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Ms. Mila Kofman
Executive Director
DC Health Benefit Exchange Authority
1225 Eye Street, NW, 4th floor
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September 20, 2017

Review of Funding and Approaches to Reduce Individual Premium Rates

Dear Mila:

In this letter, we provide estimates regarding the level of funding that would have been required by the District of Columbia (the District) in order to develop a program that would have lowered 2018 premium rates in the individual market by amounts equal to 5%, 10%, and 20%. Additionally, we include a discussion of potential approaches which could be utilized to allocate funds to carriers in order to achieve the intended objective of lowering rates in the market.

Funding Required To Reduce 2018 Carriers' Claim Costs[1]

In this section, we provide estimated funding levels required to reduce carrier claim costs by 5%, 10%, or 20% (assuming carriers would correspondingly reduce premium rates by a similar percentage and no significant population shifts occur) as well as approaches which could be utilized to allocate funding to carriers in the event a program were created to do so.

Funding Required To Reduce 2018 Claim Costs	
5% Claims Reduction	$3.7 million to $4.4 million
10% Claims Reduction	$7.4 million to $8.8 million
20% Claims Reduction	$14.8 million to $17.7 million

#1 –Reinsurance Based on Claim Thresholds

A percentage of annual claims which fall between a specified lower and upper threshold for a given member is reimbursed to carriers.

Pros:

- **Carrier Familiarity** – Carriers would be familiar with a program such as this due to past experience with the federal Transitional Reinsurance program which was in place for calendar years 2014, 2015, and 2016.

[1] For demonstration purposes; it is our understanding that a claims based reinsurance program could not be implemented in time to impact carriers' 2018 individual market premium rates

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- **Flexibility** – If desired, the parameters of the program can be adjusted up or down after the policy year end as needed to return the exact amount of any reinsurance funds back to participating carriers.

- **Ability to Cap Risk to the District** – If desired, risk to the District could potentially (e.g. if legally feasible based on the way in which the arrangement is written and communicated) be capped such that total payments to carriers do not exceed available reinsurance funds. It should be noted that this could result in carriers receiving lower payments (as a percentage of total claims) than initially expected and potential premium deficiencies, which could lead to carriers being more conservative in their development of rates.

- **Protection Against Claim Volatility Due to Large Claims** – If implemented in a way similar to that of the federal Transitional Reinsurance program with thresholds at higher claim amounts, carriers would have a level of protection against the most volatile and hardest to predict claims.

Cons:

- **"Double-Counting" with Risk Adjustment**- Carriers covering a higher than average percentage of members diagnosed with high cost conditions can have an advantage over other carriers in the market as they could be reimbursed for the cost of those members through both risk adjustment as well as reinsurance.

- **Risk of Misestimating** – Assumptions would be made for items such as projected membership, claims trends, and plan mix in the initial determination of both the required funding and the parameters to be used. In the event actual results are significantly different than the assumptions made, available reinsurance funds may be either too high or too low (to achieve the desired objective) and/or payments to carriers could be too high or too low (if parameters are not later adjusted).

- **Diminished Impact of Cost Management** - Carrier-specific cost management efforts (e.g. use of narrow networks, care management) would be somewhat diminished, as every $1.00 improvement in actual claim costs achieved would only actually result in an improvement in those costs net of the reinsurance payments (e.g. $0.80 in the scenario where claim costs are reduced 20%).

- **Reduced Federal Funding with no 1332 Waiver**– Lower premiums would lead to reduced federal funding (i.e. APTCs) financed with District funds, which likely could not be recouped without the approval of a 1332 waiver.

- **Timing of Implementation –** Could not be implemented for plan year 2018.

- **Reliance on Carriers to Implement Premium Rate Reductions –** The parameters and intended objective of the reinsurance program could be communicated, but it would ultimately be up to carriers to adjust their rates accordingly. In some cases, carriers may

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incorporate some level of conservatism. One control on this may be the rate review process which is in place.

Administration:

- **Calculation of Funding Required and Choice of Parameters -** Initial analysis would be required to determine the level of funding required to achieve the desired objective (e.g. 20% reduction to claim costs) as well as to set the preliminary program parameters. Analysis would include projections of membership and claim costs. Data could be requested from carriers in order to enhance the accuracy of the analysis.

