



**National/State Individual Insurance Trends for 2017 and Beyond**  
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# AMONG THE QUESTIONS:

- How is Covered CA positioned for 2017 and 2018?
- How well are marketplaces doing in 2017 nationally?
- What are the prospects for marketplaces for 2018 and beyond?
  - Are Insurers going to continue participating in Exchanges in the next few years or will more exit?
  - Likely trends
- What are the characteristics of the Exchange population:
  - In 2017?
  - In 2018?
- What are the possible issues for 2018 and beyond?

# ACTUARIAL BASICS – KEY FACTORS DETERMINING PREMIUMS IN ALL MARKETS

- **Risk Mix** – how can the best possible blend of healthy and less-healthy enrollees be maintained?
- **Health Care Costs** – what is the utilization of care and what are the prices charged?
- **Benefit Design** – how are designs structured to share costs with consumer and promote access to appropriate care?
- **Administrative Costs and Profits** – what the costs required or allowed to market, administer profit on behalf of carriers?
- **Financial subsidies** – what is the form and structure of financial assistance provided to consumers (e.g., from tax credits, employers or other sources)? From the federal government?
- **Rules and Regulations** – what are the rules that carriers need to abide by in offering coverage?
- **Market Uncertainty** – to what extent will actuaries add to premiums – individual and employer markets -- due to all the unknowns in the next few years?

# ACTUARIAL BASICS – EXAMPLES OF POLICIES THAT WILL DRIVE AFFORDABILITY

Cost Factor	Issues/Policies
<b>Risk Mix</b>	<ul style="list-style-type: none"><li>• Guaranteed Issue (or replace guaranteed issue for all conditions with high risk pools)</li><li>• Penalties</li><li>• Risk Adjustment Processes</li><li>• Medicaid Coverage</li><li>• Effective Outreach/Enrollment</li><li>• Auto-enrollment of over-26 children</li></ul>
<b>Health Care Costs</b>	<ul style="list-style-type: none"><li>• Network designs</li><li>• Extent of provider versus plan market power</li><li>• Delivery system and payment reforms promoting value</li><li>• Rising prescription drug costs</li><li>• Use of HSA accounts to increase personal responsibility</li></ul>
<b>Benefit Design</b>	<ul style="list-style-type: none"><li>• Definition of "Essential" or minimum coverage<ul style="list-style-type: none"><li>○ Retain or modify EHBs</li><li>○ Loosen AVC to have new low Copper Tier</li><li>○ Allow any AVC level between Tiers</li></ul></li><li>• Standardization to promote consumer understanding vs. allowing any AVC or plan type</li><li>• Allowing coverage exclusions (e.g., no benefits for cancer)</li><li>• Allowing annual or lifetime caps (at what level \$100K, \$1 mill., etc.)</li><li>• Allowing differential benefits based on gender</li></ul>

# ACTUARIAL BASICS – EXAMPLES OF POLICIES THAT WILL DRIVE AFFORDABILITY

Cost Factor	Issues/Policies
<b>Administrative Costs and Profits</b>	<ul style="list-style-type: none"> <li>Establishing limits on administration/marketing and profits (currently done through "Medical Loss Ratio" standards)</li> </ul>
<b>Financial Subsidies</b>	<ul style="list-style-type: none"> <li>Direct advanced tax credits based on financial need</li> <li>Non-advanced tax credits for health care costs (uncertain impact or utilization)</li> <li>Cost-Sharing Reduction subsidies (extremely valuable to low-income enrollees)</li> <li>Making premium payments tax deductible (of little value to lower income consumers)</li> <li>Indirect tax support through making employer coverage not subject to tax</li> </ul>
<b>Rules and Regulations</b>	<ul style="list-style-type: none"> <li>Requiring children up to 26 to be covered by parents policies</li> <li>Age bands</li> <li>Prohibiting different rates by gender</li> <li>Single Risk Pool requirements</li> </ul>
<b>Market Uncertainty</b>	<ul style="list-style-type: none"> <li>Impacts on employer costs due to coverage of the uninsured</li> <li>Threat to individual market (on-and off-Exchange) due to required guaranteed issue without subsidies or mandates</li> </ul>
<b>Geographic coverage of all counties/regions in the U.S.</b>	<ul style="list-style-type: none"> <li>Combination of guaranteed issue and no enforcement may lead many insurers to withdraw from "difficult-to-contract" areas, leading to gaps in available coverage</li> </ul>

