LEWIS & ELLIS
Actuaries and Consultants

LOUISIANA ACT NO. 412

Cost and Market Analysis of the Healthcare Coverage for Louisiana Families Protection Act & the Louisiana Guaranteed Benefits Pool

LOUISIANA DEPARTMENT OF INSURANCE

STATE OF LOUISIANA

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INTRODUCTION & EXECUTIVE SUMMARY

BACKGROUND

In accordance with Act No. 412 (Act) of the 2019 Regular Legislative Session, the Louisiana Department of Insurance (LDI) is engaged in planning and implementing activities relating to the following provisions of the Act:

1. Subpart F. Healthcare Coverage for Louisiana Families Protection Act.
2. Subpart F-1. Louisiana Guaranteed Benefits Pool (LGBP).

Subparts F and F-1 only become effective if a court of competent jurisdiction rules that the Patient Protection and Affordable Care Act (ACA), P.L. 111-148, is unconstitutional and the judgment of that court becomes final and definitive. The provisions of the Subparts would become effective ninety days after notification to the LDI of the ACA's repeal.

Lewis & Ellis, Inc. (L&E) was retained by the LDI to analyze and understand the impact to enrollment, premiums and claims in Louisiana's individual market if the ACA is repealed and a portion of the ACA's provisions (e.g. pre-existing conditions coverage) are replaced by the provision of the Act.

Specifically, L&E analyzed the impact of four key policy changes resulting from the repeal of the ACA and the subsequent implementation of the Act:

1. The establishment of the Louisiana Guaranteed Benefits Pool which is a risk-sharing program which reduces claims costs for eligible enrollees with high-cost health conditions; and
2. The restructuring of the premium age curve (i.e., premium relativities between ages) from a maximum of 3:1 to a maximum of 5:1.
3. The elimination of the Advanced Premium Tax Credits (APTC) provided to low income enrollees.
4. The elimination of the Cost Sharing Reductions (CSR) subsidies reduces cost sharing for low income enrollees.

This study finds that after the implementation of the four key policy changes above, the LGBP would result in a projected reduction of gross monthly premiums of approximately $300 per member per month (PMPM), which is an approximate 35-40% reduction.

This $300 PMPM reduction is expected to be sufficient to encourage a portion of currently unsubsidized individuals under the ACA subsidy framework to return to the individual market. While the LGBP would partially address the issue of the loss of ACA subsidies for low income individuals, additional income-based subsidies or other support would be necessary to address

the population unable to afford insurance in the absence of APTCs and CSRs to help prevent significant disenrollment from this population. Additionally, based on the amount spent on prior year ACA subsidies, significant funding would remain under the Act to address the potential disenrollment by this population.

The method in which the LBGP and APTCs affect net premiums is different. APTC reduce net premiums by providing a credit to help pay for premiums for individuals who make 100%-400% of the Federal Poverty Level (FPL). The LGBP focuses on members with certain high-cost medical diagnoses but spreads the premium impact across all households in the individual market.

Restructuring the age curve would reduce the subsidization of health care cost by younger individuals for older individuals by charging premiums closer to the claims relativity of younger versus older individuals. In isolation, going from a maximum of a 3:1 age curve to a maximum of a 5:1 age curve would make premiums cheaper for younger adults and more expensive for older adults. This change should encourage enrollment by younger adults.

The results presented in this study compare what the Louisiana market would look like after an ACA repeal *and* the implementation of the Act's provisions. That is, the study assumes that there will not be a scenario where the Louisiana market is not protected by either the protections of the ACA or the Act. Additionally, the Act addresses a portion of the ACA's provisions. The Act does not address many ACA provisions e.g. subsidies for low-income persons. This study only analyzes the Act's provisions and does not address the impact of any further possible legislation in Louisiana that could ultimately address the other ACA provisions such as subsidies for low-income persons.

