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Ms. Mila Kofman
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DC Health Benefit Exchange Authority
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July 24, 2018

Potential Impact of AHPs on ACA Premium Rates in the District of Columbia

Dear Mila:

In this letter, we provide estimates regarding the potential impact that association health plans (AHPs) could have on average 2019 premium rates in the District of Columbia's (the District's) individual and small group markets, specifically for those members covered under Affordable Care Act (ACA) plans, under specified scenarios requested by the District of Columbia Health Benefit Exchange Authority (DCHBX) which we will describe later.

Please note that the estimates that follow in this letter are not based on robust actuarial micro-simulation modeling specific to the District. However, the unique characteristics of the District's ACA market have been taken into consideration, including but not limited to its distribution of membership by age, gender, and group size, as well as actual filed rate levels for 2019. In our opinion, the estimates we have developed provide the District with reasonable estimates related to the potential impact that AHPs could have on premium rates in the District's ACA markets under the scenarios which will be specified.

Background

In a prior letter to the District of Columbia Health Benefit Exchange Authority (DCHBX) dated February 21, 2018, we provided a summary of analyses based on what was the proposed AHP rule at the time. The purpose of those analyses was to provide a reasonable starting point for discussions related to the range of potential impacts the proposed AHP rule could have on claim costs in the District's ACA markets. In our analysis, we assumed that the individual mandate penalty would be equal to $0, consistent with the changes made at the Federal level. For the small group ACA market, our estimates ranged from an increase in average claim costs of +0.2% to +25.8% (on a per member per month basis, excluding the portion which can be rated for through the District's prescribed ACA age curve), depending upon the assumptions employed. For the individual ACA market, our estimates ranged from an increase in average claim costs of +1.1% to +10.9%.

Since February 21, 2018, the following two notable events have occurred:

- **Finalized AHP Rule** – The final AHP rule was issued. Importantly, we note that the final AHP rule does not include any differences from the proposed rule that we believe would materially impact the results of our prior analysis

- **Individual Mandate Penalty** – While the Federal individual mandate penalty has been set to $0 for calendar year 2019, the District has passed a bill instituting a local individual mandate and corresponding penalty which are substantially similar in structure to that which previously existed at the Federal level.

For this letter, DCHBX requested that we provide estimates related to the impact that AHPs could have on 2019 ACA premium rates (on both a monthly and annual dollar basis) in the District, assuming the worst case scenarios for each of the Individual and Small Group markets from our prior analysis dated February 21, 2018[1],[2] were to occur. To address uncertainty with respect to how any corresponding rate increases would ultimately be implemented in each of the ACA markets (i.e., utilizing a blended claims projection approach or reflecting expected changes in claim costs specific to each market) as well as with respect to whether the District-specific individual mandate penalty will be allowed to go into effect for calendar year 2019, we will provide estimates under the following scenarios:

- **Scenario #1: No Mandate[3], Market Specific Rate Changes** – The DC specific individual mandate does not go into effect for 2019, rate changes for each of the Individual and Small Group ACA markets reflect expected claim changes as a result of the implementation of AHPs specific to each market.
- **Scenario #2: No Mandate, Blended Rate Changes** – The DC specific individual mandate does not go into effect for 2019, rate changes for each of the Individual and Small Group ACA markets reflect the average expected claim change across both markets
- **Scenario #3: w/ Mandate, Market Specific Rate Changes** – The DC specific individual mandate does go into effect for 2019, rate changes for each of the Individual and Small Group ACA markets reflect expected claim changes as a result of the implementation of AHPs specific to each market.
- **Scenario #4: w/ Mandate, Blended Rate Changes** – The DC specific individual mandate does go into effect for 2019, rate changes for each of the Individual and Small Group ACA markets reflect the average expected claim change across both markets

Results

In Table 1 below, we provide the estimated increase in average monthly premium per member per month (PMPM) rates as well as to annual premium per member rates, assuming the worst

[1] For Small Group, the worst case scenario assumed the following: all SHOP enrollees (65,798 covered lives; excludes 10,794 covered lives associated with congressional employees) and sole proprietors (8,142 covered lives out of a total of 17,017 covered lives in the Individual market) are eligible to purchase AHPs; Differences in pricing factors exist between the AHP and ACA plans; Assumes AHPs use pre-ACA rating factors, other than adjustments for group-specific morbidity differences; There are no differences in covered benefits between the plans; 25% of the highest cost employers don't consider AHPs

[2] For Individual, the worst case scenario assumed the following: AHPs do not cover maternity benefits; Assumes enrollees in the individual market only consider AHPs if there are no females between ages 21-40 included on their policy, and employers in the small group market consider AHPs only if they have less than 15 employees and 20% or less of their membership is made up of females between ages 21-40; Differences in pricing factors exist between the AHP and ACA plans; Assumes AHPs use pre-ACA rating factors, other than adjustments for group-specific morbidity differences; AHP rates reflect the exclusion of maternity benefits; 25% of the highest cost employers don't consider AHPs

[3] There is a chance that Congress will prohibit the District from implementing the local individual mandate penalty. The House recently passed an appropriations bill that includes the prohibition. The Senate is currently considering a similar amendment. Because of this uncertainty, DCHBX requested that both assumptions be modeled (i.e., with the mandate and without the mandate)

case scenarios for each of the Individual and Small Group markets from our prior analysis dated February 21, 2018 were to occur and under each of the four scenarios outlined in the Background section above.

