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PREMIUM MISALIGNMENT ANALYSIS

Individual ACA Market in Illinois

August 4, 2023

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1. Executive Summary

The Illinois Department of Insurance (the Department) has engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman, we) to perform a study and actuarial analyses as outlined in the Health Insurance Coverage Premium Misalignment Study Act (the Act).[1] Key goals of the study were to:

a) Explore rate setting approaches that may yield a misalignment of premiums across the Bronze, Silver, and Gold metal levels of coverage[2] in Illinois' Individual health insurance market, with a view to attempt to make coverage more affordable for low-income and middle-income residents.

b) Evaluate how the approaches mentioned above, if implemented, would affect costs and outcomes for Illinois residents across multiple dimensions (e.g., income levels, geography, race).

Current Pricing

Under the Affordable Care Act (ACA) the primary driver of observed variations in rates by metal level is the application of an item referred to as the AV and Cost Sharing Design of Plan factor[3]. The AV and Cost Sharing Design of Plan factor is a permitted plan level adjustment under the ACA that accounts for the impact of differences in cost sharing between plans, and is generally made up of two components:

1. ***Actuarial Value*** – This item reflects the percentage of total health care costs that a plan's benefits are expected to cover, on average. Included in the Actuarial Value is the "CSR load," which is the adjustment carriers apply in the development of their on-Exchange Silver plan rates to make up for the fact that the federal government no longer provides funding for cost-sharing reduction subsidies.[4]

   For this study, we compared the average Actuarial Values that were utilized in Illinois for 2023 by metal level to the actual observed paid-to-allowed claims ratios for those metal levels in plan years 2019, 2020, and 2021.[5] This comparison allowed us to assess how the actual average pricing relativities being utilized in 2023 compare to the actual observed paid-to-allowed cost relativities (a proxy for benefit differences) in recent years and, overall, we found that:

   a. The relativities of the historical observed paid-to-allowed ratios and the 2023 Actuarial Values between the Bronze, Silver, and Gold metal levels align well.

   b. The CSR loads that are being applied by carriers for 2023, produce a reasonable average Actuarial Value for on-Exchange Silver plans when compared to historical paid-to-allowed ratios.

2. ***Induced Demand*** – This item reflects the impact that a plan's benefit richness may be expected to have on an individual's utilization of services, relative to another plan. For 2023, there are generally two different approaches being used by carriers in the market to develop their induced demand factors; one approach relies on the slope developed by the Centers for Medicare and Medicaid

[1] https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4298&ChapterID=22

[2] In 2022, there were no individuals enrolled in Platinum plans and only 0.4% of members were enrolled in Catastrophic plans, so these plans were excluded from the study.

[3] https://www.cms.gov/files/document/urr-py23-instructions.pdf

[4] https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/

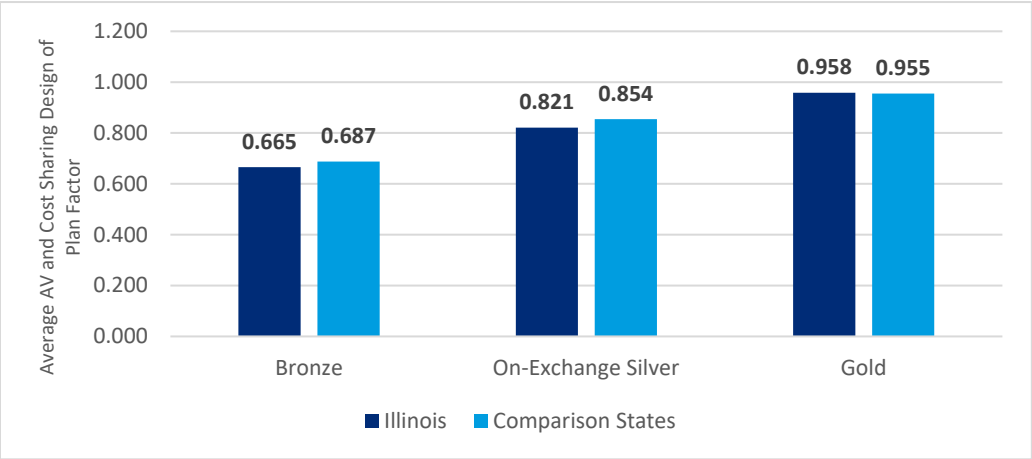
[5] Full year 2022 claims data was not available at the time this study was conducted.

Services (CMS) for the risk adjustment program established under 42 U.S.C. 18063 and the other approach produces a carrier-specific set of factors based on experience-based studies. Each approach produces different metal pricing slopes, particularly for Gold plans relative to Silver and Bronze plans; that is, the magnitude of the difference between the Gold induced demand factors and the induced demand factors for Bronze and Silver plans is generally more significant under the latter approach. In our experience, although the two approaches that are being used produce different results, both have been commonly accepted by regulators and by the Center for Consumer Information and Insurance Oversight (CCIIO) to support carriers' induced demand slopes under the ACA.

The State of Illinois does not prescribe either the Actuarial Values (including the CSR loads) or the induced demand factors that are to be used by carriers. Instead, like most states, Illinois allows carriers to develop their own factors so long as they are consistent with the ACA's rating requirements and can be actuarially supported.

We compared the average AV and Cost Sharing Design of Plan factors for Illinois to the average AV and Cost Sharing Design of Plan factors of the 35 other Medicaid-expansion states that do not have Basic Health Programs or Medicaid eligibility up to 200% FPL.[6] Based on that comparison, we found that the average metal pricing relativities being utilized in Illinois for 2023 are similar to the average of those being utilized in those states. This result is demonstrated in the following chart:

Average 2023 AV and Cost Sharing Design of Plan Factors by Metal Level



Alternative Rate Setting Approaches

As noted earlier, one of the key goals of this study was to explore alternative rate setting approaches that could potentially be implemented, with a focus on how those rate setting approaches could impact affordability and outcomes for Illinois residents. To accomplish this goal, Oliver Wyman evaluated the impact on the market of moving from the current pricing approach to four alternative rate setting approaches, each of which are summarized in the table the follows:

[6] DC, MN, and NY results were excluded

Summary of Current and Alternative Rate Setting Approaches Modeled for the Illinois Individual ACA Market

	Current Approach	New Mexico Approach	Pennsylvania-like Approach	HHS Induced Demand Approach	Broad Loading Approach
CSR Loading Methodology	Varies by carrier, based on carrier-specific support	State-prescribed factor, based on standard Metal values, includes induced demand adjustment	State prescribed factor, based on actual carrier experience	Same as current	CSR Load applied across all plans, based on carrier-specific support
Induced Demand Methodology	Varies by carrier, based on carrier-specific support	CMS standard induced demand factors	CMS induced demand slope applied to Actuarial Values	CMS standard induced demand factors	CMS induced demand slope applied to Actuarial Values

The approaches were modeled through Oliver Wyman's HRM Model to develop estimates of how membership volumes, average cost sharing per enrollee, and net premium rates per enrollee would be expected to change. The following table summarizes these results:

Projected Enrollment, Annual Net Premium, and Annual Cost Sharing

	Current	New Mexico Approach	Pennsylvania-like Approach	HHS Induced Demand Approach	Broad Loading Approach
Average Monthly Enrollment	370,000	387,000	380,000	370,000	364,000
Average Annual Cost Sharing per Enrollee	$1,900	$1,800	$1,800	$1,900	$1,800
Average Annual Net Premium Per Enrollee	$3,300	$3,100	$3,100	$3,500	$3,800

Overall, the New Mexico Approach would be projected to produce the highest enrollment volumes and lowest average annual costs (i.e., premium plus cost sharing). The Pennsylvania-like approach would also be projected to have higher enrollment volumes and result in lower average annual costs for enrollees relative to the current approach.

While these results are reflective of best estimates related to enrollment volumes and consumer affordability based on the premium rate changes assumed under each of the approaches, there are additional items that should be considered, the most significant of which include:

- In the short term, each of the alternative rate setting approaches that were modeled would create varying degrees of disruption to carriers' current rates. The disruption to current rates that is created

under these approaches could result in near-term changes to the market that are undesirable, including but not limited to: decisions by some carriers to exit the market, decisions by some carriers to no longer offer certain plans or Metal levels, consumers experiencing significant swings in their premium rates (from year-to-year), and increased uncertainty for carriers in projecting future costs if there are material changes in enrollment between carriers due to premium rate swings.

- The New Mexico Approach utilizes standard Metal Actuarial Values from the federal Actuarial Value Calculator (i.e., 0.70 for base Silver, 0.73 for 73% CSR, 0.87 for 87% CSR, and 0.94 for 94% CSR plans) in the development of the CSR load and also utilizes a CSR load that assumes only 87% and 94% CSR eligible members will enroll in on-Exchange Silver plans. Both of those items would be expected to result in an Actuarial Value that is higher than the anticipated paid-to-allowed ratio for Silver on-Exchange plans.

- The level of authority that a state has to approve or disapprove rates may play an important role in the ability to prescribe a market-wide rating approach, particularly if that approach includes state-prescribed factors that differ from carriers' actuarially supported pricing assumptions.

- The modeling results included in this report assume an ACA environment consistent with that which is in place in Illinois for 2023, including the availability of enhanced federal premium subsidies that are consistent with those made available under the Inflation Reduction Act (IRA), no Basic Health Program, and no funding of CSR subsidies by the federal government. To the extent material changes were to occur to the current environment, we would expect that actual results would vary, potentially significantly, from those being projected in this analysis.

2. Introduction

The Illinois Department of Insurance (the Department) engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) to perform a study and actuarial analyses consistent with that which is outlined in the Health Insurance Coverage Premium Misalignment Study Act (the Act).[7]

Part of the Act's focus is regarding Section 1402 of the Patient Protection and Affordable Care Act (ACA), which requires health insurance issuers to provide cost-sharing reduction subsidies (CSRs) to ACA Marketplace consumers who have household incomes that are below 250% of the federal poverty level (FPL) and who choose a Silver level plan.[8] The ACA also requires the United States Department of Health and Human Services (HHS) to reimburse issuers for these CSRs.

As described further in the Act, on October 12, 2017, the federal government, through executive action, announced that it would be discontinuing cost-sharing reduction payments to issuers in the ACA Marketplace. Illinois, like the majority of other states, took action to mitigate the losses that Illinois issuers would endure without the federal cost-sharing reduction payments by adopting a practice called "silver loading" beginning with the 2018 plan year. Silver loading allows issuers to increase their silver plan baseline premiums to make up for losses due to the discontinuation of the federal cost-sharing reduction payments.

According to Section 10(3) of the Act, "due to silver loading and resulting pricing of silver plans in the Illinois marketplace, it appears that the current metal-level premiums in the Illinois marketplace are misaligned and do not reflect coverage generosity for the plans."

