Federal exchange auto-enrollment: Emerging data and new proposals

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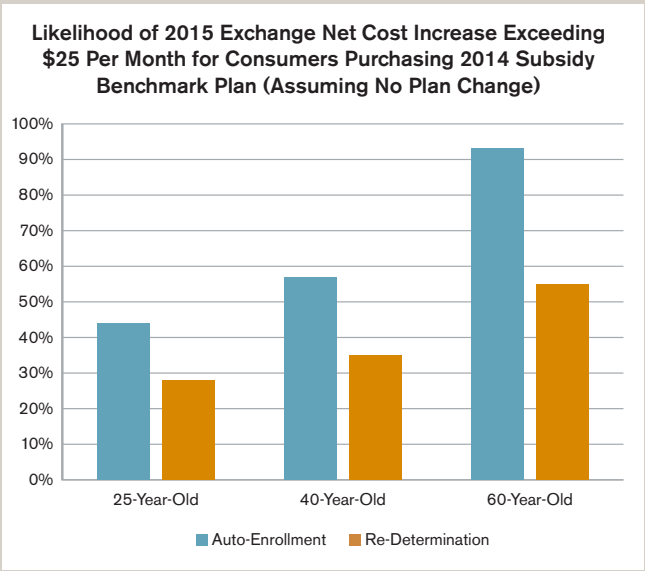
EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) released guidance on annual redeterminations for marketplace coverage in 2015, which was discussed in a Milliman Healthcare Reform Briefing Paper, "The proposed federal exchange auto-enrollment process: Implications for consumers and insurers," released in July 2014.[1] For 2014 federal exchange enrollees, these regulations outline the two options for purchasing coverage in 2015. Enrollees have the ability to automatically be enrolled in coverage consistent with their 2014 selections (auto-enrollment), or they may enroll in a manner identical to new enrollees (redetermination).

Premiums for the federal insurance exchange were made publicly available in November 2014. Additionally, HHS has released information related to federal exchange insurance renewals during the 2015 open enrollment period. This new information enables further evaluation of the federal exchange auto-enrollment process, including the cost implications for consumers of auto-enrollment versus redetermination.

For 2014 exchange consumers, there are three key issues regarding their 2015 insurance purchasing decision:

- First, regardless of insurer competition, the mechanics of the federal auto-enrollment process will result in higher monthly costs for many consumers receiving premium assistance who elected to auto-enroll into coverage for 2015.
  - Based on the distribution of federal exchange qualified health plan selections by county, more than 40% of 25-year-olds purchasing the subsidy benchmark plan in 2014 would experience more than a $25 monthly cost increase if auto-enrolled into the same plan for 2015.
  - However, for 60-year-olds, the percentage of enrollees experiencing more than a $25 monthly cost increase jumps to over 90%.
  - HHS has reported that federal exchange enrollees paid $69 per month on average for silver level coverage in 2014.[2] Therefore, in many cases, a $25 monthly cost increase would represent a substantial change in the cost of health insurance coverage.
- Second, while consumers choosing to select the 2014 subsidy benchmark plan again in 2015 would often benefit significantly from going through the re-determination process, insurer competition in the exchange still results in a material percentage of exchange consumers experiencing a monthly cost increase of $25 or more, with much greater chances of significant cost increases for older individuals.
- Finally, a consumer could ensure practically the same cost for health insurance coverage by electing to enroll in the 2015 subsidy benchmark plan. As the 2015 open enrollment period does not conclude until February 15, an individual that was auto-enrolled in their 2014 coverage at the beginning of the year has the opportunity to switch to a lower cost plan until the open enrollment period ends.



Notes:
1. **Figures are prior to the reconciliation of premium subsidy tax credit amount at tax filing.**
2. **Ages illustrated reflect an individual's age in 2014.**

1 Houchens, P.R. & Pantely, S.E. (July 2014). The proposed federal exchange auto-enrollment process: Implications for consumers and insurers. Milliman Healthcare Reform Briefing Paper. Retrieved January 27, 2015, from http://us.milliman.com/uploadedFiles/insight/2014/federal-exchange-auto-enrollment.pdf.

