Testimony of

Christopher Carlson

Principal and Consulting Actuary

Oliver Wyman Actuarial Consulting

On Behalf of America's Health Insurance Plans

House Committee on Oversight and Government Reform

"Examining the Affordable Care Act's Premium Increases"

September 14, 2016

Washington, DC

Chairman Chaffetz, Ranking Member Cummings, and distinguished members of the Committee, thank you for the opportunity to provide this testimony regarding the premium rate increases requested for 2017 in the non-group health insurance market.

My name is Chris Carlson. I am a Principal in the firm of Oliver Wyman Actuarial Consulting. I am testifying today on behalf of America's Health Insurance Plans (AHIP), the national trade association representing health insurance plans and the millions of Americans they serve across the country.

AHIP's members serve families and consumers in every insurance market, from health and supplemental benefits for businesses and their employees, to individual insurance, to public programs such as Medicare and Medicaid. AHIP advocates for solutions that deliver affordable coverage, more choices, and higher quality to all Americans.

My testimony will focus on three main issues:

- The evolution of the premium rates on the Exchanges;
- The current factors that are being considered in calculating premium rates for 2017; and
- Policy options for stabilizing the market and making health insurance premiums more affordable in the long term.

Historical Experience

The Affordable Care Act (ACA) changed many of the rules regarding premium rating that existed prior to 2014, including guarantee issue which allows individuals with pre-existing conditions to purchase coverage that otherwise would not have been available to them. This has allowed for a broad increase in the number of individuals with health insurance and has significantly reduced the uninsured population from 44.8 million during 2013[1] to the most recent estimates of 27.3 million during the first quarter of 2016.[2]

The large increase in individuals purchasing health insurance in the non-group market has come with challenges. Although carriers anticipated this growth, when the actuaries were preparing the rate filings for the Exchange products back in early 2013, there was very limited information available to support the estimates for premium rates. This made the initial rate requests very challenging, and we're still feeling the consequences today. Here I provide a brief history of the premium rates in the non-group market.

To begin, I start by looking back to the original expectations for premium rates in the Exchange marketplace. In 2009, the Congressional Budget Office (CBO) responded to Senator Evan Bayh with its expectations for the level of premium rates on the Exchange marketplace beginning in 2014. These estimates reflected the changes in the coverage requirements, the risk pool and rating restrictions required by the ACA. At that time, the CBO expected the average premium in the non-group market to be $5,800 per year for a single policy which equates to $483 per month.

It is important to recognize that in most cases I speak in regards to averages. However, the experience also varies greatly from state to state (and even within states). For example, while the average premium

[1] https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201409_01.pdf
[2] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

rates were lower in 2014 than expected, the rates for the second lowest cost silver plan ranged from $2,304 in Minnesota to $5,688 in Alaska.

It was not until several years later that we again had an opportunity to see what kind of premium rates individual policyholders were going to pay on the Exchanges. In October 2013, individuals started enrolling in the Exchange marketplace for the first time. Carriers had developed their rates based on the market rules that had been established in preceding regulations. Many were surprised that the 2014 premium rates were far lower than had been projected by the CBO. A report from HHS's Assistant Secretary for Planning and Evaluation (ASPE) determined that the average cost of the second lowest cost silver plan was $3,936.[3] Not only did many carriers propose premium rates below the CBO estimates, consumers were noticeably cost-conscious and chose plans that offered the lower cost.[4] However, after carriers were already enrolling individuals in coverage, the Administration announced in November 2013 its transitional policy which would allow consumers to remain on their pre-ACA coverage subject to state regulators and availability.