The content and goals of this premium misalignment study as stated in Section 15 of the Act are as follows:

a) Explore rate setting approaches that may yield a misalignment of premiums across different tiers of coverage in Illinois' individual health insurance market. The study shall examine these approaches with a view to attempt to make coverage more affordable for low-income and middle-income residents. The study shall follow the best practices of other states targeted at addressing metal-level premium misalignment and include an Illinois-specific analysis of:

    1) The number of consumers who are eligible for a premium subsidy under the Patient Protection and Affordable Care Act and the relative affordability of the plans;

    2) If the plan is in the silver level, the relation of the premium amount compared to premiums charged for qualified health plans offering different levels of coverage, taking into account any funding or lack of funding for cost-sharing reductions and the covered benefits for each level of coverage; and

    3) Whether the plan issuer utilized the induced demand factors developed by the Centers for Medicare and Medicaid Services for the risk adjustment program established under 42 U.S.C. 18063 for the level of coverage offered by the plan or any State-specific induced demand factors established by Department rules.

[8] On-Exchange Silver CSR variant plans have different actuarial values (AVs) based on income. For enrollees with income at or below 150% FPL the AV is 94% (94% CSR), between 151% and 200% the AV is 87% (87% CSR), and between 201% and 250% the AV is 73% (73% CSR).

b) The study shall produce cost estimates for Illinois residents addressing the metal-level premium misalignment policy as studied in subsection (a) of the Act along with the impact of the policy on health insurance affordability and access and the uninsured rates for low-income and middle-income residents, with break-out data by geography, race, ethnicity, and income level. The study shall evaluate how premium realignment, if implemented, would affect costs and outcomes for Illinoisans.

The purpose of this report is to provide the Department with the background and the actuarial analysis required under the Act.

3. Data Sources and Reliance

We reviewed information from a variety of sources in assessing the current state of Illinois' health insurance markets, including information from the Centers for Medicare and Medicaid Services (CMS) and the U.S. Census Bureau's American Community Survey (ACS), among others. Additionally, a data call was sent to insurers offering health insurance coverage in the Individual market in Illinois to collect detailed information pertaining to their enrollees. This data included membership and premium information for the time period beginning in 2019 and ending 2022 YTD[9], and provided insight into various aspects of the corresponding populations.

It is important to note that the information from the data call served as the primary basis for developing our health insurance market population estimates. A description of each of the specific data sources used in analyzing Illinois' insurance market is summarized below:

- Overall distributions by health insurance coverage type and enrollment by coverage types were based on US Census statistics, ACS data, and results from the carrier data call.
- Premium rate levels were based on Qualified Health Plans Landscape files published on Healthcare.gov as well as Illinois premium rate information from the Department.
- Paid and allowed claims experience, Actuarial Value, CSR loading, and induced demand pricing assumptions were based on information from carrier rate filings and the carrier data call.
- Uninsured rates, population demographic information, and median household incomes were based on ACS data.
- CMS open enrollment reports, statutory financial information and CMS MLR rebate reports were utilized for average premium and APTC PMPM metrics and as well for reasonableness checks for health carriers' data call submission.

For our analyses, we relied on a wide range of data and other sources of information as described throughout this report. As noted earlier, this includes information received from insurers currently or recently offering health insurance coverage in Illinois. Though we have reviewed the data for reasonableness and consistency, we have not independently audited or otherwise verified this data. Our review of the data may not reveal errors or imperfections, and we have assumed that the data provided is both accurate and complete. The results of our analyses are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised.

A significant portion of the analysis in this report is based on results from a version of Oliver Wyman's proprietary Healthcare Reform Microsimulation (HRM) Model that, using the information from the carrier data call, is calibrated to replicate the current commercial market(s) in Illinois (hereafter referred to as the Illinois Commercial Marketplace Model, or ICM Model). The HRM Model is a leading-edge tool for analyzing the impact of various ACA provisions, as well as other pricing or proposed regulatory changes. The HRM model is an economic utility-based model that captures the flow of individuals across various markets based on their economic purchasing decisions and is integrated with actuarial modeling designed to assess the impact various reforms are expected to have on the health insurance markets. The HRM Model is designed to evaluate all

[9] In most cases, carriers submitted 2022 year to date information through October 2022; however, one carrier provided information through September 2022.

insurance coverage options a household is eligible to enroll in and projects the number of individuals expected to seek coverage under each health insurance coverage type through the use of economic utility functions, taking into consideration expected claims, cost sharing under each option, and the premium they are faced with, among other things. For each project undertaken, the HRM Model is calibrated to the specific market(s) for which it is used, employing a robust calibration process that adjusts the underlying parameters of the model until it replicates purchasing decisions that produce a population projected to take up coverage consistent with the characteristics of the population known to have enrolled in those markets (e.g., total member volume by market, distributions by age, income, geographic rating region, health status), for each of the three most recent years. A more detailed overview of our HRM Model can be found in the Appendix A.

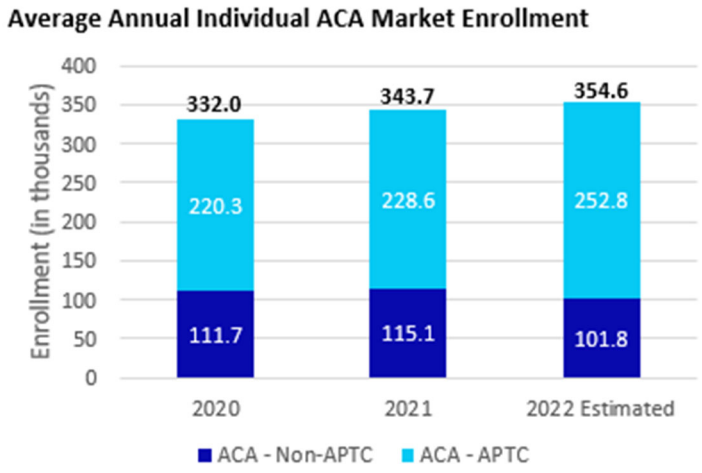
4. Overview of the Illinois Individual ACA Market Enrollment

This section provides an overview of the Individual ACA market in Illinois, including recent enrollment and demographic trends. Between 2020 and 2022 the Individual ACA market is estimated to have grown by approximately 6.8%, in large part due to expanded and more generous Advance Premium Tax Credits (APTCs), or premium subsidies, available under the American Rescue Plan Act (ARPA). Overall, enrollment distributions across age, gender, rating area, income and metal level in the Individual ACA market have remained relatively unchanged between 2020 and 2022.

Individual ACA Enrollment in Illinois between 2020 to 2022

Between 2020 and 2022, the subsidized market segment experienced a significant increase in enrollment (from 220,300 members in 2020 to 252,800 members in 2022) while the volume of enrollees who do not receive premium subsidies decreased. These changes are assumed to be, in large part, due to ARPA. The overall enrollment increased with new individuals entering the market as a result of more affordable coverage provided by ARPA. Additionally, the volume of enrollees who do not receive premium subsidies decreased as a number of individuals who were previously enrolled became newly eligible for subsidies under ARPA. Overall, the percentage of enrollees in the Illinois Individual ACA market that receive premium subsidies increased from approximately 66.4% in 2020 to 71.3% in 2022. Chart 1 summarizes average annual enrollment volumes by subsidy status in the Illinois Individual ACA market for years 2020, 2021 and estimated for full year 2022.[10]

Chart 1



[10] 2022 full year average enrollment was estimated from each carrier data request. In most cases, carriers submitted 2022 year to date information through October 2022; however, one carrier provided information through September 2022. We have estimated the full year enrollment based on historical patterns adjusted for monthly enrollment changes under ARPA subsidies. Demographic distributions in this section are based on the carrier data request for 2022 with year-to-date data without any adjustments for full year estimates.

Individual ACA Market in Illinois - Demographic Distributions

Enrollment distributions by age, gender, rating area, income and metal level in the Individual ACA market have generally remained relatively unchanged between 2020 and 2022 YTD as shown in Charts 2 through 6 below.

Across all three years, the age distribution (see Chart 2) is skewed towards older enrollees with about one-third of the enrollment being age 55 and older while the gender distribution (see Chart 3) is skewed slightly towards females who make up just over half of the membership.

Chart 2

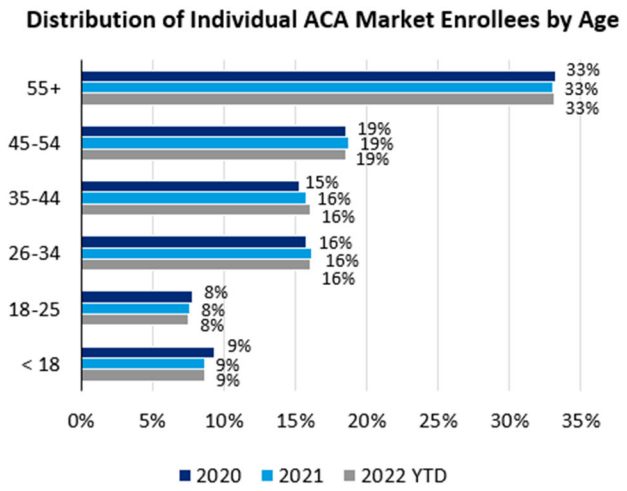
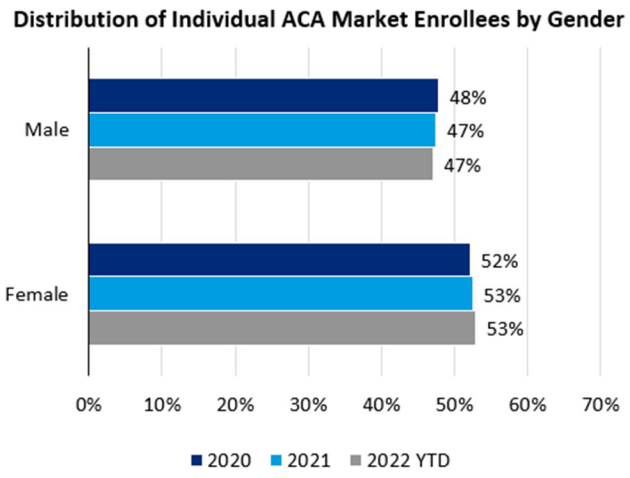
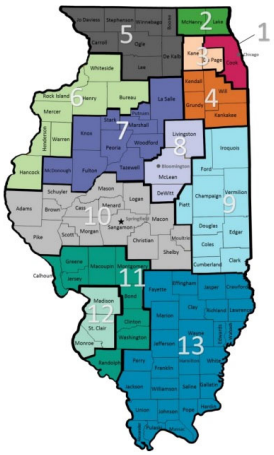


