The proposed federal exchange auto-enrollment process: Implications for consumers and insurers

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EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) has proposed, for the federal health exchange, that the majority of policyholders receiving premium subsidy assistance will be automatically reenrolled in the same plan unless they elect otherwise during the 2015 open enrollment period.[1] State-run exchanges may follow this guidance but also have the option of requiring consumers to reenroll through the exchange or proposing an alternative reenrollment methodology. Approximately 83% of enrollees on the exchanges receive federal subsidies. Policyholders who are automatically reenrolled will receive the same dollar-amount subsidy for 2015 as they did in 2014. *In most cases, this will be less than the advanced subsidy that would be applicable if the policyholder enrolls through the exchange in 2015 through the "redetermination" process. The proposed federal exchange auto-enrollment process only impacts a policyholder's net premium contribution—total premium less Advanced Premium Tax Credit (APTC)—prior to the reconciliation process.* Regardless of how a policyholder enrolls in a plan in 2015, the final premium subsidy will be reconciled with enrollees' 2015 tax returns to ensure consistency with the prescribed subsidy formula of the Patient Protection and Affordable Care Act (ACA).

The implications for policyholders and insurance companies related to changes in federal subsidies and the renewal process are plentiful. The following summarizes several of the potential implications.

Potential increased 2015 premium expenditures to low-income policyholders

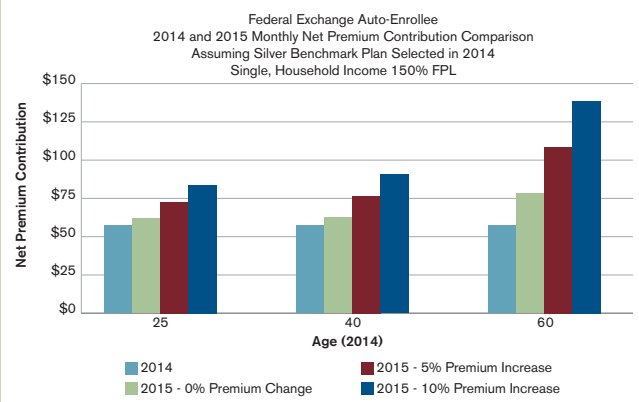
The standard notices sent to policyholders by the federal exchange will list the current subsidy but are not required to disclose the 2015 net premium contribution for the plan being enrolled. Consumers will also receive a notice from their current insurers regarding their 2015 net premium contributions based on the 2014 subsidy dollar amount.

Given the glitches in the enrollment process last year, many policyholders may choose the path of least resistance and be automatically reenrolled.

- However, even modest increases in premium by market leaders of 5% could lead to materially higher net premium contribution increases of 30% to near 100% for low-income enrollees during 2015 (prior to subsidy reconciliation).
- As the result of the ACA's permissible age rating, the highest net premium contribution increases will be experienced by enrollees over the age of 50.

Advanced Premium Tax Credit vs. Final Premium Tax Credit

When a household's subsidy eligibility was determined during the 2014 open enrollment period, qualifying households received an Advanced Premium Tax Credit (APTC) based on projected 2014 household income and size. However, the final Premium Tax Credit (PTC) amount will be determined when the household completes its 2014 tax filing. To the extent that the APTC was less than the final calculated PTC, the household will receive a tax refund. However, if the APTC was greater than the final PTC, the household will need to make an additional tax payment. This same reconciliation process will occur in years after 2014. *The proposed federal exchange auto-enrollment process only impacts a policyholder's net premium contribution (total premium less APTC) prior to the reconciliation process.*



1 Radnofsky, L. (June 26, 2014). Federal health-exchange plans to automatically renew. *Wall Street Journal*. Retrieved July 4, 2014, from http://online.wsj.com/articles/obama-administration-to-allow-automatic-health-insurance-renewals-1403809048.

Consumers will be unable to compare the financial implications of renewing their current coverage against choosing a new plan unless they go to the federal health exchange.