EXECUTIVE SUMMARY

The elimination of the APTC and CSR subsidies, without the removal of other ACA provisions, would cause a significant reduction in market enrollment. The introduction of the LGBP would address a portion of the expected disenrollment by providing premium relief of approximately $300 PMPM across the individual market.

The amount of funding needed by the State of Louisiana for providing these levels of premium relief would be approximately $209 million. As structured in Act 412, this funding would come from federal or state appropriations designed to replace the former ACA subsidies.

Although gross premiums are reduced significantly as a result of implementing the LGBP, additional subsidies would be necessary to preserve net premiums for low income individuals. These additional subsidies would help prevent significant decreases in enrollment by that population.

DATA AND ASSUMPTIONS

DATA SOURCES

L&E analyzed data provided from the carriers participating in the individual market in Louisiana which includes 2018 membership data, allowed and paid claims, premiums, and diagnosis data.

Because the base data is from 2018, it was necessary to trend that data forward to 2021. The same trend assumptions were applied to allowed claims and incurred claims, ensuring that the Actuarial Value (AV) for each member would remain constant between the base period and the projection period. The trend assumptions are described in a later section.

POPULATION ASSUMPTIONS

The policy changes were modeled for coverage starting January 1, 2021, and results are modeled through the end of 2021. The basis for the projections reflects individual market data from coverage year 2018. L&E started with the assumption that, in the absence of policy changes, the population will be similar to 2018's demographics, health status, geographic location, and plan designs.

However, most members will experience significant changes in net premium as a result of the loss of APTC, the introduction of the LGBP, the change in the age curve, and the end of CSR's[1]. L&E made assumptions regarding household behavior based on their change in total costs, whether they currently receive CSR/APTC, and the level of claims experienced in the prior year. For example, non-APTC members whose premium changes by less than $50 per month are assumed to have no change in enrollment status. Exhibit 2 summarizes these assumptions:

Exhibit 2 – Enrollment Change Assumptions

Change in Net Monthly Premium (Per Person)	CSR	APTC	Non-APTC
-$300 or more	-	+51.4%	+34.0%
-$300 to -$150	-20.0%	+33.5%	+19.8%
-$150 to -$50	-40.0%	+18.4%	+10.6%
-$50 to +$50	-70.0%	-	-
+$50 to +$150	-79.5%	-15.5%	-10.6%
+$150 to +$300	-91.6%	-50.0%	-36.8%
+$300 or more	-96.3%	-68.5%	-55.3%

[1] While CSR's do not directly impact premiums, Louisiana is a state with "silver-loaded" premiums. This means that on-exchange Silver plans have higher premiums than they would in the absence of CSR to account for the average cost of CSR for Silver members.

MARKET ASSUMPTIONS

L&E has assumed that there are no material changes to benefits between 2018 and 2021. Members are assumed to pay a similar share of their total medical costs as in 2018. Therefore, no deductible leveraging, or induced utilization is included in the analysis.

The only exception to this assumption is members who are currently eligible for CSR. For these members, L&E assumed that paid claims would be reduced by the difference between CSR cost sharing and standard Silver Plan cost sharing. Similarly, projected premiums for on-exchange Silver plans would be reduced to account for the removal of the "silver load."

MEDICAL COST AND PREMIUM TREND ASSUMPTIONS

Because the base claims data used is from 2018, L&E applied three years of medical cost trend to project claims to 2021. The trend factors from 2018 to 2021 were assumed to be an annualized annual trend of 5% from 2018 to 2021.

While different policyholders will likely have different increases in costs from 2018 to 2021, due to data limitations and availability, L&E has assumed that all providers and policyholders experience claim cost trends in a uniform, multiplicative manner.

The data L&E used for this analysis showed a 2018 loss ratio of 73%. To ensure consistency between premium and claim trend assumptions, L&E reviewed recent loss ratios.

METHODOLOGY

DATA LIMITATIONS

L&E compared the data to various external sources to ensure that it was representative of the entire risk pool. These validations did not reveal any material limitations to the use of the data for this study.

