OLIVER WYMAN

Testimony before the Committee on Oversight and Government Reform
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Rising Health Insurance Premiums under the Patient Protection and Affordable Care Act (ACA)

Introduction

Chairman Chaffetz, Ranking Member Cummings, and distinguished members of the Committee, thank you for allowing me to present this written testimony to you regarding premium increases under the ACA.

My name is Kurt Giesa. I am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries and I meet that body's qualification standards for providing this testimony. I am also a Partner in the firm of Oliver Wyman Actuarial Consulting, though this testimony reflects my views and opinions and not necessarily those of my employer.

I am here today on behalf of the Blue Cross and Blue Shield Association ("BCBSA"). BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("BCBS Plans") that collectively provide healthcare coverage for more than 107 million members – one-in-three Americans. BCBS Plans have an 85-year history providing coverage in their local communities. BCBS Plans offer individual coverage across the United States and provide coverage in the vast majority of the Exchange Marketplaces today.

My testimony will focus on the non-group market and will discuss some of the major changes the ACA brought to that market and some of the ways in which the ACA introduced significant challenges to issuers and their actuaries in setting premiums. I will also discuss the impact the actual morbidity of the single risk pool has had on issuers' premiums for 2017, and I will provide some thoughts on steps Congress and the Administration could take to stabilize the market.

Background

Issuers and their actuaries faced extraordinary challenges in setting non-group ACA premiums going into 2014, the first year of the major insurance rating reforms in the non-group market.[1] In most states prior to 2014, issuers were able to take an individual's health status, age, gender, and other relevant factors into account in setting non-group premiums. As a result, issuers were able to charge premiums based on expected costs. Matching

[1] Swenson-Moore, Karin, "Implementing the ACA: An Actuarial Perspective," The Actuary Magazine, December 2013/January 2014 – Volume 10, Issue 6

premiums to expected costs had several consequences. Underwriters were able to produce a relatively stable risk pool, and because actuaries had been accumulating experience on these relatively stable risk pools over time, they were able to set premiums at a level that was generally sufficient to cover actual costs. At the same time, prior to 2014, coverage was difficult to obtain in the traditional non-group market for those individuals with significant health burdens, although most states had mechanisms to assure these individuals had access to coverage through alternative sources, including state high risk pools.[2]

Beginning in 2014, the ACA required issuers offering coverage in the non-group market to make that coverage available to anyone during the open enrollment period, including those individuals who had obtained their coverage through state high risk pools, and to anyone qualifying for a special enrollment period.[3] Premiums for new products in the non-group market can now only vary by family status, age, though not by more than 3:1 for adults, rating area, and tobacco use, though not by more than 1.5:1.[4] The ACA requires all issuers to cover ten "Essential Health Benefits," and to offer coverage at one of four "metal" levels.[5] In addition to greater transparency, these provisions of the ACA have resulted in consumers purchasing coverage that is generally more generous, and more costly, all other things equal, than had typically been purchased in the non-group market prior to these requirements.[6]

Challenges Associated with Setting Premiums in 2014, 2015, and 2016

Issuers had to prepare premium rates for calendar year 2014 in April of 2013. Because of the significant changes to the operation of the non-group market going into 2014, and the significant uncertainty around the size and health of the non-group risk pool, issuers and their actuaries made educated guesses regarding appropriate premium levels. Regulations were being finalized as issuers were working to develop premiums, and several events that occurred after premiums were submitted had significant, negative impacts on the adequacy of issuers' 2014 premiums. These included the difficulties individuals had enrolling through federal and many state exchanges,[7] the Administration's decision to give states the authority to allow policies that had been issued prior to October 1, 2013 to renew in 2014, so that these insureds could remain outside of the single risk pool, Congress' decision not to fund the risk corridors program, and the expansion and lax enforcement of special enrolment

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[2] In 2011, roughly 225,000 individuals were covered under state high risk pools. "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis." National Association of State Comprehensive Health Insurance Plans

[3] ACA, §1201

[4] Ibid.

[5] ACA, §1302

[6] Gabel, R., et al., "More than Half of Individual Health Plans Offer Coverage that Falls Short of What Can Be Sold through Exchanges as of 2014," Health Affairs, June 2012, vol. 31, no. 6, 1339-1348

[7] Pear, Robert. "Insurers Claim Health Website is Still Flawed", New York Times, December 1, 2013. http://www.nytimes.com/2013/12/02/business/white-house-praises-gains-on-health-site.html

periods. If issuers had full knowledge of these developments when they were setting premiums in 2013, premiums would have certainly been higher.