- If consumers choose to auto-enroll because of the simple process versus evaluating their options by going to the federal health exchange, individuals who auto-enroll may have unexpected materially higher net premium contributions relative to payments in 2014 for the same plan.
- Insurer notices detailing 2015 auto-enrollment net premium contributions may prompt individuals with significant net premium contribution increases from 2014 to 2015 to elect to go through the redetermination process.
- While consumers may have the option of lowering their monthly net premium contributions through the redetermination process, historically redetermination rates for enrollees have been low in programs such as Medicaid.
- If the exchange redetermination process mirrors Medicaid experience, many enrollees may not elect to gain a larger advanced premium subsidy by going through the redetermination process.

The potential 2015 increased net premium contributions resulting from consumers avoiding the redetermination process may produce increased policy lapses during the course of calendar year 2015.

- Increased policy lapses not only affect the insurers, but also impact providers, which is due to the 90-day grace period provisions.[2]
- Navigators, insurers, and government entities need to educate health plan enrollees on the ability to potentially lower net premium contributions in 2015 by going through the redetermination process.

Impact to insurers' 2015 exchange renewal rates

HHS's proposed auto-enrollment rules appear to reflect a desire by the federal government to encourage continuous insurance coverage for enrollees. *However, most policyholders will have higher net premium contributions for 2015 coverage if they do not elect to go through the redetermination process.*

To the extent that a large portion of 2014 exchange enrollees elect to go through the redetermination process in 2015, enrollees may choose to select the same plan or insurer. However, market competition may also significantly change the net premium contribution enrollees pay to remain in the same insurance coverage in 2015 for low-income exchange enrollees.

The exchange consumer may exhibit a greater price sensitivity toward premium changes relative to other health insurance markets for two reasons:

1. *First, the premium subsidy structure exposes all enrollees, regardless of income, to the full premium differences between plans on the exchange*. The net cost of exchange coverage for subsidy-eligible enrollees is dependent on an insurance company's pricing position to the silver benchmark plan. To the extent that an insurance company's silver plan costs more than the silver benchmark plan, the enrollee pays the difference, dollar for dollar. An increase in a policyholder's plan's premium relative to the silver benchmark plan may result in the policyholder selecting a different plan for 2015. As the population purchasing insurance coverage through the exchange has significantly lower income relative to other commercial health insurance populations, insurers should anticipate heightened sensitivity to enrollee premium contribution increases.

2. Second, by design, the exchange offers products in one of four metallic tiers that cover a common set of essential health benefits. Additionally, as there is no medical underwriting process to go through, consumers have access to the final premium rates for all available plans. *As the ACA has simplified the consumer shopping experience, it is natural that consumer price sensitivity will increase.*

However, counteracting consumer price sensitivity, nearly half of the plans on the marketplace are narrow network plans.[3] Therefore, some enrollees who chose their current plans based on providers may show greater inelasticity toward increased premiums and a preference for continuity of care.

It is possible that some market leaders in 2014 may benefit from the auto-enrollment process, even with increased competition.

- This may be contingent on the ability of these insurers to maintain or decrease current rates for 2015. Policyholders receiving notices that indicate no increase in premium are likely less inclined to shop for 2015 coverage.
- As marketplace enrollment has shown strong consumer preference for the lowest-cost plans, the market leaders in 2014 that may have sacrificed profit margin in an attempt to gain market share may also have the greatest pressure to increase premiums for 2015.[4] However, sacrificing a rate increase will likely solidify their holds on the market for 2015—but with risk to their bottom lines.

2 U.S. Department of Health and Human Services (March 27, 2012). *Federal Register*, Part II, p. 18471. Retrieved July 4, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf?elq=3cbe5f3b9fce484abd1832a71f56c0b6&elqCampaignId=3327.

3 McKinsey on Healthcare (June 2014). Hospital networks: Updated national view of configurations of exchanges. McKinsey & Company. Retrieved July 4, 2014, from http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges.

4 Radnofsky, L. (June 18, 2014). Premiums rise at big insurers, fall at small rivals under health law. *Wall Street Journal*. Retrieved July 4, 2014, from http://online.wsj.com/articles/premiums-rise-at-big-insurers-fall-at-small-rivals-under-health-law-1403135040.