2 Burke, A., Misra, A. & Sheingold, S. (June 18, 2014). Premium affordability, competition, and choice in the health insurance marketplace, 2014. ASPE Research Brief, Table 2. Retrieved January 30, 2015, from http://aspe.hhs.gov/HEALTH/REPORTS/2014/PREMIUMS/2014MKTPLACEPREMBRF.PDF.

For insurers, the federal exchange auto-enrollment process and 2015 open enrollment period creates several interesting market dynamics:

- HHS data suggests the federal exchange auto-enrolled approximately 2.7 million individuals into 2015 coverage during December 2014, which represents slightly more than 35% of total federal exchange selections through January 23, 2015.[3] Auto-enrollees are likely to represent a material block of exchange enrollment for 2014 exchange issuers, particularly 2014 market leaders.

- However, insurers may also experience a shifting exchange enrollment base in January and February 2015, as individuals who were auto-enrolled switch to new plans before the February 15 open enrollment deadline.

- For insurers in the federal exchange markets, the rate changes experienced by those who auto-enroll in coverage (and elect not to switch plans prior to the end of the open enrollment period) may influence effectuation rates in the coming year, particularly for low-income households.

Additionally, HHS has outlined a new re-enrollment approach in the proposed Notice of Benefit and Payment Parameters for 2016[4] that, if implemented, would be offered during the 2016 federal exchange open enrollment period (and implemented in 2017). This revised approach would give exchange enrollees the ability to be automatically enrolled in the lowest-cost plans of their selected metallic tiers. It was proposed that plan enrollment changes could be prompted by an enrollee's required premium increasing by more than a specified percentage. The lowest-cost plan may be offered by a different carrier, have a different provider network, and have different cost-sharing requirements than an enrollee's existing plan selections. For these reasons, there are many factors to consider in evaluating how this proposal may affect consumers and insurers.

This paper discusses the potential impacts to the 2015 federal exchange market as a result of the federal auto-enrollment process based on observed premium changes from 2014 to 2015, as well as on emerging data on federal exchange plan selections released by HHS during the 2015 open enrollment period. Additionally, we examine the effects of proposed 2017 changes to the federal exchange auto-enrollment process to insurers and consumers.

HOW MANY EXCHANGE ENROLLEES ELECTED TO BE AUTO-ENROLLED?

The 2015 exchange open enrollment period began on November 15, 2014. To the extent that 2014 enrollees did not make an active plan selection and met certain criteria, these individuals were reenrolled for 2015 in their 2014 plans (or similar plans offered by their current insurers). HHS has indicated that this process took place between December 16 and 18.[5] Weekly updates on plan selections during the 2015 open enrollment period have been released by HHS. While the specific number of individuals who were auto-enrolled into plans has not been released, by comparing the open enrollment report through December 19 to the HHS report for the period of November 15 through December 15, we can deduce that the number of auto-enrollees is likely around 2.7 million.[6] This represents between 60% and 65% of the 4.5 million individuals who renewed federal exchange coverage (auto-enrollees and individuals who went through the redetermination process), and is consistent with percentages reported by HHS.[7]

A SECOND CHANCE TO CHANGE PLANS

With the 2015 open enrollment period scheduled to run from November 15, 2014, through February 15, 2015, it creates a unique dynamic for exchange consumers as well as insurers that may not be replicated in future years. Because the open enrollment period extends beyond the beginning of the benefit year (January 1, 2015), the approximately 2.7 million individuals who were auto-enrolled into coverage for 2015 will have the opportunity to switch plans after coverage is in effect, if they so desire.[8] If an individual selected a new plan by January 15, coverage would begin on February 1. If coverage is selected by February 15, it will begin on March 1. HHS has proposed that, beginning in 2016, the open enrollment period will begin on October 1 and end on December 15, preceding the beginning of the benefit year.[9] Therefore, exchange consumers will not have the opportunity to switch plans after the auto-enrollment process has taken place (presumably on December 15).