MODELING OF LBGP PROGRAM

The diagnosis and enrollment data were used to calculate member-level and diagnosis groups by using the federal risk adjustment program's HHS-HCC model. The high-risk condition pool is modeled after a similar program in Alaska and involves identifying members with any of the defined high-cost conditions. This list can be found in Appendix C.

Claims are projected forward to 2021 assuming the status quo and the implementation of the proposed LGBP program. For members with a diagnosis included in the program design, claims are reinsured by the State in exchange for a reinsurance premium equal to 98% of member premium. Due to the high costs of these members, this reduces overall claims substantially. Claims for CSR members are reduced to reflect the impact of their cost sharing reverting to a Silver level.

Projected premium is similarly calculated separately under the status quo and under the study scenario. Status quo premiums are equal to 2018 premiums plus three years of trend. The study premiums are equal to those premiums, with the following adjustments:

- A factor to achieve a 5:1 age curve rather than the current 3:1 age curve.
- The removal of the silver load from on-exchange Silver premiums, and
- An aggregate rate change factor to achieve the target loss ratio.

This methodology implicitly assumes that the rate differentials by benefit level, tobacco status, rating area, and carrier do not change as a result of the LGBP program.

Projected enrollment is based on the 2018 enrollment, adjusted at the member level based on the change in premium, income level, and morbidity level.

The cost of the program to the State is based on the projected enrollment and considers the claims covered by the high-risk pool as well as the carriers' reinsurance premiums. The cost to the State does not consider the potential increase in cost resulting from uncompensated care resulting from newly uninsured individuals and families.

RESULTS

SUMMARY OF 2021 MARKET PROJECTION

The study population consists of three cohorts delineated by income. These three cohorts are members who are currently eligible for CSR, members who are eligible for APTC but not CSR, and members who are not eligible for APTC. These groups of members are expected to respond differently to changes in their premiums.

CSR members have the lowest income and they face substantial increases to out-of-pocket costs to the loss of CSR subsidies. Members with incomes greater than 400% of FPL are not eligible for APTC under the current system and are more likely to elect coverage due to the gross premium reductions as a result of the LGBP. The projected enrollment changes by cohort are shown in Exhibit 3:

Exhibit 3 – Total Enrollment Changes

	CSR	APTC	Non-APTC	Total
2018 Members	59,245	37,993	37,073	134,311
Projected 2021 Members	7,100	24,135	45,476	76,712
Net Change	-52,145	-13,857	8,403	-57,599
Percent Change	-88.0%	-36.5%	+22.7%	-42.9%

The projected enrollment decreases substantially for the lower-income cohorts. With the repeal of the ACA, these groups would lose federal subsidies which currently significantly reduce their net premiums. It is important to note that these changes assume no additional programs are implemented to address the loss of APTCs and CSRs.

It should also be noted that these changes result in approximately 60,000 less people being insured. The people losing coverage, generally, are not able to afford the cost of their medical care without insurance. Therefore, some additional funding source would have to address these costs. Some care would be uncompensated, resulting in higher DSH[2] payments to hospitals. Other uncompensated care would result in higher reimbursement rates for commercial insureds to offset the lost revenue. These issues have not been modeled and are not included in this analysis.

ESTIMATED PREMIUM CHANGES

The premium changes resulting from the modeled market changes vary significantly by age, income, and metal tier. Unlike under the current ACA system, the proposed premiums under the