Long-term impact to the exchange health insurance market
While the auto-enrollment process may enable some insurers to retain enrollment from year to year more easily, we expect that the insurance company pricing in relation to the silver benchmark plan and consumer price sensitivity will result in exchange business being significantly more volatile for insurers relative to their traditional lines of business.

- Insurers' pricing strategies should include an additional consideration regarding the auto-enrollment process and its implications on consumer health plan selection.
- Pricing uncertainty combined with consumer price sensitivity will likely result in the exchange being more volatile for insurers relative to their traditional lines of business for many years to come.
- The auto-enrollment process may not promote the intended maintenance of coverage if consumers choosing to auto-enroll lapse when faced with higher premium contributions relative to the prior year.

INTRODUCTION

On June 26, the Center for Consumer Information and Insurance Oversight (CCIIO) released new guidance on annual redeterminations for marketplace coverage in 2015, corresponding with the publishing of the proposed rule, "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges."[5] The guidance and proposed regulations address how 2014 federal health exchange enrollees will have current qualified health plans (QHPs) renewed in 2015. State-run exchanges may follow the proposed federal exchange auto-enrollment process but also have the option of requiring consumers to reenroll through the exchange or proposing an alternative reenrollment methodology.

Health exchange enrollees in 2014 have two options for purchasing coverage. First, they can enroll in a manner identical to a new enrollee. In this case, the advanced premium tax credit (APTC) is determined based on:

- Updated 2014 federal poverty level (FPL) thresholds (2013 FPL thresholds were used in determining the APTC for the 2014 coverage year)
- Applicable silver benchmark plan for *calendar year 2015*
- Indexed premium tax credit percentages for 2015[6]

For a 2014 enrollee electing to change QHPs, update eligibility information, or use updated tax return information, the APTC would be determined in this manner.[7]

However, if a 2014 federal health exchange enrollee does not elect to enroll for 2015, had previously authorized the exchange to access updated tax return information for the redetermination process,[8] and does not have income above 500% of FPL, *the enrollee will be auto-enrolled into the same QHP in 2015*[9] *with the same APTC dollar amount as received for calendar year 2014*. In guidance released by CCIIO, it is stated that the goal of this procedure is to enable "*that an enrollee may take no action and still have his or her coverage renewed for 2015, which is important in promoting continuity of coverage while limiting administrative burden for enrollees, issuers, and Marketplaces.*"[10]

The new auto-enrollment policies raise several questions for insurers and consumers:

- How will consumers' out-of-pocket costs for 2015 change as a result of the proposed auto-enrollment rules?
- Will insurers that captured significant market share in the 2014 federal exchange be able to more easily retain that market share in 2015?
- Will the auto-enrollment policies achieve the stated goal of retaining enrollees and reducing the administrative burden on the federal health exchange?
- Do the proposed auto-enrollment rules change an insurer's pricing strategy for its exchange products in 2015 and beyond?

This paper will address each of these issues. However, first we will revisit the calculation of the premium tax credit subsidy, and the market dynamics that are created as a result of how the calculation impacts consumers' net costs after application of the premium subsidy.

This paper does not consider any impacts related to the availability of premium subsidies due to *Halbig v. Burwell*.

5 Cohen, M. (June 26, 2014). Guidance on Annual Redeterminations for Coverage for 2015. CCIIO. Retrieved July 4, 2014, from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-annual-redet-option-2015-6-26-14.pdf.
U.S. Department of Health and Human Services (June 19, 2014). Patient Protection and Affordable Care Act; Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges. Retrieved July 4, 2014, from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508_CMS-9941-P-OFRv-6-26-14.pdf.

6 After 2014, the premium tax credit percentages are scheduled to be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. Please see http://www.law.cornell.edu/uscode/text/26/36B for more information.

7 Cohen, M., ibid., p. 5.

8 Reportedly 95% (approximately 5.1 million) of federal market enrollees authorized the release of updated tax information. For more information, see http://www.cnbc.com/id/101793283#.

9 To the extent that the 2014 plan is not available, CCIIO has outlined rules for the auto-enrollment process. Please see http://healthaffairs.org/blog/2014/06/27/implementing-health-reform-exchange-eligibility-redeterminations-small-employer-tax-credit/ for a summary of this process.

