

Session 17PD, The Impact of Competing Products on ACA markets

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The Real Impact of Alternative Products on ACA Markets

Session 17 - 2018 SOA Health Meeting

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Summary of Discussion

- Overview of Individual (Nongroup) Market
- Consumer Incentives/Behavior
- Where are we? / How did we get here? / Tradeoffs
- "Single Risk Pool"?
- Predominant Concerns in Individual Market (short trip down Memory Lane)
 - Market Perspective (restriction on enrollee choices to protect market)
 - Enrollee Perspective (freedom of choices)
 - Tension between these perspectives
 - Helpful to think in these terms when evaluating problems and solutions
 - And "Yes", we should absolutely be involved the problem/solution evaluation
- 2019 (and beyond)
 - Premium Dynamics
 - Actuarial Modeling
- Conclusions/Considerations

Overriding Assumption in this Presentation: Everyone has a proper understanding of how health insurance markets function, and they behave rationally. Reminder: Health insurance is not complicated like hats.



SUNSHADE

If only you could somehow attach it to a hat.

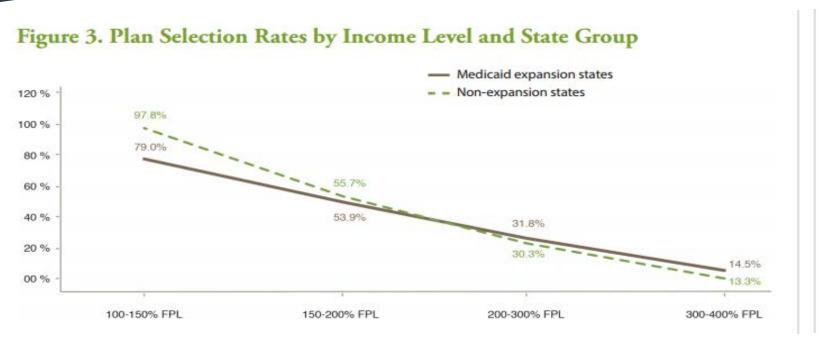
ACA Individual Market Overview

- Premium rates are generally higher due to "market rules" (guarantee issue, community rating, prescribed factors) and essential health benefits
- Majority of the market is subsidized
 - Enrollees with income <400% of FPL pay fixed % of income for 'benchmark' plan
 - Federal government pays difference between benchmark plan gross premium and enrollee premium contribution
 - This amount, the 'Advanced Premium Tax Credit' (APTC), can be applied to purchase other plans on the individual exchanges
- Result is a mixture of various value propositions
 - Some enrollees have free coverage or pay very little
 - Other enrollees are asked to pay significantly more than they otherwise would in a loosely (e.g. pre-ACA markets in many states) regulated market

Enrollment Incentives/Disincentives

- The ACA largely benefits:
 - People with expensive chronic conditions
 - Elderly
 - Low-income individuals
 - People in high cost areas
 - Large families
- Conversely, the ACA generally harms:
 - Healthy individuals
 - High-income individuals
- Consequently, skewed enrollment and pricing challenges
- Income is large differentiator; high-income individuals look for other options

2015 Enrollment by Subsidized Income Level



Source: The Urban Institute. HIPSM-ACS 2015, Medicaid expansion status is being defined as of September 2015, Effectuated Enrollment Data from CMS. https://www.cms.gov/ Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html

Where are we? How did we get here? / Tradeoffs

- ACA Impact on Groups of People
 - Helped individuals with chronic conditions and/or low incomes
 - Increased premiums for others and costly for taxpayers
 - Brookings estimated that ACA only benefited 20% of lowest income earners

http://triblive.com/opinion/featuredcommentary/5590974-74/income-obamacare-percent

- Individual market is smaller than expected. Consensus agreement that rates are high. Annual (and overemphasized in my opinion) focus on annual rate changes.
- Structural issues ASOP 12 risk classification challenge: misalignment between market rules (premium impact) and subsidies
- Transitional policies (existing enrollees vs. market concern)
- CSR defunding (subsidized enrollees vs. taxpayers) http://axenehp.com/wp-content/uploads/2017/08/ahp inspire 20170809.pdf
- Some commentators now openly suggest ACA will work long-term but only for subsidized individuals; original opinion of some actuaries

Where are we? How did we get here? / Tradeoffs

- President Trump's Executive Order in January 2017 (Enrollee Perspective)
 - Directed HHS "to interpret regulations as loosely as allowed to minimize the financial burden on individuals, insurers, health care providers"
 - Targeted to population (healthy, high income) most harmed by ACA
- Individual Mandate Repeal (individual freedom vs. market concern)
- "Alternative Product" options (individual freedom vs. market concern)
- Each change largely helps some and harms some; we can (and should) agree on that fact, even if we have different values on whether good outweighs bad. Our values are unremarkable; our expertise is unique.
- Direction is easier to predict than magnitude, but understanding direction doesn't provide a license to exaggerate magnitude.

"Single Risk Pool"?