Table 1

	Individual	Small Group
Projected Average 2019 Premium PMPM[4]	$474	$531

Scenario 1: No Mandate, Market Specific Rate Changes

	Individual	Small Group
% Increase in Premium Rates	10.9%	25.8%
New Average Premium PMPM	$526	$667
Increase in Monthly Premium per Member	$52	$137
Increase in Annual Premium per Member	$622	$1,640

Scenario 2: No Mandate, Blended Rate Changes

	Individual	Small Group
% Increase in Premium Rates	23.0%	23.3%
New Average Premium PMPM	$583	$654
Increase in Monthly Premium per Member	$109	$124
Increase in Annual Premium per Member	$1,307	$1,486

Scenario 3: w/ Mandate, Market Specific Rate Changes

	Individual	Small Group
% Increase in Premium Rates	8.7%	12.7%
New Average Premium PMPM	$516	$598
Increase in Monthly Premium per Member	$41	$68
Increase in Annual Premium per Member	$497	$810

Scenario 4: w/ Mandate, Blended Rate Changes

	Individual	Small Group
% Increase in Premium Rates	12.0%	12.1%
New Average Premium PMPM	$531	$595
Increase in Monthly Premium per Member	$57	$64
Increase in Annual Premium per Member	$681	$768

Additional detail related to the methodology which was utilized to develop these estimates is provided in the following section of this letter.

Methodology

In conducting our analysis, we began with projections developed by carriers who intend to offer ACA coverage in the District in 2019, which were provided in the carrier specific 2019 Unified

[4] This is based on initially proposed rates and not on final approved rates. See Methodology for details.

Rate Review Templates (URRTs) initially filed on June 1, 2018[5]. Next, we aggregated the URRT data to develop estimated market-wide average premium rates on a PMPM basis.

For Scenario 1, to develop the estimated increase in premium rates, we applied the estimated worst case change in claims (i.e.,10.9% for Individual and 25.8% for Small Group) from our prior letter dated February 21, 2018 to the respective average premium rates for each market.

For Scenario 2, for carriers offering coverage in both the Individual and Small Group markets, we assumed the worst case change in claims for each market would be blended such that, in aggregate the same overall average change would be applied to the premium rates in both markets (for those carriers). For carriers offering coverage in the Small Group market only (i.e., Aetna and United), only the worst case change in claims for the Small Group market was applied.

To develop estimates for Scenario 3 and 4, we updated the modeling that was previously performed to incorporate an assumption that if an individual were to purchase coverage through an AHP under the final federal rules rather than the ACA, they would be responsible to pay a penalty associated with the District specific individual mandate. To develop the assumed cost of the individual mandate penalty, we reviewed mandate payment information released by the Internal Revenue Service for calendar year 2015 in the District and made adjustments to reflect the estimated cost that would apply for individuals with incomes equal to 400+ FPL as well as to reflect changes in the cost of the penalty between 2015 and 2019 (i.e., a change from 2.0% of income to 2.5% of income, plus three years of inflation).

For Scenario 3, to develop the estimated increase in premium rates, we applied the updated estimated change in claims (8.7% for Individual and 12.7% for Small Group, assuming an individual mandate remains in place) under the two scenarios from our prior letter dated February 21, 2018 which represented the worst chase scenarios for the Individual and Small Group markets to the respective average premium rates for each market.

For Scenario 4, for carriers offering coverage in both the Individual and Small Group markets, we assumed the updated estimated change in claims for each market (under the two worst case scenarios from our prior letter dated February 21, 2018) used for Scenario 3 would be blended such that, in aggregate the same overall average change would be applied to the premium rates in both markets (for those carriers). For carriers offering coverage in the Small Group market only, the updated estimated change in claims for the Small Group market was applied.

Limitations and Considerations

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

- Estimates rely on membership information provided by DCHBX as well as DC carrier specific projections which were included in the initial 2019 rate filings. If the information used is inaccurate or has been misinterpreted, the underlying findings and conclusions may need to be revised

- Estimates assume that carriers have not accounted for any impact of AHPs in the initially filed 2019 premium rates

[5] https://disb.dc.gov/event/notice-public-hearing-2019-proposed-health-insurance-rates

- Estimates are not based on robust microsimulation modeling and therefore may not fully recognize all interactions specific to the District's ACA markets that might exist.
- Values are based on estimates of future events; therefore, actual results will vary
- Actual results are expected to vary on a carrier specific basis
- Unless specified, estimates are based on the isolated impact of the rule related to AHPs and do not consider the impact of other changes in legislation or regulation at either the District or Federal level
- AHP pricing factors were developed based on external data sources and may vary from actual cost differences (e.g., by group size) observed within the District's employer market
- Estimates assume that carrier expenses in the District's Individual and Small Group ACA markets are 100% variable such that if claims are expected to increase by some percentage, premium rates would be expected to increase by the same percentage
- For simplicity, estimates related to scenarios #3 and #4 assume that the individual mandate penalty for those individuals enrolling in AHPs are a consistent amount for all; in reality, the individual mandate penalty would be expected to vary by household income

Distribution and Use

This report was sponsored by DCHBX with the purpose of providing estimates related to the impact that AHPs would have on 2019 ACA premium rates (on both a monthly and annual dollar basis) in the District, assuming the worst case scenario for each of the Individual and Small Group markets from our prior analysis dated February 21, 2018 were to occur. Oliver Wyman's consent to any distribution of this report (whether herein or in the written agreement pursuant to which this report has been issued) to other parties does not constitute advice by Oliver Wyman to any such third parties and shall be solely for informational purposes and not for purposes of reliance by any such third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

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

Thank you.

Sincerely,

Ryan Schultz, FSA, MAAA

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