10 Cohen, M., ibid., p. 1.

REVISITING THE PREMIUM SUBSIDY CALCULATION: AN ELABORATELY CALCULATED DEFINED CONTRIBUTION

While each specific premium subsidy amount will depend on the household's size, income, and the cost of the second-lowest-cost silver plan, the subsidy structure effectively creates a defined contribution from the federal government for the purchase of health insurance. While the federal government's contribution is defined by the prescribed subsidy formula, the consumer, whether having a household income of $15,000 or $150,000, is fully exposed to all of the premium differences between QHPs.

To illustrate this effect, let's examine the hypothetical insurance choices made available to an individual with an income of 150% FPL. The subsidy formula indicates this individual will pay a maximum of 4% of household income for the second-lowest-cost silver QHP. Figure 1 illustrates the calculation of the premium subsidy value and corresponding consumer costs (net of subsidy) for three available plans. After application of the premium subsidy, the consumer cost for Plan 3 is two and half times that of Plan 1.

FIGURE 1: SILVER QHP CONSUMER CHOICES, 2014 SINGLE HOUSEHOLD, 150% FPL

	PLAN 1	PLAN 2	PLAN 3
FULL PREMIUM	$300	$325	$350
SUBSIDY AMOUNT	$268	$268	$268
MONTHLY NET PREMIUM	$32	$57	$82
% OF INCOME	2.2%	4.0%	5.7%

During the 2014 open enrollment period, 87% of individuals selecting a plan in the federal health exchange qualified for premium assistance,[11] with an average out-of-pocket premium for silver coverage of $69 per month.[12] This information suggests that the vast majority of exchange enrollees have household incomes below 400% FPL, with average household income ranging from 150% to 200% FPL. This is in stark contrast to the employer health insurance market, where more than half of insured individuals are estimated to have incomes above 400% FPL.[13] Because of the concentration of low-income households in the federal exchange, consumer price sensitivity may be heightened relative to an insurer's traditional individual or group lines of business.

ADVANCED PREMIUM TAX CREDIT AND THE RECONCILIATION PROCESS

When a household's subsidy eligibility was determined during the 2014 open enrollment period, qualifying households received an Advanced Premium Tax Credit (APTC) based on projected 2014 household income and size. However, the final Premium Tax Credit (PTC) amount will be determined when the household completes its 2014 tax filing. To the extent that the APTC was less than the final calculated PTC, the household will receive a tax refund. However, if the APTC was greater than the final PTC, the household will need to make an additional tax payment. These tax payments are capped for low-income households by the amounts shown in Figure 2.[14] *It should be noted that proposed auto-enrollment rules do not impact this reconciliation process.*

FIGURE 2: LIMITS ON REPAYMENT OF EXCESS PREMIUM TAX CREDITS, CALENDAR YEAR 2014

HOUSEHOLD INCOME FPL%	SINGLE FILERS	JOINT FILERS
LESS THAN 200%	$300	$600
AT LEAST 200% BUT LESS THAN 300%	750	1,500
AT LEAST 300% BUT LESS THAN 400%	1,250	2,500

Note: Limits will be indexed by inflation.

THE MARKET DYNAMICS BETWEEN AGGREGATE PREMIUM CHANGES AND CONSUMER'S NET COST

In 2014 insurers developed premiums without reference to what other insurers were pricing in the market, without existing claims experience, and with significant uncertainty regarding the number of individuals that would purchase coverage. In some geographic areas, large premium differences existed between one insurer and other insurers in the market. For insurers that have significant market share in 2014 that is due to being priced attractively relative to other insurers, existing or new insurers in the market may eliminate or reverse this advantage in 2015. Even if 2014 market leaders do not increase premiums at all, the net premium contribution a subsidy-eligible consumer pays in 2015 may increase dramatically if that person's relative position to the subsidy benchmark plan changes unfavorably. Therefore, for the premium subsidy-eligible population, a plan's pricing relative to the silver benchmark plan highly leverages net premium contributions.