- Primary 2019 Concern that has been publicly expressed is the Market Perspective; "alternative products" pollute the single risk pool concept
- News flash: We never really had a single risk pool
- Escape Routes (people leaving market)
 - For young: adults <26 on parents' policies, student insurance
 - For existing policyholders: grandfathered plans, transitional plans
 - For others: group coverage opportunities (as dependent or job change) or depressing income for Medicaid eligibility, choose to be uninsured.
 - For healthy: Existing STLD plans, health sharing ministries
 - For unhealthy: high risk pools (still a few out there), Section 1332 reinsurance waivers
- Unanticipated Entry (people entering market)
 - 21st Century Cures Explicitly allows small employers to utilize HRAs and access individual market.
 - What about large employers? Already there.

http://axenehp.com/new-insurance-industry-study-features-axene-health-partners-report/

October 2016 was a Fascinating Month

- Monumental presidential election
 - Health insurance is a huge issue
- State of Individual Market
 - Signs of trouble:
 - Listed in November 2016 Health Watch article:

https://www.soa.org/Library/Newsletters/Health-Watch-Newsletter/2016/november/hsn-2016-iss-81-fann.aspx

- High 2017 Premium Increases
- Enrollment starting downward slide (realization that market would be about 50% of projected)
- Carriers exiting market, others remaining amid staggering losses
- 12.6% a number that needs no explanation
- 3Rs lawsuits
- Regret over transitional plans
- Whoa! Where did this STLD growth come from? Impacting ACA market concern.

- NBPP comments on risk adjustment (following CMS white paper and conference) <u>https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf</u>
- Emergency risk adjustment regulation in New York (residence of both presidential candidates) to "correct the current imbalance due to issues that are not accounted for in the federal program"
- Let's not forget that this followed some encouraging times and the positive developments in 2015:
 - Early implementation struggles resolved
 - Markets were growing
 - Some carriers that sat out in 2014 joined in 2015
 - Victories in the courts
- So new "Market Perspective" concerns were top of mind...

- A political campaign speech on 10/24 raised some eyebrows
 - Delivered by spouse of one of the two presidential candidates
 - You can probably guess who was more likely to give a campaign speech on health care policy when the choices are Bill Clinton and Melania Trump https://youtu.be/HpciJcyG tY
 - Problem/Solution? In spite of all of the current market challenges, the 'problem' and the 'solution' were addressed entirely from an Enrollee Perspective
 - 'Current system works fine for people covered by Medicaid, Medicare, or if "you get enough subsides on modest income"'
 - "Small business people getting killed in this deal and individuals who make just a little too much. Why?"
 - Probably shouldn't have asked himself that question....

- Rand Paul style pro-AHP arguments on why unsubsidized rate are high
 - 'They are not organized'
 - 'They don't have any bargaining power'
 - 'Insurers overcharge because the unsubsidized risk pool is "little"'
 - Ignores MLR rules, market morbidity and insists rates based on market size
- "It's a crazy system"
 - "people out there busting it, sometimes 60 hours a week, wind up with premiums doubled and coverage cut in half"
 - "Getting whacked"
 - "Craziest thing in the world"
 - "It doesn't make any sense"
 - Not insurance like life and casualty (connection unclear)
- Enrollee Perspective concern demands Enrollee Perspective solution

- A "simple" solution
 - Allow individuals adversely impacted by the ACA to buy non-ACA affordable coverage
 - "Hillary believes we should let people above the line have affordable entry" into alternative products
 - Does that sound familiar?
 - He didn't advocate STLD plans or AHPs
 - "Let people buy into Medicare or Medicaid"
 - No one raised any concern about the residual impact on the market
 - Did anyone even think about that?
 - Is that interesting?

Compared to 2018:

- What's the same?
 - Both parties identify same problem
 - Both parties offer similar solutions
 - Let chips in the market fall where they may; affordable options for adversely impacted individuals is primary goal
- What's different?
 - Oversized rhetoric
 - STLD plans and AHPs aren't subsidized by the government
 - An element of health status bifurcation
 - STLD plans and AHP will generally attract a healthier population
- Substance vs. Semantics

2017 SOA Health Meeting Survey on ACA Solution?

Do you want?

- a) Market-based solution
- b) 'Fix' the ACA
- c) Single-payer
- d) I don't know

Follow Up Survey

Is the recently House bill (AHCA)?