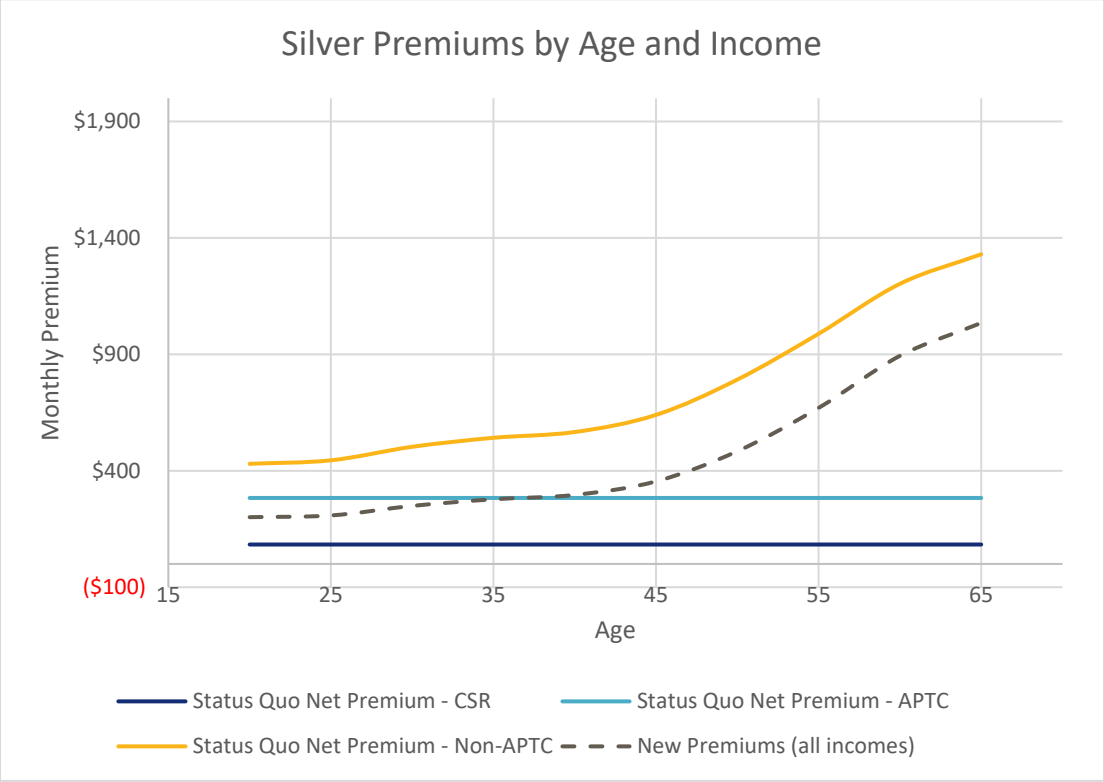
[2] This is federal funding to hospitals that addresses the burden of providing care to individuals who cannot pay for it.

Act would not vary by income for the household paying them. Therefore, understanding the premium changes requires looking at premiums by various income levels. The following illustrative examples show the net premiums by age for sample plans within each of the metal tiers in order to demonstrate the impact of the modeled changes on various cohorts of members. Three hypothetical members are modeled under the status quo – a member with an income that puts them into the CSR cohort, a member in the APTC-only cohort, and a member not eligible for APTC.

Premiums are projected to increase for all members currently eligible for CSR. This is because those members currently receive substantial amounts of APTC. The effect varies by age, as shown below.

The premiums shown are "net premiums", meaning they are the actual premiums paid by the member, after federal premium subsidies.

