Considerations for 2016 Health Insurance Rate Development, Rate Filing, and Rate Review

April 9, 2015

State Health Reform Assistance Network
Charting the Road to Coverage

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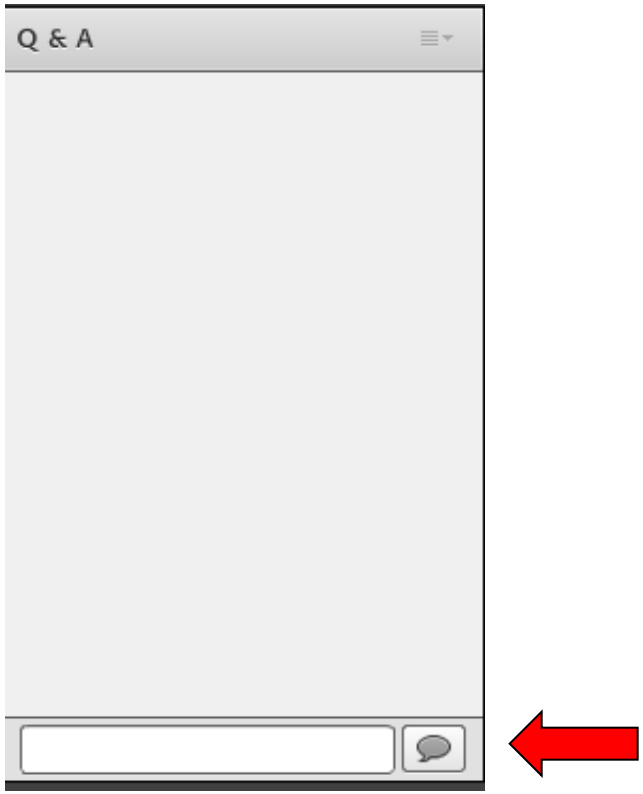

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WAKELY CONSULTING GROUP

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Introduction and Disclaimer

- The materials presented today are designed to assist states with the ongoing implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) and considerations for 2016 rating.
- There is an accompanying White Paper that provides more detail than will be discussed today (see http://www.wakely.com/wp-content/uploads/2015/04/White-Paper-2016-Rate-Considerations.pdf).
- The information is based on the most current guidance available and is subject to change.
- The information is not intended to be an exhaustive list of changes, and presumes an advanced understanding of the insurance provisions of the ACA.
- Any opinions shared are those of the presenters, and not Wakely Consulting Group.

Brought to you by the letters…

- ACA = Affordable Care Act
- APTC = Advance Premium Tax Credit
- AV = Actuarial Value
- CSR = Cost Sharing Reduction
- FFM = Federally-Facilitated Marketplace
- HIOS = Health Insurance Oversight System
- QHP = Qualified Health Plan
- SBM = State-Based Marketplace
- SHOP = Small Business Health Options Program
- URRT = Unified Rate Review Template

(Re)Sources

Resource	Date of Most Recent Version	Link
Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces	February 20, 2015	http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf
Unified Rate Review Template (URRT) and instructions (which include instructions for the actuarial memorandum)	February 21, 2015	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html

(Re)Sources

Resource	Date of Most Recent Version	Link
HHS Notice of Benefit and Payment Parameters for 2016; Final Rule	February 27, 2015	http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf
Final 2016 Actuarial Value Calculator	January 16, 2015	http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-Methodology.pdf
Exchange and Insurance Market Standards for 2015 and Beyond	May 27, 2014	http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf
Extended Transition to Affordable Care Act-Compliant Policies	March 5, 2014	http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf

PLAN DESIGN CHANGES FOR 2016

Cost sharing changes

Component	Description
Actuarial Value Calculator	Continuance tables trended two years (6.5% per annum) Impact will be more noticeable on leaner plans
MOOP for Family Coverage	Annual limit on cost sharing for self-only applies to each individual covered under a family policy Impact could be up to 5.0% for a given plan design

Cost sharing changes

Increase in maximum out-of-pocket (MOOP) limits:

Plan Type	2015 (Self-only / Family)	2016 (Self-only / Family)
All non-CSR plans	$6,600 / $13,200	$6,850 / $13,700
73% CSR plans	$5,200 / $10,400	$5,450 / $10,900
87% and 94% AV CSR plans	$2,250 / $4,500	No Change

CSR = Cost-sharing reduction; these plans are available to individuals and families with household incomes up to 250% of the federal poverty level (FPL) who enroll in silver level plans through the marketplace.

