

Ms. Mila Kofman
Executive Director
DC Health Benefit Exchange Authority
1225 Eye Street, NW, 4th floor
Washington, DC 20005

February 21, 2018

Potential Impact of Association Health Plans in the District of Columbia

Dear Mila:

In this letter, we provide estimates regarding the potential impact to the District of Columbia's (the District's) individual and small group markets, specifically for those members covered under Affordable Care Act (ACA) plans, that could occur as a result of the proposed rule related to association health plans (AHPs). Please note that the estimates that follow 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. In our opinion the estimates we have developed provide the District with a reasonable starting point for discussions related to the range of the potential impact the proposed AHP rule could have on claim costs in the District's ACA markets.

Results

In general, the impact that the proposed AHP rule will have on claim costs in the District's ACA markets could vary significantly, depending on the interest of both issuers and employers to utilize AHPs in the coming years. Given that, we have developed estimates under several scenarios to demonstrate the sensitivity of our results to changes in assumptions, particularly with respect to which groups will ultimately have AHPs made available to them as well as how results could be impacted to the extent carriers are successful in developing AHP plans for which the highest cost groups will not be interested (e.g., due to specific benefit exclusions).

The results of the scenarios we have performed are summarized in Exhibit A. For the small group ACA market, our estimates range 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 ACA age curve), depending upon the assumptions that are employed. For the individual ACA market, our estimates range from an increase of +1.1% to +10.9%. Exhibit B provides the estimated coverage losses that would occur in both the small group and individual ACA markets. Note that these estimates assume full implementation of AHPs as proposed in the rule promulgated by the U.S. Department of Labor. This study does not account for future rule changes pursuant to the RFI specific to self-insured AHPs and does not attempt to reflect that the impact of AHPs on the ACA markets could be lower in the initial year(s) following effectuation of the proposed rule.

The methodology which was utilized to develop our estimates is provided in the following section of this letter.

Methodology

In conducting our analysis, we began with a dataset provided by the District of Columbia Health Benefit Exchange Authority (DCHBX) which includes the following key information for each member enrolled in the individual and small group ACA markets as of January 2018: Group ID (for small group), Policy ID, Member ID, Date of Birth, and Gender. Utilizing this membership information, US Census data, and claim continuance tables which vary by age group and gender, we created a cohort of simulated small groups/policies to represent the membership enrolled in the DC ACA markets and their corresponding claim costs (e.g., for small group, a similar distribution of employers by group size, age, gender, and industry, calibrated such that average claim costs for each segment described vary as would be expected while the overall average claim cost for the membership is approximately equal to that incurred in the District's actual small group market).

To assess the impact of the proposed rule related to AHPs, we calculated an AHP rate for each group,¹ assuming carriers would be able to use most rating factors which existed prior to the ACA (including group size, industry, full claim based age/gender). Further, we assumed carriers would be able to develop rates based on the average morbidity of all covered lives enrolled in the AHP (but would not be able to develop rates that vary for each group based on the specific morbidity of the group). We then determined which employers would be eligible for an AHP based on the scenario being modeled (e.g., the AHP is made available only to the Finance and Insurance industry). Note that in some scenarios (i.e. Scenarios 1a, 2a, 3a, and 4a of Exhibit A) we assumed that a segment of the highest cost employers and sole proprietors would not enroll in an AHP regardless of their eligibility or their calculated AHP rate (if eligible) due to the targeted exclusion of specific benefits (e.g., behavioral health, pharmacy, chemotherapy) in the AHP plans.

For those employers and sole proprietors meeting the eligibility requirements to enroll in an AHP under each scenario, we compared their calculated AHP rate to the rate the employer or sole proprietor would otherwise be charged under the ACA. If the AHP rate was less than the ACA rate, it was assumed that the group or sole proprietor would exit the ACA market. Note that in making this comparison, unless otherwise noted as in Scenarios 1a, 2a, 3, 3a, and 4a, it is being assumed that the only significant differences between the AHP plans and ACA plans are the rates (e.g. similar networks, benefits).

Based on the results from the prior step, we then calculated the percentage difference between the average allowed claim costs (on a per member per month basis, excluding the portion which can be rated for through the ACA age curve) of the employers or sole proprietors expected to remain in the ACA and the overall ACA population. Finally, the calculated difference in average allowed claim costs was increased by a factor of 20% (e.g. if the initial estimated change in average claim costs was 1.0%, the estimate was increased to 1.2%) to reflect the impact which would be expected to occur assuming any changes in average claim costs due to shifts in

¹ It is assumed that approximately 48% of the District's individual ACA market is made up of self-employed individuals who would be eligible to purchase AHPs based on results from a November 2015 survey conducted by the District

enrollment to AHPs will be passed to remaining ACA enrollees in the form of a rate increase, driving additional coverage losses.

Combined Impact of the AHP Rule and Repeal of the Individual Mandate Penalty

In a prior letter dated February 6, 2018, we provided an estimate that the repeal of the individual mandate penalty is expected to result in an increase in average claim costs in the individual ACA market equal to approximately +7.2% (on a per member per month basis, excluding the portion which can be rated for through the ACA age curve). To the extent AHPs are fully implemented at the same time as the repeal of the individual mandate, we would not expect the net impact to average claim costs in the individual market to simply be the sum of the previously referenced +7.2% estimate and the AHP estimates provided for the individual ACA market in Exhibit A. Instead, we would expect that some of the policyholders who would exit as a result of the repeal of the individual mandate would also be those who would move an AHP if given the opportunity. Overall, to the extent both items are fully implemented at the same time, we would expect the combined impact on average claim costs in the individual ACA market to be equal to approximately +7.9% to +16.4%, depending upon the assumptions that are employed.

