Ten potential drivers of ACA premium rates in 2017

Aaron S. Wright
Hans K. Leida, PHD, FSA, MAAA
Lindsy Kotecki, FSA, MAAA

Even though open enrollment for the 2016 benefit year is still underway in the individual and small group markets subject to the Patient Protection and Affordable Care Act (ACA), health insurance issuers are already beginning to lay plans for their 2017 premium rate-filing processes, which need to be completed in the spring of 2016.

We have gathered a top 10 list of potential factors that may influence those 2017 rates. For each factor, we provide a brief background and also explain how it may affect rates. We also provide a list of additional resources for further reading.

The impact of each of these factors will vary for any particular state, market, or issuer. However, broadly speaking, some factors will create upward or downward pressure on rates–by this we mean that the factor tends to cause rates to be higher or lower than they otherwise would have been in the absence of the factor, all else being equal. But "upward pressure" is not a guarantee that rates will increase for all carriers across the board, just as "downward pressure" does not guarantee a decrease. As we will see, the rate-setting process remains a complex and challenging task for issuers, even given the additional data that is now available.

1: TREND

What is it? Trend in healthcare costs and utilization were significant premium rate drivers long before the ACA and will continue to drive premium rates in 2017. Healthcare cost trend consists of an increase in cost for each service or product, while utilization trend results from a change in the amount that a particular service is utilized.

Impact on 2017 rating: Healthcare cost and utilization trends are expected to increase on average, creating upward pressure on premium rates for 2017.

Remarks: Prescription drug trends have been particularly high in recent years, driven in part by the high cost and demand for new high-cost specialty drugs. Predicting trends for pricing purposes is difficult because there is no guarantee that trends from the recent past will continue into the future.

In 2014, many issuers introduced narrow networks in which participating providers often agreed to reduced reimbursement rates in order to be included in the network. Some issuers have also experimented with alternative payment mechanisms in which providers take risk for ACA members. Now that several years have gone by, issuers or providers may want to renegotiate these arrangements in light of the additional information now available about the volume and morbidity of the ACA populations.

FURTHER READING

- 'Growth Clouds' On The Horizon For Health Spending? http://healthaffairs.org/blog/2015/11/23/growth-clouds-on-the-horizon-for-health-spending/
- S&P Healthcare Claims Indices. http://us.spindices.com/documents/factsheets/fs-sp-healthcare-claims-indices-ltr.pdf
- The 2014 Drug Trend Report (Express Scripts). http://lab.express-scripts.com/~/media/PDFs/Drug%20Trend%20Report/ExpressScripts_DrugTrendReport

2: CHANGES TO ESSENTIAL HEALTH BENEFITS AND THE CMS ACTUARIAL VALUE CALCULATOR

What is it? The essential health benefits (EHB) package defines the minimum set of benefits and services that are required to be covered by individual and small group health insurance plans under the ACA. For 2017, the benchmark plans that define these benefits in each state will be updated, meaning that the package of services and the minimum coverage level for those services may change.

The Actuarial Value Calculator (AVC) is a tool published by the Centers for Medicare and Medicaid Services (CMS) that is used to provide an estimate of the proportion of total plan costs expected to be paid by the issuer. The actuarial value (AV) of each plan the issuer offers must fall within the AV range of one of four metallic tiers (platinum, gold, silver, or bronze); there is also a fifth catastrophic plan tier in the individual market. The AVC is updated periodically and an updated draft revision for the 2017 plan year was recently released.[1]

Impact on 2017 rating: Changes to the EHB package will likely have a mixed impact on premium rates in 2017, and we expect that in many cases the impact will be modest. In states that expand coverage under the new benchmark plan, the change may create some upward pressure on rates. Conversely, in states that reduce or remove coverage requirements there may be some downward pressure on rates. Changes in cost-sharing parameters will have less of an impact, given that issuers must design their plans to conform to one of the AV metallic tiers.

1 https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-AV-Calculator-111615xlsm.xlsm

When the AVC is updated for trend, the leveraging of fixed dollar cost sharing increases the plan's measured AV. If AVC changes push plan AVs outside of the allowable range for a given metallic level, issuers must modify benefits to bring the AV back within the range. All else equal, modifications made to reduce a plan's AV will generally create downward pressure on premium rates (because the plan's portion of the cost will decrease).