Chart 3



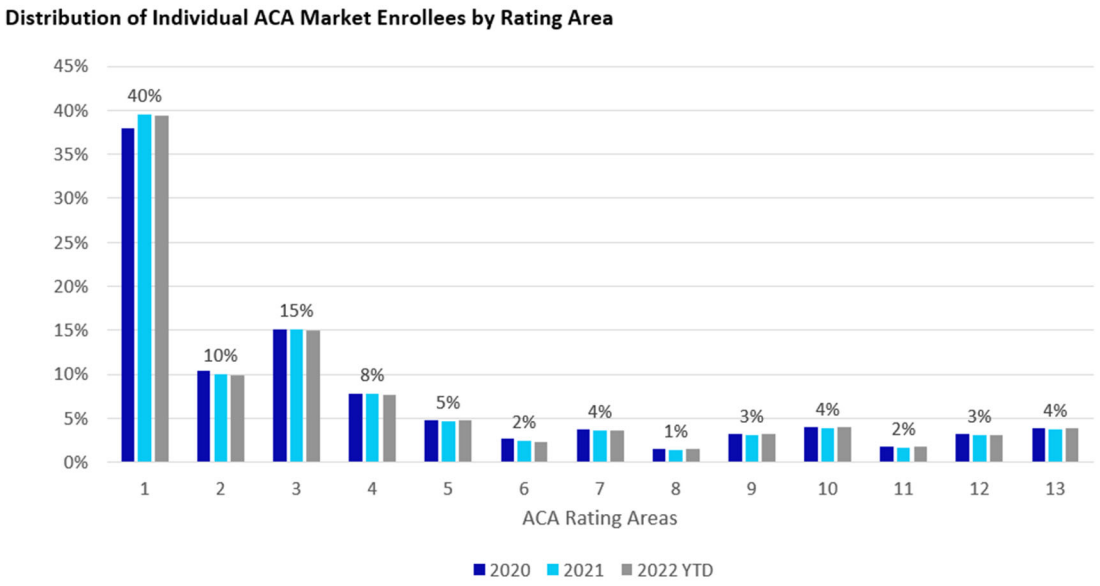
Rating Areas[11] 1 through 4, which are generally considered to be the 'Chicagoland' area, make up approximately 73% of enrollees (see Chart 4) in the Individual ACA market.

Figure 1: Illinois ACA Rating Areas



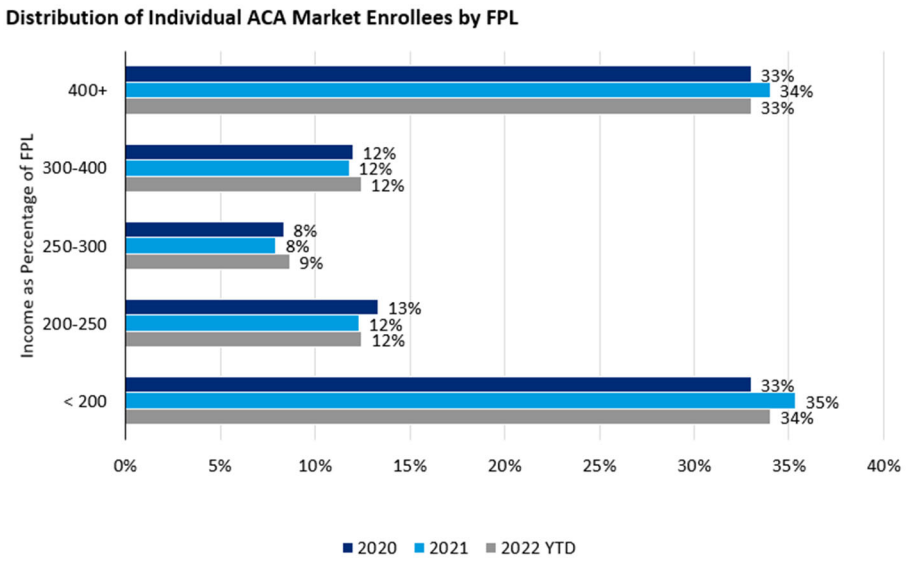
[11] Illinois county allocation by the 13 ACA rating areas: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/il-gra; see also Figure 1

Chart 4



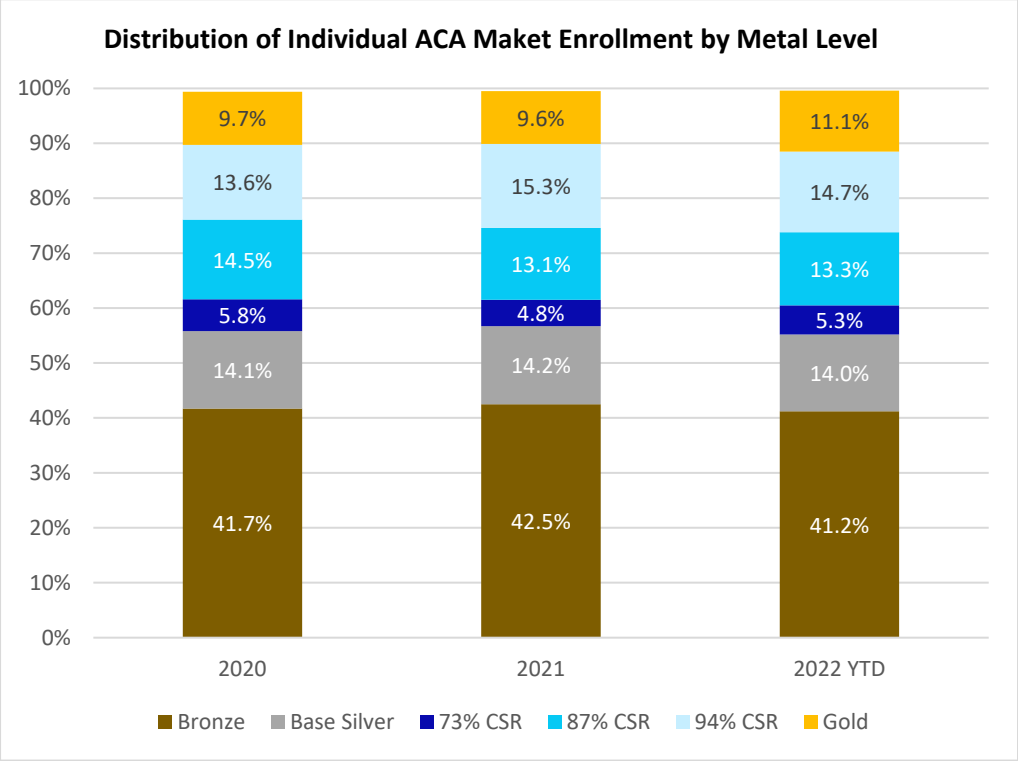
With respect to enrollment by FPL range (see Chart 5), approximately one-third of enrollees have had household incomes greater than or equal to 400% FPL and nearly half of the Individual ACA market enrollees have household incomes at or below 250% FPL.

Chart 5



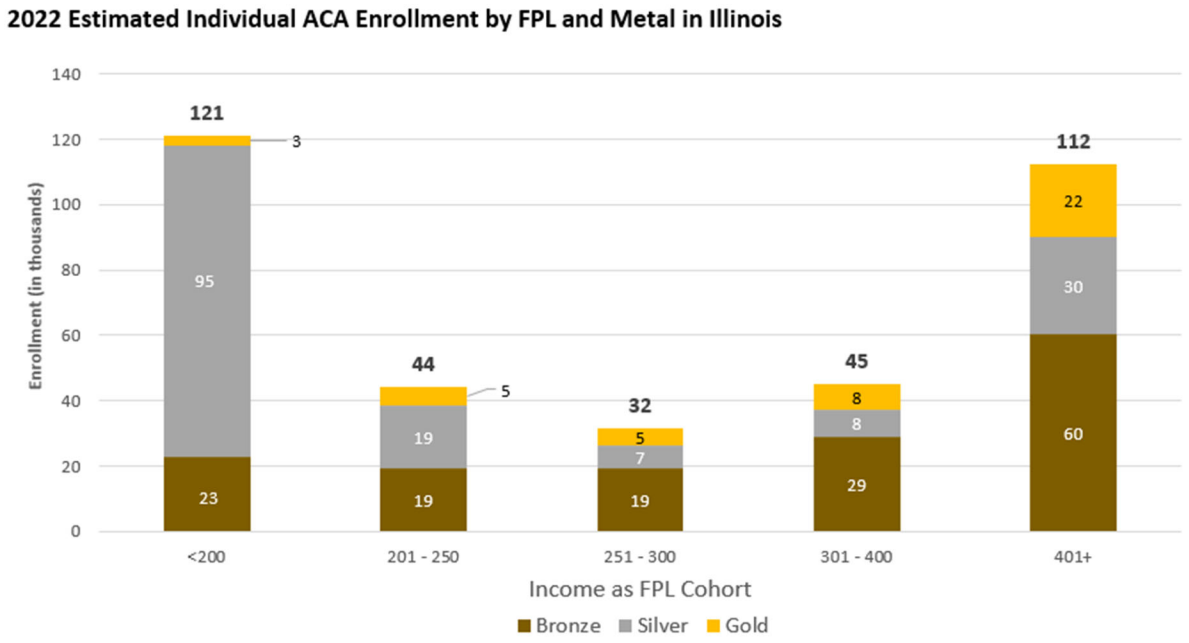
A significant percentage of the membership between 2020 and 2022 YTD has chosen to enroll in Bronze plans (see Chart 6), the leanest benefit plans offered through the Marketplace. In fact, of the individuals who did not enroll in CSR-eligible plans (i.e., 73% CSR, 87% CSR, and 94% CSR plans) in 2022, 62% of those individuals enrolled in a Bronze plan. This result is assumed to be due in large part to the current metal pricing relativities in the market, which we discuss in greater detail in Section 6.

Chart 6



At the lowest household income levels (i.e., at or below 200% FPL), approximately 79% of individuals chose Silver plans due to the availability of CSR plans. This result is shown in Chart 7 below. The majority of the remaining enrollees (about 19%) at the lowest income range have Bronze metal coverage, likely to reduce their net premium payment. Individual ACA enrollees with household incomes between 201% and 250% FPL select Bronze and Silver equally as the 73% CSR plan that is available for those individuals does not provide the same level of cost sharing subsidies as the 87% or 94% CSR plans. At higher income ranges (i.e., between 251% and 400% FPL), Individual ACA enrollees gravitate towards lower premium cost Bronze plans while Gold plan selections start to pick up slightly at the highest income levels (i.e., 401% FPL and above) where individuals become less price sensitive.