Covered benefit changes

Component	Description
Drug Coverage	Expanded exception process and formulary drug list transparency are new policies for 2016
Habilitative Services	In the absence of a state provided definition, HHS is defining habilitative services as coverage for health care services and devices that help a person keep, learn, or improve skills and functioning for daily living
Discriminatory design	Increased focus on benefit designs that HHS believes would discourage enrollment by individuals based on age or based on health conditions
Pediatric Services	Coverage until at least the end of the month in which the enrollee turns 19

RATING CHANGES FOR 2016

Key changes for 2016 rating

- Data availability
  - 2014 claims
  - Impact of transitional policies
  - Risk adjustment
- Continued phase down of reinsurance
- Plan design changes
- Small group expansion
- Consideration of King v. Burwell

Components of rate change and expected impact for 2016

Rate Pressure ⬆

- Reinsurance phase-down
- Trend (unit cost and utilization for stable population)
- Ruling in favor of King in FFM states
- Risk Corridor?

Rate Relief ⬇

- Increased expected take-up
- Decreased impact of pent-up demand
- Transitional policies ending

Either way ⬌

- Base period experience
- Network changes
- Risk adjustment
- Morbidity / demographics vs. expected
- Plan design changes
- Total fees
- Small group expansion

Changes related to experience and population

Component	Description
Base year experience	First year issuers may have a full calendar year (2014) of ACA claims experience, consider adjustments for: • Partial year enrollments • Non-recurring pent-up demand
Trend	Revised based on updated experience, normalization likely considerable
2016 demographics / morbidity	Adjustments will be made to the experience period to account for the expected risk in 2016; King v. Burwell may impact projections as will increased penalties / take-up
Impact of transitional policies	Pre-2014 non-grandfathered policies that can continue into 2016 in some states will affect the single risk pool as they transition back in

Changes related to 3 Rs

Reinsurance	Risk adjustment	Risk corridors
Less protection for issuers as attachment point increases from $45,000* to $90,000 for 2016	No significant program changes 2014 results available in June may inform reasonability of 2016 rates	Cost neutral basis may result in less aggressive pricing

* Some issuers/states were able to incorporate the recently finalized lower attachment point of $45,000 for 2015, but others utilized $70,000 attachment point in rules at the time of rate filings

Changes related to fees

Fee	2015	2016
Reinsurance	$44.00 (annual per capita)	$27.00 (annual per capita)
Risk adjustment user fee	$0.96 (annual per enrollee)	$1.75 (annual per enrollee)
Issuer fee	$11.3 billion nationally (varies by issuer, but roughly 3% of premium)	$11.3 billion nationally (varies by issuer, but roughly 3% of premium)
Exchange user fee	3.5% of exchange premium for FFM states; SBM states set their own	No change for FFM; SBM states will vary

Other rating changes

Adjustment/Factor	Clarification in URRT / Actuarial Memorandum instructions
Geographic area factors	Geographic factors can reflect delivery cost differences but not morbidity differences by region; actuaries must certify
Catastrophic adjustment	Plan adjusted index rate cannot include catastrophic adjustment for non-catastrophic plans
Adjustment for 3-child cap	Plan adjusted index rate cannot include adjustment for 3-child cap

Small Group Rating

Component	Description
Expansion of Small Group Market	Small group to include groups with up to 100 employees. States can allow issuers to renew current policies through October 1, 2016
Small Group Composite Premiums	Although initially proposed for 2016, CMS recently announced that this functionality will not be in place
Employee Choice in SHOP	In all FF-SHOPs, employers will have a choice of two methods to make QHPs available to qualified employees: • Choice of all QHPs at a single metal level • Offer a single QHP

What it feels like to be an actuary working on ACA rate filings…

RATE FILING PROCESS

Timeline for 2016 rate filings

Activity	Federal Deadline
Issuers submit all QHP and non-QHP Unified Rate Review rate filings to CMS and the applicable State [a]	May 15, 2015 (states may set earlier deadline)
Public disclosure of Parts I, II, and III of Rate Filing Justification for proposed rate increases subject to review [b]	10 business days following receipt of all rate filings in the relevant market segment
Deadline for all risk pools with QHPs to be in "final" status in URR system	August 25, 2015
Deadline for all risk pools with no QHPs to be in "final" status in URR system	October 9, 2015
Public disclosure for all rate increases (including those not subject to review)	November 1, 2015 (states may post earlier with notification to HHS)
2016 Open Enrollment Period	November 1, 2015 – January 31, 2016

[a] All QHP issuers and issuers with a rate increase for any plan in 2016 in the single risk pool are required to submit Unified Rate Review rate filings.