Exhibit 4[3] – Silver Premium Changes



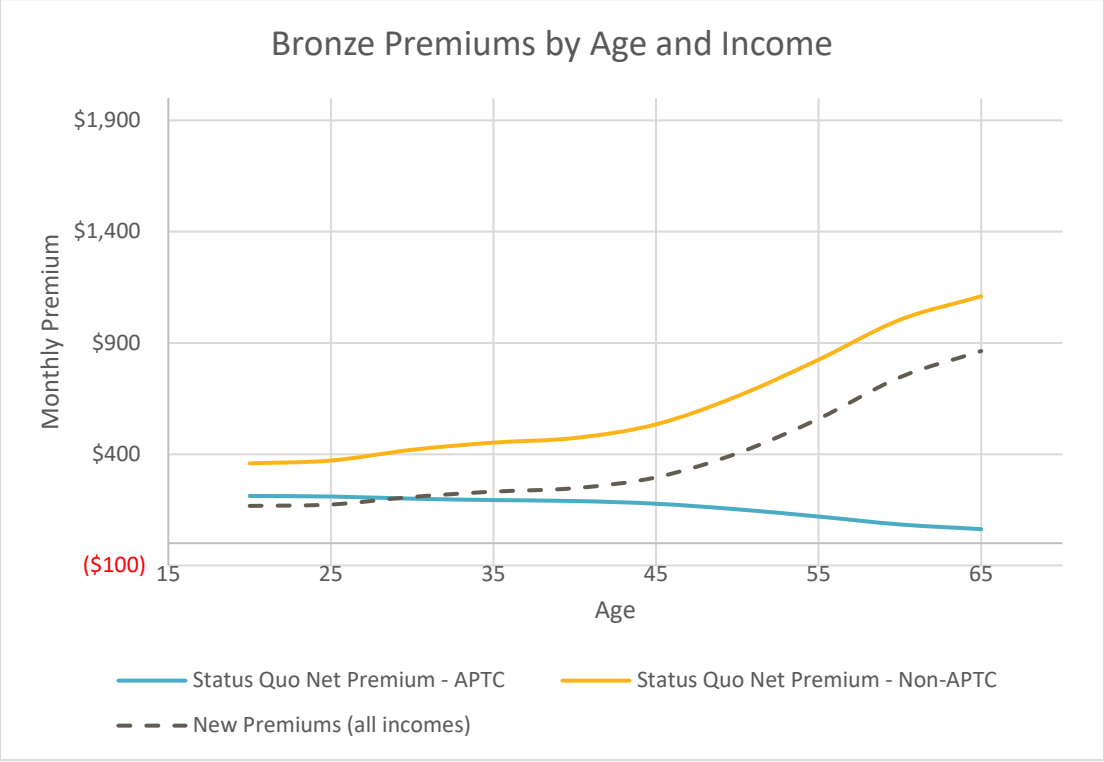
The Silver premiums for members without federal premium subsidies drop significantly, by approximately $300 PMPM at nearly all ages. This is due to the introduction of the LGBP which would cover the cost of members with high-cost diseases. The state funds used to fund the LGBP would be spread over a smaller pool of members due to the substantial membership reductions.

[3] This is the same as Exhibit 1 which is repeated here for comparison to other metal tiers.

The above graph demonstrates why CSR members are projected to overwhelmingly leave the market with the repeal of the ACA. With incomes at or below 250% of FPL (e.g., approximately $30,000 in 2021), these members simply will not be able to afford premiums that start around $200 for the youngest members and go as high as approximately $1,000 per month for older members. Additionally, these members will not be able to afford the cost sharing for a standard silver plan without the benefit of the CSR subsidies. The revised premium structure would likely cause retention of non-CSR APTC members at the youngest ages, as the loss of APTC is balanced by the LGBP funds as well as the steepening of the age curve.

For Bronze plans, the effect is very similar for higher-income households, with premiums reducing a nearly fixed amount PMPM across most ages. The updated premium for a 20-year-old purchasing a Bronze plan is approximately $167 per month, as opposed to the current unsubsidized premium of approximately $400. This is shown in Exhibit 5 below. Note that CSR members are strongly disincentivized from purchasing non-Silver plans. Therefore, the modeling does not assume any CSRs member in the bronze, gold, or platinum projections.

Exhibit 5 – Bronze Premium Changes



In general, the proposed structure makes Gold and Platinum plans more affordable relative to Bronze and Silver plans, when purchased by lower-income households. The current APTC system provides a fixed amount of subsidy regardless of the plan purchased. Under the modeled system, the cost savings resulting from the steeper age curve and State funds are applied proportionally and therefore increase with more generous plan designs. Rate changes for Gold and Platinum plans are provided below.

Exhibit 6 – Gold and Platinum Premium Changes

Due to the significant shifts in enrollment by age and income, it is difficult to accurately describe the average rate change. Exhibit 7 below summarizes the members in the various income cohorts that would experience rate changes of various magnitudes.