Remarks: The impact of changes in the EHB benchmark plan will vary from state to state. The EHB benchmark plans in effect during the 2014-2016 plan years were based on plans offered prior to 2014, modified to fill in any missing essential health benefits and comply with federal rules. The 2017 EHB benchmark plans are based on 2014 plans, again modified as necessary to meet federal requirements.

Changes in the AVC other than the underlying trend in claims costs could have mixed effects and are hard to predict. For example, changes in the mix of services between service categories such as pharmacy, professional, or facility can change the proportion of cost subject to deductibles versus copayments, which could move the AV up or down depending on the specifics of the plan design.

FURTHER READING

- Actuarial value, benefit richness, and the implications for consumers. http://us.milliman.com/insight/2015/Actuarial-value--benefit-richness--and-the-implications-for-consumers/
- Information on Essential Health Benefits (EHB) Benchmark Plans. https://www.cms.gov/cciio/resources/data-resources/ehb.html

3: ADDITIONAL DATA

What is it? Until plan year 2016, issuers had to rely on pre-ACA data to develop ACA plan rates. When issuers set rates for plan year 2016, some 2014 ACA data was available, but it was often not fully credible, given the extension of pre-ACA coverage in many states (i.e., the transitional policy). In addition, 2014 risk adjustment, reinsurance, and risk corridor results (the 3Rs) were not released until well after 2016 rates were initially filed (though some states allowed carriers to make adjustments after the results came out). Two years of experience data and one year of 3R outcomes will be available to issuers filing 2017 rates.

Impact on 2017 rating: In theory, more relevant data means rate development decisions are better informed. Issuers that find they were underpriced or overpriced in prior years are likely to reevaluate their assumptions, leading to an increase or decrease in rates, respectively.

Remarks: Originally, the ACA and its implementing regulations intended that most population migrations would be complete by the time 2017 rates were being set, so that issuers would start having more stability and relevant data. The transitional policy delaying the migration of pre-ACA enrollment has prevented that from occurring in many states, lessening the usefulness of the additional data issuers have.

In addition, ACA market rules give insureds flexibility with respect to plan choice, which increases the level of churn (that is, the number of members changing plans) within the market from year to year. An issuer's experience in one year may not be a good indication of experience in future years. This is especially true for smaller carriers, making it more difficult for them to predict their market position from one year to the next.

FURTHER READING

- The ACA Cost Predictability Question. https://www.soa.org/Library/Newsletters/The-Actuary-Magazine/2014/october/act-2014-vol11-iss5-wrobel.pdf

4: CONTINUED MIGRATIONS

What is it? Pre-ACA plans granted "grandfathered" or "transitional" status are exempt from many of the ACA's main provisions that went into effect in 2014. These provisions fundamentally changed the characteristics of the population eligible for coverage, and this led to a gap between the health status of members enrolled in ACA versus pre-ACA plans. Perhaps most significantly, issuers selling ACA-compliant plans are required to offer coverage on a guaranteed issue basis, while members in grandfathered and transitional plans were underwritten in most markets. As these pre-ACA members migrate to ACA-compliant plans, the characteristics and overall average health status of the ACA market will change.

The role of the individual mandate penalty in encouraging uninsured individuals to enter the market is another factor to consider for 2017. As the penalty for failing to obtain minimum essential coverage grows, the awareness of subsidies increases, and the state marketplaces operate more smoothly, we may see a larger portion of these members enrolling in the ACA individual market.

The small group market was originally scheduled to expand in 2016 to include groups with 51 to 100 employees as well as those under 50 employees. This expansion was made optional by recent legislation, with the result that some states will expand the market and others will not. Carriers in the small group market may need to adjust rates upward or downward to reflect this changing guidance and any new information on the groups entering the small employer market in states that expand the definition.

Impact on 2017 rating: States and issuers were permitted significant flexibility in whether or not to permit transitional policies, so the impact on each state and market will vary widely. Current regulatory guidance at the federal level requires transitional plans to sunset no later than October 1, 2017, resulting in an influx of these members into the ACA market. Integrating these underwritten members into the ACA pool is expected to improve the health status of the market as a whole, which could lower the relative cost of coverage on average.

Grandfathered plans do not expire, but members or groups leaving these plans are required to purchase new coverage through the ACA market. Because grandfathered plans are generally older in duration, the effects of initial underwriting will have faded, narrowing the gap

in health status from the ACA block. Nonetheless, the dissolution of grandfathered plans is expected to happen gradually over time, so the premium implications for 2017 are likely minor.

