DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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Date: **August 11, 2016**

Subject: **Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool**

Key Findings

- Per-enrollee costs in the ACA individual market were essentially unchanged between 2014 and 2015. Specifically, after making comparability adjustments described below, per-member-per-month (PMPM) paid claims in the ACA individual market fell by 0.1 percent from 2014 to 2015. For comparison, per-enrollee costs in the broader health insurance market grew by at least 3 percent

- Available evidence indicates that the slow ACA individual market cost growth resulted at least in part from a broader, healthier risk pool. In particular, states that saw stronger-than-average enrollment growth in 2015 saw greater-than-average reductions in PMPM costs. For example, in the 10 states with the highest 2015 growth in ACA individual market member months, PMPM claims costs fell by an average of 5 percent.

- Nearly all states saw continued growth in Marketplace enrollment in 2016, suggesting continued risk pool improvement. Moreover, the 2015 claims data also predate important steps CMS has taken over the six months to further strengthen the Marketplace risk pool. These steps include implementing new processes to prevent misuse of Special Enrollment Periods, reducing the number of consumers losing coverage or financial assistance due to data-matching issues, helping consumers who turn 65 move from the Marketplace onto Medicare, and proposing to curb abuses of short-term plans.

Analysis

On June 30th, the Centers for Medicare & Medicaid Services (CMS) released data on reinsurance payments for 2015.[1] Reinsurance payments are based on issuers' claims paid amounts for the full individual market, excluding grandfathered and transitional plans; the data include all plans sold on the Health Insurance Marketplace, including the federal HealthCare.gov Marketplace and the individual State-based Marketplaces, as well as off-Marketplace plans that are subject to the same pricing and

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

coverage rules. Therefore, these data provide the first snapshot of how costs in the ACA individual market evolved from 2014 to 2015.

In the broader health insurance market, such as employer coverage and Medicare, per-enrollee costs grew 3 to 6 percent from 2014 to 2015. For example, the CMS Office of the Actuary estimates that per-enrollee growth in employer sponsored insurance (ESI) grew 3 percent[2]; the Kaiser Family Foundation's annual survey[3] and the Medical Expenditure Panel Survey[4] both estimate that average premiums for employer-based family coverage grew 4 percent; and insurers' projections of medical cost trend for 2015 averaged 6 percent.[5]

In contrast, in the ACA individual market, per-enrollee costs were essentially unchanged from 2014 to 2015. Specifically, after making comparability adjustments described below, per-member-per-month (PMPM) paid claims in the ACA individual market fell by 0.1 percent from 2014 to 2015. Moreover, this estimate likely overstates the true growth in per-enrollee costs, since it does not account for improvements in data reporting which likely increased measured PMPM costs.

Available evidence implies that the slow ACA individual market cost growth results at least in part from a broader, healthier risk pool. Supporting that interpretation, states that saw stronger enrollment growth in 2015 saw larger reductions in costs. For example, in the 10 states with the highest 2015 growth in ACA individual market member months, PMPM claims costs fell by an average of 5 percent. Likewise, states with higher enrollment growth saw larger improvements in risk adjustment program risk scores.[6] These data are encouraging for the future, since the Marketplace and the broader ACA individual market continue to grow.

Data and Methodology

This analysis draws on data collected by CMS to administer the ACA's transitional reinsurance and risk adjustment programs. To operationalize these programs, CMS implemented a distributed data approach through External Data Gathering Environment or "EDGE" servers. Issuers upload enrollee, pharmaceutical claim, medical claim, and supplemental diagnosis information from their systems to an

[2] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html
[3] http://kff.org/health-costs/report/2015-employer-health-benefits-survey/
[4] https://meps.ahrq.gov/data_stats/summ_tables/hc/hlth_insr/2014/alltablesfy.pdf
[5] 6 percent is the average medical cost trend insurers reported on the Uniform Rate Review templates filed for the 2015 plan year.
[6] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

issuer-owned and controlled EDGE server. [7] Our analysis is based on claims data submitted to EDGE servers for calendar years 2014 and 2015. [8]