Exhibit 7 – Distribution of Net Premium Changes

Change in Net Monthly Premium (Per Person)	Number of Current Members		
	CSR	APTC	Non-APTC
-$300 or more	2	160	9,077
-$300 to -$150	93	1,196	27,236
-$150 to -$50	1,223	2,558	1,661
-$50 to +$50	2,486	2,603	7
+$50 to +$150	17,051	10,586	3
+$150 to +$300	13,660	7,528	17
+$300 or more	23,740	13,143	6

ESTIMATED COST TO THE STATE

The reductions in gross premium described above are achieved by the introduction of the LGBP for high-risk members. This program replaces the claims for those individuals, who typically exhibit loss ratios of over 400%, with a loss ratio of 98%. This has a dramatic effect on overall insurer claims costs. However, as the 98% reinsurance premium is inadequate to cover the claims for those individuals, this program produces a net cost to the State.

The total claims cost for members with high-cost diagnoses is projected to be $242 million. This cost is partially offset by the reinsurance premiums paid by the carriers for these individuals. Considering this offset, the net cost of the program is therefore projected to be $209 million. This is not a surprising result based on the magnitude of the projected approximate $300 PMPM reduction to gross premiums.

The aggregate claims, premiums, and costs are summarized in Exhibit 8 below.

Exhibit 8 – Aggregate Costs [4]

	2021 Status Quo	2021 – Modeled
Enrolled Members	134,036	78,036
Gross Premium PMPM	$691	$379
APTC PMPM	$406	$0
Net Premium PMPM	$285	$379
Net Reinsurance PMPM	$0	$292
Member Premium Plus Subsidies	$691	$671
CSR PMPM	$19	$0
Claims PMPM	$556	$596
Total APTC	$509,227,769	$0
Total CSR	$24,174,282	$0
Total Net Reinsurance	$0	$208,773,435

[4] All PMPM values in this exhibit reflect the total cost spread over the entire market, not only members relevant to that line item.

POTENTIAL ISSUES

The consequence of the repeal of the ACA and its APTC provision, without introducing an income-based subsidy, would be a substantial increase in the uninsured rate, particularly among low-income individuals. While the LGBP is expected to lower gross premiums per member, it does not fully address the problem of unaffordability for low-income households.

As stated previously, the study only analyzes Act No. 412's provisions and does not address the impact of any further possible legislation in Louisiana that could ultimately address the other ACA provisions such as subsidies for low-income persons.

Without addressing the issue of unaffordability and subsidies for low-income persons, market instability and high uninsured rates may be unavoidable. This report presents L&E's best estimate of what would occur. However, the smaller insured population would be increasingly susceptible to rate spirals and may produce higher volatility than the current market.

The modeled program uses 98% of member premium to fund the reinsurance premium. The program would be notably less expensive if this factor were increased. For example, if this parameter were increased to 200%, the cost of the LGBP would decrease to about $140 million. However, this would come at the cost of higher premiums and approximately 9,000 additional uninsured Louisianans.

The modeling assumes that carriers will increase the premium differentials by age to a ratio of 5:1 rather than the 3:1 age curve required by the ACA. While the proposed 5:1 age curve does more accurately mirror the underlying relationship between age and claims costs, the modeling suggests that the reinsurance would disproportionately fund claims for older policyholders. The result is that projected loss ratios decline with age.

This implies that a 5:1 age curve in combination with the proposed LGBP program could either create distorted incentives for carriers to enroll older individuals or could lead to actual premium curves that are flatter than the maximum 5:1 permitted by law. A flatter age curve would tend to decrease the premiums for older adults and slightly increase premiums for younger individuals, as has been seen under the ACA's 3:1 age curve.

APPENDICES

APPENDIX A: CAVEATS & LIMITATIONS

The guidance provided in this report is based on evaluating a specific set of assumptions and should be used to evaluate a range of potential outcomes. Actual experience will deviate from the projections evaluated.