While the impact of the uninsured pool entering the market is unknown and could vary widely from state to state, it may be practical to assume that the least healthy cohort of uninsureds were the first to enroll over the last few years. To the extent that healthier cohorts of uninsureds start to migrate to the ACA pool, we could see a neutral or downward effect on premium rates.

Remarks: Although current guidance requires transitional plans in most states to discontinue at their first renewal after October 1, 2016, federal regulators have hinted[2] that the policy may be extended further into the future. If an extension is granted, the migration of the transitional population into the ACA pool may be further delayed, and any impact on 2017 premium rates will likely be dampened.

FURTHER READING

- Canceled plans, part III: An extension, an expansion, and more changes to 2014 rules. http://us.milliman.com/insight/2014/Canceled-plans--part-III-An-extension--an-expansion--and-more-changes-to-2014-rules/

5: CARRIER SHUFFLING

What is it? As the markets continue to evolve, carriers are entering and exiting the public exchanges. Similar to any market, carriers may choose to enter or exit the exchange market for competitive reasons. Additionally, carriers may be required to exit the market based on solvency concerns of their regulators. Some exchanges have adopted an active purchaser model where they get to decide which and how many issuers can sell exchange plans.

Impact on 2017 rating: Generally speaking, one would expect an increase in the number of competitors in a market to create downward pressure on rates with the reverse being true when there is a decreased number of competitors. For instance, a 2015 Milliman study[3] estimated that having one additional carrier operating in a rating area was correlated with a $6.50 decrease in per member per month (PMPM) premium rates for 21-year-olds in the second-lowest-cost silver plan.

Remarks: Although the ACA markets have not altogether stabilized, new entrants to the market will generally make the markets more competitive, creating downward pressure to some extent.

The lack of payout on risk corridor receivables has had an impact on companies' solvency positions and, in some cases, has been cited[4] as one of the primary reasons for exiting the market.

It is not yet clear how the competitive landscape may evolve in 2017. It is likely that some players that have sat on the sidelines until now will enter[5] the ACA exchange markets, but the final tally is unlikely to be known until well after rates are locked in for the year–and it is far from certain that the carriers currently selling exchange products will continue to do so.[6]

FURTHER READING

- 2016 ACA marketplace rate change overview. http://us.milliman.com/insight/2015/2016-ACA-marketplace-rate-change-overview/
- Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace. http://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace

6: ONGOING POLITICAL UNCERTAINTY: COURT CASES AND ELECTIONS

What is it? The upcoming year, 2016, is an election year, and major candidates across the political spectrum have advanced a wide variety of proposals that would affect health insurance issuers. At the same time, various legal challenges to the ACA continue to work their way through the courts. One of the lawsuits currently being considered is House v. Burwell, in which the U.S. House of Representatives is challenging the administration's funding of certain cost-sharing subsidies (CSRs) for lower-income enrollees under the ACA.

Impact on 2017 rating: The impact of these political forces on 2017 premium rates is unknown. In the interim, the uncertainty may lead insurers to increase risk margins.

Remarks: In some jurisdictions, the review process for premium rate filings has been pulled into the political fray. This trend seems likely to continue and perhaps even intensify in the lead-up to the presidential election in November 2016.

Once the new president takes office in 2017, there may be additional changes to the law or its enforcing regulations.

If House v. Burwell were to prevent the federal government from making CSR payments, it would not mean the end of any programs, but could create significant market disruptions. In that scenario, if Congress were unable to come to a solution, issuers would potentially be liable for subsidies that were supposed to be paid by the government. Because the plans eligible for these subsidies are only offered on the exchanges, a potential solution for issuers would be to stop selling policies on-exchange but continue to sell policies off-exchange.

2 CMS (March 5, 2014). Extended Transition to Affordable Care Act-Compliant Policies. Retrieved November 17, 2015, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.

3 Bennett, S. et al. (February 2015). 2015 Health Insurance Marketplace Competitiveness Study. Milliman Healthcare Reform Briefing Report. Retrieved November 17, 2015, from http://www.milliman.com/uploadedFiles/insight/2015/2015-health-insurance-marketplace-study.pdf.

4 Bell, A. (October 13, 2015). PPACA risk corridors gap rocks more carriers. LifeHealthPro. Retrieved November 17, 2015, from http://www.lifehealthpro.com/2015/10/13/ppaca-risk-corridors-gap-rocks-more-carriers?t=individual-health&ref=channel.

5 Herman, B. (October 6, 2015). Wellmark commits to Iowa exchange for 2017. Modern Healthcare. Retrieved November 17, 2015, from http://www.modernhealthcare.com/article/20151006/NEWS/151009954.