To illustrate this effect, let's return to the three silver plans, shown above in Figure 1, with hypothetical 2015 premiums. The insurer offering Plan 3 makes a strategic decision to develop its 2015 plans at a significantly lower price point in an attempt to gain market share. A decrease may be achieved by modifying the provider network, gaining more favorable provider reimbursement terms, enhanced managed care, or a lower assumed profit margin.

11 Burke, A., Misra, A., & Sheingold, S. (June 18, 2014). Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014. HHS ASPE Research Brief, p. 5. Retrieved July 4, 2014, from http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

12 Burke et al., ibid., p. 6, Table 2.

13 Kaiser Family Foundation. State Health Facts: Distribution of the Nonelderly with Employer Coverage by Federal Poverty Level (FPL). Retrieved July 4, 2014, from http://kff.org/other/state-indicator/distribution-by-fpl-3/.

14 Fernandez, B. (March 12, 2014). Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA), pp. 12-13. Congressional Research Service. Retrieved July 4, 2014, from http://fas.org/sgp/crs/misc/R41137.pdf.

FIGURE 3: SILVER QHP CONSUMER CHOICES, 2015, SINGLE HOUSEHOLD, 150% FPL

	PLAN 1	PLAN 2	PLAN 3
FULL PREMIUM	$320	$325	$295
PERCENT CHANGE FROM 2014	7%	0%	-16%
SUBSIDY AMOUNT	$263	$263	$263
2015 NET PREMIUM	$57	$62	$32
2014 NET PREMIUM	$32	$57	$82
% NET PREMIUM CHANGE	78%	9%	-61%

Note: Indexing of FPL and premium tax credit subsidies in 2015 have not been reflected.

The revised pricing strategy for Plan 3 allows the insurer to have the lowest-cost plan in 2015, with Plan 1 becoming the subsidy benchmark plan. As the premium for the subsidy benchmark plan has decreased from $325 to $320, the dollar value of the premium subsidy correspondingly decreased by $5.

While the full premium changes for each plan ranged from a significant decrease to a moderate increase (-16% to 7%), the reordering of the relative premium between plans creates significant net premium contribution swings for the subsidy-eligible consumer who had selected either Plan 1 or Plan 3 in 2014. For example, if a consumer wanted to renew Plan 1 for 2015, that person would be faced with a net premium 78% greater than in 2014.

In the absence of the auto-enrollment rules (as illustrated in Figure 3), it may be expected that significant market share swings would occur from 2014 to 2015, as health exchange enrollees migrate from Plan 1 and Plan 2 to Plan 3. However, do the proposed auto-enrollment rules change this consumer dynamic?

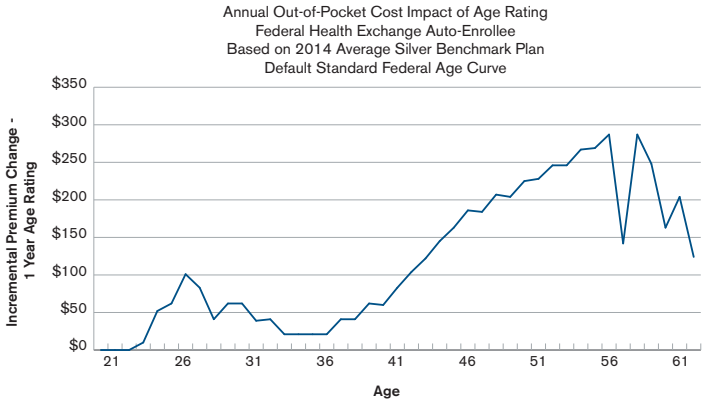
THE PROPOSED FEDERAL EXCHANGE AUTO-ENROLLMENT PROCESS

As stated in the Introduction above, federal health exchange enrollees auto-enrolling into the same QHP in 2015 will receive an APTC dollar amount identical to that received in calendar year 2014. What does that mean in terms of a consumer out-of-pocket cost change from 2014 to 2015? Because the APTC is set equal to its 2014 amount, consumers' net premium contributions will be subject to the full dollar amount of premium changes between 2014 and 2015, resulting from age rating and an insurer's 2015 pricing decisions.