Issuers were required to submit exchange premiums for 2015 in June 2014 in most states. Due to the lag between when claims are incurred and when they are processed and paid, most issuers were likely finalizing 2015 premium rates in May 2014 using actual claims experience through only March 2014. Given the difficulties individuals had enrolling through HealthCare.gov and some state-based exchanges, the potential for pent-up demand among the previously uninsured, and the fact that issuers had very limited knowledge of the impact that risk adjustment would have on their financial results,[8] issuers were again forced to set premium rates for 2015 with very little relevant information.

For 2016, issuers had to submit exchange premiums by May 2015 in most states. Again, issuers were likely finalizing premiums in April using claims incurred through February 2015. In other words, issuers likely had full knowledge of a very turbulent 2014, and very little knowledge of 2015, but given emerging experience, and the losses issuers were reporting in 2015 on their 2014 non-group business, issuers were coming to understand that premiums in 2015 were likely to be understated.[9]

CMS required issuers to make other changes to their policies that caused premiums to increase for 2016, including the application of self-only maximum out-of-pocket limits to each member of a family and changes to prescription drug coverage. In addition, the Shared Responsibility Payment, or ACA penalty, for not maintaining coverage increased significantly in 2016.[10] The effect of these changes on the cost of providing coverage and the make-up of the single risk pool was uncertain.

Health of the Single Risk Pool

2017 will be the first year that premiums in the non-group market will be based on a relatively thorough understanding of the make-up of the single risk pool. It is smaller than many initially thought it would be, and the enrollees are older, and less healthy than is needed for a stable pool.

Earlier this year, BCBSA released its *Health of America* Report on the cost of those insured under the ACA. BCBSA found that those non-group members who were newly insured under the ACA have a higher disease burden, use more services, and cost more to insure than those covered in the employer group market and also than those covered in the non-group

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[8] Actual risk adjustment transfers were made available to issuers on June 30, 2015.Risk adjustment transfer payments had a significant impact on issuer's financial results. The absolute value of risk adjustment transfers in the non-group market was equal to 10% of total premium.

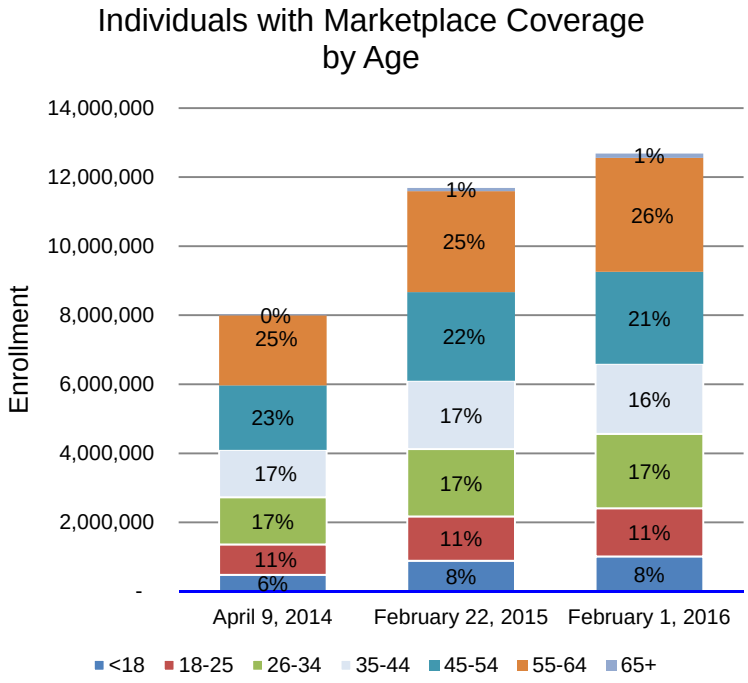
[9] Author's calculations based on annual statement information, ASPE reports on Exchange enrollment, and CMS data on the impact of the transitional policy on the risk corridors payments (http://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/rc_transitionaladjguidance_5cr_041715.pdf)

[10] http://obamacarefacts.com/individual-shared-responsibility-payment/

market prior to the ACA. The report shows, for example, that the prevalence rates of HIV and hepatitis C that are roughly 400% and 200% higher respectively than those covered in the employer group market. Inpatient hospital admissions are roughly 40% higher for the newly insured than those covered in the employer market, and allowed costs per member are 22% higher.[11]

