2020 VIRTUAL ANNUAL MEETING & EXHIBIT
OCTOBER 26–29, 2020
Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act

Paul Houchens, FSA, MAAA
Lindsay Kotecki, FSA, MAAA
Hans Leida, PhD, FSA, MAAA

October 27, 2020
SOCIETY OF ACTUARIES
Antitrust Compliance Guidelines

Active participation in the Society of Actuaries is an important aspect of membership. While the positive contributions of professional societies and associations are well-recognized and encouraged, association activities are vulnerable to close antitrust scrutiny. By their very nature, associations bring together industry competitors and other market participants.

The United States antitrust laws aim to protect consumers by preserving the free economy and prohibiting anti-competitive business practices; they promote competition. There are both state and federal antitrust laws, although state antitrust laws closely follow federal law. The Sherman Act, is the primary U.S. antitrust law pertaining to association activities. The Sherman Act prohibits every contract, combination or conspiracy that places an unreasonable restraint on trade. There are, however, some activities that are illegal under all circumstances, such as price fixing, market allocation and collusive bidding.

There is no safe harbor under the antitrust law for professional association activities. Therefore, association meeting participants should refrain from discussing any activity that could potentially be construed as having an anti-competitive effect. Discussions relating to product or service pricing, market allocations, membership restrictions, product standardization or other conditions on trade could arguably be perceived as a restraint on trade and may expose the SOA and its members to antitrust enforcement procedures.

While participating in all SOA in person meetings, webinars, teleconferences or side discussions, you should avoid discussing competitively sensitive information with competitors and follow these guidelines:

• Do not discuss prices for services or products or anything else that might affect prices
• Do not discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
• Do not speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
• Do leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
• Do alert SOA staff and/or legal counsel to any concerning discussions
• Do consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone’s responsibility; however, please seek legal counsel if you have any questions or concerns.
Presentation Disclaimer

Presentations are intended for educational purposes only and do not replace independent professional judgment. Statements of fact and opinions expressed are those of the participants individually and, unless expressly stated to the contrary, are not the opinion or position of the Society of Actuaries, its cosponsors or its committees. The Society of Actuaries does not endorse or approve, and assumes no responsibility for, the content, accuracy or completeness of the information presented. Attendees should note that the sessions are audio-recorded and may be published in various media, including print, audio and video formats without further notice.
March 23, 2010

**The Dallas Morning News**

**Health Care Overhaul**

New law, old divisions collide

President Barack Obama, embattling Democrats vote Tuesday night with 205 House Republicans, voted Wednesday to block a bill that would alter the structure of the health care law and the way it works.

Change coming, but essence of plan is years off

**The Washington Post**

With bill passed, November is now

Both parties plan to use health-care law as a key election issue in 2010.

**Senate panel passes financial regulation bill**

**CONSUMER AGENCY INFEED**

Obama's agenda takes another big step

61 days from near-defeat to victory

"How Obama revived his health-care bill"

**Chicago Tribune**

It's Ozzie vs. Oney on Twitter

QUANTUM? Call 1-844-TRIBLINE

24 hours of chicagonow.com

HEALTH CARE OVERHAUL

WHAT'S IN IT FOR YOU?

Google to stop Web censoring in China

How VIPs lobbied schools

Milliman
Shelter in place ordered
Dallas County measure takes effect at 11:59 p.m. today to 'save as many lives as possible'

Nearly 300 new cases in state
Illinois officials call for volunteers to step up

NY fast turning into US hot spot
Pasta Wars, state for most deaths as restrictions set in

No deal in Senate on stimulus bill yet

Labs, and Congress, racing for answers
Vaccine, treatments in works; lawmakers consider remote voting

Scientists in all-out effort to find vaccine

Rules clash with virus guidelines

Some dentists driven by dollars

Private system puts from overcharged

Congress to probe Trump's 'price gouging'

Coronavirus pandemic

Milliman
The Patient Protection and Affordable Care Act

STAGES OF THE ACA IN ITS FIRST DECADE

Preparation and Implementation (2010–2013)
These were the years leading up to the full implementation of the ACA’s market and rating rules. States were preparing for coverage expansions through Medicaid and the insurance exchanges, and insurers were preparing to comply with new market rules.