For insurers developing 2016 premium rates or trying to make financial projections for calendar year 2015, the prospect of a shifting enrollment base in January and February of 2015 presents an added degree of uncertainty in an immature market.

3 7.3 million federal exchange selections were reported through January 23, 2015. http://www.hhs.gov/healthcare/facts/blog/2015/01/open-enrollment-week-ten.html

4 U.S. Department of Health and Human Services (November 26, 2014). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule. Federal Register. Retrieved January 27, 2015, from http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf.

5 U.S. Department of Health and Human Services (December 23, 2014). Open Enrollment Week 5: December 13 - December 19, 2014. Facts and Features, Blog. Retrieved January 27, 2015, from http://www.hhs.gov/healthcare/facts/blog/2014/12/open-enrollment-week-five.html.

6 HHS reported that 1.64 million cumulative individuals had renewed coverage through the federal exchange as of December 15, 2014. As of December 19, 2014, 4.48 million cumulative individuals had renewed coverage in the federal exchange, implying 2.84 million renewals between December 16 and December 19. We have assumed that a portion of the renewals that occurred between December 16 and December 19 were not auto-renewals (assuming the ratio of non-auto-renewals to new plan selections was consistent with the December 13 through December 15 time frame), resulting in our 2.7 million auto-enrollee estimate.

7 Sanger-Katz, M. (December 24, 2014). People are shopping for health insurance, surprisingly. *New York Times*. Retrieved January 27, 2015, from http://www.nytimes.com/2014/12/25/upshot/people-are-shopping-for-health-insurance-surprisingly.html?abt=0002&abg=0.

8 HealthCare.gov. Important Marketplace Deadlines: 2015 Open Enrollment. Individuals and Families. Retrieved January 27, 2015, from https://www.healthcare.gov/marketplace-deadlines/2015/.

9 Centers for Medicare and Medicaid Services (November 21, 2014). CMS issues the HHS Notice of Benefit and Payment Parameters for 2016 Proposed Rule. Press release. Retrieved January 27, 2015, from http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-11-21.html.

WHAT IS THE LIKELIHOOD OF AUTO-ENROLLEES SWITCHING PLANS PRIOR TO THE END OF THE OPEN ENROLLMENT PERIOD?

As indicated in Milliman's July 2014 report on the federal exchange auto-enrollment process, the potential for material cost increases (prior to the subsidy reconciliation process) was greatest for exchange enrollees over the age of 50. Because the federal exchange auto-enrollment process provides the same subsidy dollar amount in 2015 as the enrollee received in 2014, the auto-enrollee must pay the net cost increase of age rating (along with any trend increases).

By summarizing federal exchange premiums for 2014 and 2015 at the county level, we can compare changes in the cost of health insurance coverage for individuals who elected to be auto-enrolled in the exchange, as well as individuals who went through the redetermination process.

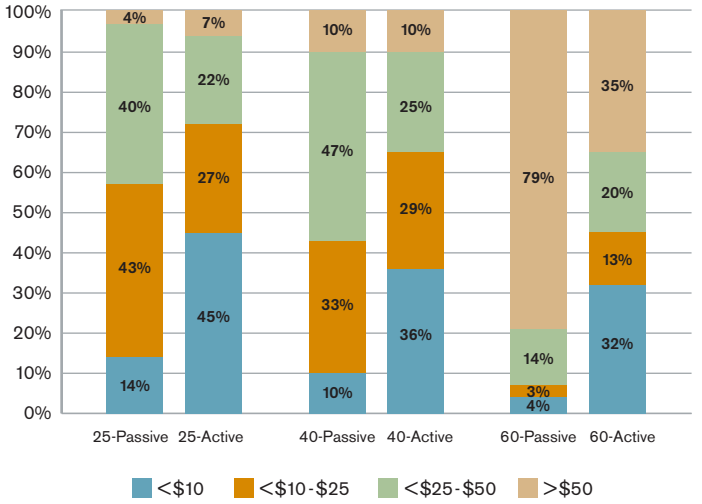
Net cost changes for consumers who elected to be auto-enrolled versus redetermined