In the chart below, we show that while there was significant growth in the Exchange market between 2014 and 2016, increasing from 8.0 million to 12.7 million in 2016, most of that growth came in 2015 and the growth slowed considerably in 2016. Further, the chart shows that in spite of this growth, the demographics of the population changed very little.[12] We note that the size of the non-group market is considerably lower than many analysts expected.[13,14]

Chart 1



[11] BlueCross BlueShield and BHI, "The Health of America Report: Newly Enrolled Members in the Individual Health Insurance Market after Health Care Reform: the Experience from 2014 and 2015." March 2016. http://bcbs.com/healthofamerica/

[12] This chart is taken from the following article: Armour, Stephanie and Radnofsky, Louise. "Health Law Faces Key Time – Officials Look to Enroll More Healthy People During this Year's Critical Sign-up Period." The Wall Street Journal, September 8, 2016, page A3.

[13] Jost, Timothy. "CBO Lowers Marketplace Enrollment Projections, Increases Medicaid Growth Projections (Updated)." Health Affairs Blog. January 26, 2016. http://healthaffairs.org/blog/2016/01/26/cbo-lowers-marketplace-enrollment-projections-increases-medicaid-growth-projections/

[14] Haught, Randy and Aherns, John. "Cost of the Future Newly Insured under the Affordable Care Act (ACA." Society of Actuaries. March 2013

Data from the U.S. Census Bureau shows that in 2013, individuals age 45 to 64 made up 29% of the uninsured population.[15] In 2016, the chart above shows that this cohort made up 47% of the Exchange market.

Two provisions of the ACA work to produce an older risk pool. These are the Advance Premium Tax Credits ("APTCs," or subsidies) that lower-income individuals receive to offset the cost of purchasing insurance, and the 3:1 age curve. The APTCs are structured such that an individual's or family's cost for the second-lowest-cost silver plan is limited to be no more than a specified percentage of their household income, which is defined as a percentage of the Federal Poverty Level ("FPL"). The percentage of household income an individual or family must pay towards the cost of coverage decreases as household income decreases, but does not vary by age.

The structure of the APTCs and the 3:1 age banding alter the value equation for individuals to purchase coverage by making it more attractive for older individuals (who would naturally be motivated to purchase coverage because they generally have more health care needs) to buy coverage while making insurance less attractive for younger purchasers (who may not be inclined to purchase insurance in the first place because they are generally in much better health). In Table 1, we show the ratio of the value of the insurance being purchased to the net cost of insurance after APTCs by age and FPL.

[15] Smith, Jessica and Medalia, Carla. "Health Insurance Coverage in the United States: 2013." U.S. Census Bureau. September 2014. https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf

Table 1
Actuarial Premium Relative to Out-of-Pocket Cost of Coverage
by Age and FPL

	Age		
	Age 24	Age 44	Age 64
Actuarial Premium	$ 133.87	$ 263.51	$ 593.70
ACA Premium (3:1 Age Slope)	$ 183.51	$ 256.37	$ 550.53
Out-of-Pocket Cost of Coverage after APTCs by FPL			
150% FPL	$ 58.64	$ 58.64	$ 58.64
250% FPL	183.51	196.93	196.93
350% FPL	183.51	256.37	325.40
400%+ FPL	183.51	256.37	550.53
Actuarial Premium Relative to Out-of-Pocket Cost by Age and FPL			
150% FPL	2.28	4.49	10.12
250% FPL	0.73	1.34	3.01
350% FPL	0.73	1.03	1.82
400%+ FPL	0.73	1.03	1.08

At the top of Table 1, we show premiums that would be roughly representative of premiums in the market in 2015 if premiums were not restricted to 3:1 for age.[16] In the next row, we show premiums using the same market wide average premium as in the first row, but now restricted to 3:1 for age using the HHS prescribed age curve. In the middle of the table, we show the individual's out-of-pocket cost for coverage after the APTCs based on the FPL and applicable percentages for 2015.

The 24 year-old at 150% FPL receives an APTC that lowers the cost of coverage to $58.64, but because the applicable percentage of income for individuals at 250% of FPL and above is greater than the premium at age 24, 24 year-olds must pay the entire premium at the higher FPLs, as illustrated.