# HOW IS COVERED CA POSITIONED FOR 2017 AND 2018?

- The Covered CA average rate increase for 2017 of 13.2% is well under the national average increase of 22%
- There are 3+ insurers in every one of the 19 Covered CA regions, in contrast to about 25% of counties in the country with only 1 insurer
- Risk mix in California:
  - Per 2016 HHS report, lowest in the country (perhaps 17% lower than the national average risk in 2015)
  - Appears from OSHPD state hospital discharge/ER database to be fairly stable from 2014 to 2015 to 2016 for chronic conditions

# HOW ARE EXCHANGES PERFORMING NATIONALLY IN 2017?

- A “mixed bag” in various states
  - Rates are up 25% on average for 2017 for FFM states and 22% for all states (ASPE Research Brief, Oct. 24, 2016) vs. 13.2% in Covered CA
  - Very uneven rate increases:
    - Some are very high (e.g., Phoenix has a 145% or Chicago at 60% increase in 2nd Lowest Silver plan)
    - Some are low (e.g., Ft. Lauderdale, FL at 4% or Detroit at 5%)
    - Premiums are dropping in Providence, RI, Cleveland, and Indianapolis
  - Number of insurers for FFM states:
    - 298 in 2016, down to 228 in 2017 (net change of -73)
    - About 25% of counties (mostly rural) have only 1 insurer
- The Premium subsidy is of substantial help to 85% of Exchange members
  - Approximately 85% of FFM enrollees receive a premium subsidy
  - For a 27-year-old with a \$25,000 income, the subsidy is projected to average \$160 per month, yielding a net premium of 2nd lowest Silver premium of \$142 per month

# ARE INSURERS GOING TO CONTINUE PARTICIPATING IN EXCHANGES OR WILL MORE EXIT (OR ENTER)?

- For 2017 – outside of California -- some exits by:
  - Big For-Profits (Aetna, United, Humana)
  - A few Blues
  - PPO plans are being withdrawn, leaving HMO and EPO options
- For 2018,
  - Big rate increases were approved in many states in 2017 allow a return to “break-even” or better; possible return to “normal” rate increases for 2018 depending on policies and risk mix
  - Insurers have “learned the lesson” to offer Narrow Network plans
  - Now insurers have complete years of claims data upon which to build premiums
- Future:
  - Uncertain, due to the election results
  - Most Blue plans have an ongoing commitment to this market
  - Many regional plans (e.g., Kaiser, HealthPartners) have also had success
  - Managed Medicaid plans (Centene, Molina, others) have “extended” their business into the Exchange markets successfully
  - Seems unlikely that For-Profits will be back (without more incentives)



# WHAT ARE THE CHARACTERISTICS OF THE EXCHANGE POPULATION?

- Another “mixed bag” in 2016/17
  - In states – like California – that expanded Medicaid and didn’t extend grandmothers plans, risk mix is good:
    - Fewer of the truly sick from a Medicaid population (100-138% of FPL)
    - Many more healthy people who bought insurance from 2010-2013 who were underwritten at that time – these people are 10-20% healthier than newer enrollees
  - In Non-Medicaid expansion states, not as robust for 2015-16
    - Fewer enrollees in total, so those that did enroll with health conditions were a higher % of the total
    - More enrollees in the 100-138% FPL category who are likely to be more in need of health care services
    - In some of these states, former High Risk Pool enrollees were another significant factor (at 200% of average spending)
- For 2018:
  - “Grandmothered” enrollees are those people who bought policies between enactment of the ACA and January 1, 2014
  - Under current law, in ALL states, “grandmothered enrollees” will all move into the ACA risk pool after 12/31/17, thus reducing the average risk/cost by 2-4% (will vary by state) in current “grandmothering” states
  - No “bump in rates” due to termination of Transitional Reinsurance for 2018