Limitations and Considerations

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

- Estimates rely on membership information provided by DCHBX. If the information used is inaccurate or has been misinterpreted, the underlying findings and conclusions may need to be revised
- 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
- Estimates assume that Congressional employees currently enrolled through the SHOP would not be eligible to move to an AHP
- Unless specified, estimates are based on the isolated impact of the proposed 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

Distribution and Use

This report was sponsored by DCHBX with the purpose of providing a reasonable starting point for discussions related to the range of the potential impact the proposed AHP rule could have on claim costs in the District's ACA markets. 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,

A handwritten signature in black ink, appearing to read 'RS', with a long horizontal flourish extending to the right.

Ryan Schultz, FSA, MAAA

Copy: MaryBeth Senkewicz, DCHBX
Purvee Kempf, DCHBX
Debra Curtis, DCHBX
Tammy Tomczyk, Oliver Wyman

Exhibit A - Estimated Impact of AHP Rule on Average ACA Claim Costs

Scenario	AHP Available To:	Change in Average ACA Claim Costs ^{6,7}	
		Small Group	Individual
1 ¹	All employers	+9.9%	+5.0%
1a	Scenario 1, but 25% of highest cost employers don't consider AHP ²	+25.8%	+8.9%
2 ³	All except employers in highest cost industries	+5.9%	+4.1%
2a	Scenario 2, but 25% of highest cost employers don't consider AHP	+12.9%	+8.7%
3 ⁴	All employers, but exclude maternity in AHP	+0.2%	+4.8%
3a	Scenario 3, but 25% of highest cost employers don't consider AHP	+3.1%	+10.9%
4 ⁵	Professional, Scientific, and Technical Services industry	+0.9%	+1.1%
4a	Scenario 4, but 25% of highest cost employers don't consider AHP	+2.9%	+4.0%

Notes

¹All SHOP enrollees (excluding congressional employees) and sole proprietors are eligible to purchase AHPs; Differences in pricing factors exist between the AHP and ACA plans; Assumes AHPs use pre-ACA rating factors; There are no differences in covered benefits between the plans

²Assumes carrier actions through the exclusion of benefits such as behavioral health and high cost prescription drugs discourage 25% of the top quartile of employers (based on average claim cost per employee) from considering the AHP

³All SHOP enrollees (excluding congressional employees) and sole proprietors are eligible to purchase AHPs except for those in the following industries: Accommodation and Food Services; Arts, Entertainment, and Recreation; Educational Services; and Health Care and Social Assistance; Differences in pricing factors exist between the AHP and ACA plans; Assumes AHPs use pre-ACA rating factors; There are no differences in covered benefits between the plans

⁴AHPs 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; AHP rates reflect the exclusion of maternity benefits

⁵Only SHOP enrollees (excluding congressional employees) and sole proprietors in the Professional, Scientific, and Technical Services industries are eligible to purchase AHPs; Differences in pricing factors exist between the AHP and ACA plans; Assumes AHPs use pre-ACA rating factors; There are no differences in covered benefits between the plans

⁶ On a per member per month basis, excluding the portion which can be rated for through the ACA age curve

⁷ Estimates reflect the impact of additional changes in morbidity which would be expected to occur assuming changes in average claim costs resulting from enrollment in AHPs will be passed to remaining ACA enrollees in each respective market (i.e. small group and individual) in the form of rate increases, driving additional coverage losses; at a high level, it is being assumed that the additional coverage losses would lead to further increases in average claim costs (on a per member per month basis, excluding the portion which can be rated for through the ACA age curve) equal to approximately 20% of those which were calculated solely due to enrollment in AHPs

Exhibit B - Estimated Coverage Losses (Covered Lives¹)

Scenario	AHP Available To:	ACA Small Group		ACA Individual	
		To AHP ²	Terminate Coverage ³	To AHP	Terminate Coverage
1	All employers	54,700	700	2,400	200
1a	Scenario 1, but 25% of highest cost employers don't consider AHP	57,700	1,600	2,900	400
2	All except employers in highest cost industries	39,400	700	2,000	200
2a	Scenario 2, but 25% of highest cost employers don't consider AHP	41,400	1,500	2,900	400
3	All employers, but exclude maternity in AHP	12,600	0	2,600	200
3a	Scenario 3, but 25% of highest cost employers don't consider AHP	14,100	600	4,200	500
4	Professional, Scientific, and Technical Services industry	11,800	200	700	100
4a	Scenario 4, but 25% of highest cost employers don't consider AHP	13,200	600	1,500	200

Notes

¹Total covered lives in the District's individual and small group ACA markets were assumed to be equal to approximately 17,000 and 76,600, respectively

²Reflects the volume of covered lives who would be expected to shift from ACA plans to AHPs under the scenario described

³Reflects the expected volume of enrollment that will terminate coverage entirely due to increases in the ACA rates (driven by the migration of lower cost groups to the AHPs) equal to the values shown in Exhibit A for each respective market (i.e. small group and individual)