Chart 7


2022 Estimated Individual ACA Enrollment by FPL and Metal in Illinois
Enrollment (in thousands)
140
120
100
80
60
40
20
0
121
3
95
23
44
5
19
19
32
5
7
19
45
8
8
29
112
22
30
60
<200
201 - 250
251 - 300
301 - 400
401+
Income as FPL Cohort
Bronze
Silver
Gold

5. Overview of Uninsured Rate Levels in Illinois

In this section, we summarize the recently observed uninsured rate levels in Illinois. We first provide the historical change in uninsured rates from 2013 to 2021, the most recent data point available from the US Census ACS data. We also provide the 2021 demographic and geographic distributions of the uninsured population.

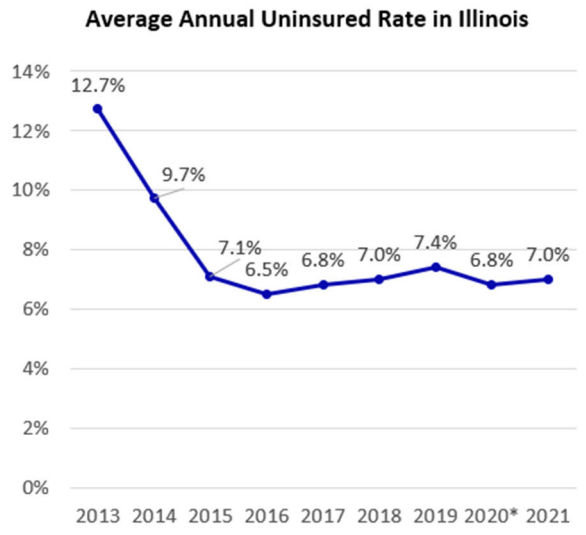
Overall, the average uninsured rate has remained stable in Illinois in recent years, however there are some observations that stand out, such as the following:

- The uninsured rate is higher than average for:
  - The Black and Hispanic population (see Chart 10);
  - Age cohorts of 26-34 years and 35-44 years (see Chart 12); and
  - Individuals in Cook County (see Chart 16).
- Males have higher uninsured rates than females across all age cohorts (see Chart 14).
- Uninsured rates are inversely correlated with household income, where lower income individuals have the highest uninsured rates and higher income individuals have the lowest uninsured rates (see Chart 18).

Historical Uninsured Rates

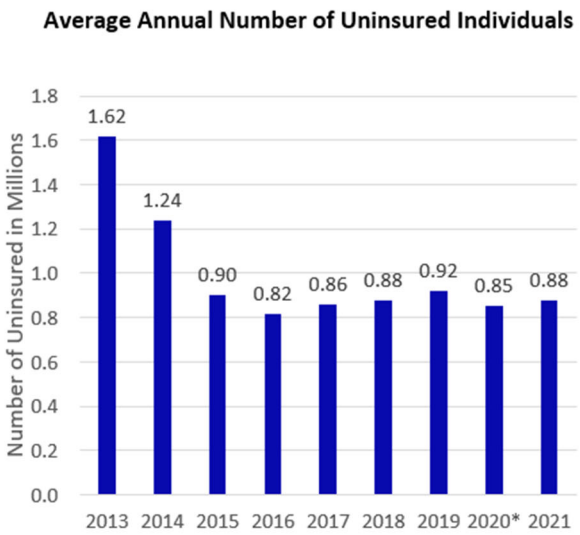
As shown in Charts 8 and 9, uninsured rates in Illinois have increased slightly from a low point in 2016 (6.5%) to 2021 (7.0%). However, overall, uninsured rates have remained relatively steady at around 7.0% since calendar year 2015.

Chart 8



2020*: U.S. Census Bureau, ACS 5-Year Estimates Subject Tables, estimates are impacted by COVID-19 pandemic

Chart 9



Uninsured Distributions by Ethnicity

In 2021, Hispanic and Black ethnicities had the highest uninsured rates at 15.6% and 8.3%, respectively. Combined, both cohorts represent over 56% of the total uninsured population in Illinois as shown in Chart 11.

Chart 10

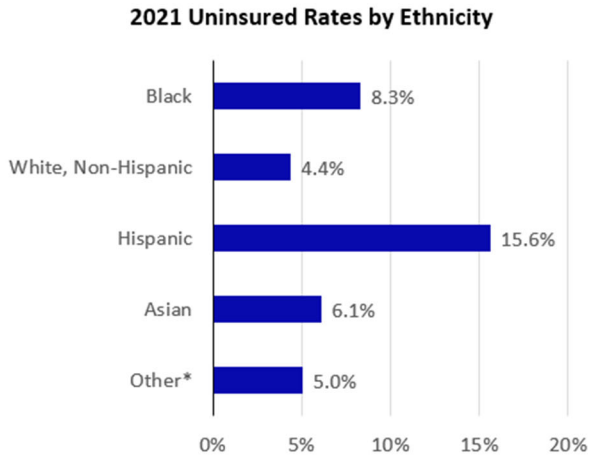
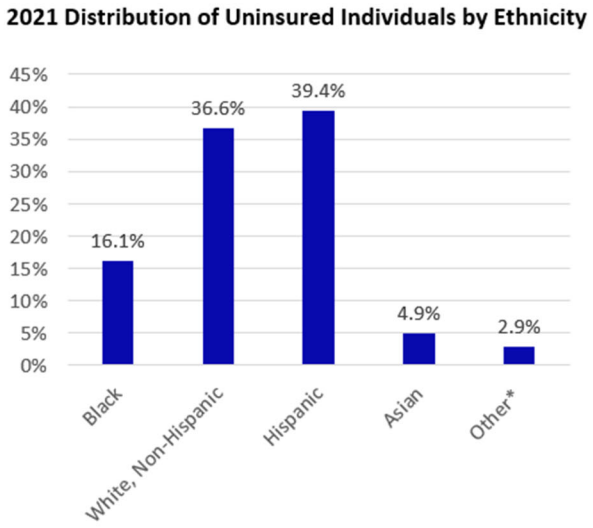


Chart 11



Uninsured Distributions by Age

Chart 12 demonstrates that the age ranges of 26-34 years and 35-44 years have the highest uninsured rates and represent about 43.3% of all uninsured individuals in Illinois. The age ranges with the lowest uninsured rates are the youngest (0-17) and oldest (55+), likely due to greater access to public health coverage such as CHIP and Medicare.

Chart 12

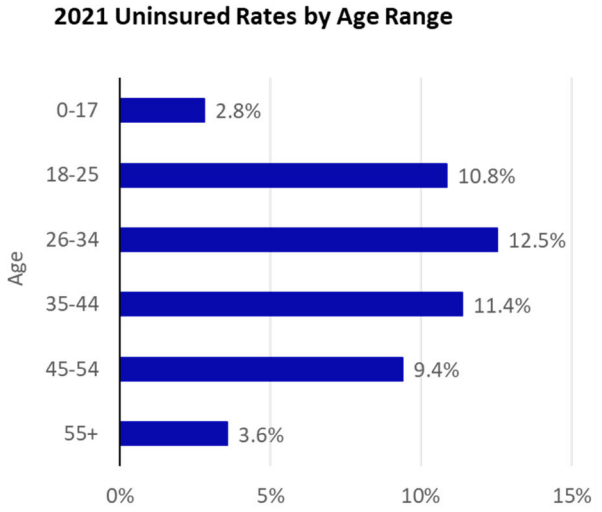
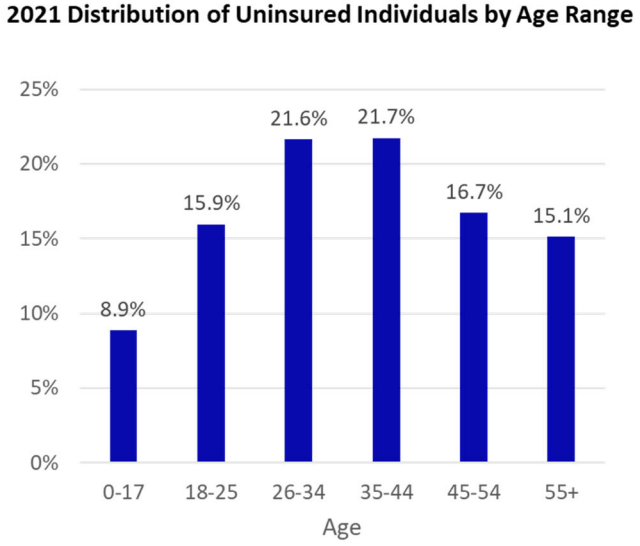


Chart 13



Uninsured Distributions by Age and Gender

Age distributions by gender show that males have higher uninsured rates than females across all age segments and that adult males between ages 18 to 54 have the highest uninsured rates (10.6% to 15.2%), as shown in Chart 14.

Chart 14

2021 Uninsured Rates by Age and Gender

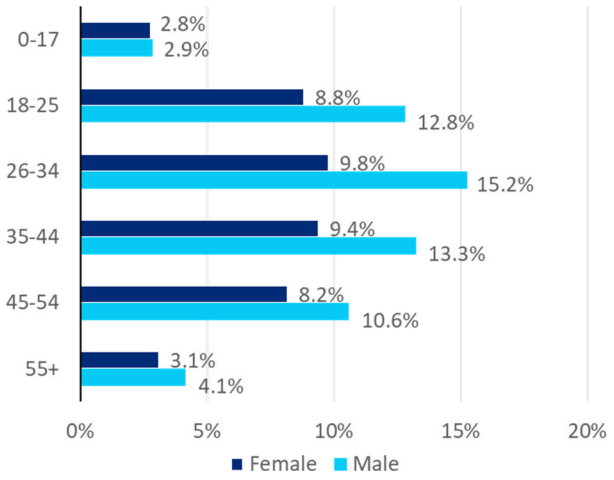
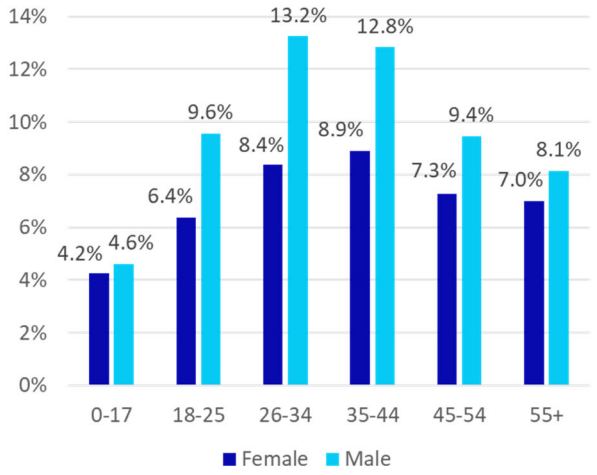


Chart 15

2021 Distribution of Uninsured Individuals by Age and Gender



Uninsured Distributions by ACA Rating Area[12]

In Charts 16 and 17, we can see that ACA Rating Area 1 (Cook County) represents over half of the state's total uninsured population and has the highest uninsured rate in the state at 8.7%. Other Illinois regions show variation in uninsured rates with a low of 4.7% in Rating Area 10 (Springfield) to a high of 7.5% in Rating Area 9 (Champaign).

