Testimony

Mila Kofman, J.D.
Executive Director, Health Benefit Exchange Authority

Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
B22-1001, Health Insurance Marketplace Improvement Act of 2018
November 7, 2018
11:00am

John A. Wilson Building, Room 500
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Chairman Gray and members of the Committee, my name is Mila Kofman. I am the Executive Director of the DC Health Benefit Exchange Authority (HBX). HBX is a private-public partnership established pursuant to the Affordable Care Act to create and operate DC's state-based on-line health insurance marketplace called DC Health Link.

Nearly 5000 small businesses and nonprofits have health insurance through DC Health Link. Currently there are approximately 78,000 people (including Congress) covered through the DC Health Link Small Business marketplace and 16,000 people through the individual marketplace. In addition to serving District residents and small businesses, we are designated as a source of coverage for Congress. We cover approximately 11,000 Congressional designated staff on the Hill and in their district offices and Members of Congress.

For 2019, DC Health Link offers 152 health plans from three United Health companies, two Aetna companies, Kaiser, and CareFirst Blue Cross Blue Shield to District small businesses. These plans fit every budget and include zero deductible and HSAs plans through PPO, HMO, POS, and EPO options with nationwide networks and local/regional networks.

With the purchasing power of thousands – in our case 78,000 – DC's small businesses have insurers competing for their business. Every year since we opened for business we have advocated for the lowest possible rates and for quality health insurance. And because of the way DC structured its market reforms, insurers actually compete for small businesses. Every year insurers decrease premiums for some of their products for small businesses. For example, for 2019, Kaiser lowered premiums for four small group plans (-0.41%, -0.97%, -4.71%, -6.86%); CareFirst also lowered premiums for four plans (-0.46%, -0.80%, -1.84%, -4.28%); Aetna lowered premiums for two plans (-0.17% and -2.93%) and United for one plan (-0.40%).

Just like large employers, small businesses through DC Health Link can offer their employees "choice." That means the employer chooses the level of coverage and how much to contribute, employees choose plans from all insurers at that level, and the employer gets one bill even when employees chose different insurers. It is easy to sign up. Employers set and control their budgets and employees like being able to get coverage that fits their needs.

Our award-winning on-line platform makes it easy for employers to offer coverage. DC Health Link is ranked number one for consumer decision support tools (2017 and 2018) among all state-based marketplaces and the federal marketplace. And in 2016 and 2018, Amazon Web Services (AWS) awarded DC Health Link "Best Practices in Innovation Award" for our cloud-based agile open source technology.

In addition to on-line easy shopping and enrollment, we have portals for brokers and General Agencies/Third Party Administrators. There are more than 800 DC Health Link certified brokers who help District employers (at no cost to the employer). Nine in 10 employers have brokers.

People buying coverage in the individual marketplace have a choice of 25 health plans (including catastrophic) from Kaiser and CareFirst. According to a federal government report, we have the second lowest health insurance premiums in the nation for self-employed people and residents covered through the individual marketplace. And premiums would be even lower if the Trump Administration did not attack and destabilize private coverage; the instability contributes to increases in premiums.

I would like to thank you and all Councilmembers for your commitment to health care reform and all your efforts to help District residents and small businesses gain and maintain affordable quality health coverage. Chairman Gray, when you were Mayor you set up DC Health Link and worked with the Council to pass ACA consumer protections. Mayor Bowser has worked hard to defend the ACA, including the individual responsibility requirement to help keep premiums stable. Together, you as Chair of the Health Committee, Mayor Bowser, and all Councilmembers have taken a strong stance to protect the ACA and people with preexisting conditions.

With more than 96% of our residents having health coverage, the District ranks second among states with the lowest uninsured rate in the nation.

This is not the time to stop being vigilant. The Trump Administration continues its attacks on the ACA trying to accomplish through executive action what Congress did not do --- that is repeal the ACA.