Rollout and Disruption (2014–2016)
These were the early years of the ACA’s exchanges, when many markets experienced large shifts in insurer market share and many insurers endured financial losses.

Repeal and Replace (2017–2018)
These years saw many insurers exit the exchange markets, followed by substantial premium rate volatility as insurers adjusted to emerging experience and regulatory changes led to greater uncertainty.

Patchwork Quilt (2019–2020)
There were signs of increased stability as data matured, competition became more steady and more states used waivers to implement reinsurance programs.
### Outcome measures associated with the ACA’s stated goals

<table>
<thead>
<tr>
<th>ACA Goal</th>
<th>Outcome Metrics</th>
<th>Assessment Criteria</th>
</tr>
</thead>
</table>
| Reducing the uninsured rate      | ▪ Uninsured rate—percentage of the population that does not have comprehensive health insurance coverage  
▪ Enrollment in Medicaid and the individual market | Reductions in the uninsured rate and increases in Medicaid and individual market enrollment would suggest improvements in access and/or the affordability of coverage.                                                                 |
| Competition in the exchanges     | ▪ Change in the number of insurers participating in the exchanges               | More insurers participating in the exchange fosters competition and more coverage options for consumers. Reductions in the number of insurers signals instability and fewer choices for consumers.                                      |
| Premium rate level and volatility| ▪ Individual market premium rate levels  
▪ Changes in individual market premium rates over time | Substantial increases or variability in premium rates indicate growth in health care spending, lack of market stability, or both. Low or moderate premium changes (reflecting changes in health care costs more than changes in the risk profile of consumers or the competitive landscape) are indicative of more stable markets. |
ACA outcomes associated with stated goals

Notes: Premium rate levels reflect the nationwide average monthly premium for the lowest premium on-exchange silver plan for a person age 40. Insurer counts reflect the count of parent insurance companies, where each company is counted once for each state exchange it participates in. The uninsured rate is for individuals under age 65.
Distribution of under age 65 population: 2013 - 2018

- **Employer and all other Non-ACA compliant ACA Traditional Medicaid Medicaid expansion Uninsured**

2013:
- Employer and all other: 58%
- Non-ACA compliant: 4%
- ACA: 17%
- Medicaid expansion: 3%
- Traditional Medicaid: 21%
- Uninsured: 1%

2014:
- Employer and all other: 56%
- Non-ACA compliant: 2%
- ACA: 14%
- Medicaid expansion: 5%
- Traditional Medicaid: 22%
- Uninsured: 1%

2015:
- Employer and all other: 56%
- Non-ACA compliant: 1%
- ACA: 11%
- Medicaid expansion: 5%
- Traditional Medicaid: 22%
- Uninsured: 1%

2016:
- Employer and all other: 56%
- Non-ACA compliant: 1%
- ACA: 10%
- Medicaid expansion: 5%
- Traditional Medicaid: 22%
- Uninsured: 0.5%

2017:
- Employer and all other: 57%
- Non-ACA compliant: 1%
- ACA: 11%
- Medicaid expansion: 5%
- Traditional Medicaid: 22%
- Uninsured: 1%

2018:
- Employer and all other: 57%
- Non-ACA compliant: 0.5%
- ACA: 11%
- Medicaid expansion: 5%
- Traditional Medicaid: 21%
- Uninsured: 11%
Public opinion of the ACA

Larger Share Of Public View ACA Favorably Than Unfavorably

Do you have a generally favorable or generally unfavorable opinion of the 2010 health reform law?

SOURCE: KFF Health Tracking Polls. See topline for full question wording and response options.
Observation #1
Medicaid expansion played a bigger role than expected in reducing the uninsured rate

- CBO estimated non-elderly uninsured rate would be 10% in 2018
- While estimated actual uninsured rate was 11%, Medicaid has played a significantly greater role in reducing the uninsured rate relative to the exchanges.