Age rating

Regarding age rating, because the ACA permits age rating in the individual health insurance market by a 3:1 age ratio, this will result in most enrollees' premiums increasing as they turned a year older during calendar year 2014. Figure 4 illustrates the incremental premium increase in 2015 based on the enrollee's 2014 age and the reported national average silver benchmark plan ($226 for a 27-year-old, adjusted by the standard federal age curve for other ages).[15]

FIGURE 4



Notes:
1. Age 20 not illustrated. A person turning 21 would experience a $945 premium increase (not including the impact of premium subsidies).
2. Age reflects age as of January 1, 2014. Incremental premium change reflects 2015 age rating impact.

As shown in Figure 4, the incremental impact of age rating varies significantly between the ages of 21 and 64. Adults under the age of 40 have substantially lower premium increases relative to adults over age 50, resulting from the slope of the standard 3:1 age curve being flatter at younger ages. Figure 4 provides the incremental age-rated premium change if an insurer does not change its base premium rates from 2014 to 2015. Therefore, even if an insurer had a 0% premium increase in 2015 relative to 2014, many eligible enrollees would need to pay $200 or more annually in additional net premium contributions to remain on the plan (and prior to a reconciliation of the APTC to PTC during tax filing). HHS reported that the average net cost for individuals receiving premium assistance and selecting a silver plan in the federal exchange was approximately $830.[16] Therefore, even if insurers elected to keep 2014 pricing in place for 2015, many eligible auto-enrollees may have a 2015 net premium increase approaching or exceeding 20% before potentially receiving a tax refund during the reconciliation process. For example, an individual who turned age 61 in 2014 would have a $248 annual net premium increase, resulting from the monthly premium increasing from $585 (60-year-old) to almost $606 (61-year-old).[17]

Insurer 2015 pricing

With regard to insurer pricing levels in 2015 relative to 2014, it is important to remember that consumers have gravitated heavily toward the lowest-cost plans in 2014. Based on HHS reported data, almost two-thirds of federal exchange enrollees selecting the silver metallic tier chose the plan with the lowest or second-lowest cost. Our analysis of federal exchange premium data indicates the median premium differential between the lowest-cost and second-lowest-cost silver plan is approximately $11 on a monthly basis for a single 40-year-old (based on the national average silver benchmark premium). This pricing advantage grows to approximately $20 and $40 on a monthly basis relative to the third- and fourth-lowest-cost silver plans offered, respectively. As stated previously, because of the premium subsidy structure, households at all income levels are fully exposed to these premium differentials.

15 Burke et al., ibid., p. 10, Section II Highlights.
16 Burke et al., ibid., p. 6, Figure 1.
17 Based on national average silver benchmark premium of $226 for a 27-year-old.

FIGURE 5: HHS-REPORTED QHP SELECTION BY RELATIVE PLAN COST, FEDERAL HEALTH EXCHANGE, INDIVIDUAL HEALTH INSURANCE MARKET

METALLIC TIER	PERCENT WHO SELECTED PLAN WITH LOWEST OR SECOND-LOWEST COST	PERCENT WHO SELECTED LOWEST-COST PLAN	PERCENT WHO SELECTED PLAN WITH SECOND-LOWEST COST	PERCENT WHO SELECTED OTHER PLANS	MEDIAN NUMBER OF QHPS AVAILABLE TO CONSUMERS
BRONZE	60%	39%	21%	40%	11
SILVER	65%	43%	22%	35%	13
GOLD	54%	37%	16%	46%	10
PLATINUM	69%	50%	19%	31%	1

Sources:

1) Plan selection excerpted from Table 4 of June 18 HHS ASPE Research Brief, Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014.[18]