6 Mathews, A. and S. Armour. (November 19, 2015). Biggest Insurer Threatens to Abandon Health Law. The Wall Street Journal. Retrieved November 17, 2015, from http://www.wsj.com/articles/unitedhealth-cuts-guidance-evaluating-its-insurance-exchange-segment-1447933310.

FURTHER READING

- Implementing Health Reform: House Can Sue Administration Over ACA Cost-Sharing Reduction Payments (Sept. 10 Individual Market Update). http://healthaffairs.org/blog/2015/09/10/implementing-health-reform-house-can-sue-president-over-aca-cost-sharing-reduction-payments/

7: TRANSITIONAL REINSURANCE

What is it? For the first three years of the ACA markets, the federal government has operated a transitional reinsurance program. This program uses funds collected from group and individual health insurance plans to partially reimburse high claims in the individual ACA market. The amount plans are reimbursed for each high claimant is based on certain formulas and parameters set by the government in regulation, and the government has changed the parameters for 2014 and 2015 several times.

Under current law, the transitional reinsurance program is scheduled to end after the 2016 benefit year, and as such, will not collect contributions or reimburse claims for the 2017 benefit year.

Impact on 2017 rating: The phase-out of the reinsurance program will create upward pressure on 2017 individual market rates versus 2016 rates. Conversely, because issuers across all markets were contributing to fund the program, the small and large group markets should see modest downward pressure on rates (see the "Changes in fees and taxes" section below for more information), which is due to the elimination of the reinsurance fee in 2017.

Remarks: Individual market issuers could offset the additional variability they face without transitional reinsurance by purchasing private commercial reinsurance, but that would come at an increased cost. Reinsurance recovery payments have been very favorable to insurers thus far, with 2014 recoveries being paid at 125% of what was expected. The payment of recoveries for 2015 has also been accelerated, which may help with cash flow.

It is possible that additional payments could be made for the 2017 benefit year if excess collections are left over from prior years. This seems unlikely, though, given that the government has taken action several times to increase and accelerate payments under the program in order to pay out collected funds as quickly as possible. Indeed, in recently released proposed rules,[7] the government has indicated it intends to adjust parameters for the 2016 plan year as needed in order to pay out all remaining reinsurance funds.

FURTHER READING

- Transitional reinsurance at 100% coinsurance: What it means for 2014 and beyond. http://us.milliman.com/insight/2015/Transitional-reinsurance-at-100-coinsurance-What-it-means-for-2014-and-beyond/

8: RISK CORRIDORS

What is it? For the first three years of the ACA markets, the federal government was to share in Quality Health Plan (QHP) issuers' risk for exchange plans via the risk corridor program. Well after 2014 rates had been set, the program's rules were adjusted to impose revenue neutrality for the government (so the program will only move money around between insurers, rather than potentially creating a net transfer of funds from the federal government to insurers). Under current law, the program will sunset after the 2016 plan year.

Impact on 2017 rating: While risk corridor results are not generally directly incorporated into the rate setting calculations, the program was intended to reduce the need for issuers to incorporate high-risk charges in their rates during the initial years of the ACA markets. There may be some upward pressure on rates in 2017 because of the sunset of the risk corridor program and the continuing uncertainty regarding collections under the program. However, many insurers may have already assumed the program would provide little protection when setting 2016 rates.

Remarks: Because of the revenue neutrality requirement, at this point it is not clear whether funds will be available to the government to pay risk corridor receivables for plan years 2015 and 2016. On October 1, 2015, CMS notified carriers that only 12.6 cents of each dollar they were owed for 2014 receivables would be paid out in 2015 with the remainder subject to collections on 2015 and 2016 risk corridor payables.

Because all prior rates were set without knowledge of the actual payout on risk corridors, there is the potential for increased margins in 2017 rates to offset additional risk caused by the lack of risk corridors.

FURTHER READING

- Headwinds cause 2014 risk corridor funding shortfall. http://us.milliman.com/insight/2015/Headwinds-cause-2014-risk-corridor-funding-shortfall/
- Risk Corridors Collectability. http://www.naic.org/documents/committees_e_app_eaiwg_related_int_1501_risk_corridors.pdf
- Risk corridors episode IV: No new hope. http://us.milliman.com/insight/2014/Risk-corridors-episode-IV-No-new-hope/

9: RISK ADJUSTMENT

What is it? Risk adjustment is the only permanent risk stabilization program under the ACA. It applies to all non-grandfathered individual and small group market issuers and is administered as a zero-sum program at the state and market levels (individual, small group, or combined). Its main goal is to stabilize premium rates in a given state and market by attempting to redistribute premium revenue from issuers covering low-risk members to issuers covering high-risk members, thereby reducing incentives for issuers to selectively target members with favorable health status. Risk scores derived from each member's medical diagnosis codes are a major driver of these transfers.