I want to thank you for being proactive and successfully defending the District against attacks on the ACA. The bill you have introduced, *the Health Insurance Marketplace Improvement Act of 2018*, is necessary to protect people with preexisting conditions and mitigate some of the negative consequences of the Trump Administration rules.

As you know, the Trump Administration issued regulations related to association health plans (AHPs) and short-term limited duration plans. These regulations encourage proliferation of junk plans and unregulated insurers, put people at risk, jeopardize people's comprehensive coverage, and undermine the gains we have made through successful implementation of the ACA. These junk plans take us back to the pre-ACA days.

If the Trump Administration rule on AHPs becomes law in the District, these are some of the many negative outcomes we expect:

- Unregulated insurers will proliferate;
- Promoters of health insurance scams will defraud District residents and businesses;
- Unregulated AHPs will become insolvent;
- AHPs will be exempt from ACA consumer protections for small businesses and individual consumers;
- AHPs will cherry pick healthy people and leave sicker and older people in the regulated market; and
- AHPs will destabilize and eventually collapse private individual and small group markets; that means people will lose access to quality private health insurance.

Additionally, Oliver Wyman actuaries estimate, based on the characteristics of the District's small group and individual health insurance markets (once AHPs proliferate) the following:

- Some people will become uninsured because of the final rule;
- The District's small group market could shrink by as much as 90% and the individual market by as much as 25%. (See Attachment A, Oliver Wyman Letter, February 21, 2018);
- Small businesses could see their premiums ***increase by as much as 12.7% paying $810 more per year per employee*** (note that if the District did not adopt a local individual responsibility requirement, then premiums could increase by as much as 23.3%, $1,640 more per year per employee); and
- Individual market premiums could ***increase by as much as 12.1%; meaning that a resident would pay $768 more per year*** because of the Trump Administration rule (note that if the District did not adopt a local individual responsibility requirement premiums could increase by as much as 23.0% costing $1,307 *more* per year because of the Trump Administration rule) (See Attachment B, Oliver Wyman Letter, July 24, 2018).

The Trump Administration rule on short-term, limited-duration plans will also have many negative outcomes:

- Short-term, limited-duration plans will cherry pick healthy people and leave sicker and older people in the regulated market;
- Health insurance premiums will increase and some residents will become uninsured; and
- Promoters will induce unsuspecting consumers into buying junk plans.

Oliver Wyman actuaries estimate that, based on the characteristics of the District's individual market, the new federal short-term, limited-duration rule would:

- Increase claims costs by as much as 3.1% in the District's individual market (note that if the District did not adopt a local individual responsibility requirement, then we could see as much as a 21.4% increase in claims cost); and
- Result in as many as 900 people leaving the individual market (note that if the District had not adopted a local individual responsibility requirement, then we could see approximately 6,100 people leaving the individual market.) (see Attachment C, Oliver Wyman Letter, April 11, 2018).

HBX strongly supports local legislative action to address the attacks on the ACA by the Trump Administration and help to protect District residents and small businesses. We support B22-1001 with amendments submitted to staff for your consideration.

This past summer, to address the Trump Administration's rules Mayor Bowser asked the Department of Insurance, Securities and Banking (DISB) and HBX to develop legislation, which she recently transmitted to Council. The Mayor submitted emergency, temporary, and permanent legislation, which shows her commitment to have protections for our small businesses, workers, and self-employed residents in place as soon as possible. The additional provisions in that legislation help to clarify that the consumer protections in the ACA continue to apply in the District. I thank you for your leadership and your consideration of the amendments.

The Trump Administration Rule on Association Health Plans applies as of September 1, 2018 to fully insured AHPs and the Rule on Short Term Limited Duration Plans applies as of October 2, 2018. We applaud your leadership and efforts to pass local legislation expeditiously to protect residents from harm.

Your legislative effort will help keep District's health insurance markets stable and affordable and will help to protect health insurance consumers from the negative effects of the Trump Administration rules.

Below is a detailed discussion of the final federal rules on AHPs and short-term, limited-duration plans.