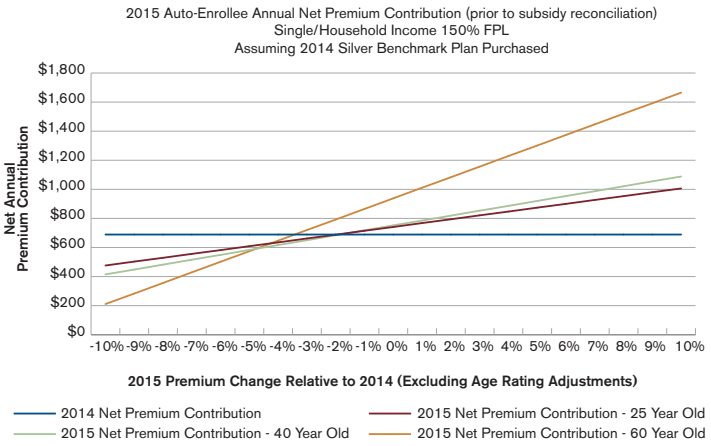
2) Values for median number of QHPs available to consumers taken from Milliman research report: 2014 Federal Insurance Exchange: Evaluation of Insurer Participation and Consumer Choice.[19]

While it may be expected that insurers in the marketplace will have a large variance in premium rate changes from 2014 to 2015, the impact to the auto-enrollment process is heavily focused on the 2015 pricing decisions of the insurers that offered the lowest-cost plans in 2014. While these insurers may have developed lower-priced plans based on network and provider reimbursement strategies, along with enhanced managed care efficiencies, it may also be possible that insurers offering the lowest-cost plans assumed lower profit margins relative to other insurers in the market. Therefore, if 2015 pricing results in a "regression to the mean," where the variance across insurers' premium levels is reduced, the lowest-cost plans in 2014 may have larger premium increases relative to insurers that were more conservative in 2014.

Figure 6 illustrates the combined effects of age rating and insurer pricing decisions for a single individual with household income of 150% FPL who in 2014 selected the silver benchmark plan (premiums based on national HHS-reported average), and elected to auto-enroll into the same QHP in 2015. In 2014, individuals at this income level regardless of age would pay $689 (12 months of premium) for the silver benchmark plan.

As Figure 6 indicates, the combined effects of age rating and an insurer's pricing decisions may result in auto-enrollees being faced with prohibitively high net costs after APTC is applied. Particularly for older individuals who have low income, it may be a financial necessity to go through the normal exchange enrollment process rather than face significantly higher 2015 net premium contributions. While the subsidy reconciliation process may result in a refund to the household when 2015 taxes are filed, the APTC under the auto-enrollment process may result in the household having insufficient funds to pay for the coverage during the year.

FIGURE 6



Notes:

1. Calculations based on national average second-lowest-cost silver plan adjusted by the federal age curve.

2. Illustrated age reflects age as of January 1, 2014.

For insurers that have even nominal premium increases for 2015, the auto-enrollment process may deliver few 2015 enrollees, as members will have significant financial incentives to purchase coverage using the normal application process. To the extent that the majority of insurers that offered the most affordable plans in 2014 file premium increases for 2015, the federal exchange should not anticipate a large percentage of members eligible for the auto-enrollment process to renew coverage in this manner.

For insurers that have no rate increases or decrease rates, there is the potential for the auto-enrollment process to result in a high renewal rate.

18 Burke et al., ibid.

19 Clarkson, J., Sturm, M.J., & Houchens, P.R. (December 2, 2013). 2014 Federal Insurance Exchange: Evaluation of Insurer Participation and Consumer Choice. Milliman Healthcare Reform Briefing Paper. Retrieved July 4, 2014, from http://www.milliman.com/uploadedFiles/insight/2013/2014-federal-insurance-exchange-insurer-participation.pdf.

SHORT-TERM IMMUNITY FROM MARKETPLACE COMPETITION?

As illustrated in Figure 6, it is possible for consumers who selected a 2014 QHP that had a rate decrease to experience a net cost decrease when the APTC (based on the 2014 APTC) is applied to 2015 premiums. In this situation, how could 2015 health plan selection be influenced by the auto-enrollment process? To illustrate this effect, let's return to the example used in Figure 3 above, but add a fourth competing insurer, Plan 4, which is new to the marketplace in 2014.