![Bar chart showing millions of persons in 2013 and 2019 for Individual, Medicaid, and Uninsured categories.]
- Individual: 21% increase from 10.9 to 13.2
- Medicaid: 24% increase from 57.7 to 71.4
- Uninsured: 33% decrease from 46.2 to 30.9
Observation #1
Medicaid expansion played a bigger role than expected in reducing the uninsured rate
Medicaid and exchanges role during COVID pandemic

Emerging data points

Figure 1: SEP Enrollment from the end of Open Enrollment through May, 2017-2020 Coverage Years

Note: 2017 has approximately 1.5 fewer months in the reporting period than the other years due to a longer Open Enrollment Period.


Note: Health Industry data excludes companies that file on non-orange blanks and many California insurers

Figure 1: National Medicaid and CHIP enrollment, July 2019 to June 2020, CMS Performance Indicator Data


Health Industry (Orange Blank) - Comprehensive Individual and Group Coverage Quarter-End Enrollment

Observation #2

State decisions to expand Medicaid led to greater reductions in the uninsured rate relative to non-expansion states.
Observation #3
Price is a key consideration for individual market consumers

- Every exchange enrollee is exposed to the total difference in premium among offered plans (excluding cases where subsidy value exceeds plan’s total premium)
- In 2014, 64% of healthcare.gov consumers selected the lowest or second-lowest cost plan across metallic tiers
Observation #4
Insurer competition in the exchanges and insurer profitability were consistent with the underwriting cycle

- What is the underwriting cycle?

- PHASE 1 -
  New entrants deliberately set premiums lower than their competitors to gain market share.

- PHASE 2 -
  Existing firms respond by undercutting the new entrants.

- PHASE 3 -
  Intense competition ensues, pushing premiums below costs, causing poor insurer financial performance and/or market exits.

- PHASE 4 -
  Remaining insurers turn attention to returning to profitability.
Insurer competition in the exchanges and insurer profitability were consistent with the underwriting cycle.

Observation #4

• SHCE reported underwriting margin of approximately 6% in CY 2019
• CY 2020 Quarterly MLRs tracking similar to CY 2019

Note: 2014 through 2016 underwriting results do not reflect any risk corridor recoveries as a result of Maine Community Health Options v. United States.
Observation #5
Initial exchange rates were unsustainable

<table>
<thead>
<tr>
<th>Lowest silver monthly premiums</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest state</td>
<td>$397</td>
<td>$488</td>
<td>$684</td>
</tr>
<tr>
<td>Median state</td>
<td>$257</td>
<td>$257</td>
<td>$281</td>
</tr>
<tr>
<td>Lowest state</td>
<td>$175</td>
<td>$178</td>
<td>$202</td>
</tr>
<tr>
<td>Nationwide average</td>
<td>$256</td>
<td>$265</td>
<td>$286</td>
</tr>
</tbody>
</table>

1. Highest, median, and lowest states can change each year.

Nationwide average rate increase was 4% in 2015 and 8% in 2016.
Observation #5

Initial exchange rates were unsustainable

<table>
<thead>
<tr>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>-10%</td>
<td>-5%</td>
<td>0%</td>
</tr>
<tr>
<td>5%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Average MLR was **89%** in 2014, **95%** in 2015, and **94%** in 2016.
Observation #6

Substantial premium rate increases were associated with poor financial experience, decreases in competition, and political uncertainty.
Observation #6

Substantial premium rate increases were associated with poor financial experience, decreases in competition, and political uncertainty

<table>
<thead>
<tr>
<th>Lowest silver monthly premiums</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest state</td>
<td>$397</td>
<td>$488</td>
<td>$684</td>
<td>$910</td>
<td>$862</td>
</tr>
<tr>
<td>Median state</td>
<td>$257</td>
<td>$257</td>
<td>$281</td>
<td>$339</td>
<td>$474</td>
</tr>
<tr>
<td>Lowest state</td>
<td>$175</td>
<td>$178</td>
<td>$202</td>
<td>$239</td>
<td>$287</td>
</tr>
<tr>
<td>Nationwide average</td>
<td>$256</td>
<td>$265</td>
<td>$286</td>
<td>$340</td>
<td>$452</td>
</tr>
</tbody>
</table>

1. Highest, median, and lowest states can change each year.

Nationwide average rate increase was **19%** in 2017 and **33%** in 2018.
Observation #7
With few exceptions, insurer financial results were consistent with national trends.

Average MLR was **87%** in 2017 and **80%** in 2018.