For simplicity, we will focus on the cost changes for 2014's subsidy benchmark plans (the second-lowest-cost silver plan in each county) resulting from a single individual either passively (auto-enrolling) or actively (redetermination process) enrolling in the same plan in 2015.[10] The distribution of cost changes reflects weighting by 2014 county plan selections in the federal exchange.[11] In Figure 1, we have illustrated individuals who were 25, 40, and 60 years old in 2014. The 2015 premiums reflect the cost of coverage for a 26-, 41-, and 61-year-old, respectively. *It should also be noted that an individual could effectively keep the net cost the same[12] from 2014 to 2015 if the subsidy benchmark plan was selected in 2015*; however, this may require changing plans or insurers.

Several key observations may be made from Figure 1.

- A significant percentage of older individuals may be unable to afford net cost changes under the federal exchange auto-enrollment process. The likelihood of monthly net cost increases in excess of $50 from 2014 to 2015 increases from less than 4% for a 25-year-old to nearly 80% for a 60-year-old. For perspective, the average 2014 net cost for silver plans in the federal exchange after the application of premium assistance was $69.[13]

FIGURE 1: 2015 PASSIVE VS. ACTIVE ENROLLMENT NET COST CHANGE, 2014 SUBSIDY BENCHMARK PLAN



Notes:
1. Percentages are rounded.
2. Income as a percentage of the federal poverty level is assumed to remain constant in 2014 and 2015.
3. Ages illustrated reflect an individual's age in 2014.

- While the redetermination process does not eliminate the potential for significant cost increases for individuals who remain in the same plan from 2014 to 2015, it will financially benefit many individuals, particularly older exchange enrollees. The percentage of 60-year-olds in the federal exchange experiencing monthly net cost increases in excess of $50 decreases from 79% to 35%. While younger ages will also benefit in aggregate from going through the redetermination process, the consequences for failing to do so may be most financially severe for older individuals.

- As indicated by Figure 1 above and by HHS,[14] a large portion of 2014 exchange consumers may benefit financially from switching plans or insurers to reduce their net costs in 2015.

10 In some cases, insurers may have selected a similar plan for auto-enrollment. For more information, see slide 13, Centers for Medicare and Medicaid Services, Annual Eligibility Redeterminations for Exchanges and Health Insurance Issuer Standards Final Rule and Guidance, https://marketplace.cms.gov/technical-assistance-resources/eligibility-redeterminations.pdf.

11 Developed from data at a ZIP Code level released by HHS.See http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/EnrollmentByZip/rpt_EnrollmentByZip.cfm. To the extent that an insurer did not provide a 2015 auto-enrollment plan (see https://data.healthcare.gov/dataset/Plan-ID-Crosswalk-PUF/srri-3w2q), the county's population was excluded. In total, the distribution represents 5.3 million plan selections.

12 Assuming an individual's household income, as a percentage of the federal poverty level (FPL), was the same in 2014 and 2015, a minimal cost increase would be required to purchase the subsidy benchmark plan, which is due to the indexing of the FPL and premium tax credit percentages. For example, an individual with household income of 150% of FPL would have a monthly net cost increase of $57.45 to $58.70 to purchase the subsidy benchmark plan.

13 Burke, A., Misra, A., & Sheingold, S. (June 18, 2014). Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014: Table A2. ASPE Research Brief, p. 24. Retrieved January 27, 2015, from http://aspe.hhs.gov/HEALTH/REPORTS/2014/PREMIUMS/2014MKTPLACEPREMBRF.PDF.