7 https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-29884.pdf

Impact on 2017 rating: Prior to 2017, issuers had very little data to inform their assumptions about their potential risk adjustment outcomes. Because the risk adjustment program measures risk relative to the statewide average, estimating the impact of risk adjustment was (and still is) particularly difficult for small issuers with low market share, and less difficult for larger issuers with a strong influence on the statewide average. Risk adjustment results from 2014 were first released in June 2015, offering issuers some insight into their market positions as of 2014—but that was after rates had already been set for 2016. It is unclear whether these results will provide issuers with much to lean on for 2017 pricing, given the level of churn and shifting in the marketplace over the preceding three-year period.

Remarks: The risk adjustment program can have a real impact on an issuer's bottom line, so many are directing resources to improve risk adjustment outcomes. As issuers learn which populations are most likely to produce the largest gain (or loss), they may begin to adjust their strategies with respect to benefit design, provider networks, care management, and other functions accordingly. They may also expand efforts to improve coding and expand chart reviews. Issuers that are successful at improving risk scores (and transfer payments) may be able to pass along some of the added savings to consumers in the form of more competitive premium rates. On the other hand, issuers that fall behind will need to pass along the additional expense.

Despite efforts to understand the implications of the current risk adjustment program, changes in the risk adjustment model introduce new challenges and uncertainty. For example, the implementation of ICD-10 could affect the accuracy of provider coding, and changes in the U.S. Department of Health and Human Services-Hierarchical Condition Categories (HHS-HCC) coefficients could change the expected return for certain diagnoses.

FURTHER READING

- ACA risk adjustment: Special considerations for new health plans. http://us.milliman.com/insight/2015/ACA-risk-adjustment-Special-considerations-for-new-health-plans/
- 2016 HHS risk adjuster coefficient updates. http://us.milliman.com/insight/2015/2016-HHS-risk-adjuster-coefficient-updates/
- Summary report on transitional reinsurance payments and permanent risk adjustment transfers for the 2014 benefit year. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

10: CHANGES IN FEES AND TAXES

What is it? The ACA imposed a variety of new fees and taxes on health insurance issuers. These change each year, sometimes decreasing and other times increasing in amount.

- Transitional reinsurance fees will decrease to zero in 2017 because the reinsurance program is set to expire at the end of 2016.
- The Health Insurance Provider Fee (aka Section 9010 tax) is set to increase in 2017 from 2016.
- Exchange fees, risk adjustment user fees, and other smaller ACA fees may or may not increase.

Impact on 2017 rating: Generally an increase to fees will increase rates, while a decrease to fees will decrease rates.

Remarks: With the end of the transitional reinsurance program, carriers will no longer be required to pay the associated fee (which was $2.25 per member per month in 2016). Reinsurance contribution fees were levied on carriers regardless of the market they operated in, although the reinsurance recoveries only benefited carriers in the individual ACA market.

The total target amount the government will try to collect via the Health Insurance Provider Fee is set to increase 23% from $11.3 billion in 2016 to $13.9 billion in 2017. This will almost certainly lead to an increase in the amount a carrier needs to pay.

It is not clear at this point, but there is the potential for exchange fees to increase as regulatory authorities look for additional income sources to ensure exchanges become self-sustaining as required under the ACA.

FURTHER READING

- ACA health insurer fee: Estimated impact on the U.S. health insurance industry. http://us.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf

Aaron S. Wright is an actuary in the Salt Lake City office of Milliman. Contact him at aaron.wright@milliman.com.

Hans K. Leida is a principal and consulting actuary with the Minneapolis office of Milliman. Contact him at hans.leida@milliman.com.

Lindsy Kotecki is an actuary with the Minneapolis office of Milliman. Contact her at lindsy.kotecki@milliman.com.

The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.

Copyright © 2015 Milliman, Inc. All Rights Reserved.

FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE

Visit our reform library at www.milliman.com/hcr
Visit our blog at www.healthcaretownhall.com
Or follow us on Twitter at www.twitter.com/millimanhealth