The premium rates for 2015 were developed by actuaries in a manner consistent with the 2014 premium rates. There was a limited amount of data available, especially in light of the difficulty in enrolling through Healthcare.gov and the extensions of the open enrollment period and the transitional policies. As a result, premium rates in 2015 reflected increases consistent with medical trend. The weighted average increase for individuals that were enrolled during 2014 was 7% assuming that they kept the same plan.[5]

Premium rates for 2016 followed a similar pattern. While there was a wide range of rate increases, from a reduction of 10.6% in Seattle to an increase of 38.4% in Nashville[6], the average increase for the second lowest cost silver plan was 7.5% for plans on the Federal Exchange.[7]

2017 Premium Rates

The ACA Exchanges will soon begin enrolling individuals for 2017. There has been concern that premium rates will be higher in 2017. I will address the key components of premium rate calculations that actuaries considered in developing premium rates for 2017. These components include:

- Underlying medical trend
- Risk pool composition
- Market turnover
- The expiration of two of the ACA's three premium stabilization programs
- Special enrollment periods
- Health Insurer Tax

[3] https://aspe.hhs.gov/sites/default/files/pdf/177626/ib_premiumslandscape.pdf
[4] http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/
[5] http://healthcare.mckinsey.com/sites/default/files/2015%20OEP%20Emerging%20Trends%20-%20McK%20Reform%20Center_0.pdf
[6] http://kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/
[7] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-26-2.html

To put it simply, health insurance is a reflection of medical care delivery – and is priced accordingly. Underlying medical trend has always been the primary driver in the increased cost of health insurance. The trend reflects a number of factors including, but not limited to: increased cost of medical services, increased utilization of services, change in the type of services to more costly modalities (e.g., high-cost prescription drugs), and technological advancements. When the costs of delivering medical care go up, so, too, does the cost of health insurance.

Actuaries use the experience of the risk pool in setting the premium rates. However, as discussed earlier, the risk pool was relatively unknown when premiums were priced for 2014 and 2015, and to some extent in 2016. In general, the actual composition of the risk pool has been less healthy than originally expected. The two primary reasons are the extension of policies through the transitional plans, and lower enrollment than projected. The transitional plans, in states that allowed them, have led to many individuals that otherwise would have enrolled through the Exchanges keeping their non-ACA insurance. These individuals are likely to be healthier since they chose to maintain policies that likely provide less coverage than the benefit-rich plans on the Exchanges.

The annual open enrollment allows consumers to have the opportunity to change their plans to meet their needs. However, this frequent rate of transition is a drawback for insurers because of uncertainty regarding the enrollment in their plans. This uncertainty results in an inability to confidently rely upon the experience of the health plan and requires actuaries to be more conservative in their pricing.

The temporary reinsurance program functions to reduce premiums for consumers in the Exchange. The elimination of this program for 2017 will force insurers to build an additional 4% to 6% into their premiums to reflect that they will not receive any funding to offset large claims. Moreover, the temporary risk corridors program also has not worked as originally designed, which has led to upward pressure on premiums.

Oliver Wyman reviewed the impact of the special enrollment periods on health insurers.[8] We found that individuals that enrolled during the special enrollment periods were higher cost than those that enrolled in the open enrollment period. Whether this was intentional by the consumers to take advantage of lax oversight, or endemic of those that required the special enrollment periods, it led to far higher health care costs than were anticipated by the health insurers.

While health insurers are trying to utilize their best estimates of the cost to provide health insurance, this continues to be a market in flux. The membership is fluid and continues to grow as more people sign up for non-group insurance. However, there is more that can be done to maintain a stable and affordable market for consumers. I discuss some policy decisions that could help move toward this goal in the next section.

Policy Options to Stabilize the Market

To make health insurance premiums more affordable in the long term, additional action must be taken to address the factors that are driving underlying health care costs. While the Administration has taken positive steps in key areas – tightening the rules for special enrollment periods (SEPs), improving risk

[8] https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf

adjustment, and targeting outreach to the uninsured – much more needs to be done. Below I discuss several areas where there are opportunities for legislative and regulatory action to provide relief from rising health care costs and to stabilize the market.

Strengthening the risk adjustment program to promote greater payment accuracy: The ACA risk adjustment program plays an important role in promoting market stability, a level playing field, and affordable coverage for consumers in the marketplace – particularly for patients with chronic health conditions. Additional targeted changes to improve the accuracy and effectiveness of the model – such as better accounting for the effects of partial year enrollment and including prescription drug data in the model – can help strengthen the risk adjustment program so it can better fulfill its goals of promoting affordability and stability in the new marketplace. I appreciate that the Administration has addressed this in its proposed rule for the 2018 Notice of Benefit and Payment Parameters.