Observation #8

Subsidized exchange consumers experienced lower out-of-pocket premium costs as premium rates increased in 2017 and 2018, while non-subsidized individual market enrollment dropped substantially as a result of decreased coverage affordability.

*Premium reflects the average 40 year old premium by metro and rural regions by state.*
Observation #8

Subsidized exchange consumers experienced lower out-of-pocket premium costs as premium rates increased in 2017 and 2018, while non-subsidized individual market enrollment dropped substantially as a result of decreased coverage affordability.

- While subsidy-eligible consumers are insulated from premium rate increases, non-subsidy-eligible consumers bear full impact of premium rate increases.
Observation #9

Premium rates began to plateau in 2018 with implementation of state-based reinsurance programs via Section 1332 waivers and improvements in insurer financials

- Premium rate impacts from state-based reinsurance programs

Note: Premiums reflect the average monthly exchange premium for the silver premium plans available to a person age 40.
Observation #10

Vast majority of the remaining 30 million uninsured persons have income <250% FPL

UNINSURED PERSONS BY CITIZENSHIP STATUS AND HOUSEHOLD INCOME LEVEL

| Household Income (FPL%) | Uninsured Rate | | | | |
|------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                        | Citizen        | Non-citizen    | Citizen        | Non-citizen    | Citizen        | Non-citizen    | Citizen        | Non-citizen    |
| <139%                  | 21.4%          | 9.8%           | 54.5%          | 33.8%          | 28.0%          | 21.4%          | 71.3%          | 59.4%          |
| 139% to 250%           | 19.0%          | 10.3%          | 50.2%          | 34.3%          | 22.5%          | 17.3%          | 62.7%          | 49.0%          |
| 251% to 400%           | 10.3%          | 6.2%           | 33.6%          | 23.1%          | 12.4%          | 10.3%          | 40.5%          | 33.3%          |
| 400%+                  | 4.0%           | 2.6%           | 13.7%          | 9.6%           | 5.1%           | 4.6%           | 17.7%          | 15.4%          |

**States That Expanded Medicaid**

<table>
<thead>
<tr>
<th>Income (FPL%)</th>
<th>2013</th>
<th>2018</th>
<th>2013</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;139%</td>
<td>21.4</td>
<td>9.8</td>
<td>54.5</td>
<td>33.8</td>
</tr>
<tr>
<td>139% to 250%</td>
<td>19.0</td>
<td>10.3</td>
<td>50.2</td>
<td>34.3</td>
</tr>
<tr>
<td>251% to 400%</td>
<td>10.3</td>
<td>6.2</td>
<td>33.6</td>
<td>23.1</td>
</tr>
<tr>
<td>400%+</td>
<td>4.0</td>
<td>2.6</td>
<td>13.7</td>
<td>9.6</td>
</tr>
</tbody>
</table>

**States That Did Not Expand Medicaid**

<table>
<thead>
<tr>
<th>Income (FPL%)</th>
<th>2013</th>
<th>2018</th>
<th>2013</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;139%</td>
<td>28.0</td>
<td>21.4</td>
<td>71.3</td>
<td>59.4</td>
</tr>
<tr>
<td>139% to 250%</td>
<td>22.5</td>
<td>17.3</td>
<td>62.7</td>
<td>49.0</td>
</tr>
<tr>
<td>251% to 400%</td>
<td>12.4</td>
<td>10.3</td>
<td>40.5</td>
<td>33.3</td>
</tr>
<tr>
<td>400%+</td>
<td>5.1</td>
<td>4.6</td>
<td>17.7</td>
<td>15.4</td>
</tr>
</tbody>
</table>

Notes: Uninsured rates are for the under-age-65 population. The split of states in the table are based on Medicaid expansion status as of 2018. See Appendix A for additional detail.
Observation #11

Medicaid-focused insurers achieved the largest market share gains in the individual health insurance market