Chart 16

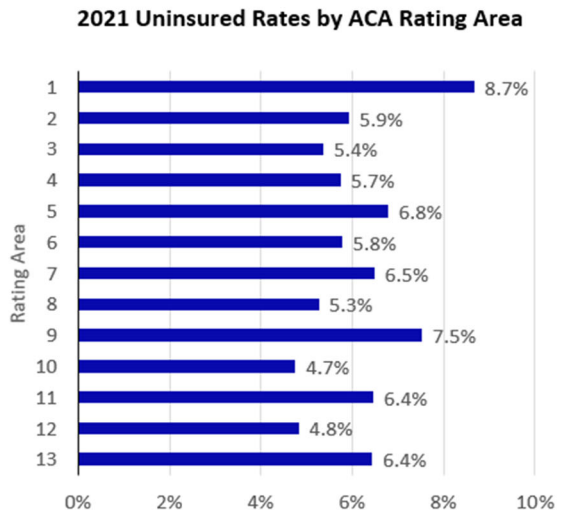
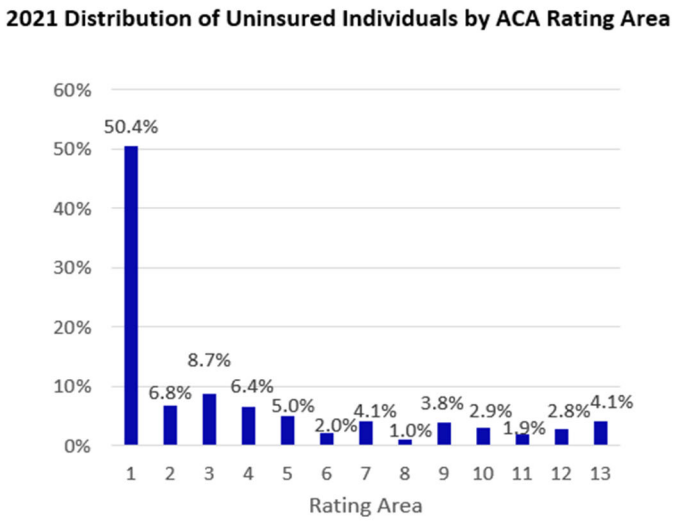


Chart 17



[12] For map of ACA rating areas see Figure 1 in section 4 of this report.

Uninsured Distributions by Household Income

The income distribution of the Illinois uninsured population in 2021 is displayed in Charts 18 and 19. The uninsured rate is inversely correlated with income where lower income individuals have the highest uninsured rates while higher income individuals have the lowest uninsured rates. About 54% of uninsured individuals have household incomes equal to 200% FPL or less.

Chart 18

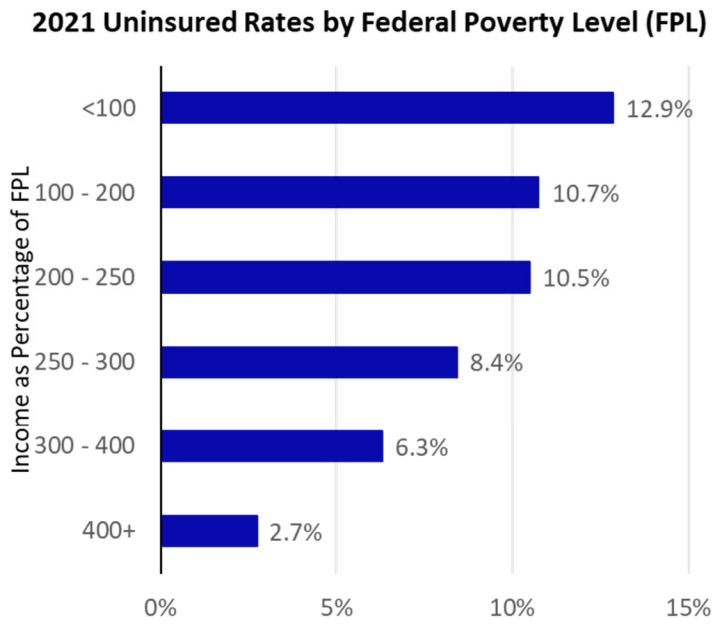
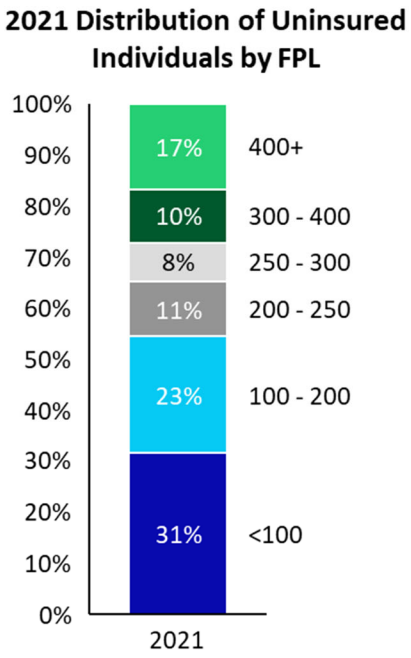


Chart 19



6. Current Metal Pricing in the Illinois Individual ACA Market

In this section, we summarize the metal pricing relativities currently being observed in the Illinois Individual ACA market for plan year 2023. Additionally, we provide our observations and analysis related to the key pricing factors that are driving those metal pricing relativities.

Under the ACA, the primary driver of observed variations in rates by metal level is the application of an item referred to as the AV and Cost Sharing Design of Plan factor[13] . The AV and Cost Sharing Design of Plan factor is a permitted plan level adjustment under the ACA that accounts for the impact of differences in cost sharing between plans, and is generally made up of two components:

1. ***Actuarial Value*** – This item reflects the percentage of total health care costs that a plan's benefits are expected to cover, on average. Included in the Actuarial Value is the "CSR load", which is an adjustment carriers apply in the development of their on-Exchange Silver plan rates to make up for the fact that the federal government no longer provides funding for cost-sharing reduction subsidies.[14]
2. ***Induced Demand*** - This item reflects the impact that a plan's benefit richness may be expected to have on an individual's utilization of services, relative to another plan.

The State of Illinois does not prescribe either the Actuarial Values (including the CSR loads) or the induced demand factors that are to be used by carriers offering coverage in the Individual ACA market. Instead, like most states, Illinois allows carriers to develop their own factors so long as they are consistent with the ACA's rating requirements and can be actuarially supported.

Actuarial Values

Removing the induced demand adjustments from the AV and Cost Sharing Design of Plan factors that were filed in Illinois for 2023 produces the Actuarial Values that were developed by carriers for their plan benefit offerings. While results vary from carrier-to-carrier, by doing this, we find that the overall member-weighted average Actuarial Values being used in the Illinois Individual ACA market in 2023 are 0.697, 0.827, and 0.812 for Bronze, Silver, and Gold plans, respectively.

As noted previously, Actuarial Values are intended to represent the portion of claim costs that are expected to be covered by a plan for an average individual in the single risk pool. As such, a reasonable approach to use in comparing how the Actuarial Values being used by carriers in Illinois' Individual market align with actual benefit plan relativities is to compare them to the actual paid-to-allowed ratios that have been observed across metal levels in recent years. This is because the historical ratio of paid-to-allowed claims represents the actual average percentage of total costs that were covered by those health plans. In other words, we are looking at how the historical richness of plans based on actual experience (paid-to-allowed ratios) aligns to the projected richness of plans (Actuarial Value).

Table 1 below provides a comparison of the average Actuarial Values for 2023 to the actual observed paid-to-allowed claims ratios for plan years 2019, 2020, and 2021 for on-Exchange plans. Then, in Chart 20, we provide the relativity of these values for the Bronze and Gold plans to those of the on-Exchange Silver plans; this

[13] https://www.cms.gov/files/document/urr-py23-instructions.pdf
[14] https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/

comparison allows us to consider how the actual average pricing relativities between metal levels compare to the actual observed paid-to-allowed cost relativities.

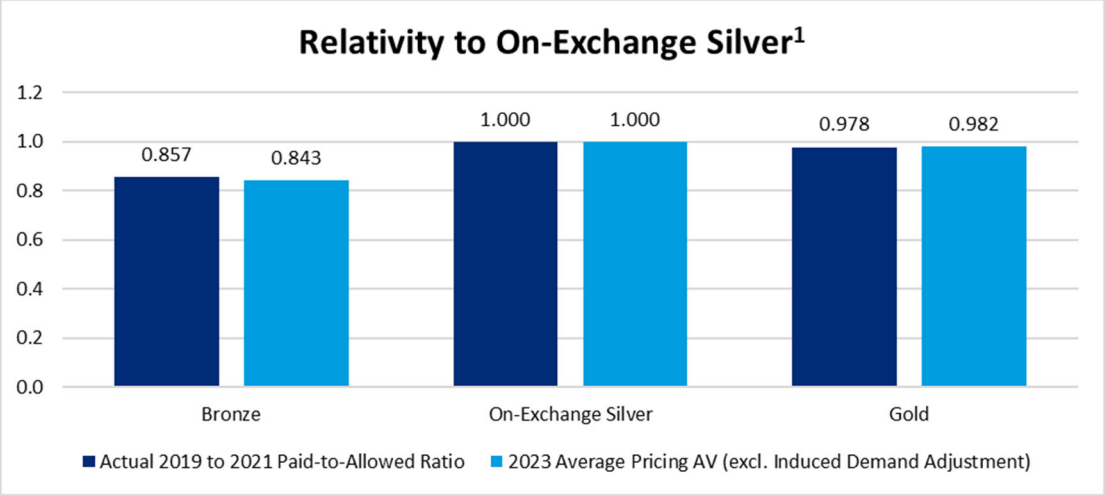
Table 1 – Comparison of Actual Paid-to-Allowed Ratios to Actuarial Values by Metal Level

Metal	Actual Paid-to-Allowed Ratios[1] 2019	2020	2021	2023 Average Actuarial Values[2]
Bronze	0.719	0.749	0.748	0.697
On-Exchange Silver	0.856	0.862	0.868	0.827
Gold	0.833	0.856	0.841	0.812

[1]Calculated as incurred claims / allowed claims

[2]Weighted averages based on projected member months and allowed claims PMPM

Chart 20



[1]For paid-to-allowed ratios, calculated as the straight average across 2019 to 2021 for the specified metal level, then divided by the straight average for on-Exchange Silver. For Actuarial Values, calculated as the Actuarial Value for the specified metal level, divided by the on-Exchange Actuarial Value.