- a) Market-based solution
- b) 'Fix' the ACA

Enrollment Impact (IM Repeal & Expanded STLD)

2019 Projection (thousands)		Subsidized	Unsubsidized	Total Nongroup	Uninsured	Expanded STLD
Baseline	226,967	9,748	9,700	19,448	27,901	
IM Repeal	225,996	7,990	6,002	13,992	34,328	
Expanded STLD	225,595	·	·		·	

• Source: Urban Institute, March 2018, US Population under age 65

ACA Enrollment/Premium Dynamics due to STLD Expansion

- Due to premium subsidy structure, market is immune from a premium death spiral
- Largely static morbidity level for large subsidized population who is mostly unimpacted by gross premium levels
- Unsubsidized population
 - Shrinking and becoming less healthy each year (adverse selection)
 - Having smaller relative contribution to aggregate risk pool
 - Offsetting impact could cause aggregate rates to increase or decrease
 - Not likely to have significant impact in future years

Modeling Example (Illustrative Purposes Only)

	Enrollment			Distribution			Average Morbidity (Subsidized = 1.00)			Morbidity
Year	Subsidized	Unsubsidized	Total	Subsidized	Unsubsidized	Total	Subsidized	Unsubsidized	Total	Relative to 2019
2019*	7,990,000	6,002,000	13,992,000	57.1%	42.9%	100.0%	0.962	1.154	1.045	0.930
2019	7,357,000	4,441,000	11,798,000	62.4%	37.6%	100.0%	1.000	1.328	1.124	1.000
2020	7,357,000	3,774,850	11,131,850	66.1%	33.9%	100.0%	1.000	1.434	1.147	1.021
2021	7,357,000	3,208,623	10,565,623	69.6%	30.4%	100.0%	1.000	1.548	1.167	1.039
2022	7,357,000	2,727,329	10,084,329	73.0%	27.0%	100.0%	1.000	1.672	1.182	1.052
2023	7,357,000	2,318,230	9,675,230	76.0%	24.0%	100.0%	1.000	1.806	1.194	1.062
2024	7,357,000	1,970,495	9,327,495	78.9%	21.1%	100.0%	1.000	1.951	1.201	1.069
2025	7,357,000	1,674,921	9,031,921	81.5%	18.5%	100.0%	1.000	2.107	1.206	1.073
2026	7,357,000	1,423,683	8,780,683	83.8%	16.2%	100.0%	1.000	2.275	1.207	1.074
2027	7,357,000	1,210,130	8,567,130	85.9%	14.1%	100.0%	1.000	2.457	1.206	1.074
2028	7,357,000	1,028,611	8,385,611	87.7%	12.3%	100.0%	1.000	2.654	1.203	1.071
2029	7,357,000	874,319	8,231,319	89.4%	10.6%	100.0%	1.000	2.866	1.199	1.067
2030	7,357,000	743,171	8,100,171	90.8%	9.2%	100.0%	1.000	3.095	1.193	1.061
2031	7,357,000	631,696	7,988,696	92.1%	7.9%	100.0%	1.000	3.343	1.186	1.055
2032	7,357,000	536,941	7,893,941	93.2%	6.8%	100.0%	1.000	3.610	1.178	1.048
2033	7,357,000	456,400	7,813,400	94.2%	5.8%	100.0%	1.000	3.899	1.170	1.041
2034	7,357,000	387,940	7,744,940	95.0%	5.0%	100.0%	1.000	4.211	1.161	1.034

^{*}Before STLD Expansion

Conclusions/Considerations

- Important to think about competing dynamics rather than rely on understanding of traditional markets
 - "Live at 5" is not going to do that, expect continued misinformation from other sources
- The presence of varying subsidies for a large portion of the eligible population creates a nontraditional market with mixed incentives
 - -bifurcation largely by income rather than health status
- Market is more "stable" and predictable with only subsidized enrollees
- So "What's the Real Impact of Alternative Products on ACA markets?"
 - With STLD expansion, the individual ACA market will be unattractive to healthy, high income enrollees
 - Before STLD expansion, the individual ACA market was unattractive to healthy, high income enrollees
- Long-term equilibrium: Premiums driven largely by morbidity level of subsidized market? Is that where we were heading anyway? Only on faster track now?
- 2034 lookback presentation

Association Health Plans and Short Term Limited Duration Insurance

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Principal and Consulting Actuary
Milliman
Tampa, FL

June 25, 2018





Association Health Plans



New rule vs old rule

Old rule

- AHPs may be offered but coverage (individual, SG or LG) is based on the size of the member group
- Required to be in same industry to form an AHP



New rule vs old rule

New rule

- Insurance rules based on the aggregate size of all members
- Can be formed for the sole purpose of providing health insurance
- Employers from unrelated industries can band together if in same region
- Employers from different regions can band together if in same industry
- Self-employed can join



New Rule Features

- Consumer protections still in place
 - Cannot restrict membership based on health status
 - Cannot charge higher premiums to less healthy individuals
 - Meet formal organizational requirements, with a governing body and by-laws to ensure the AHP acts in the best interest of member groups
 - Rate similarly situated employees of different member groups by the same criteria



Implementation Dates

- September 1, 2018 for new fully insured arrangements
- January 1, 2019 for existing self-insured arrangements that meet the new AHP definition and want to comply with the new rules
- April 1, 2019 for new self-insured AHPs



So how are AHP's attractive?