At the bottom of the table, we show the ratio of the age-specific actuarial premium (the actual cost of covered health care benefits for someone of that age) to the out-of-pocket cost of coverage to illustrate how the value equation changes for consumers at different ages and income levels.[17] At 250% FPL, for example, the ratio for a 24 year-old is equal to 0.73. This means that for every $1.00 they pay out-of-pocket for coverage, they receive $0.73 in value. At age 64, the ratio is 3.01; for every $1.00 a 64 year-old at 250% FPL pays towards coverage, they receive $3.01 in value. Even above 400% FPL, where APTCs are not

[16] The age slope for these actuarial premiums is taken from "Health Care Costs – From Birth to Death." Yamamoto, Dale. Society of Actuaries. June 2013. https://www.soa.org/Files/Research/Projects/research-health-care-birth-death-report.pdf

[17] Note that we have not factored in the value of cost sharing reduction subsidies or the penalties for not maintaining coverage in this analysis to simplify the presentation.

available, 64 year-olds receive more value from purchasing coverage than the out-of-pocket cost of that coverage due to the 3:1 age banding.

While the subsidy structure and age bands are not the only provisions of the ACA that impact the price of insurance for younger people (benefit structure and other rating rules are also important), these examples illustrate why it has been more difficult for health plans and exchanges to enroll the younger, healthier population that is needed for a balanced risk pool.

Stabilizing the Single Risk Pool

Health plans have worked to better manage the cost of the population enrolled in the ACA risk pool by introducing new products and networks tailored to the exchange population. Given the rate of high cost conditions for new enrollees in the individual market, plans are using care coordination and medical management tools to help people with complex conditions get the care they need in the most effective and efficient manner. BCBS companies are expanding patient-focused care programs that emphasize prevention, wellness and coordinated care so that individuals get healthy faster and stay healthy longer. BCBS companies have engaged with more than 327,000 physicians and 2,000 hospitals that now serve 42 million members through these innovative care models.

Congress could help to stabilize the health of the single risk pools and assure the long-term viability of the markets by encouraging continuous coverage and adjusting the rating and subsidy structures to change the value equation for young people.

Specifically, Congress could pass legislation to accomplish the following:

- Ensure individuals are eligible for a special enrollment period before enrolling;
- Align grace periods for non-payment of premium with state requirements;
- Allow issuers to reward insureds for maintaining continuous coverage through benefit designs and other means;
- Make coverage more attractive to younger insureds by redesigning the subsidy structure to more accurately reflect younger consumers' lower demand for health insurance;
- Modify age variation in premium rates to 5:1 or a rate set by a state; and
- Repeal the health insurance tax (or at a minimum extend the moratorium) to prevent a 3% premium increase starting in 2018.

The Administration could help to stabilize the health of the single risk pool by improving its outreach efforts to younger, uninsured Americans, by working with plans to both avoid over-burdensome regulation and assure that appropriate premium increases are approved by state regulators, and by providing a stable regulatory environment.

The Administration could also take the following administrative action to help stabilize the market:

- Require upfront verification of special enrollment period eligibility prior to coverage;
- Require payment of outstanding premiums before re-enrolling on the exchange; and

- Issue a final rule to stop the inappropriate steering of Medicare and Medicaid eligible individuals to private coverage.

I appreciate the opportunity to present this testimony and I welcome any questions you may have.

Thank you.

OLIVER WYMAN

BIOGRAPHICAL SUMMARY – KURT GIESA, FSA, MAAA

Kurt Giesa is the National Practice Leader of Oliver Wyman Actuarial Consulting's Health Care Practice. He works with health insurers, regulators, and providers. Kurt's work with health insurers has been focused on helping them understand and respond to the changes resulting from the Affordable Care Act. His work with insurers also includes product design and pricing, the preparation of regulatory filings, and provider contracting. His work with health care providers includes assistance in contracting with payers, the design of risk-sharing mechanisms, and the development of business strategies to anticipate and respond to the changing health care environment. His work with regulators includes providing expert testimony, market analyses, the development of regulation, and the review of health insurance rate filings. He is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

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

Name: Kurt Giesa

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 to 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 Blue Cross and Blue Shield Association. I am an employee of Oliver Wyman Actuarial Consulting, Inc., and the Blue Cross and Blue Shield Association 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.

Federal Employees Health Benefit Plan -- Service Benefit Plan
2013 – $28.5B
2014 – $29.2B
2015 – $30.5B
2016 – TBD

Federal Employees Dental and Vision Insurance Program -- Federal Employees Blue Vision
2013 – $91.2M
2014 – $99.7M
2015 – $107.4M
2016 – TBD

Federal Employees Dental and Vision Insurance Program -- Federal Employees Blue Dental
2013 – N/A
2014 – $32.5M
2015 – $64.6M
2016 – TBD

Health Resources Services Administration -- Childrens Hospital Graduate Medical Education Resident Counts Project
Though September 2017 -- $1.1M

Health Resources Services Administration -- Teaching Hospital Graduate Medical Education
Through September 25, 2016 -- $229,000