AHP Rule Summary and Implications

In June of 2018, the U.S. Department of Labor (DOL) issued a rule to expand dramatically the availability of AHPs (also known as Multiple Employer Welfare Arrangements or MEWAs), which have a long history of fraud and insolvency. The rule exempts AHPs from ACA consumer protections applicable to small group and individual markets. It does this by reinterpreting the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA is a federal law that governs benefits provided by private employers. Generally, ERISA preempts states from regulating ERISA covered plans. However, ERISA allows states to regulate insurance coverage sold to ERISA covered employers. ERISA also allows states to

regulate MEWAs, which means that even when a MEWA is an ERISA covered plan, states can regulate it. In 1982 Congress amended ERISA to clarify that both DOL and states have authority to regulate and oversee MEWAs. This amendment was enacted to try to address widespread MEWA fraud and insolvencies.

The new federal AHP rule overturns decades of federal guidance on MEWAs and exempts AHPs/MEWAs from key requirements under the ACA.

The new federal rule destabilizes the individual and small group markets by exempting these plans from critical ACA consumer protections, such as rating restrictions, essential benefit requirements, guaranteed issue requirements, single risk pool requirements and risk adjustment requirements.

The new federal AHP rule is a dramatic departure from long established AHP standards and we believe is an impermissible overreach by DOL. Twelve Attorneys General, including Karl Racine, have filed a law suit against DOL to challenge the legality of this rule. While the validity of the DOL rule is litigated, it is essential that the District establish clear rules governing AHPs to mitigate harm of the federal proposal and try to ensure that the robust District insurance markets remain stable and affordable for District small businesses and residents.

Association Health Plans and Fraud

There is a long, well documented history of health insurance scams promoted through AHPs. Promoters use ERISA as a shield to evade state oversight and enforcement. In the 1970s after ERISA was enacted, promoters claimed that ERISA preempted states from regulating multiple employer entities such as associations. At that time DOL believed that it only had authority over ERISA plans and that multiple employer entities were not ERISA plans. In 1982 a Republican-led effort clarified ERISA to say that both states and DOL have authority over AHPs. The 1982 amendment was intended to remove ambiguity over preemption. It gave states full authority over multiple employer entities like associations but exempted collectively bargained arrangements (union plans) from state authority. Promoters continued to look for ways to evade state oversight, and some promoters set up fake unions and argued ERISA preemption. For example, an entity called International Workers' Guild (IWG) left thousands of people in 32 states with $25 million in unpaid medical bills. Generally, the 1982 amendments worked well and enabled states to go after scams effectively, but promoters of scams continue falsely to claim ERISA preemption.

There have been several documented cycles of health insurance scams. According to the GAO, between 1988 and 1991, operators of MEWAs left 400,000 people with medical bills exceeding $123 million; and between 2000 and 2002, 144 entities left 200,000 policyholders with $252 million in unpaid medical bills. Before the ACA, promoters targeted small businesses and self-employed people who could not pass medical underwriting or were charged higher rates based on their health. Promoters of scams set up fake associations and also sold through well-established professional and trade associations. For example, the National Writers Union was duped into buying phony coverage from a nation-wide scam called Employers Mutual LLC that

had 30,000 victims and according to some estimates had owed as much as $54 million in medical claims at the time it was finally shut down.

Since the ACA was enacted, there has been less fraud because affordable coverage became available, for small businesses prices became more affordable, and underwriting became illegal. When the demand is low, the supply of phony insurance is low. Nonetheless, there are always promoters looking to scam small businesses and individuals.

The new federal DOL rule adds new ambiguity to ERISA that will be used by promoters to evade state oversight, and overturns decades of ERISA guidance that will make it easier for promoters to set up scams. There is no requirement that an entity be in existence for any period of time or have a proven track record. These entities can spring up with ease and target unsuspecting small businesses and self-employed people. Overturning many decades worth of guidance, the new federal rule also allows entities to form for the primary purpose of offering health coverage, making it even harder to figure out if an entity is legitimate or an illegal insurer.