- Additional plan design flexibility
 - Not required to comply with EHB requirements
 - Not required to meet AV metallic tier requirements
- Exempt from CMS age curve
- Not restricted to ACA rating areas
- Not subject to ACA risk adjustment
- Better bargaining position with carriers (large group rating)
- Ability to self-insure
- Lower admin through economies of scale



Some Challenges

- Providers concerned about uncompensated care
 - History of fraud among AHPs
 - Many left with no coverage and unpaid claims
- As many as 4M projected to leave the individual and ACA markets
 - Impacts to the ACA risk pool
 - Impacts to provider contracts due to uncompensated care
- Manual rating in early years could set the pace for future increases



Short Term LimitedDuration Insurance



Not Subject to ACA Major Reforms

- Guaranteed issue? No
- Pre-ex? Yes
- EHBs? No
- Annual and lifetime coverage limits? Yes
- Health status rating? Yes!
- 3:1 age curve? Nope
- Gender rating? Why not
- Guaranteed renewability? Negative
- Calendar year duration? How does 364 days sound?



Other Features

- Subject to state rules
 - Vary from flat out prohibition to complete exemption from state regulations
- Not required to offer ACA-like benefits, but issuers have the discretion
- Health status rating could lead to significantly reduced premiums
- Could become effectively offered 60 days after final rule is published, which it has not



Some Challenges

- ACA impacts
 - If healthy employees leave
- Potential for negative PR
 - Non guaranteed renewable
 - Lack of understanding of benefits
- A viable long term option with significant enrollment?
 - Or still a niche product for specific circumstances



Questions?





