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
Risk Mix	• Guaranteed Issue (or replace guaranteed issue for all conditions with high risk pools) • Penalties • Risk Adjustment Processes • Medicaid Coverage • Effective Outreach/Enrollment • Auto-enrollment of over-26 children
Health Care Costs	• Network designs • Extent of provider versus plan market power • Delivery system and payment reforms promoting value • Rising prescription drug costs • Use of HSA accounts to increase personal responsibility

Benefit Design	• Definition of "Essential" or minimum coverage
	  ○ Retain or modify EHBs
	  ○ Loosen AVC to have new low Copper Tier
	  ○ Allow any AVC level between Tiers
	• Standardization to promote consumer understanding vs. allowing any AVC or plan type
	• Allowing coverage exclusions (e.g., no benefits for cancer)
	• Allowing annual or lifetime caps (at what level $100K, $1 mill., etc.)
	• Allowing differential benefits based on gender

ACTUARIAL BASICS – EXAMPLES OF POLICIES THAT WILL DRIVE AFFORDABILITY

Cost Factor	Issues/Policies
Administrative Costs and Profits	• Establishing limits on administration/marketing and profits (currently done through "Medical Loss Ratio" standards)
Financial Subsidies	• Direct advanced tax credits based on financial need • Non-advanced tax credits for health care costs (uncertain impact or utilization) • Cost-Sharing Reduction subsidies (extremely valuable to low-income enrollees) • Making premium payments tax deductible (of little value to lower income consumers) • Indirect tax support through making employer coverage not subject to tax
Rules and Regulations	• Requiring children up to 26 to be covered by parents policies • Age bands • Prohibiting different rates by gender • Single Risk Pool requirements
Market Uncertainty	• Impacts on employer costs due to coverage of the uninsured • Threat to individual market (on-and off-Exchange) due to required guaranteed issue without subsidies or mandates
Geographic coverage of all counties/regions in the U.S.	• Combination of guaranteed issue and no enforcement may lead many insurers to withdraw from “difficult-to-contract” areas, leading to gaps in available coverage

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 grandmothered 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?

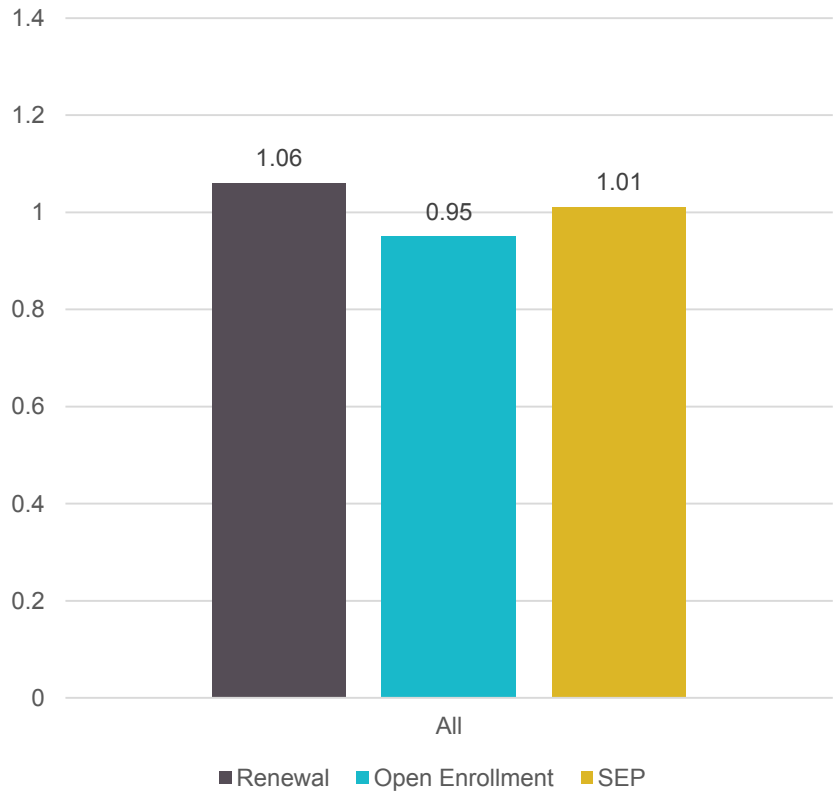
Insurers' profits vary widely:

- 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

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