Improving verification of SEPs: While the Administration has taken steps to address the misuse of SEPs, more action is needed to assure appropriate use of SEPs – which is critical to assuring stability in the new Exchange marketplaces and promoting affordability for consumers. HHS has clarified the availability of certain SEPs – notably, tightening the eligibility requirements for most instances of permanent move by requiring prior coverage – to limit potential abuse. Earlier this year, the Administration also announced that it would conduct an assessment of enrollments made through SEPs. Additional policy steps include further streamlining and reducing the number of SEPs and implementing pre-enrollment verification for high-priority SEPs (such as permanent move and loss of minimum essential coverage). AHIP supports a House bill, H.R. 5589, which would implement a pre-enrollment verification process for SEPs.

Promoting stability and flexibility in benefit and network design to promote consumer choice and affordability: Benefit design flexibility is a hallmark of private sector coverage, and innovations in benefit and network design can help promote affordability and value for consumers in the new marketplace. Moreover, flexibility in network design – including the ability of plans to offer high-value network plans – provides consumers with a broader range of affordable health plan choices and providers that meet their own financial and health care needs.

Enhancing the effectiveness of outreach and enrollment strategies to build on coverage gains: Expanding participation in the new marketplace – including through more targeted educational and outreach efforts to subsidy-eligible individuals – can not only build on the progress made in reducing the number of uninsured, but can also help stabilize the risk pool and promote more affordable premiums.

Providing further relief from the health insurance tax: In December 2015, Congress approved bipartisan legislation providing for a one-year suspension, in 2017, of the ACA health insurance tax. An analysis by Oliver Wyman[9], commissioned by AHIP, estimates the following per enrollee premium savings, for each market segment, that will result from suspension of the ACA health insurance tax in 2017: $350 for Medicare Advantage enrollees; $270 for small business employees; $250 for employees of large businesses; $210 for consumers who buy coverage in the individual market; and $150 for state Medicaid programs. Looking ahead, Congress has an opportunity to further improve the affordability of coverage for consumers by suspending the health insurance tax for an additional year in 2018 and

[9] Oliver Wyman, Estimated Impact of Suspending the Health Insurance Tax from 2017-2020, December 16, 2015

eventually taking action to fully repeal this tax. Under the ACA, the total dollar amount of the health insurance tax is set at $14.3 billion in 2018. Unless Congress takes action, this massive tax bill will be passed onto consumers in the form of higher premiums. AHIP strongly supports a bipartisan House bill, H.R. 928, which calls for the full repeal of the health insurance tax. This bill has been cosponsored by 236 House members.

Allowing states to set their own age rating bands: AHIP supports a House bill, H.R. 5921, which would amend the ACA to allow states to set their own age rating rules. The flexibility granted to states under this bill would promote more affordable coverage and expand participation among younger, healthier individuals. The ACA established 3:1 age rating bands that led to higher premiums for certain younger consumers – particularly those who purchased individual market coverage prior to the ACA and/or are not currently eligible for subsidies. Providing flexibility for states to adopt wider age bands could encourage younger and healthier people to enroll in coverage. This, in turn, could improve affordability for consumers by promoting greater stability of the risk pool.

Recognizing fraud prevention programs as quality improvement activities: Health plans devote significant resources to fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. These programs employ innovative techniques to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients. The federal government also is refocusing its anti-fraud efforts to emphasize prevention, moving away from the "pay and chase" approach used in the past. Accordingly, the regulations for the ACA's medical loss ratio (MLR) requirement should be revised to recognize investments in fraud prevention programs as quality improvement activities, rather than administrative expenses.

Aligning the grace period with state law and regulation: AHIP supports a House bill, H.R. 5410, which would align the current grace period for recipients of advanced premium tax credits (APTC) with existing state law and regulation. Under current law, Exchange enrollees who receive the APTC are provided with a three-month grace period before coverage is discontinued if they are delinquent on their premium payment, and health plans are required to pay health care claims during the first month of the grace period. Current law should be amended to make the grace period requirements consistent with existing state rules, most of which currently allow for a 30-day grace period. This legislation could help promote continuous coverage and consumer affordability by improving the stability of the risk pool.