Employer Choice: Alternative Funding in The Small Group Market

PATRICK PAULE

EMPLOYEE BENEFITS PROFESSIONAL

TOLEDO, OHIO



Agenda

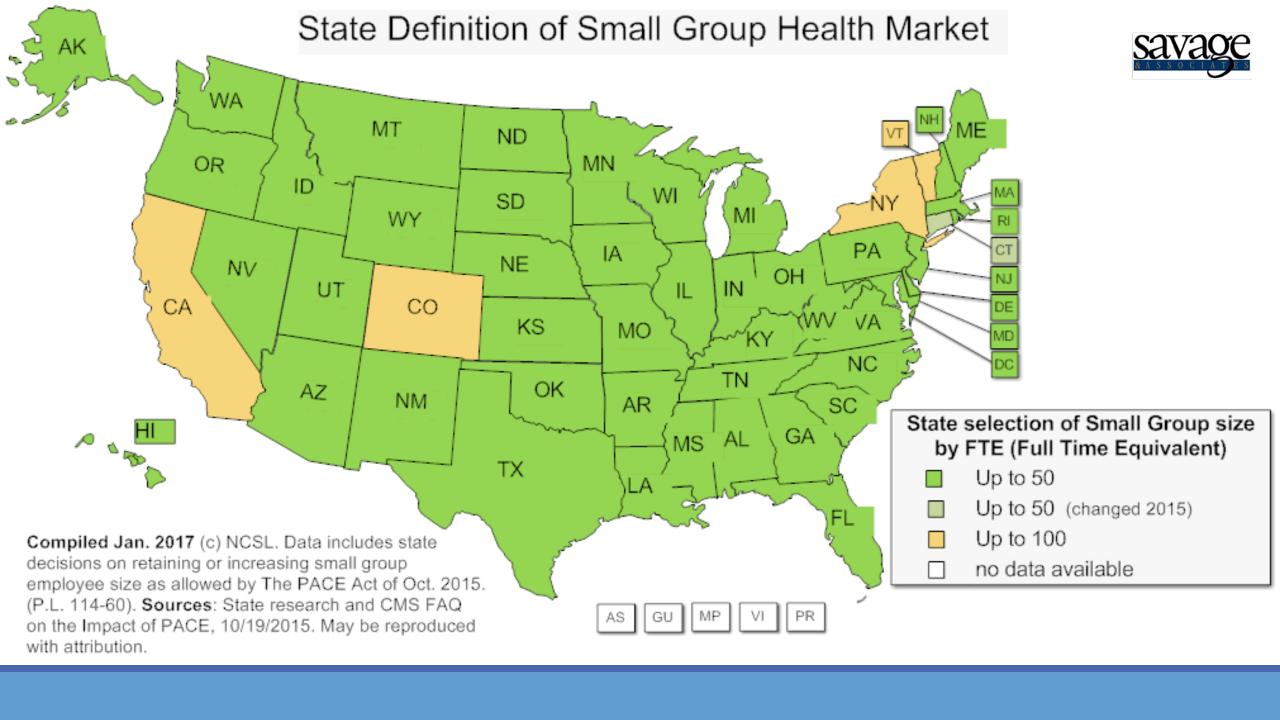
Defining Small Employer

Transitional Policies – The Ohio Experience

Employers Want Flexibility

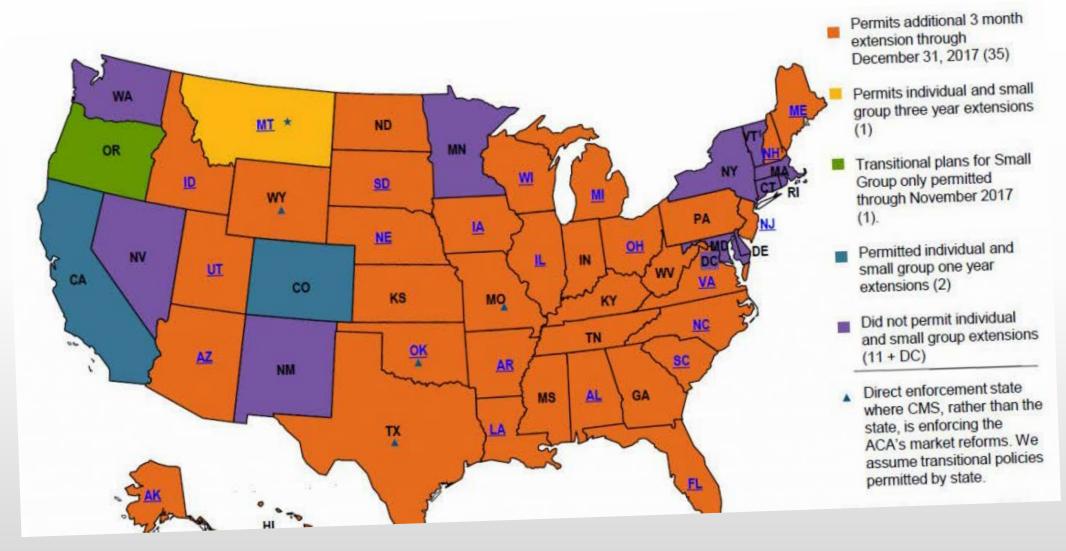
- Grandfathered
- Grandmothered
- ACA
- Self Funded
- Captive
- Level Funded
- MEWA

Whispers From Insurers

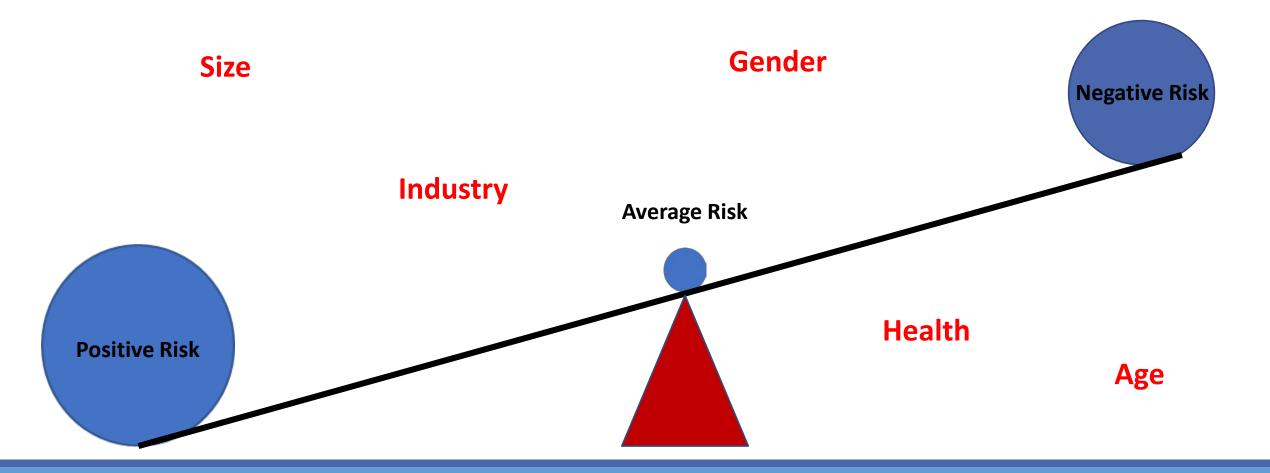


If You Like It, You Can Keep It...For Three or So Years





Pre ACA Landscape





What Type of Plan Do You Have?

Grandfathered Plans

Existed prior to March 23, 2010.

The only way to maintain this status is to stay within strict benefit design parameters and cost structures.

These plans can continue forever as long as the guidelines are kept.

Are medically underwritten.

Have broader definition for age rating factors.

Can charge different prices based on sex.

Don't have to meet strict actuarial value definitions for benefits.

Grandmothered Plans (Transitional)

Created by HHS in November of 2013.

Allows small employers to keep their noncompliant plans for an additional two years.

Plan design changes are allowed as well as changes in cost structures.

These plans will end at renewal after January 1, 2019.

Can be medically underwritten.

Don't have to meet strict actuarial value definitions for benefits.

ACA Compliant Plans

Any plan that has been introduced since January 1, 2014.

These plans must meet all ACA mandates for benefits and cost structures.

Can't discriminate on sex.

Limited age rating factors.

Are forbidden to have medical underwriting.