14 ASPE Research Brief (January 8, 2015). Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace. Retrieved January 27, 2015, from http://www.aspe.hhs.gov/health/reports/2015/premiumReport/healthPremium2015.pdf.

KEY CONSIDERATIONS FOR INSURERS IN DEVELOPING 2015 EXCHANGE MARKET FORECASTS AND 2016 PREMIUMS

Without publicly available data on the percentage of 2014 exchange enrollees who have elected to be auto-enrolled versus going through the redetermination process by age or income level, it is difficult to assess how the federal exchange auto-enrollment process will impact insurance coverage effectuation rates in Federally Facilitated Marketplace (FFM) exchanges, as well as the number of auto-enrollees who elect to go through the redetermination process in January or February of 2015. For example, if older individuals in the federal exchange elected to go through the redetermination process at a much greater percentage than the aggregate 35% to 40% that has been reported, the likelihood of individuals switching plans or experiencing a "rate shock" may be lessened.

However, insurers may have internal data related to exchange enrollment. We would recommend that exchange issuers conduct an examination of their current membership bases by income level, and whether they auto-enrolled into their 2015 plans or went through the redetermination process. Insurers should assess the monthly net cost of maintaining coverage by enrollment cohorts (age group, income level). If costs for enrollees have changed substantially relative to 2014, current enrollees may lapse at greater rates than observed in 2014. The issues raised by the federal exchange auto-enrollment process are likely to vary significantly by insurer and geographic area, which is due to the potential price sensitivity of exchange consumers. Additionally, *proposed regulations issued by the HHS in December 2014 concerning the federal exchange auto-enrollment process may throw a new twist into the premium development process for 2017 rates*.

PROPOSED 2017 AUTO-ENROLLMENT PROCESS

In the proposed Notice of Benefit and Payment Parameters for 2016, HHS noted that the current auto-enrollment process focuses on continuing coverage for enrollees, but does not mitigate the fluctuation in premiums a member may experience by being reenrolled in the same plan each year.[16] For example, if an individual was enrolled in the lowest-cost silver plan in 2014 and takes no action during 2015 open enrollment, there is no guarantee that the individual will still be in the lowest-cost silver plan in 2015.

Within these proposed regulations, HHS outlined an alternative method that may change the competitive landscape and help individuals remain in low-cost plans. This method would allow individuals to be automatically enrolled into a low-cost plan each year, even if that means changing plans or insurers. Note that HHS is not proposing to eliminate the current auto-enrollment method; individuals would have the ability to choose between the current auto-enrollment method and this new proposed alternative when signing up for coverage.

Exceptions to the rule

While not visible in Figure 1, it should be noted that not all individuals who purchased the second-lowest-cost silver plan in 2014 would reduce the monthly net costs in 2015 for their 2014 plans by going through the redetermination process. As observed in several counties in Georgia and Mississippi in particular, this situation may occur when the premium rate for the subsidy benchmark plan was reduced significantly from 2014 to 2015 and the subsidy value for exchange enrollees decreases correspondingly. For example, an individual may have received a $200 monthly subsidy in 2014 to purchase a subsidy benchmark plan with a $300 monthly premium rate, resulting in a monthly net cost to the exchange enrollee of $100. If the 2015 premium is reduced to $250 (while retaining subsidy benchmark status), the following may occur:

- An individual who auto-enrolls in the plan for 2015 would retain the same 2014 subsidy value ($200) and apply it to the 2015 premium ($250), resulting in a 2015 monthly net cost of $50.
- An individual who went through the redetermination process (assuming no change in household income) would again have a monthly net cost of approximately $100, as the premium subsidy value is reduced from $200 to $150.

While the auto-enrollee may owe taxes on the additional $50 subsidy received in 2015 ($200 vs. $150), regulations may limit the amount that is owed to the Internal Revenue Service (IRS)[15] to an amount below the financial benefit gained from auto-enrolling versus going through the redetermination process.