L&E performed reasonability tests on the data used; however, L&E did not perform a detailed audit of the data. To the extent that the information provided was incomplete or inaccurate, the results in this report may be incomplete or inaccurate.

L&E made several assumptions in performing the Act 412 analysis. Several of these assumptions are subject to material uncertainty and it is expected that actual results could materially differ from the projections.

Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
  - L&E relied on the data submitted from the insurers to the LDI for significant portions of this analysis. To the extent that the data is inaccurate, the analysis will be impacted.
- Enrollment Uncertainty.
  - Beyond changes to premiums and market wide programs, consumer responses to premium changes has inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change premiums and enrollment in 2021 and beyond.
  - This study only analyzes the Act's provisions and does not address the impact of any further possible legislation in Louisiana that could ultimately address the other ACA provisions, e.g. subsidies for low-income persons, that are not addressed in the Act.

This report has been prepared for the LDI for discussion purposes in relation to the possible implementation of the provisions of Act No. 412 if the ACA were repealed. Any other use may not be appropriate. L&E understands that this report may be distributed to other parties; however, any user of this report must possess a certain level of expertise in actuarial science and/or health insurance so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranties as to the

accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

The responsible actuaries for this report are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. The guidance and analysis expressed in this report are those of the authors only and do not necessarily represent the opinions of other L&E consultants.

The authors of this report are not attorneys and are not qualified to give legal advice. Users of this report should consult legal counsel for interpreting proposed legislation and/or state laws.

APPENDIX B: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[5], promulgates Actuarial Standards of Practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[6], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal
- Kevin Ruggeberg, ASA, MAAA, Associate Actuary & Officer
- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Brian Stentz, ASA, MAAA, Assistant Vice President

The actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is March 10, 2020.The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is February 28, 2020.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Louisiana Department of Insurance. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the LDI with the impact of the provisions of Act 412.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a

[5] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conoference of Consulting Actuaries, and the Society of Actuaries.
[6] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

- L&E is not aware of any subsequent events that may have a material effect on the findings.

ACTUARIAL FINDINGS

The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA

The methods, procedures, assumptions and data used can be found in the body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW

This report was prepared as prescribed by applicable law, statutes, regulations and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS

The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP

The actuaries do not believe that material deviations from the guidance set forth in an applicable ASOP have been made.

APPENDIX C: HIGH-COST CONDITIONS

The following is the list of medical conditions that were used in the analysis of high-cost conditions.

HHS_HCC	Eligible Condition Categories
1	HIV/AIDS
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
8	Metastatic Cancer
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
10	Non-Hodgkin's Lymphomas and Other Cancers and Tumors
11	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
26	Mucopolysaccharidosis
27	Lipidoses and Glycogenosis
29	Amyloidosis, Porphyria, and Other Metabolic Disorders
35	End-Stage Liver Disease
38	Acute Liver Failure/Disease, Including Neonatal Hepatitis
45	Intestinal Obstruction
46	Chronic Pancreatitis
48	Inflammatory Bowel Disease
56	Rheumatoid Arthritis and Specified Autoimmune Disorders
66	Hemophilia
69	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
70	Sickle Cell Anemia (Hb-SS)
71	Thalassemia Major
75	Coagulation Defects and Other Specified Hematological Disorders
94	Anorexia/Bulimia Nervosa
109	Paraplegia
112	Quadriplegic Cerebral Palsy
113	Cerebral Palsy, Except Quadriplegic
115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
118	Multiple Sclerosis
119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
159	Cystic Fibrosis
184	End Stage Renal Disease
247	Premature Newborns, Including Birthweight 2000-2499 Grams
251	Stem Cell, Including Bone Marrow, Transplant Status/Complications
254	Amputation Status, Lower Limb/Amputation Complications
37	Chronic Hepatitis (Unspecified)
37_1	Chronic Hepatitis (Chronic Viral Hepatitis C)
37_2	Chronic Hepatitis (Chronic Hepatitis, Except Chronic Viral Hepatitis C)