[b] Rate filings subject to review include those with rate increases, at the product level for 2016, of 10% or greater.

Timeline for quarterly small group filings

- Rate filings due 105 days prior to effective date of rate change (or earlier if required by the state)
- Rates must be finalized at least 45 days prior to effective date
- State review time = 60 days

Who, what and where?

Plan Type	Filing requirements
Single risk pool (QHP and non-QHPs)	All issuers must file 1/1 index rates with the appropriate regulator annually • URRT (Part I) and federal actuarial memorandum (Part III) must be filed through HIOS (federal system) for all QHP issuers, all other issuers with a rate increase, or when otherwise submitted to a state • Narrative justification (Part II) is required for increases over 10% • States may have additional filing requirements • Annual filings due on uniform timeline (previously, most states accepted rate filings for issuers without any QHPs at a later date than the QHP rate filings) • Federal deadlines also defined for quarterly small group filings
Transitional policies	Products with rate increases of 10% or higher file the following through the old Rate Review Justification system • The old Part I template and narrative (Part II) through the old Rate Review Justification system • Actuarial memorandum (Part III) if the state does not have an effective rate review program and the federal government is performing the rate review • State requirements also apply
Grandfathered policies	No federal filing requirements, state requirements apply

Public Posting of Rate Filings

- New requirements for states with Effective Rate Review program to post information from Parts I, II and III of the rate filing justification to the State's website or link to CMS's website on a schedule prescribed by HHS or earlier
  - Information for proposed rate increases exceeding 10% threshold to be posted 10 business days following submission of last filing
  - Information for final rate increases (including those not exceeding 10% threshold) posted by beginning of open enrollment (November 1, 2015)
- Applies to single risk pool rates in both the individual and small group markets regardless of whether issuers participate on the Marketplace
- A redacted version of the actuarial memorandum can be used for public disclosures

CONSIDERATIONS FOR REGULATORS AND EXCHANGES

Potential areas of focus for states

- King v. Burwell outcome
- Consumer impact analysis of rate changes before and after subsidies
- Public posting of rate filings
- Market analysis
- Impact of small group expansion
- Phase out of transitional policies
- Rate outlier analysis
- Risk score analysis
- Issuer financial performance monitoring
- Supporting transparency

Never too early

Anticipated changes in 2017

- States will be required to select a new benchmark plan for purposes of defining EHB for the 2017 plan year based on available plans in 2014
- For EHB compliance, issuers must use a Pharmacy and Therapeutics committee for reviewing drug formularies and utilization management practices for clinical appropriateness
- Rate increases for threshold calculation at the plan rather than product level
- The reinsurance and risk corridors premium stabilization programs are scheduled to end in 2017
- Phase-out of transitional policies

QUESTIONS?

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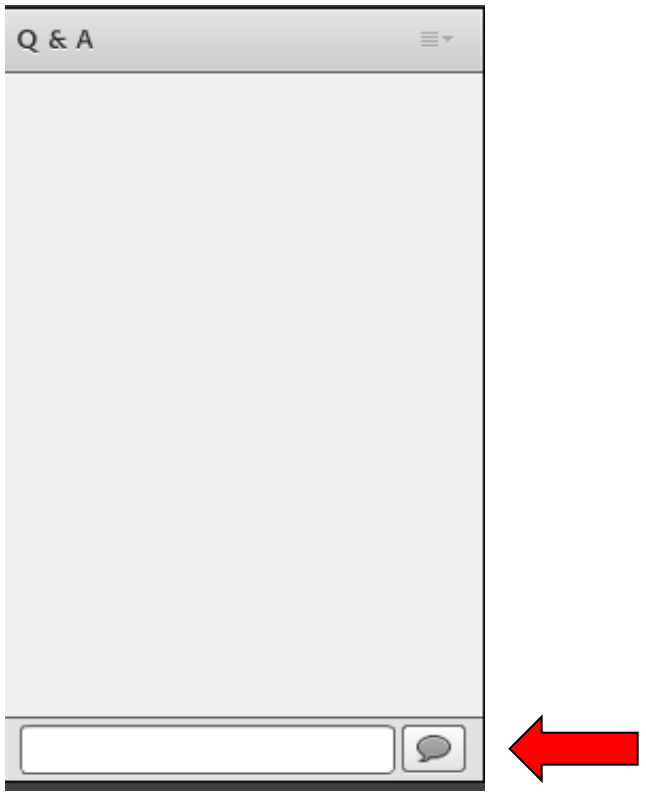

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