The particulars of the program were not established in the proposed regulations; however, a variety of options were proposed. For clarification, we will refer to this newly proposed method as "low-cost auto-enrollment" and individuals who select this method as "low-cost auto-enrollees." Proposed options discussed by HHS included:

- Low-cost auto-enrollees who did not take action would be enrolled in the qualified health plan (QHP) of the same metallic tier level in the same service area with the lowest premium.
- An alternative option of randomly assigning low-cost auto-enrollees into one of the three lowest-cost QHPs at the same metallic tier level in the same service area.
- The potential for movement into a lower-cost plan that would only be triggered if a member's current premium increased above a specified threshold (HHS suggests 5% or 10% measured as either the net premium increase or the increase relative to similar plans).

15 Houchens & Pantely (http://us.milliman.com/uploadedFiles/insight/2014/federal-exchange-auto-enrollment.pdf), ibid. See Figure 2 for more information.

16 HHS Notice of Benefit and Payment Parameters for 2016 (http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf), ibid., p. 120.

QUANTIFYING THE IMPACT

To give some perspective on the potential impacts of the low-cost auto-enrollment method, we analyzed what would have happened if FFM exchange enrollees selected this proposed auto-enrollment method when first signing up for coverage during the 2014 open enrollment period. Though HHS offered various options for the parameters of the program, our analysis assumes that a low-cost auto-enrollee would be moved to the lowest-cost plan in the same metal level tier and county if the member experienced a premium increase of greater than 5% or 10%. Furthermore, we have assumed that if a member's plan is no longer offered the member would be automatically enrolled into the most similar plan using the current auto-enrollment methodology unless the premium increase is above the specified threshold.

Lowest-cost silver plan

For the purpose of this analysis, we focused on the silver metallic tier because this was the most popular tier for 2014 enrollees, garnering 65% of sign-ups.[17] We compared the lowest-cost silver plan offered in 2014[18] to the lowest-cost silver plan offered in 2015 at the county level. Figure 2 illustrates the hypothetical movement from 2014 to 2015 among QHPs and insurers in the federal exchange.

FIGURE 2: MOVEMENT AMONG PLANS OF HYPOTHETICAL LOW-COST AUTO-ENROLLEES IN FEDERAL EXCHANGE

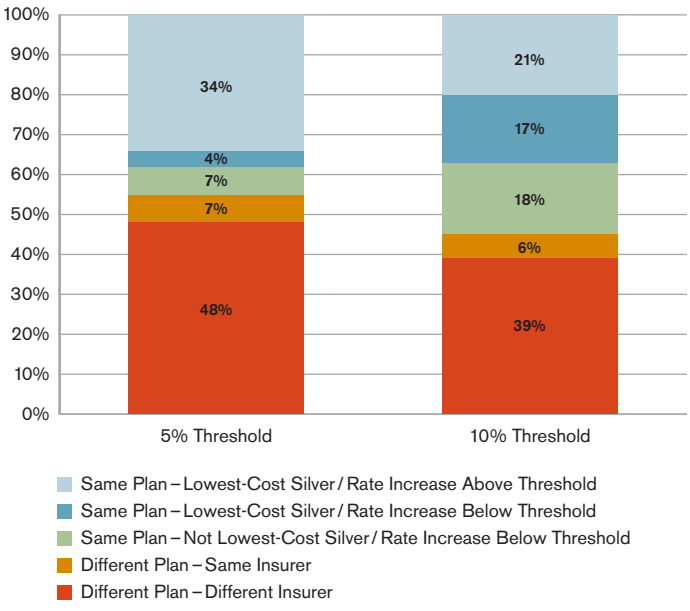


Figure 2 illustrates that significant movement would occur between plans and insurers as a result of the low-cost auto-enrollment methodology:

- A large percentage of 2014 FFM enrollees were covered in counties where the lowest-cost silver plan would have lost any low-cost enrollees who did not actively reenroll.
  - 55% using a 5% threshold
  - 45% using a 10% threshold
- Of those that would be automatically moved to a different plan in 2015, 87% would also be moving to a different insurer (for both threshold scenarios).
- In counties representing 38% of 2014 FFM enrollees, the lowest-priced silver plan did not change from 2014 to 2015.
  - 34% were enrolled in counties where the increase was greater than 5%.
  - 21% were enrolled in counties where the increase was greater than 10%.