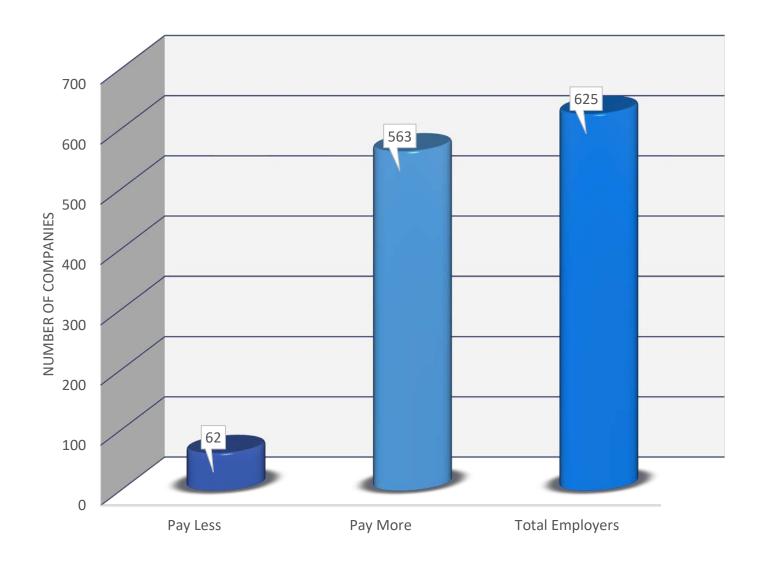


Ohio Experiment – Let Grandma Live!



- The Ohio Association of Health Underwriters (OAHU) performed a study of real data provided by its membership.
- The data included fully insured medical plan premiums for 625 small employers.
- > Results were staggering.



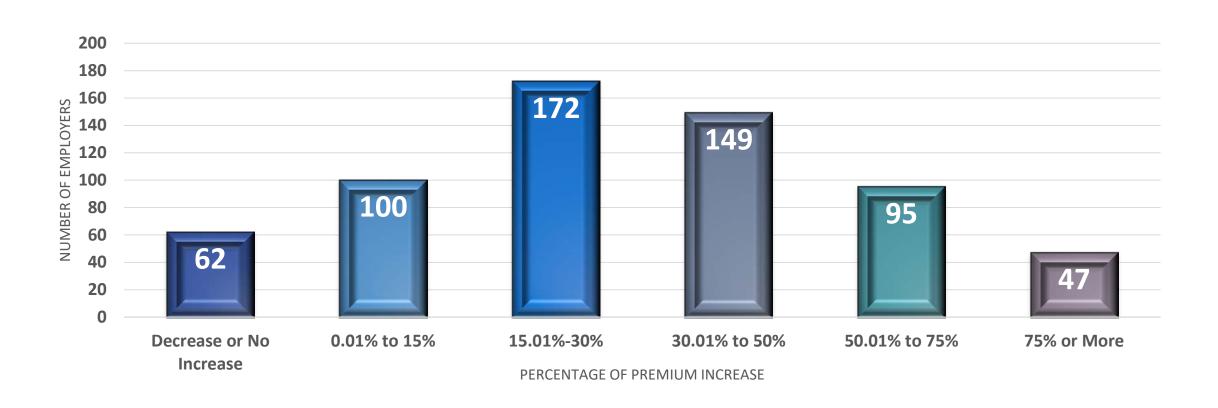


Survey Of 625 Small Employers in Ohio...