In order to accurately capture year-over-year changes in claims costs, we make two comparability adjustments to the EDGE data. First, we exclude from this analysis a small number of issuers who had self-admitted material errors in their EDGE submissions for either 2014 or 2015. In 2014 in particular, a small minority of issuers experienced difficulties with their EDGE submissions and failed to submit a material fraction of their claims; this would naturally distort year-over-year comparisons. (Issuers with errors in either year are excluded from the data in both years.)[9]

Second, we adjust the 2015 data to remove the estimated effect of cross-year claims. For the first time in 2015, issuers could submit cross-year claims, or claims that began in the year before the benefit year. In contrast, cross-year claims were not allowed in 2014 since the ACA individual market did not exist in 2013. The inclusion of cross-year claims in 2015 but not 2014 distorts any comparison of 2015 and 2014 claims costs. Unfortunately, it is not possibly to directly identify cross-year claims in the EDGE data. Instead, we used two different data sets from similar markets to estimate the magnitude of cross-year claims relative to total claims. The analysis of indicates that cross-year claims comprise about 4 percent of total claims costs. [10] This estimate is also consistent with issuer estimates of incurred but not received claims costs in the past year's MLR filings, which measure a different but related set of claims.

Even with the comparability adjustments described above, our estimates likely overstate 2015 claims growth. In particular, by 2015, most issuers had a year of experience submitting claims to the EDGE servers, meaning that the 2015 claims data are probably more complete than the 2014 data (even excluding those issuers who had self-admitted material errors).

Key Findings

With comparability adjustments, PMPM claims cost in the ACA individual market were essentially unchanged from 2014 to 2015, falling by 0.1 percent. As noted above, estimates of 2015 cost growth in the broader private insurance market range from 3-4 percent, while projected estimates of 2015

[7] EDGE data requirements differ from other data submission requirements (e.g., MLR). Unlike the MLR data, the EDGE data include only ACA risk pool plans (both individual and small group) and thus provide the best available information on the ACA individual market.

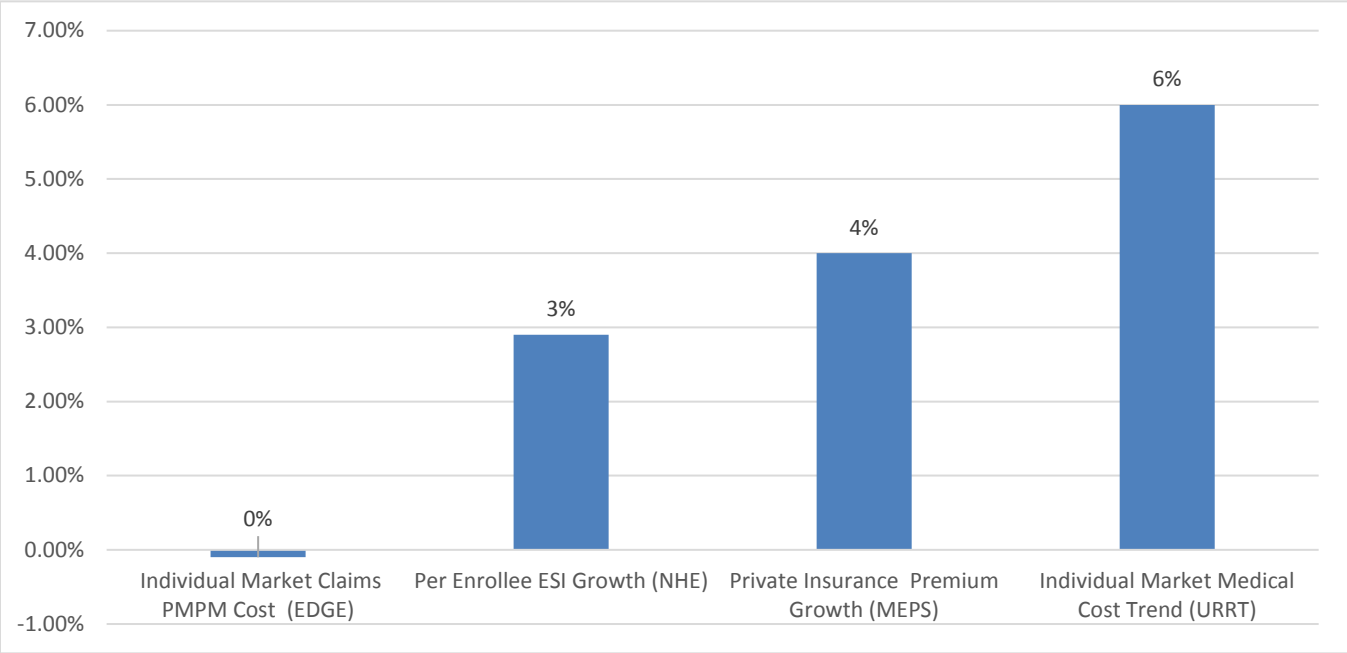
[8] The data exclude Massachusetts, which operated its own risk adjustment program for 2014 and 2015 and therefore did not provide CMS with some of the data needed for this analysis.