How this may impact exchange insurers' pricing strategies and exchange enrollees

For insurers aiming to have a meaningful market share of the subsidy-eligible population, the structure of premium subsidies in the exchange incentivizes them to establish low premiums relative to others in the market, as enrollees across all income levels are exposed to the full premium cost difference between plans. Potential effects of the proposed 2017 auto-enrollment process (including the premium threshold increase trigger) include:

- The low-cost auto-enrollment method is likely to further encourage insurers to restrict rate actions, as the loss in market share from exceeding the rate threshold, in either the 5% or 10% scenario, may be substantially greater than under the 2015 auto-enrollment process.
- For insurers that entered the exchange market with a strategy of pricing aggressively initially to gain market share and later increasing rates, initial market share gains may be lost through the low-cost auto-enrollment process.
- For consumers, if implemented, the proposal would assist in ensuring that a member's net cost remains low compared to other available plans. This may come with drawbacks as members would potentially face differences in cost-sharing requirements, provider networks, and covered services each year. However, for individuals simply wanting to comply with the individual mandate by purchasing the lowest-cost plan possible, this may be a favorable option.

17 U.S. Department of Health and Human Services (May 1, 2014). Enrollment in the health insurance marketplace totals over 8 million people. Press release. Retrieved January 27, 2015, from http://www.hhs.gov/news/press/2014pres/05/20140501a.html.

18 The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) indicated that 43% of silver-tier exchange enrollees selected the lowest-cost silver plan in a given county. See Table 4 at: http://aspe.hhs.gov/HEALTH/REPORTS/2014/PREMIUMS/2014MKTPLACEPREMBRF.PDF.

It is important to remember that members would still have the ability to actively enroll and select a different (or the same) plan. The potential for having benefit and network changes annually would only occur if a member does not take action during the open enrollment period. This dynamic has the potential to result in insurers putting more effort into member outreach during open enrollment. However, doing so would mean encouraging members to go back to the marketplace where competitors' plans are on display.

The 2017 exchange market

HHS proposed offering this low-cost auto-enrollment option to individuals when they sign up during the 2016 open enrollment period, which means enrollees would not be automatically moved to a low-cost plan until the 2017 open enrollment period. The rate increases and changes in plan offerings available in each county from 2016 to 2017 will likely be different from the changes seen during 2014 to 2015. There is the potential for increased stability in the market three to four years after the introduction of the exchanges, yet there are still many questions, proposed regulatory changes, and forthcoming challenges that could result in premium variation in line with recent experience, including:

- 2017 will be the first year where risk adjustment will be the sole remaining risk mitigation component of the "3Rs" (with reinsurance and risk corridors) found in the Patient Protection and Affordable Care Act (ACA).
- 2017 will be the first year states may implement the ACA's state innovation waivers,[19] which could result in a much more diverse exchange market if states seek this path.

As we have seen over the last 24 months, insurers will need to actively update and enhance exchange market strategies for continued ACA regulatory changes.

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19 Patient Protection and Affordable Care Act (2010). 42 U.S. Code § 18052 - Waiver for State innovation. Legal Information Institute. Retrieved January 27, 2015, from http://www.law.cornell.edu/uscode/text/42/18052.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

The analyses present in this paper are based on proposed federal regulations as of January 2015 and publicly available data released by the U.S. Department of Health and Human Services. To the extent future regulations materially modify these proposed regulations, the statements and conclusions in this paper may require modification. The views expressed in this report are made by the authors of this report and do not represent the collective opinions of Milliman. Other Milliman consultants may hold different views and reach different conclusions. Materials may not be reproduced without the express consent of Milliman.

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