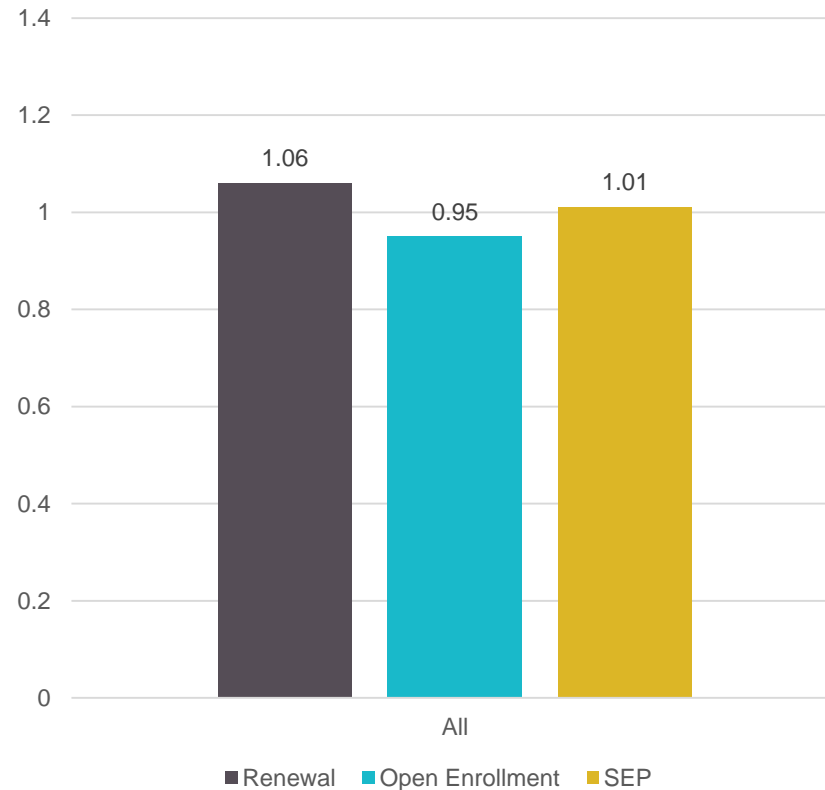
# HOW ARE INSURERS DOING NATIONALLY IN 2017?

Insurers' profits vary widely:

- Some insurers were profitable in 2015:
  - Blue Cross of Arkansas had a 6.2% individual block profit margin
  - Blues in FL, MI and NJ “thrived”
  - Half of 34 Blue plans examined had positive underwriting results
- Some insurers had terrible experience:
  - Blue Cross of Tennessee lost \$195 million on \$866 mill of revenue (a loss of 22.5% of revenue)
  - Other Blues in AL, IL, MN and TX also had poor experience
  - Blue Cross of NE dropped all Exchange plans for 2017
- Other plans
  - Big For-Profits: United, Aetna, Humana had big losses
  - Regional/Specialty Plans like Kaiser, UPMC Health Plan, Centene and Molina were profitable
    - *Data from Modern Healthcare article dated Oct. 15, 2016*
- Observation: insurers were more likely to be profitable in states where:
  - Medicaid was expanded
  - “Grandmothered plans” were not extended

# RISK SCORES BY ENROLLEE COHORT

For 2015 Enrollees Remaining after OE 2016,  
CDPS Concurrent Risk Scores  
(Renewal, Open Enrollment, Special Enrollment)



# WHAT ARE THE POSSIBLE ISSUES FOR 2018+?

- Prescription Drug prices continue to rise at a high rate
  - Recent (Segal Group, Fall 2016) survey indicates overall drug prices are increasing at 11.6% (vs. about 7% for medical services)
    - Specialty drugs (i.e., biologic or “big molecule” drugs) trend is almost 19% projected for 2017
    - 200+ biologics in the FDA “pipeline” for approval in the next few years
- Further action needed to clarify SEP rules and Third Party Payment rules
- Need more outreach to move:
  - Tell subsidized enrollees they are “protected” from many premium increases by income-related subsidies
  - Perhaps 2.5 million off-Exchange enrollees who are missing out on subsidies
- Need to monitor whether push for Alternative Payment Methods (APMs) continues under a new Administration

# REFERENCES

- ASPE: Health Plan Choice and Premiums In the 2017 Health Insurance Marketplace <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace>
- Kaiser Family Foundation: The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review <http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/>
- Effects of “Grandmothered Plans” – plans bought between 3/23/2010 (passage of ACA) and 1/1/14: <https://www.healthinsurance.org/blog/2016/03/22/like-your-grandmothered-health-plan/>
- <http://kff.org/health-reform/issue-brief/data-note-effect-of-state-decisions-on-state-risk-scores/>
- Effects of subsidies on 2017 net premiums: <http://healthaffairs.org/blog/2016/11/16/higher-marketplace-benchmark-plan-premiums-could-reduce-post-subsidy-premiums-for-many/>