As illustrated in Figure 7, the insurer offering Plan 3 reduced its premium significantly from 2014 to 2015 in an attempt to gain market share. However, the plan offered by a new market entrant, Plan 4, was priced $5 lower than Plan 3. For 2015 auto-enrollees, the APTC is set at $268, the premium subsidy value for 2014. This results in the following consumer pricing dynamics:

- For new enrollees or enrollees going through the redetermination process, Plan 3 and Plan 4 are $25 to $35 cheaper on a monthly basis than purchasing Plan 1 or Plan 2. *Therefore, among new enrollees, Plan 3 and Plan 4 are likely to capture the greatest market share if initial 2014 consumer pricing preferences continue to hold.*

- However, within the auto-enrollee cohort, the renewal rates between the three 2014 plans may vary drastically.
  - Plan 1 was the least expensive plan in 2014, as enrollees only had to pay $32 on a monthly basis relative to $57 for the silver benchmark plan. However, because Plan 1 filed a 7% increase, net premiums for auto-enrollees increase by 60%. This price jump may result in many Plan 1 enrollees shopping for new coverage in 2015.
  - Plan 2 did not increase its premiums, and therefore the net premium for auto-enrollees is the same as it was in 2014. Enrollees may renew their plans at high rates, which is due to the price stability.
  - Plan 3 is likely to auto-enroll many of its enrollees because their net premium costs would decrease from $82 to $27 as a result of a 16% premium decrease. In addition to high renewal rates, it may gain market share in 2015 from new enrollees and enrollees who enrolled in Plan 1 in 2014.

Because Plan 2 did not increase its premium in 2014, it may be able to retain its market share despite the increased competition from Plan 3 and Plan 4. However, consumers that enrolled in Plan 2 will experience the unpleasantness of owing $300 when they file their taxes for calendar year 2015. This subsidy repayment may not occur until April 2016, after the *2016* open enrollment period has finished.

FIGURE 7: SILVER QHP CONSUMER CHOICES, 2015, SINGLE HOUSEHOLD, 150% FPL
CONSUMER IMPACT OF AUTO-ENROLLMENT VS. REDETERMINATION

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
2014 FULL PREMIUM	$300	$325	$350	NA
2015 FULL PREMIUM	$320	$325	$295	$290
PERCENT CHANGE FROM 2014	7%	0%	-16%	NA
2015 SUBSIDY AMOUNT (2014 SUBSIDY AMOUNT $268)	$238	$238	$238	$238
2015 NET PREMIUM NEW ENROLLEES/REDETERMINATION	$82	$87	$57	$52
2015 NET PREMIUM AUTO-ENROLLEES	$52	$57	$27	NA
2014 NET PREMIUM	$32	$57	$82	NA
AUTO-ENROLLEE NET PREMIUM CHANGE	63%	0%	-67%	NA
SUBSIDY RECONCILIATION TAX CREDIT (PAYMENT)*	($300)	($300)	($300)	NA

Notes:

1. Subsidy tax credit repayment capped at $300 annually for single household with income under 200% FPL (see Figure 2 above).

2. Premium and out-of-pocket cost values shown on a monthly basis.

3. Impact of age rating not reflected.

CONCLUSION

HHS's proposed auto-enrollment rules appear to reflect a desire by the federal government to promote continuous insurance coverage and provider networks for enrollees. However, for many of them, required net premiums for 2015 coverage may be significantly higher if they do not elect to go through the redetermination process. The potential fluctuations in net premiums created by the auto-enrollment process may create financial barriers in the maintenance of insurance coverage during 2015 for low-income enrollees. *There is a significant need for insurance navigators, brokers, and government entities to clearly explain the available 2015 insurance choices to consumers through the redetermination process, which may result in lower monthly out-of-pocket health insurance costs during 2015 relative to plan auto-enrollment.* However, in some cases, consumers may have to change plans or insurers to lower their costs.

For insurers in the federal exchange, the auto-enrollment process requires a reevaluation of the 2015 competitive landscape. The new market dynamics of the auto-enrollment process create an added layer of complexity to predicting consumers' 2015 health plan selections. While insurers have likely already developed their 2015 rates, consideration of the auto-enrollment process should be reflected in projections of 2015 membership and future pricing strategies.

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