The bill before Council would help protect District businesses and residents from fraudulent AHPs by clarifying DISB's authority to oversee these plans and take enforcement action when necessary.

Association Health Plans and Insolvencies

AHPs have a long history of insolvencies. There are numerous examples of professional and trade associations becoming insolvent. For example, Sunkist Growers, Inc., a licensed MEWA in California, covering 23,000 people became insolvent in 2001 after collecting over $30 million in premiums. At the time of its bankruptcy the plan owed around $11 million for unpaid medical claims. An insolvency of the New Jersey Coalition of Automotive Dealers left 20,000 people with $15 million in unpaid medical bills. The Indiana Construction Industry Trust, which had been in existence for over 40 years, became insolvent in 2002, leaving over 22,000 people with more than $20 million in unpaid medical bills.

When not licensed like an insurer, self-insured AHPs are inherently less stable than state regulated insurance companies because solvency requirements are lower and AHP operations are higher-risk operations compared to traditional insurers. Low reserves make it harder for AHPs to avoid insolvency resulting from mismanagement or from large unexpected claims. For example, an AHP in Michigan became insolvent due to unexpected claims from two premature babies. Furthermore, generally AHPs cannot participate in guaranty funds and the application of receivership laws can be unclear. Different from an insurer, when an AHP becomes insolvent, its members are stuck with unpaid medical bills. Self-insured AHPs have joint and several liability; participating employers are assessed and are responsible for any unpaid medical bills. This liability exposes participating employers to significant financial risk. State receivership laws, which allow insurance departments to take over financially failing insurance companies, sometimes exclude AHPs or are unclear. Without a receivership, an AHP ends up in bankruptcy court, where consumers line up with other creditors. Different from receiverships, outstanding medical claims do not receive priority status in bankruptcy court. When self-insured AHPs

become insolvent, their members' medical bills go unpaid, leaving consumers with huge debt for medical care and harming medical providers when those debts are not paid.

The new federal rule does not have any new solvency standards or protections for AHP members in cases of insolvency.

The bill before Council would require self-insured AHPs to be licensed just as other insurance risk assuming entities. This legislation will help DISB to ensure that AHPs operating in the District are meeting the same requirements as any other insurer, including meeting reserve and solvency requirements. The bill mitigates risk of insolvency by clarifying that insurance solvency and oversight standards apply.

Association Health Plans and Market Destabilization

Under the ACA, associations offering health insurance to small businesses must comply with consumer protections applicable in the small group market. And, when associations offer coverage to individuals, that coverage must comply with consumer protections in the individual market. This "look through" standard has been in effect since the mid-nineties when HIPAA was enacted by Congress putting some private market reforms in place. The new federal rule eviscerates the decades-old standard.

As a way of background, since January 1, 2014, all health insurance sold to District residents and small businesses must cover essential health benefits including primary and specialty care, hospital stays, lab work, prescription drugs, preventive care (with no cost sharing), maternity care, mental health and substance abuse treatment. Annual and lifetime limits on coverage are prohibited. People cannot be denied health insurance or charged more because they had a medical condition in the past or currently. Preexisting medical conditions cannot be excluded from coverage. Rating based on industry or occupation as well as employer size is now prohibited. And, women cannot be charged higher rates than men. There are limits on how much more an insurer can charge someone based on age. The District went beyond minimum federal standards to prohibit insurers from tobacco rating – charging people more because they smoke.

The new federal rule exempts associations selling to small businesses and/or self-employed people from all of the ACA protections applicable in the small group and individual markets. AHPs can keep older and sicker groups and people out through rating practices like industry rating, gender rating, employer group size rating, age rating, etc. Also, AHPs can offer limited benefits at prices lower than what comprehensive coverage costs. Additionally, using benefit design, an AHP can attract healthier groups and individuals. For example, an AHP can offer coverage without maternity care, mental health benefits, and expensive prescriptions. People who need such coverage will not enroll in AHP coverage. AHPs attracting and enrolling healthier and younger people and businesses will mean older and sicker people will be left in the rest of the market. This action will destabilize and eventually collapse private health insurance markets across the nation, will lead to higher premiums for small businesses and individuals, will leave people who need comprehensive coverage with no private options, and will force some people to become uninsured.