[9] We excluded approximately 6 percent of member months in 2014 and 4 percent of member months in 2015. The impact on overall per-enrollee claims growth of these exclusions is about 1 percentage point.

[10] Cross-year claims comprise about 4 percent of total claims costs, even though they comprise a smaller share of claims, because they are disproportionately expensive claims. CMS estimated the additional cost of cross-year claims using data from the California Office of Statewide Health Planning and Development (OSHPD) files. Claims costs were categorized by the admission and discharge date with claims that started in the preceding year but were completed in the following year were categorized as cross year claims. Special thanks to Jim Watkins for the OSHPD analysis. The estimate was cross-validated using the same specifications w Truven Marketscan data.

medical trend averaged 6 percent. This implies that per-enrollee costs for the ACA individual market, adjusted for underlying medical cost growth, fell from 2014 to 2015.

Figure 1. Cost Changes 2014 to 2015 (Percent Change)



In principle, the below-trend growth in claims costs in the ACA compliant market could reflect multiple factors. For example, changes in plan designs, such as greater enrollment in plans with higher cost sharing or increased utilization management by insurers, could have contributed to lower costs. In practice, however, average plan actuarial value, a measure of the overall level of cost sharing plans include, was roughly constant between 2014 and 2015.[11] Likewise, an independent analysis concluded that network breadth also remained roughly constant from 2014 to 2015.[12] Plan costs could also have gone down as pent-up demand effects faded for 2014 newly-ensured enrollees, but many new 2015 enrollees were themselves recently uninsured. Meanwhile, changes in average enrollment duration likely put upward pressure on costs from 2014 to 2015 since the average plan participant was enrolled for a longer period in 2015 than in 2014.[13] Typically, PMPM claims costs increase the longer a member is enrolled because people who are enrolled longer are more likely to meet their deductibles and then be enrolled for some period in which they face low or no cost sharing.

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[11] The ACA individual market member month weighted actuarial value level, excluding effects of cost-sharing reductions, was approximately 1 percent lower in 2015 than it was in 2014 (June 30th report for 2014 and 2015 Appendix A). The proportion of enrollees with cost sharing reductions was also similar in 2014 and 2015.