**TOP 10 INDIVIDUAL MARKET INSURERS IN ENROLLMENT: 2013 AND 2018**

<table>
<thead>
<tr>
<th>Top 10 Insurers</th>
<th>Membership (in Thousands)</th>
<th>Top 10 Insurers</th>
<th>Membership (in Thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2018</td>
<td>Growth</td>
</tr>
<tr>
<td>Anthem</td>
<td>1,773.3</td>
<td>658.1</td>
<td>−1,115.2</td>
</tr>
<tr>
<td>UnitedHealth Group</td>
<td>1,000.4</td>
<td>307.4</td>
<td>−693.0</td>
</tr>
<tr>
<td>HCSC Group</td>
<td>868.9</td>
<td>850.5</td>
<td>−18.3</td>
</tr>
<tr>
<td>Aetna</td>
<td>711.3</td>
<td>2.5</td>
<td>−708.8</td>
</tr>
<tr>
<td>Humana</td>
<td>502.5</td>
<td>0.0</td>
<td>−502.5</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of NC</td>
<td>394.7</td>
<td>475.0</td>
<td>80.3</td>
</tr>
<tr>
<td>Kaiser Foundation Group</td>
<td>389.6</td>
<td>1,184.1</td>
<td>794.5</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of FL</td>
<td>385.0</td>
<td>1,174.7</td>
<td>789.6</td>
</tr>
<tr>
<td>Assurant</td>
<td>347.9</td>
<td>0.0</td>
<td>−347.9</td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td>256.8</td>
<td>786.3</td>
<td>529.5</td>
</tr>
<tr>
<td>Top 10 total</td>
<td>6,630.4</td>
<td>5,438.5</td>
<td></td>
</tr>
<tr>
<td>Total individual market</td>
<td>10,960.3</td>
<td>13,105.0</td>
<td></td>
</tr>
<tr>
<td>Top 10 market share</td>
<td>60.5%</td>
<td>41.5%</td>
<td></td>
</tr>
</tbody>
</table>
Lessons learned

Looking forward, we ask what lessons may be drawn to inform the next 10 years under the ACA—or whatever new programs or reforms follow after it?

Learn to embrace change

Insurance markets remain fundamentally local

Insurers and regulators were able to adapt – eventually

Actions intended to stabilize markets can destabilize them
Looking forward - Key considerations related to the impact of COVID-19

- Potential impact on 2020 insurer financial results
  - Increases to claim costs due to testing and direct cost of COVID-19 care
  - Reductions in claim costs due to deferred/eliminated services
  - Premium credits and interplay with APTCs
  - MLR implications (three-year impact)

- Potential impact on 2021 individual market commercial rates / premium subsidies
  - Potential pent-up demand
  - Continuation in deferred services / additional waves
  - Direct COVID-19 costs (treatment, testing, vaccines, etc.)
  - Population health
  - Provider reimbursement arrangements
  - Potential impact of economic disruptions leading to population shifts between markets

- Potential impact in 2022 and beyond?
Looking forward – Other regulatory considerations

- Court cases
  - Implications of Supreme Court decision on risk corridors
  - Future CSR lawsuits
  - California vs. Texas

- 2020 United States elections
  - Protect and build
  - Repeal and replace
Life of an ACA pricing actuary
Life of an ACA pricing actuary
Thank you

Paul Houchens, FSA, MAAA
paul.houchens@milliman.com

Lindsay Kotecki, FSA, MAAA
lindsy.kotecki@milliman.com

Hans Leida, PhD, FSA, MAAA
hans.leida@milliman.com

LINK TO FULL REPORT:
https://www.soa.org/resources/research-reports/2020/50-states-50-stories/
Caveats

We relied on publicly available data and other information for this analysis. We have performed a limited review of the data and other information and checked for reasonableness and consistency, and we have not found material defects in the data or information used. If there are material defects in the data or other information, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

We have reviewed the models used in this analysis, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). We developed this analysis to conduct fact-based, data-driven research on measurable outcomes in the individual and Medicaid markets 10 years following the inception of the Patient Protection and Affordable Care Act. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Differences between estimates in this analysis and actual amounts depend on the extent to which estimated outcomes conform to the assumptions made for this analysis. It is certain that actual amounts will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from estimated outcomes to the extent the assumptions in this analysis are not realized. This analysis of historical data and outcomes may differ materially from future outcomes.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. Paul Houchens, Lindsy Kotecki and Hans Leida are members of the American Academy of Actuaries and meet its qualification standards to perform the analysis and render any actuarial opinions contained herein.