- **Calculation of Payments to Carriers -** Carriers would need to submit claim files to the District at the end of year (with some specified level of runout), providing total annual claim costs on a per member basis. The District would validate the information provided and calculate the amount to be paid to carriers using the established parameters. To the extent calculated payments are greater than or less than total available reinsurance funds, parameters could be adjusted and payments recalculated as necessary. Overall, the level of administration associated with the program could be relatively low, especially to the extent federal reporting data could be utilized to validate the accuracy of the claims information submitted by carriers.

#2 - Reinsurance Based on Total Annual Claim Costs Net of Risk Adjustment

Carriers are reimbursed a specified percentage of their overall annual claim volume net of risk adjustment payments/receipts.

Pros:

- **Simplicity and Predictability**– The reimbursement percentage can easily be set to produce the desired percentage reduction in claim costs.

- **Coordinated with Risk Adjustment** – Given that reimbursement would be based on claims net of risk adjustment payments/receipts, there would be no “double-counting” between the two programs.

- **Flexibility** – If desired, the reimbursement percentage can be adjusted up or down after the policy year end as needed to return the exact amount of any reinsurance funds back to participating carriers.

- **Ability to Cap Risk to the District** – If desired, risk to the District could potentially (e.g. if legally feasible based on the way in which the arrangement is written and communicated) be capped such that total payments to carriers do not exceed available reinsurance funds. It should be noted that this could result in carriers receiving lower payments (as a percentage of total claims) than initially expected and potential premium deficiencies, which could lead to carriers being more conservative in their development of rates.

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Cons:

- **Risk of Misestimating Required Funding**– Assumptions would be made for items such as projected membership, claims trends, and plan mix in the initial estimation of required funding. In the event actual results are significantly different than the assumptions made, available reinsurance funds may be either too high or too low (to achieve the desired objective).

- **Diminished Impact of Cost Management** - Carrier-specific cost management efforts (e.g. use of narrow networks, care management) would be somewhat diminished, as every $1.00 improvement in actual claim costs achieved would only actually result in an improvement in those costs net of the reinsurance payments (e.g. $0.80 in the scenario where claim costs are reduced 20%).).

- **Reduced Federal Funding with no 1332 Waiver**– Lower premiums would lead to reduced federal funding (i.e. APTCs) financed with District funds, which likely could not be recouped without the approval of a 1332 waiver.

- **Timing of Payments** – Final payments for a given calendar year would likely not be calculated until after risk adjustment results are finalized by CMS, which occurs approximately mid-way through the following calendar year.

- **Large Claim Volatility**– This approach does not reduce the pricing risk of high cost claimants in the way an approach similar to that of the federal Transitional Reinsurance program would.

- **Timing of Implementation –** Could not be implemented for plan year 2018.

- **Reliance on Carriers to Implement Premium Rate Reductions –** The parameters and intended objective of the reinsurance program could be communicated, but it would ultimately be up to carriers to adjust their rates accordingly. In some cases, carriers may incorporate some level of conservatism. One control on this may be the rate review process which is in place.

Administration:

- **Calculation of Funding Required and Choice of Parameters -** Initial analysis would be required to determine the level of funding required to achieve the desired objective (e.g. 20% reduction to claim costs) as well as to set the preliminary program parameters. Analysis would include projections of membership and claim costs. Data could be requested from carriers in order to enhance the accuracy of the analysis.

- **Calculation of Payments to Carriers -** Carriers would submit claim files to the District at the end of year (with some specified level of runout), providing total annual claim costs. Additionally, resulting payments/receipts from the risk adjustment program would need to be confirmed. The District would validate the information provided and calculate

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the amount to be paid to carriers using the reimbursement percentage intended. To the extent calculated payments do not equal total available reinsurance funds, the reimbursement percentage could be adjusted and payments recalculated as necessary. Overall, the level of administration associated with the program could be relatively low, especially to the extent federal reporting data could be utilized to validate the accuracy of the claims information submitted by carriers.