AHPs are not a new or novel idea. In the 1990s, Kentucky implemented market reforms but exempted AHPs from these reforms. Within 90 days of the exemption, enrollment nearly doubled in AHP coverage. AHPs covered healthy people. Sicker people were left in the regulated market. Kentucky's private market collapsed. Insurers left Kentucky. Two insurers stayed and one of the two had $30 million in losses over a period of 20 months.

In the District, the harm to small businesses and self-employed people who need quality health insurance would be substantial. Small business premiums would increase by as much as 12.7%, employers paying as much as $810 more per year per employee. Individual market premiums would increase by as much as 12.1% or $768 per year because of the cherry-picking by AHPs allowed by the Trump Administration rule. Additionally, if only sicker and older people are covered, then insurers may leave the market and small businesses and District residents will lose access to private health insurance.

B22-1001 would preserve the ACA consumer protections established during the Obama Administration. The legislation is necessary to mitigate the harm of the new rule to protect District residents and businesses that have and need affordable quality health insurance and to protect people with preexisting conditions.

SHORT-TERM, LIMITED-DURATION PLANS

The federal government issued a final rule on August 1, 2018 that will dramatically expand the availability of short term limited duration (STLD) plans for up to 364 days, rather than less than three months permitted under the Obama Administration rules. In addition, the final rule allows carriers to renew these plans for up to 36 months.

The ACA exempts STLD plans from consumer protections applicable to individual health insurance. For example, STLD plans can exclude coverage for preexisting conditions, use medical underwriting to cover healthy people only and to keep people with medical needs out, cap benefits using annual and lifetime dollar limits, exclude maternity and mental health from coverage, and not cover all of the benefits considered "essential." STLD plans do not provide comprehensive health insurance coverage and can discriminate against people with preexisting conditions.

STLD plans are specifically designed to attract and cover healthy people only. And when healthy people leave the individual market, premiums increase for everyone left in the individual market.

For the District of Columbia, actuaries from Oliver Wyman estimate that individual market claims cost will increase by as much as 3.1% and approximately 900 consumers will leave the individual market – 700 would buy STLD plans and 200 would become uninsured. Note that if the District did not adopt a local individual responsibility requirement, then we would see a 21.4% increase in claims cost and approximately 6,100 people would become uninsured or leave quality individual health insurance.

Some who sell STLD plans use abusive marketing practices to mislead consumers into believing that a person is enrolling in comprehensive health insurance. The Trump Administration rule changed the length of STLD plans from less than three months to almost one year, further exacerbating this problem by making STLD plans look like regular health insurance. Some consumers will believe falsely that a short-term, limited-duration plan that is 364 days long is just like comprehensive health insurance coverage.

We have seen firsthand the devastating impact on consumers who enroll, falsely believing they are enrolling in major medical coverage. For example, one resident was diagnosed with a life threatening condition and learned too late that he purchased a STLD policy that did not cover treatment. The resident told our staff that he thought he was signing up for comprehensive coverage and would have signed up for real coverage during open enrollment had he understood the true nature of the policy he bought.

B22-1001 includes essential protections that will keep Obama Administration consumer protections for District residents and help protect residents against the harmful effect of the new federal rule.

Conclusion

HBX supports B22-1001 and encourages your consideration of language we submitted to your staff reflected in B22-1022, "*The Health Insurance Marketplace Improvement Amendment Act of 2018*."

District residents and small businesses built DC Health Link from the ground up to ensure that our communities have quality, affordable health coverage. With your support, the support of all policymakers and the entire District government we effectively implemented the ACA and succeeded in creating a robust and stable health insurance market, reducing premiums for small businesses, and cutting the rate of uninsured by 50%. Now, because of ongoing attacks on the ACA by the Trump Administration, local legislation is needed to ensure that we continue to protect the gains made under the ACA and to keep consumer protections put in place by the Obama Administration. These provisions are necessary to help protect against the harm of junk insurance, protect people against premium increases caused by the new federal rules and help prevent people from losing their coverage. In the District, we want to continue to build on the ACA, not tear it down. Local legislation is needed to protect residents and small businesses that need quality health insurance.