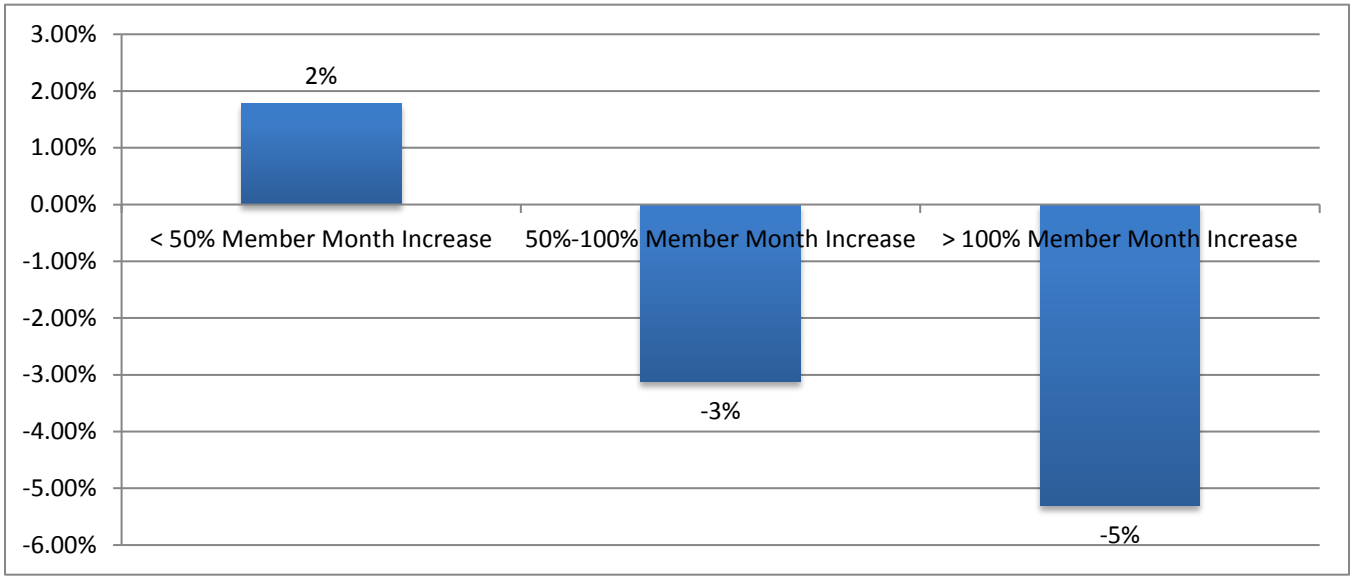
[12] http://healthcare.mckinsey.com/sites/default/files/McKinsey%20Reform%20Center_2016%20Exchange%20Networks_FINAL.pdf

[13] The average number of member months per enrollee increased approximately 8% between 2014 and 2015 in the ACA individual market according to EDGE data.

Rather, it seems likely that the below trend growth in ACA individual market claims costs reflects at least in part an improving risk pool. Supporting that interpretation, cost growth was lower, and often negative, in states that saw the most growth in Marketplace enrollment – growth that would have been expected to broaden their risk pools. Overall, total ACA individual market member months increased 66 percent in 2015, reflecting higher Marketplace enrollment, increased enrollment duration, and shifts from grandfathered and transitional plans into the ACA individual market. On average across states, stronger growth in individual market enrollment translated into larger improvement in PMPM claims costs. In the 13 states with member-month growth of less than 50 percent, PMPM claims increased by an average of 2 percent. Meanwhile, in the 27 states with member-month growth between 50 and 100 percent, PMPM claims fell by an average of 3 percent, and in the 10 states with member-month growth exceeding 100 percent, PMPM claims fell by an average of 5 percent. (See Figure 2 and appendix maps.)

Also consistent with the interpretation that slow cost growth reflects an improving risk pool, risk adjustment program risk scores fell in states experiencing higher enrollment growth relative to those that experience lower enrollment growth.

Figure 2. Average Claims Cost PMPM Change by Member-Month Growth Group



Of note, states in the Federally-Facilitated Marketplace saw higher than average growth, an 81 percent increase in total member months. Consistent with that, they also saw a larger than average reduction in their PMPM claims, a 3.5 percent decline on average.

Conclusion and Implications

These data are very encouraging for the long-term health and stability of the Marketplace. They suggest that the individual market evolved as would have been expected in 2015: with moderate but real progress toward a broader risk pool as Marketplace enrollment grew.

Nearly all states saw continued growth in Marketplace enrollment in 2016, suggesting continued improvement in their risk pools.[14] Moreover, the 2015 claims data also predate important steps CMS has taken over the past six months to further strengthen the Marketplace risk pool. These steps include implementing new processes to prevent misuse of Special Enrollment Periods, reducing the number of consumers losing coverage or financial assistance due to data-matching issues, helping consumers who turn 65 move from the Marketplace onto Medicare, and proposing to curb abuses of short-term plans that are keeping some of the healthiest customers out of the ACA risk pool. Going into the next Open Enrollment, CMS will also be strengthening outreach, especially to young adults, by communicating with people who paid the individual responsibility penalty, facilitating 26-year-olds' transitions from their parents' plans to Marketplace coverage, and undertaking even more timely and targeted email and other campaigns. With these new actions in 2016, as well as the expiration of remaining transitional policies by the end of 2017, we expect the Marketplace risk pool will continue to grow and improve going forward.