Two takeaways from this comparison include the following:

1. The relativities of the actual average paid-to-allowed ratios and 2023 Actuarial Values between the Bronze, Silver, and Gold metal levels align well.
2. The CSR loads that are being applied by carriers for 2023 produce a reasonable average Actuarial Value for on-Exchange Silver plans relative to historical paid-to-allowed ratios.

For 2023, the average CSR load that is being applied in the development of the on-Exchange Silver Actuarial Values is 12.8%, with variations by carrier, ranging from 7.3% to 21.1%. Potential reasons for this variation include differences in the distribution of enrollment by Silver CSR Variant (i.e., base Silver, 73% CSR, 87% CSR, 94% CSR) as well as differences in the benefits and/or projected Actuarial Values underlying the carriers' base Silver plans.

Induced Demand Factors

As part of the carrier data call that was conducted for this study, all carriers were asked to provide the induced demand factors that were utilized for each of their Individual ACA Marketplace plans in 2023. Based on the responses provided, we calculated that the average induced demand factors being used for 2023 are 0.955, 0.993, and 1.181 for on-Exchange Bronze, Silver and Gold plans, respectively (or 1.000, 1.040, and 1.236 when these factors are indexed to Bronze plans).

Based on our review of the factors provided by the carriers, it appears that five carriers are using induced demand factors that reflect a slope that is either the same or very similar to the induced demand slope developed by the Centers for Medicare and Medicaid Services (CMS) for the risk adjustment program established under 42 U.S.C. 18063 (i.e., 1.000 for Bronze plans, 1.030 for Silver plans, and 1.080 for Gold plans). The other six carriers, are using alternative carrier-specific sets of induced demand factors.

It is of note that the two approaches that appear to be used by carriers in the Illinois Individual ACA market to develop their induced demand factors (i.e., relying on the CMS induced demand slope and developing a carrier-specific set of factors based on experience-based studies) produce two different induced demand slopes, particularly for Gold plans relative to Silver and Bronze plans. It is outside the scope of this study to assess whether one of the two approaches being used by Illinois' carriers is more appropriate than the other. However, in our experience, the two approaches have both commonly been accepted by regulators and by the Center for Consumer Information and Insurance Oversight (CCIIO), to support carriers' induced demand slopes under the ACA.

Gross Premium Rate Relativities

Multiplying the average 2023 Actuarial Values by the induced demand factors produces the average AV and Cost Sharing Design of Plan factors utilized by carriers in the Illinois Individual ACA market – which are the factors that are the primary drivers of observed variations in rates by metal level. This calculation of the AV and Cost Sharing Design of Plan factors is demonstrated in Table 2 below:

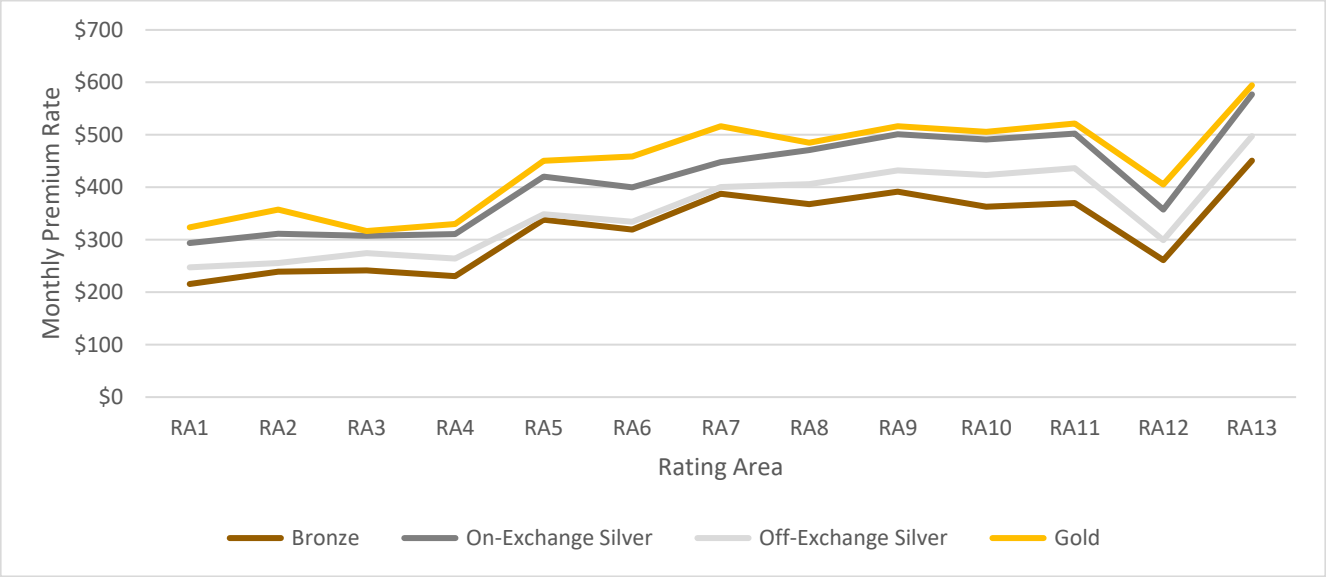
Table 2 – Calculation of Average 2023 AV and Cost Sharing Factors

	A	B	= A x B
Metal	**Actuarial Values**	**Induced Demand**	**AV and Cost Sharing Design of Plan Factors**
Bronze	0.697	0.955	0.665
On-Exchange Silver	0.827	0.993	0.821
Gold	0.812	1.181	0.958

On a statewide basis, the AV and Cost Sharing Design of Plan factors shown in Table 2 indicates that Gold plans are, on average, being priced higher than Silver plans. This is driven primarily by differences in the induced demand factors that are applied between the two metal levels. Bronze plans are, on average, being priced lower than Silver plans due to carriers' assumptions for both actuarial values and induced demand factors being lower for Bronze plans than for Silver plans.

Chart 21 below shows the actual lowest-cost Bronze, Silver, and Gold gross premium rates[15] offered for a 21-year-old through the Exchange in each of Illinois' 13 rating areas (i.e., RA1 to RA 13 in the chart) in 2023. Here, we've chosen to look at the lowest-cost plan premium rates because they represent the most affordable option available to consumers (on a premium basis) within each of the specified metal levels and, as a result, tend to be some of the most popular plan options. Consistent with the results of the statewide average AV and Cost Sharing Design of Plan factor comparison by metal level provided in Table 2, we see in Chart 20 that for every rating area, the lowest-cost Gold plans are higher than the lowest-cost on-Exchange Silver plans and the lowest-cost on-Exchange Silver plans are higher than the lowest-cost Bronze plans.

Chart 21 - 2023 Lowest-Cost Gross Monthly Premium Rates by Metal Level
21 Year-Old, Non-Smoker



We've also included in Chart 21 the lowest cost off-Exchange Silver plan rates, represented by the light gray line. Off-Exchange Silver plans are only offered outside of the Exchange and do not include silver loading. These plans represent a lower-cost Silver option (relative to the on-Exchange Silver plans) for enrollees who may not expect to receive federal premium subsidies. If silver loading were not being utilized, we estimate that on-Exchange Silver plan rates would be roughly equal to the off-Exchange Silver plan rates.

Comparison of Illinois Metal Pricing Relativities to Other States

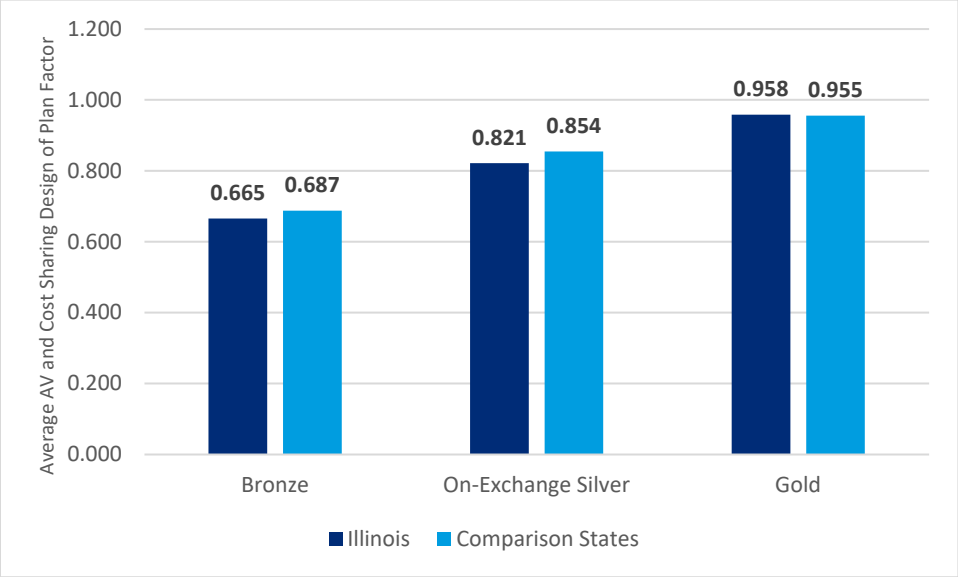
We previously noted that Illinois is like most other states in that it allows carriers to develop their own Actuarial Values and induced demand factors, so long as the factors are consistent with the ACA's rating requirements and can be actuarially supported. To assess how Illinois' resulting average metal pricing relativities under this approach compare to the average metal pricing relativities in other states, we utilized the 2023 federal Unified Rate Review Templates (URRTs) to calculate average AV and Cost Sharing Design of Plan factors for on-Exchange Bronze, Silver, and Gold plans in the 35 other Medicaid-expansion states that do not have Basic Health Programs or Medicaid eligibility up to 200% FPL.[16] A comparison of the average AV and

[15] Gross premium rates represent premium rates prior to the application of federal premium subsidies; figures shown are represent the enrollment-weighted average of the lowest-cost plan available in each county within the specified rating area

[16] DC, MN, and NY results were excluded

Cost Sharing Design of Plan factors being used in Illinois to those being used in these other states for the specified metal levels is provided in Chart 22.

Chart 22 – Average AV and Cost Sharing Design of Plan Factors by Metal Level 2023 Individual ACA Market



The chart above shows that the average metal pricing relativities utilized in Illinois are similar to the average of those utilized in the comparison states for 2023; that is, Illinois is not an outlier relative to these other states in terms of average metal pricing relativities.