Thank you for the opportunity to testify today. I am available for any questions you may have.

Attachment A

OLIVER WYMAN

Ryan Schultz

Oliver Wyman
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202-4419
414-277-4608
Ryan.Schultz@OliverWyman.com

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

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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

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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

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

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

		Change in Average ACA Claim Costs[6,7]	
Scenario	**AHP Available To:**	**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

[1]All 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

[2]Assumes 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

[3]All 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

[4]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; AHP rates reflect the exclusion of maternity benefits

[5]Only 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

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Exhibit B - Estimated Coverage Losses (Covered Lives[1])

		ACA Small Group		ACA Individual	
Scenario	**AHP Available To:**	**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

[1]Total 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

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

[3]Reflects 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)

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Attachment B

OLIVER WYMAN

Ryan Schultz

Oliver Wyman
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202-4419
414-277-4608
Ryan.Schultz@OliverWyman.com

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

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)

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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.

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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

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- 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

Copy: MaryBeth Senkewicz, DCHBX
Jennifer Libster, DCHBX
Tammy Tomczyk, Oliver Wyman

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Attachment C

OLIVER WYMAN

Ryan Schultz

Oliver Wyman
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202-4419
414-277-4608
Ryan.Schultz@OliverWyman.com

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

April 11, 2018

Potential Impact of Short-Term Limited Duration Plans

Dear Mila:

In this letter, we provide estimates regarding the potential impact to the District of Columbia's (the District's) individual market, specifically for those members covered under Affordable Care Act (ACA) plans, which could occur as a result of the proposed rule related to short-term limited duration (STLD) plans. 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 overall cost levels. In our opinion the estimates we have developed provide the District with a reasonable starting point for discussions related to the potential impact the proposed STLD rule could have on claim costs in the District's individual ACA market.

Results

In general, the impact that the proposed STLD rule is expected to have on claim costs in the District's individual ACA market could vary significantly depending on both issuer and consumer interest in STLD plans in the coming years. Given that, we have developed estimates for two separate scenarios related to STLD plans: a "Low" scenario which assumes individuals would be more risk averse when evaluating whether to purchase STLD plans and a "High" scenario which assumes individuals would be less risk averse in their STLD decision making process.

Overall, we are estimating that the proposed rule related to STLD plans could be expected to have the following impacts, depending on the assumptions employed:

Exhibit A - Estimated Impact of STLD Rule on Individual ACA Market

		Increase in Average Claim Costs[1,2]		Change in Enrollment[3]	
Scenario	**Description**	**Low**	**High**	**Low**	**High**
1	STLD plans fully implemented, individual mandate penalty remains	1.7%	3.1%	-500	-900
2	STLD plans fully implemented, individual mandate penalty is $0[4]	11.7%	21.4%	-3,800	-6,100

Notes

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

[2] Estimates reflect the impact of additional changes in morbidity which would be expected to occur assuming initial changes in average claim costs resulting from enrollment in STLD plans and/or the repeal of the individual mandate penalty will be passed to remaining ACA enrollees 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 STLD plans and/or the repeal of the individual mandate penalty

[3] The assumed enrollment volume prior to the changes described is approximately 17,000 covered lives

[4] Reflects the combined impact of the repeal of the individual mandate penalty and STLD plans being fully implemented

We note that these estimates assume full implementation of STLD plans as proposed in the draft rule released by the Internal Revenue Service, Employee Benefits Security Administration, and the Health and Human Services Department[1]. As a result, this study does not attempt to reflect that the impact of STLD plans on the ACA markets could be lower in the initial year(s) following effectuation of the proposed rule. Additionally, we note that we did not look at the impact on employer coverage or the Medicaid program and, therefore, these estimates do not include any increase in costs resulting from loss of coverage in the employer market or to the Medicaid program.