Preventing third party payments that skew the risk pool: There is concern that the risk pool is skewed when pharmaceutical companies, providers and other organizations are allowed to pay premiums on behalf of Exchange enrollees or inappropriately steer high-cost Medicare and Medicaid eligible individuals to the private market to maximize their reimbursement. These practices result in a risk pool that is weighted more heavily with older and less healthy people – thereby driving up premiums for everyone and destabilizing the market. AHIP has urged CMS to issue regulations to prevent third party payments by, or on behalf of, entities with a financial interest in the payment of health insurance claims, and prevent the selective shifting of Medicare and Medicaid beneficiaries into private coverage.

Improving Health Savings Accounts (HSAs): AHIP supports a House bill, H.R. 5445, which proposes three important policy changes that would allow consumers to maximize the value they get from their HSAs: (1) increasing the annual limit on the amount account-holders are permitted to contribute to their

HSAs; (2) allowing consumers the flexibility to use HSA funds to pay medical expenses incurred in the 60-day period before the account was established; and (3) allowing both spouses to make "catch-up" contributions to the same HSA. These improvements would be beneficial to the growing number of Americans who rely on HSAs to accumulate savings for their future medical needs and take a more active role in making decisions about their health care.

These changes will help deliver more affordable coverage – and more choices – in the Marketplaces. That's what consumers deserve – and that's what health insurance plans are committed to delivering.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Christopher Carlson

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2012. Include the source and amount of each grant or contract:

My firm is a subcontractor to LMI Government Consulting Inc., performing health insurance premium rate reviews for the Centers of Consumer Information and Insurance Oversight.

Year	Invoiced
2012	$ 591,000
2013	200,000
2014	773,000
2015	1,102,000
2016	636,000

My firm is a subcontractor to George Washington University, performing evaluation services relative a Round Two Health Innovation award from the Center for Medicare & Medicaid Innovation optimizing the HIV care continuum.

Year	Invoiced
2015	$ 30,281
2016	20,488

My firm was a subcontractor to Mercer Health & Benefits, Inc., a sibling company, providing Medicare Advantage Audit Services to the Centers for Medicare & Medicaid Services.

Year	Invoiced
2012	$ 114,000
2013	87,000

Oliver Wyman Actuarial Consulting, Inc is a wholly owned subsidiary of the March & McLennan Companies, Inc., as is Guy Carpenter, Inc. Guy Carpenter, Inc. was recently awarded a contract by the National Flood Insurance Program. The contract is estimated to have a value between $2.5 million and $8.6 million depending on the scale of reinsurance secured during the contract period which runs from August 22, 2016 through December 31, 2017.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities

I am appearing on behalf of the America's Health Insurance Plans. I am an employee of Oliver Wyman Actuarial Consulting, Inc., and the America's Health Insurance Plans is paying the firm that employs me to appear on their behalf.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2012 by the entity(ies) you listed above. Include the Source and amount of each grant or contract.

See attached.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2012 by the entity(ies) you listed above. Include the Source and amount of each grant or contract.

CDC:

"Health Plans Preventing Diabetes and Improving Well-being", # 93.739, $4,901,000.00

"Million Hearts/Heart Disease & Stroke", #3U38OT000161, subcontractor to Association of State and Territorial Health Officials (ASTHO), amount of subcontract $40,000.00

Safety and Healthcare Epidemiology Prevention Research Development (SHEPheRD), #200-2011-42040, order #0003, $155,030.63

"Wellness & Prevention Survey of Health Plans", #200-2013-55917, $149,957.33

EPA:

"Strategies for Managing Asthma and Reducing Exposure to Environmental Triggers", # 83576401, total award $598,541.00

FDA:

"Incorporating PRISM into FDA's Routine Vaccine Safety Monitoring System", subcontractor to Harvard Pilgrim Health Care Institute under Master Agreement #HHSF2232009100061, amount of subcontract $12,687.00.