7. Analysis of Alternative Rate Setting Approaches

As discussed earlier, one of the goals of this study per Section 15 of the Act is to explore rate setting approaches that may yield a misalignment of premiums across different tiers of coverage in Illinois' individual health insurance market, with a focus on how those rate setting approaches impact affordability for low-income and middle-income residents. To accomplish this goal, Oliver Wyman evaluated the impact on the market of moving from the current pricing approach to four alternative rate setting approaches, each of which are summarized below:

- Approach #1, which we refer to as the **"New Mexico Approach**," utilizes the following methodology:
    - The State prescribes a uniform factor for CSR loading under the assumption that the only enrollees who will purchase on-Exchange Silver plans are those that have 87% and 94% CSR plans available to them (i.e., enrollees with household incomes equal to 200% FPL or less); the overall CSR load is equal to 1.440 and is applied only to on-Exchange Silver plans for all carriers.
    - The CSR load calculation includes an adjustment for induced demand and is developed using both standard metal actuarial values as well as the CMS induced demand factors.[17]
    - Although the 1.440 CSR load includes an adjustment for induced demand, per New Mexico's 2023 QP Issuer Rate Guidance [18], the "1.440 adjustment should not be normalized and therefore should not result in any impact to any plans which are not silver on-exchange plans."
    - Induced demand factors are required to be consistent with the standard metal level induced demand factors developed by CMS for use with the federal Risk Adjustment program (i.e., 1.00 for Bronze, 1.03 for Silver and 1.08 for Gold).
- Approach #2, which we refer to as the **"Pennsylvania-like Approach**," utilizes the following methodology:
    - The State prescribes a narrow range of appropriate factors to be used by all carriers for CSR loading.
        - For our modeling, we have assumed the use of a single CSR load that is uniform across all carriers and that is consistent with the total adjustment needed to cover actual CSR costs across all on-Exchange Silver plans statewide.
        - Based on the resulting metal pricing relativities that would be produced by this approach, we have also assumed the factor for CSR loading that would be developed by Illinois would be developed under the assumption that the only enrollees who will purchase on-Exchange Silver plans are those individuals who are eligible for 87% and 94% CSR plans.

[17] https://a.storyblok.com/f/132761/x/b1808b6512/responses-csr-defunding-adjustment_210527_final.pdf
[18] https://www.osi.state.nm.us/wp-content/uploads/2022/04/2023PY-QHP-Issuer-Rate-Guidance_Final.pdf

- Induced demand factors are required to be consistent with the metal level induced demand factors developed by CMS for use with the federal Risk Adjustment and developed using the following formula: (Actuarial Value)^2 – (Actuarial Value) + 1.24.
    - This formula produces the CMS factors by metal level (e.g., a 0.60 Actuarial Value produces a 1.00 factor, a 0.80 Actuarial Value produces a 1.08 factor) but accounts for the fact that not all plans within a metal level will have the same Plan AV.
    - For on-Exchange Silver plans, the induced demand factor is calculated based on the product of the base Silver Actuarial Value and the CSR load.
- Pennsylvania confirms the use of a narrow, prescribed range of appropriate factors for the CSR load and the use of the above-referenced formula for calculating induced demand factors in its 2023 ACA-Compliant Health Insurance Rate Filing Guidance.[19]

- Approach #3, which we refer to as the **"HHS Induced Demand Approach"**, utilizes the following methodology:
    - Carriers continue to use their current CSR loading methodology (i.e., the average market-wide CSR load is equal to 1.128, but the actual CSR load varies by carrier).
    - Induced demand factors are required to be consistent with the standard metal level induced demand factors developed by CMS for use with the federal Risk Adjustment program (e.g., 1.00 for Bronze, 1.03 for Silver, 1.08 for Gold); for on-Exchange Silver plans, the induced demand factor is 1.03.
    - This approach allows carriers to continue to develop CSR load factors that align most closely with their carrier-specific CSR costs but requires carriers to utilize a consistent approach when developing induced demand factors.
- Approach #4, which we refer to as the **"Broad Loading Approach"**, utilizes the following methodology:
    - Carriers develop their own CSR loading factor but are required to spread the CSR load across all plans (i.e., as opposed to applying the CSR load only to the on-Exchange Silver plans); the average market-wide CSR load that is applied to all plans is estimated to be equal to 1.057 but varies by carrier.
    - Induced demand factors are required to be consistent with the metal level induced demand factors developed by CMS for use with the federal Risk Adjustment and developed using the following formula: (Actuarial Value)^2 – (Actuarial Value) + 1.24. This approach produces metal pricing relativities between Bronze, Silver and Gold plans that align most closely with the relativities that would have been expected to be observed prior to the termination of federal CSR funding.
    - According to healthinsurance.org, for 2023, Indiana and Mississippi both required carriers to utilize a broad loading approach to account for the cost of CSRs.[20]

[19] https://www.insurance.pa.gov/Companies/Documents/2023%20ACA%20Rate%20Filing%20Guidance%2005132022.pdf
[20] https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/

Table 3 summarizes the four approaches and how they compare to the current rate setting approach being used in Illinois. Note that the projected carrier-specific premium impacts of each approach can be found in Appendix B.

Table 3: Summary of the Current and Four Alternative Rate Setting Approaches Modeled for the Illinois Individual ACA Market

	Current Approach	New Mexico Approach	Pennsylvania-like Approach	HHS Induced Demand Approach	Broad Loading Approach
CSR Loading Methodology	Varies by carrier, based on carrier-specific support	State-prescribed factor, based on standard Metal values, includes induced demand adjustment	State prescribed factor, based on actual statewide experience	Same as current	CSR Load applied across all plans, based on carrier-specific support
CSR Loading Factor (on-Exchange Silver, except where specified)	Average of 1.128, varies by carrier	1.440, same for all carriers	1.195, same for all carriers	Same as current	Average of 1.057 across all metal plans, varies by carrier
Induced Demand Methodology	Varies by carrier, based on carrier-specific support	CMS standard metal induced demand factors	CMS induced demand slope applied to Actuarial Values	CMS standard metal induced demand factors	CMS induced demand slope applied to Actuarial Values
Average Induced Demand Factors[21]					
Gold	1.23	1.08	1.06	1.08	1.06
Silver	1.04	1.03[22]	1.09	1.03	1.02
Bronze	1.00	1.00	1.00	1.00	1.00

For each of the approaches described above, premium rates were developed using existing 2023 plan rates which were modified to reflect the changing rate setting methodology described in Table 3. We assumed no change in health plans' assumptions for non-benefit expenses, risk adjustment transfers, population morbidity, geographic factors, demographic factors or network factors. We also did not assume any changes in the plan offerings to be made by carrier.

The alternative sets of premium rates were then run through Oliver Wyman's HRM Model, which is described in greater detail in Section 3, to develop estimates regarding how membership volumes, average premium rates, and average actuarial values may be expected to change within the Illinois Individual ACA market under each approach.

[21] Indexed to Bronze plans

[22] With the additional induced demand load for on-Exchange Silver plans that is included within the CSR Loading Factor, the total on-Exchange Silver induced demand factor is approximately 1.15

Gross Premium Rate Relativities by Metal Level

For each of the rate setting approaches that were modeled, Charts 23 and 24 show the relativity of the lowest cost on-Exchange Silver premium to that of the lowest cost Bronze premium (Chart 23) and lowest cost Gold premium (Chart 24) by rating area. As an example, a relativity of 0.90 for Bronze in Chart 23 means that the Bronze premium is equal to 90% of the premium rate for Silver.

Chart 23

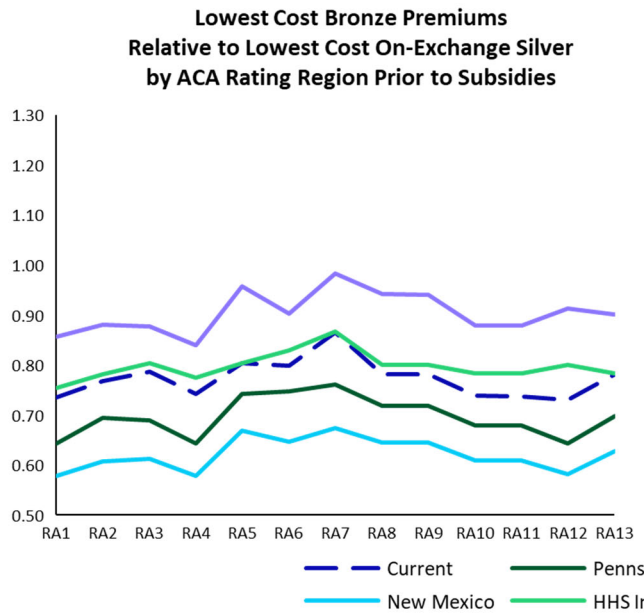
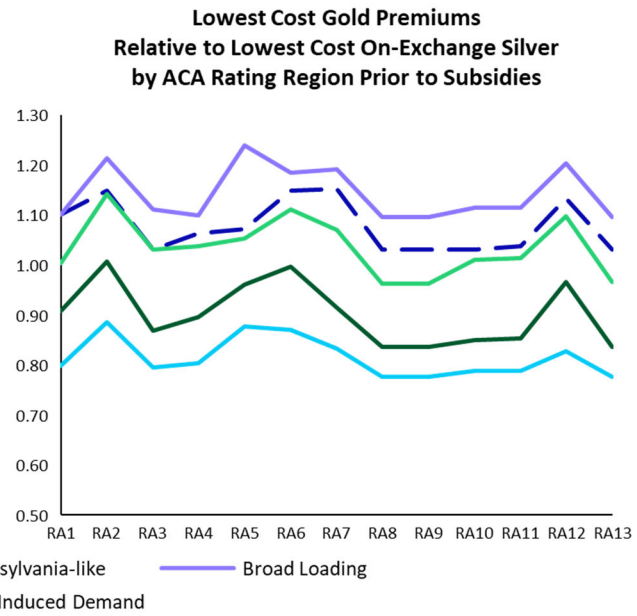


Chart 24



The New Mexico Approach results in Bronze and Gold premium rates that are the lowest relative to on-Exchange Silver premium rates among all scenarios. This is due to the large CSR load that is applied to on-Exchange Silver plans under the New Mexico Approach. When compared to the current pricing, the Pennsylvania-like Approach also results in Bronze and Gold premium rates that are lower relative to on-Exchange Silver premium rates. On the other hand, the Broad Loading Approach reduces Silver premium rates relative to current levels, resulting in an increased cost relativity of Bronze and Gold plans to on-Exchange Silver plans.

This comparison is important because due to the way in which premium subsidies under the ACA are indexed to the Second Lowest Cost Silver (SLCS) plan, the higher the on-Exchange Silver premium rates are relative to Bronze and Gold premium rates, the lower the net premium rates will be for subsidy-eligible enrollees purchasing Bronze and Gold plans.

Market-wide Average Premiums

Charts 25 and 26 show the projected average[23] net premium[24] for subsidized enrollees and the projected average[25] gross premium for non-subsidized enrollees under each of the alternative rate setting approaches as well as for the current pricing. Of note when comparing across scenarios is that the premiums shown reflect differences in the cost of coverage in addition to differences in the metal distribution of enrollees (e.g., some enrollees may shift from Silver plans under the current pricing to Gold plans under one of the alternative approaches); therefore, the metrics do not represent an apples-to-apples comparison of changes in net premium at the individual enrollee level.