Funding Required To Directly Subsidize 2018 Premium Rates

In this section, we discuss estimated funding levels required to provide direct premium subsidies to members which would reduce premium rates by 5%, 10%, or 20% for ***non-subsidy eligible*** enrollees.

Funding Need To Subsidize 2018 Premium Rates	
5% Premium Reduction	$4.3 million to $4.4 million
10% Premium Reduction	$8.7 million to $8.8 million
20% Premium Reduction	$17.4 million to $17.6 million

#3 – Direct Premium Subsidies

The District would directly fund a specified percentage of premiums for individual market enrollees who are not eligible for APTCs. Subsidies from the district would be provided directly to carriers with enrollees being billed the reduced premium rates (i.e. net of the District subsidies).

Pros:

- **Guaranteed Reduction to Premium Rates**- Able to ensure that premium rates are reduced by a specified percentage.
- **No Reduction to Federal Funding** – Given that gross premium rates are not reduced, and premium subsidies are for enrollees who are not eligible for APTCs, federal funding to the District would not be reduced.
- **Ability to Cap Risk to the District** – If desired, risk to the District could potentially (e.g. if legally feasible based on the way in which the arrangement is written and communicated) be capped such that total subsidies to carriers do not exceed available reinsurance funds. It should be noted that this would likely result in carriers receiving total premium payments below gross levels and, therefore, potential losses, which could lead to carriers being more conservative in their development of rates.
- **Full Incentives to Manage Care Remain**– Impacts of cost management are not diminished under this approach.
- **Coordinated with Risk Adjustment** – Assuming that carriers incorporate anticipated risk adjustment payments/receipts into their rate development, there would be no “double-counting” between the two programs.

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- **Timing of Implementation –** Could be implemented for plan year 2018.

Cons:

- **Risk of Misestimating Required Funding** – Assumptions would be made for projected membership and premium rates. In the event actual results are significantly different than the assumptions made (e.g. significant membership growth), available reinsurance funds may be too low to cover the direct premium subsidies.

- **Increased Cost to District Relative to Reinsurance Approach** – The District would be subsidizing retention components such as premium tax and the ACA Insurer Fee which would not subsidized under a claims reinsurance approach.

- **Potential for Non-APTC Premiums to Be Lower Than APTC Premiums?** – To the extent the District subsidies were significant (e.g. 20% of premium) it is not clear whether there would be the potential for premiums available to non-APTC members to be lower than those available to APTC members through the Marketplace, in particular at younger ages.

- **Large Claim Volatility**– This approach does not reduce the pricing risk of high cost claimants in the way a claims reinsurance approach similar to that of the federal Transitional Reinsurance program would.

Administration:

- **Calculation of Funding Required -** Initial analysis would be required to determine the level of funding required to achieve the desired objective (e.g. 20% reduction to premium rates for non-APTC enrollees). Analysis would include projections of membership and premium rates.

- **Calculation of non-APTC Premium Rates –** The carrier billing process would need to be modified such that amounts billed to enrollees are the premium rates net of District subsidies.

- **Calculation of Payments to Carriers –** The Marketplace would track and record amounts owed by the District to carriers. To the extent calculated payments are more than total available reinsurance funds, the amounts owed could potentially be reduced accordingly. In this case, the District could pay carriers at the end of the year after reconciling amounts owed vs. available reinsurance funds.

Limitations and Considerations of this Analysis

Key limitations and considerations associated with our analysis include the following:

- Values are based on estimates of future events; therefore, actual results may vary

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- Estimates rely on information provided by DCHBX as well as other external sources. If the information used is inaccurate or has misinterpreted incorrectly, the underlying finding and conclusions may need to be revised.
- Estimates assume no shift in membership to or from the individual market, or between metal plans, as a result of any premium reductions.
- Cost estimates do not incorporate any estimated expenses associated with administration of the corresponding program.
- Calculated premium rate reductions assume carrier expenses with the corresponding program in place remain the same fixed percentage of premium as currently filed levels.
- Estimates are on a projected 2018 cost basis.

Please let me know if you have any questions related to this letter.

Thank you.

Sincerely,

Ryan Schultz, FSA, MAAA

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