A description of the assumptions and 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 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 District's individual ACA market as of January 2018: Policy ID, Member ID, Date of Birth, and Gender. Utilizing this membership information, we created a cohort of simulated policies representative of the District's individual ACA market. That is, the simulated

[1] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance

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policies have a similar distribution of membership by age and gender, have corresponding claim costs which vary as would be expected in the District, and have medical conditions which are representative of those that would be expected based on the underlying demographic mix.

To assess the impact of the proposed rule, we first estimated what each enrollee's projected cost would be if they were to enroll in an STLD plan, including their out-of-pocket costs for both covered and non-covered services, the annual premium rate for the STLD plan and, in the scenario where the individual mandate penalty is assumed to remain in place, the penalty owed as a result of not purchasing ACA-compliant coverage. Several assumptions were incorporated into the development of these cost estimates and we have outlined the key assumptions we have made related to STLD plans below:

- *Underwriting* - Coverage can be denied to individuals who do not meet a carrier's underwriting requirements
- *Pre-Existing Conditions* - Services associated with treating a pre-existing condition will not be covered
- *Pricing Assumptions*
    i. STLD carriers will utilize all rating factors which existed prior to the ACA (e.g. full age curve)
    ii. STLD carriers will target an overall loss ratio equal to 50%
    iii. STLD rates will be adjusted to account for the morbidity of the individuals projected to enroll in the plans
    iv. Allowed cost levels for services commonly covered by STLD plans and ACA plans will be the same (i.e., similar provider discounts will be available to insurers offering STLD plans as are available to insurers offering ACA plans)
- *Policy Limits* – A lifetime policy limit of $1,000,000 will be in force
- *Renewability* – STLD plans will be available for up to 364 days and will be "optionally renewable" (i.e. renewable at the option of the insurer)
- *Essential Health Benefits* – Coverage for the ten essential health benefits, excluding services associated with pre-existing conditions, will be as follows:
    i. Ambulatory Patient Services (i.e. outpatient services) – Covered
    ii. Prescription Drugs – NOT Covered
    iii. Emergency Services – Covered
    iv. Mental Health Services – NOT Covered
    v. Hospitalization (i.e. inpatient services) - Covered
    vi. Rehabilitative and Habilitative Services – NOT Covered
    vii. Preventive and Wellness Services – NOT Covered
    viii. Lab – Covered
    ix. Pediatric Care (i.e. pediatric dental and vision services– NOT Covered
    x. Maternity Care – NOT Covered
- *STLD Plan Design*[2] - For the purpose of this analysis, the STLD plan is assumed to have a $1,000 deductible (per person), 70% coinsurance rate (insurer responsibility), and a $5,000 out-of-pocket maximum (per person, in addition to the deductible)

[2] These assumptions related to plan design were chosen based on a review of short-term limited duration products which are currently available in the individual market

- *Cost Levels of Not Covered Services* - For services not covered by STLD plans (e.g. maternity), it is assumed that the “allowed charges” for those services will be approximately 45% higher under the STLD plans than under ACA plans, due to a lack of provider discounts being available for those services.

Next, we estimated each enrollee’s projected cost assuming they were to enroll in a silver level ACA plan. Similar to the approach used when assessing each enrollee’s projected costs if they were to enroll in a STLD plan, we developed estimates for what each enrollee’s expected out-of-pocket costs for covered services would be as well as what each enrollee’s annual premium rate would be expected to be if enrolled in an ACA plan.