563 Faced Premium Increases

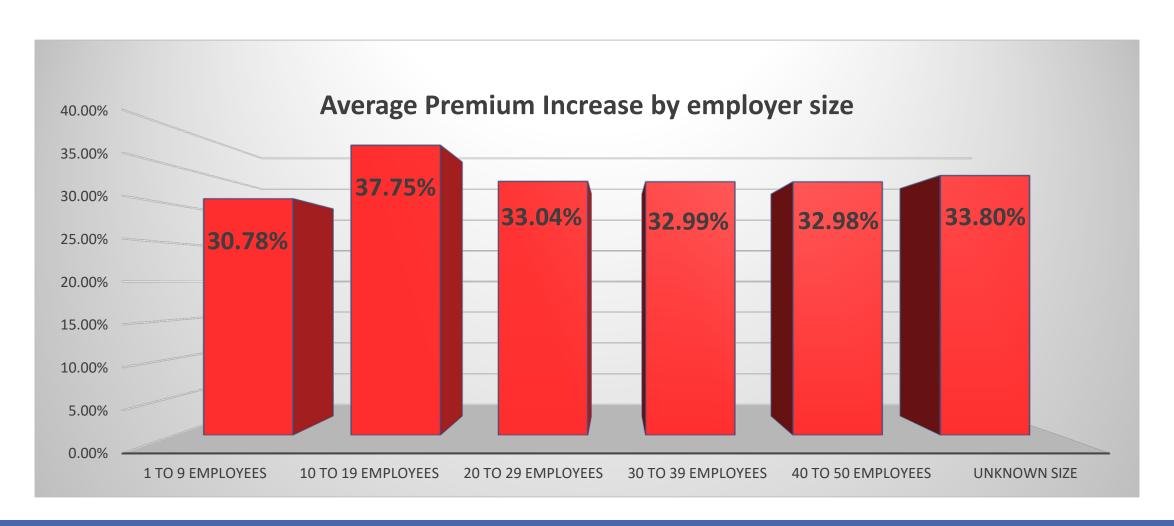


The Effect of Community Rating on 625 Small Employers in Ohio





Premium Increases are Consistent Regardless of Employer Size



"Leveling The Playing Field" Age **Positive Risk Average Risk Negative Risk**

Location

NATIONAL CATASTROPHIC TOP 10 claims conditions

Total payments	Rank	Medical condition	Value of stop-loss claims reimbursements 2013–2016	Percentage of total stop-loss claims reimbursements 2013–2016	Change* (compared to 2012–2015)	Percentage of employers with at least one stop-loss claim for this condition
32.3% Top 3 conditions 51.7% of all catastrophic claims were top 10 conditions	1	Malignant neoplasm (cancer)	\$487.4M	18.4%		48.7%
	2	Leukemia/ lymphoma/multiple myeloma (cancers)	\$219.2M	8.3%	•	17.6%
	3	Chronic/end-stage renal disease (kidneys)	\$148.3M	5.6%	•	16.4%
	4	Congenital anomalies (conditions present at birth)	\$108.9M	4.1%	No material change	10.8%
	5	Transplant	\$81.6M	3.1%	•	6.9%
	6	Disorders relating to short gestation and low birth weight (premature birth)	\$75.9M	2.9%		7.0%
	7	Septicemia (infection)	\$69.7M	2.6%	•	9.9%
	8	Complications of surgical and medical care	\$62.9M	2.4%	•	13.5%
	9	Cerebrovascular disease (brain blood vessels)	\$58.8M	2.2%	•	10.9%
	10	Pulmonary collapse/ respiratory failure (lungs)	\$57.4M	2.2%	•	10.6%
		Top ten total	\$1.4B	51.7%	1.3%	70.0%

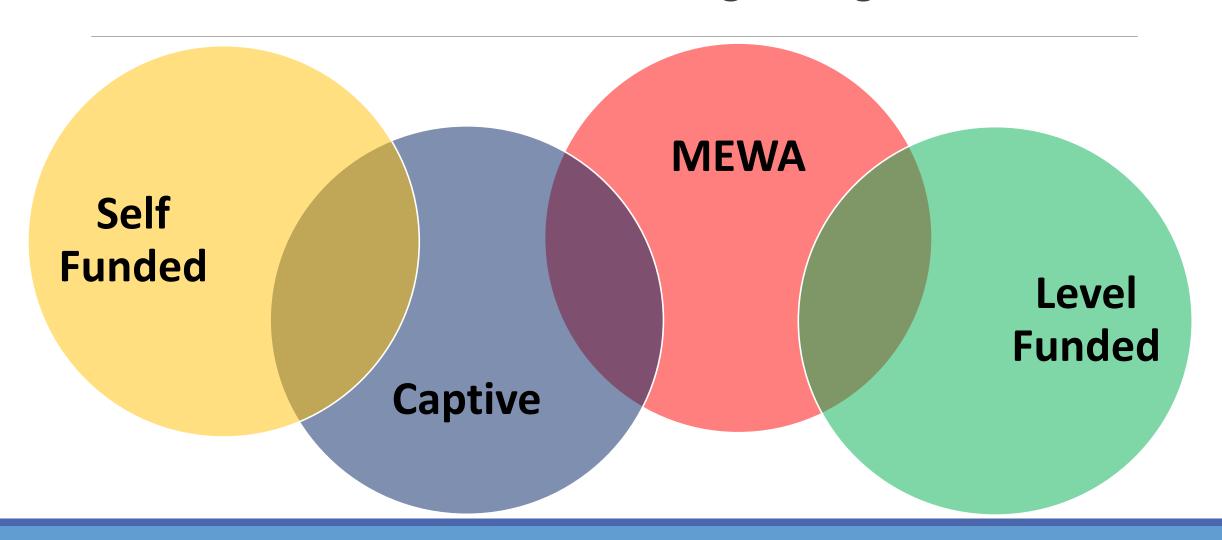
Risk vs. Reward

Source: 2013-2016 Sun Life Stop-Loss claims reimbursements that Sun Life provided to its policyholders.

