.0%</td>
<td>0.0% - 2.8%</td>
</tr>
<tr>
<td>2019+</td>
<td>Growth of fee indexed to rate of premium growth</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Average for all affected lines of business with income tax recognition; Milliman Research Report, “ACA health insurer fee”, Doucet and Yahnke, April 2013

- Fees are higher for for-profits and large plans than for non-profits and small plans
- Commercial business expected to pay 60% of fees
The “Cadillac Tax”

- Becomes effective in 2018
- Aims to discourage very rich benefit plans
- Equals 40% of the excess of actual costs over base costs
- Base costs equal:
  - $10,200 for self-only coverage
  - $27,500 for other coverage, including all multi-employer plan coverage
  - Increased for retirees, high-risk professions, and telecommunication/electrical lines installers by $1,650 for self-only coverage and $3,450 for other coverage
  - Adjusted for excess BCBS FEHBP trend
The “Cadillac Tax”

- Purposes of the excise tax
  - Discourages rich benefit plans that tend to have higher utilization and cost levels
  - Reduces the tax deductions that employers take if they move to less costly plans
  - Increases tax revenues through the excise tax
  - Increases tax revenues if employers increase wages

- Employers are in the process of reviewing the likelihood of triggering the tax and making their plans leaner to avoid the tax
Extension of small group rules to groups up to 100

- Extension effective in 2016
- These groups need to contend with same plan design, rating and underwriting issues that groups under 50 faced – but likely not to be as dramatic impact on average except perhaps the rating issues
- Groups may self-select to avoid new requirements
  - Move to self-funding if healthier than average small group
  - Change to leaner coverage to avoid the “pay or play” penalty
  - Convert to PEO or join an eligible association or MEWA to maintain large group status
- Likely to impact ACA small group community rates
Employer mandate effective in 2015

“Free ride” penalties apply if employer:

- **Does not offer a health plan to at least 70% of full-time employees during transition period and 95% after transition**
  - Penalty is $2,000* x FTEs (less 30 FTEs), if at least one employee received premium tax credit [transitional policy extended the 30 FTE deductible to 80]

- **Offers a health plan considered not affordable**
  - Employee single contribution exceeds 9.5% of household income
  - Penalty is lesser of $3,000* x FTE who receives premium tax credit or $2,000* x FTEs (less 30 FTEs) [extended to 80 during transitional period]

- **Offers a health plan less than 60% actuarial value**
  - Penalty is lesser of $3,000* x FTE who receives premium tax credit or $2,000 x FTEs (less 30 FTEs) [extended to 80 during transitional period]

* at 2014 levels; will increase annually indexed to national per capita premium growth rate
**Employer mandate – avoiding the penalty**

- Cover at least 70% of full-time employees during transition period and 95% after transition.

- Could offer plan with excluded benefits that still meets 60% minimum value (MV) per the federal calculator.

- Could offer plans with less than 60% MV as additional options to a 60% (or higher) MV plan.

- Could raise wages of lowest paid employees to assure no employee will be charged more than 9.5% of household income [as noted in last slide – there is a 30 employee exemption (80 during transition)].
Small employer strategies for avoiding ACA rating rules or reducing premium rates

- Low attachment point stop-loss reinsurance for small employers
- Use of Professional Employer Organizations (PEOs) for health coverage
- Use of eligible MEWAs and associations to avoid ACA rating and underwriting requirements
- Endorsement or adoption of worksite products to supplement low MV or limited service coverage
Exchanges after 2016

Individual Public Exchanges
- Will continue to thrive and increase enrollment as long as they are the only source of premium and benefit subsidies
- May see larger rate increases though as 2 of 3Rs go away and as provider market coalesce to resist deep discounting

Small Group Public Exchanges (SHOPs)
- Will struggle to become a meaningful option for small employers

Private Exchanges
- Greater likelihood for success than SHOPs
- Can they differentiate themselves from current multiple plan choice?
- More plan choice; less cost; less administrative hassle?
Other possible changes after 2016

- Waivers for state innovation
  - May be quite varied in allowed changes
- States can extend exchanges to large groups
- Interstate compacts
- May stimulate already allowed variations at state level
  - Merging of individual market with small group market
  - Increased compression of premium rates
Providers and the ACA Marketplace after 2016

Narrow networks – will deep discounts from health care providers be sustainable?

Will high-value networks proliferate?
- More coordination and collaboration between providers and health plans
- Pay for results rather than pay for services
- Increased reliance on care management
- Easier to assure accurate risk-score coding

Without payer data, providers do not know how patients might be accessing the system inefficiently (yet they are being asked to take on this risk)

Will accountable care organizations (ACOs) and provider-owned plans continue to increase?

Can these models be successful on a large scale?
For further information contact

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