Importantly, an improving risk pool does not assure issuer profitability in any given year, since profitably depends on both costs and pricing decisions. Evidence suggests that many issuers priced below cost for 2014, for reasons that included difficulty predicting cost in a new market and a desire to offer strongly competitive rates to gain share in a new market.[15] Meanwhile, the EDGE data show that premiums increased an average of just 2 percent in 2015. This increase would have been sufficient, on average, to keep pace with claims costs, because of the exceptionally slow growth in per-enrollee claims. However, it would not have been sufficient to make up for 2014 gaps between prices and costs or to accommodate the partial phasedown of the transitional reinsurance program.

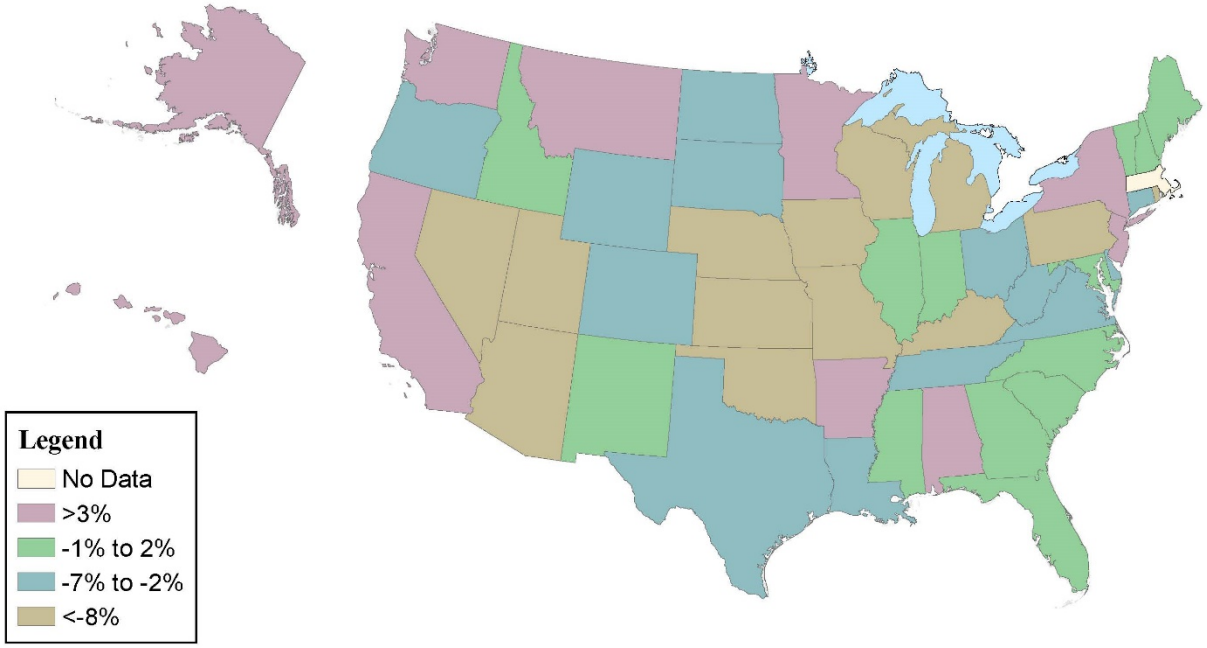
But a risk pool that is getting stronger over time does assure that the Marketplace is well positioned for the long run. As the Marketplace continues to mature and grow, it will continue to be a place where insurers want to do business and where consumers are able to find affordable coverage that meets their needs.

[14] Pennsylvania and Indiana implemented their Medicaid expansion over this period, shifting consumers with incomes 100-138 percent of the federal poverty line out of the Marketplace, and New York introduced a Basic Health Program, shifting most consumers with incomes up to 200 percent FPL out of the Marketplace. Other than these states, all but three states saw growth in Marketplace plan selections, and most states saw growth exceeding 10 percent.

[15] http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/the-affordable-care-act-and-health-insurers-financial-performance

Appendix: State Growth in ACA Individual Market Member Months and Per-Enrollee Claims

Percent Change in Per-Member-Per-Month Claims in ACA Individual Market



Percent Change in Member Months of Enrollment in ACA Individual Market