^{*}In percentage of total stop-loss claims reimbursements



Market Choices - Alternative Funding Arrangements



Who Are Ideal Candidates for Alternative Funding

- Groups with history of low premium to claims loss ratios
- Groups that desire lower long-term costs
- Groups that desire greater control and flexibility
- Management that wants better claims reporting
- Employers that want to reap the rewards from health and wellness promotion
- Groups experiencing adverse premium impact from ACA
- Groups who utilize disease management programs
- Groups who are engaged in transparency tools

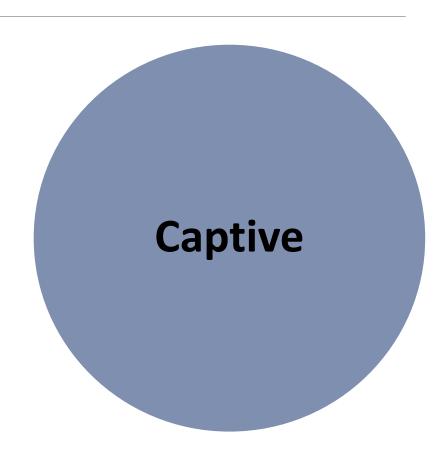


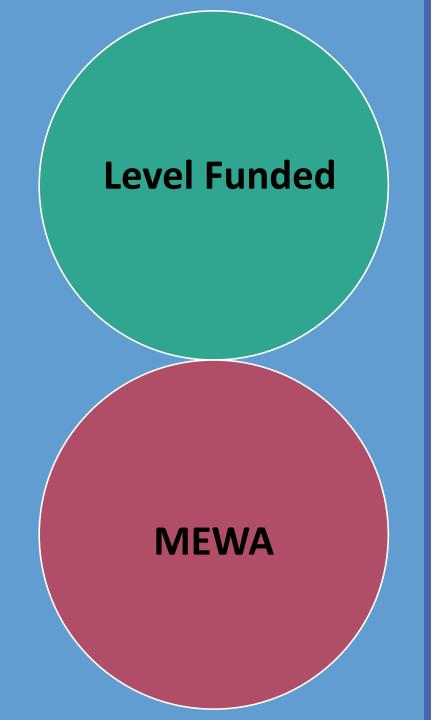
- ➤ High volatility for small employers
- Cash flow issues could be problematic for smaller employers
- ➤ Administrative and stop loss costs are high in most cases
- ➤ State regulation of stop-loss policies varies significantly
 - ➤ Minimum attachment points
 - ➤ Limit the sale of these products to smaller businesses
 - ➤ Outlaw small group self funding completely
- The NAIC adopted a nonbinding model stop-loss law for states in 1995, which recommends a minimum individual-attachment point of \$20,000. It was recommended to be changed to \$60,000 but didn't pass

Self Funded



- Built for employers with 10-300 employees
- Three layers of risk
 - Employer retains base layer and most predictable risk
 - Captive shares the mid layer of "moderate" risk
 - Captive uses reinsurance to transfer top layer of unpredictable risk
- More scrutiny by IRS with growth
- New rules as part of PATH Act
- Barriers to entry and exit







- Employers between 1 and 50 eligible employees
- Fully-insured employers who desire greater access to data to understand what is driving costs
- Employers who have or are developing robust Population Health Management programs
- Employers seeking to control their bottom line without subsidizing other employers
- Employers looking for a "baby step" to self funding their plans





Advantages of level funding for small employers

- Predictability of monthly payments (excluding change in enrollment)
- Provides set Run-out Liability component.
 When a group terminates the plan-reserve is "pre-funded"
- Minimizes cash flow problems due to large claims and/or unfavorable claims experience
- Provides immediate reimbursement of stop loss coverage
- Has no hidden fees or 'pass through' costs that make budgeting difficult
- Share in claims surplus













- Expands eligibility to Chambers of Commerce
- Extends the timeframe during which an eligible Professional Association, Association, Trade Association or Business League must be organized and maintained before registering as a MEWA (5 years instead of 1 year)
- Increases the required minimum surplus for MEWAs (\$150k to \$500k)
- Tightens reporting requirements

- Subject to Risk Based Capitol
- Required to file annually with ODI
- Not required to be actuarial value compliant
- Not subject to community rating
- Becoming popular due to uncertainty of ACA premiums
- Avoidance of certain Taxes and Fees of the ACA
- Medically Underwritten
- Employer Assessable for potential deficit

MEWA

https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA131-HB-64

What Insurers are Saying...



- ACA business is less than 10%, 70% GM, 20% GF
- Underwritten business quoting is up 375% from Q4 of 2016 to Q4 of 2017
- MEWA 1 year in, already have 16,000 subscribers



- ACA offering was too appealing initially. Low rates in small group. Product distribution was roughly 50% ACA and 50% GM/GF
- Increased ACA rates (two year increase of over 40%) have the book is closer to 60% GF/GM and 40% ACA
- Not having Alternative Funding option has hurt growth
- Rolling out MEWA in Q3 of 2018

aetna®

- Eliminating GM (KWYH) starting 9/1
- Pushing groups of 5-50 into Aetna Funding Advantage
 Platform
- Reducing ACA portfolio
- Last 24 months have seen 300% increase in AFA quoting volume
- Proactive moving ACA "good performers" to AFA



- 63% of business is ACA, 27% is GF, 10% GM
- Currently lowest cost ACA options in market
- Significant increase in underwritten quote requests for AllSavers product

Thank You For Your Attention!