After developing projected costs at the enrollee level for both STLD and ACA coverage, in order to determine which ACA policyholders would potentially shift to an STLD plan, the assumptions outlined below were applied:

- If an individual had an occurrence of a Hierarchical Condition Category (HCC) over the past five years, that individual would be declined for STLD coverage
- If an individual is in the top quartile of ACA enrollees with respect to total claim costs in the prior year, that enrollee would choose not to enroll in STLD coverage due to the expectation that they would be more risk averse
- If an individual incurred a high volume of annual claim costs at some point over the past five years such that it would have been in the enrollee’s best interest to remain in the ACA market in that year:
    - *More Risk Averse Scenario:* 100% of those individual will not purchase STLD coverage
    - *Less Risk Averse Scenario*: 100% of the individuals where this result occurred in the most recent year will not purchase STLD coverage, 80% of the individuals where this result occurred two years ago will not purchase STLD coverage, 60% of the individuals where this occurred three years ago will not purchase STLD coverage, 40% of the individuals where this result occurred four years ago will not purchase STLD coverage, and 20% of the individuals where this result occurred five years ago will not purchase STLD coverage
- For all other policyholders (i.e. after removing the enrollees identified in the three bullet points above), we compare their projected annual costs under both the STLD plan and the ACA plan. If the net cost to purchase the ACA plan is cheaper, it is assumed that the individual will remain in the ACA market. If the net cost to purchase the STLD plan is cheaper, it is assumed the individual will leave the ACA market to purchase an STLD plan
- Decisions to keep or change coverage are made at the policy/household level

After applying the criteria outlined above and ensuring that the projected STLD rates adequately reflect the morbidity of the membership expected to enroll in those plans, the average projected allowed claim costs of the enrollees expected to remain in the ACA market after the STLD plans are fully implemented was compared to the overall average allowed claim costs of the ACA market prior to the implementation of STLD plans. This comparison provides the expected change in average allowed claim costs in the individual ACA market (on a per member per month basis), and was then adjusted to exclude the portion of the change which can be rated for through the existing ACA age curve.

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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 additional impact which would be expected to occur in the individual ACA market assuming the changes in average claim costs due to shifts in enrollment to STLD plans will be passed to remaining ACA enrollees in the form of a rate increase, driving additional coverage losses.

Combined Effect of STLD Plans, the Repeal of the Individual Mandate, and AHPs
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). In an additional letter dated February 21, 2018, we provided an estimate that the combined effect of the proposed AHP rule being fully implemented and the repeal of the individual mandate penalty would be expected to have an impact on average claim costs in the individual ACA market equal to approximately +7.9% to +16.4%

To the extent STLD plans are fully implemented at the same time as the repeal of the individual mandate and the full implementation of AHPs, we would not expect the net impact to average claim costs in the individual ACA market to simply be the sum of the estimates referenced above and the STLD estimates provided earlier in the letter in Exhibit A. We would expect that a number of the policyholders who would exit the ACA market as a result of the full implementation of the STLD rule would also be those policyholders who would exit due to the repeal of the individual mandate penalty and/or the implementation of the AHP rule.

Overall, to the extent all three 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 +13.3% to +19.9% in the scenario where consumers are assumed to be more risk averse in determining whether to purchase STLD plans (i.e., the “Low” scenario) and +22.8% to +31.3% in the scenario where consumers are assumed to be less risk averse in determining whether to purchase STLD plans (i.e., the “High” scenario). The range provided within each of the “Low” and “High” scenarios is dependent upon the assumptions that are employed for AHPs. The low end of the ranges provided assumes the following related to AHPs: Only 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; AHPs use pre-ACA rating factors; and there are no differences in covered benefits between the ACA and AHP plans. The high end of the ranges provided assumes the following related to AHPs: AHPs do not cover maternity benefits (for employer groups with fewer than 15 employees); sole proprietors in the individual market only consider AHPs if there are no females between ages 21-40 included on their policy; 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; AHPs use pre-ACA rating factors; and AHP rates reflect the exclusion of maternity benefits (for employer groups with fewer than 15 employees).

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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
- Unless specified, estimates are based on the isolated impact of the proposed rule related to STLD plans and do not consider the impact of other changes to the proposed rule or in legislation or regulation at either the District or Federal level

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 STLD rule could have on claim costs in the District's individual ACA market. 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

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

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