Chart 25

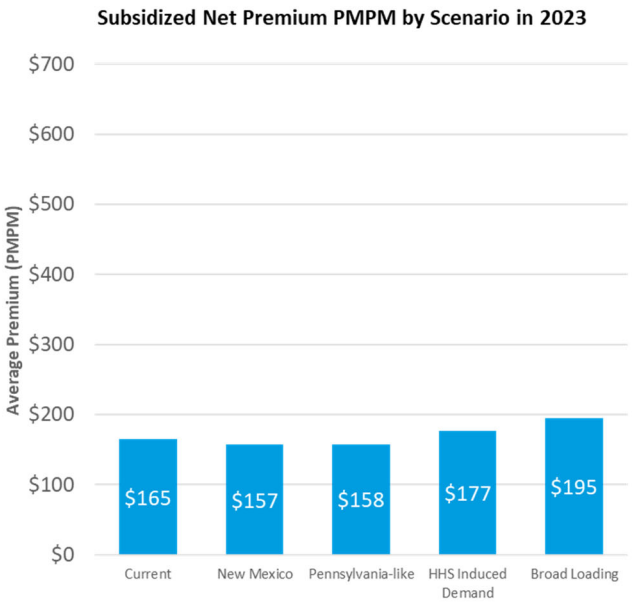
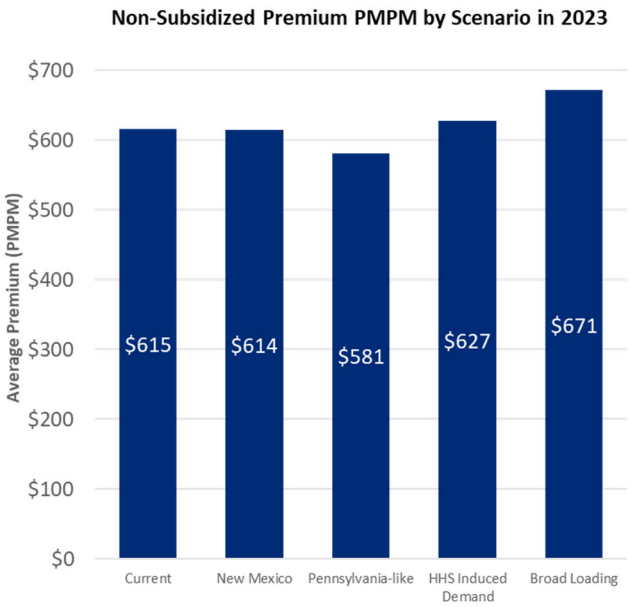


Chart 26



As shown, the average net premium for subsidized enrollees is expected to be lowest under both the New Mexico and the Pennsylvania-like approaches. For subsidy-eligible enrollees, this result is due to the resulting relativity of metal level rates as discussed in the prior section. On the other hand, both the HHS Induced Demand and the Broad Loading approaches would be expected to increase average market-wide premiums, driven primarily by a decrease in the average premium rate difference between Bronze and on-Exchange Silver plans (which reduces the magnitude of available premium subsidies relative to the cost of Bronze plans, resulting in a higher net cost to certain enrollees).

While the New Mexico Approach produces the lowest average net premium for subsidy eligible enrollees, the Pennsylvania-like Approach produces the lowest average premium for non-subsidized enrollees. When comparing premium rates between the two approaches, we find that one key driver of the difference is that under the Pennsylvania-like Approach, the higher induced demand assumed for on-Exchange Silver plans gets normalized such that the overall average induced demand factor applied at the plan level is 1.00. This results in lower average premium rates for the other plans (i.e., relative to if the higher induced demand were not

[23] Average across all FPL ranges and Metal levels

[24] Net premium refers to the gross premium rate less federal premium subsidies

[25] Average across all FPL ranges and Metal levels

normalized for). Under the New Mexico Approach, consistent with our interpretation of the State's 2023 rate guidance, the higher induced demand assumed for on-Exchange Silver plans and that is included in the 1.440 CSR load is not normalized.

For more detail of the impact to net premium rates by FPL, metal level, and rating area under each of these approaches, please see Appendix D.

Overall Affordability

In Table 4, we show the projected average annual cost sharing (i.e., the portion of claim costs the enrollee is responsible for through deductibles, copays, and coinsurance) per enrollee for each of the approaches that have been modeled based on the projected 2023 enrollment distribution by metal level, Actuarial Values, and projected allowed costs. We also show the projected average annual net premium per enrollee.

Table 4 – Projected Annual Net Premium and Annual Cost Sharing Per Enrollee

	Current	New Mexico Approach	Pennsylvania-like Approach	HHS Induced Demand Approach	Broad Loading Approach
Average Annual Cost Sharing per Enrollee	$1,900	$1,800	$1,800	$1,900	$1,800
Average Annual Net Premium Per Enrollee	$3,300	$3,100	$3,100	$3,500	$3,800

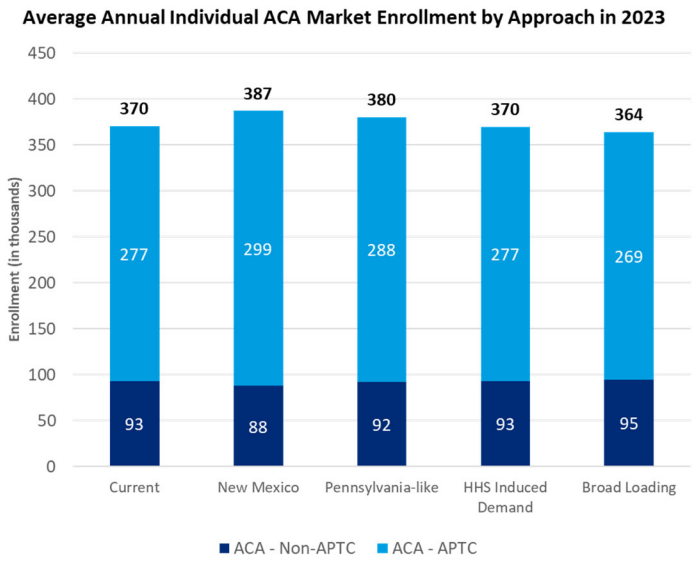
As shown in Table 4, the average annual cost sharing per enrollee is expected to decrease in all approaches relative to current as more enrollees would be expected to move from Bronze plans to richer metal level plans (e.g., Silver, Gold), resulting in a reduction of average member cost sharing. This result is primarily due to the reduced cost of Gold premium rates relative to Bronze and Silver premium rates (see Charts 23 and 24). The New Mexico and Pennsylvania-like approaches would also be expected to see a decrease in the average annual net premiums relative to current pricing as the available subsidies for eligible enrollees increase due to higher on-Exchange Silver premium rates.

More detail regarding projected shifts in the metal distribution of enrollees is provided in the "Projected Enrollment by Metal Level" section that is provided later in this report.

Projected Enrollment by Subsidy Status

Chart 27 below compares the projected enrollment within the Illinois Individual ACA market for each of the alternative rate setting approaches that we explored to that which would be projected under the current rates.

Chart 27

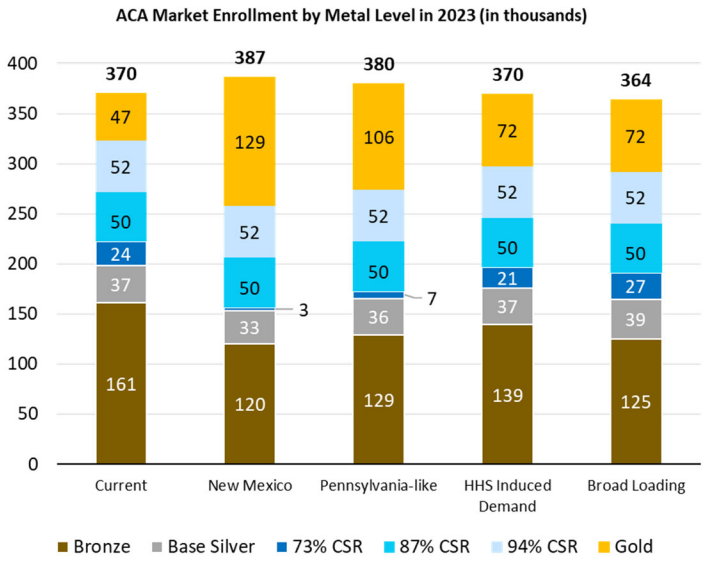


As shown in Chart 27, the New Mexico and Pennsylvania-like approaches would both be expected to result in increased enrollment in the Illinois Individual ACA market. This is due to the higher Silver on-Exchange premium rates that would be expected to be produced under both approaches. Under the Broad Loading approach, enrollment would be expected to decrease relative to current pricing levels. The Broad Loading Approach leads to reduced enrollment primarily due to the fact that the magnitude of available premium subsidies for enrollees would decrease with the lower on-Exchange Silver plan rates.

Projected Enrollment by Metal Level

Chart 28 provides the projected enrollment by metal level under each of the approaches that were explored.

Chart 28



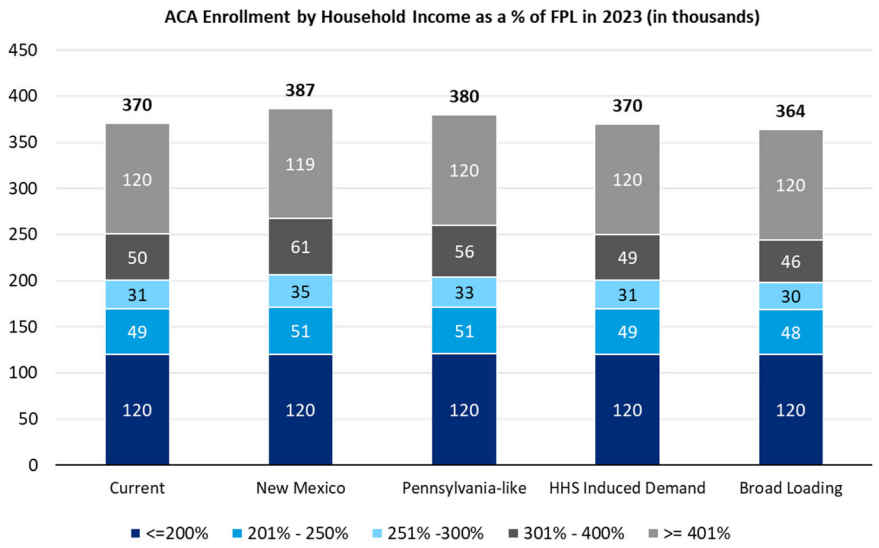
Relative to current pricing, the number of individuals enrolled in Gold plans would be expected to increase in all approaches while Silver enrollment would be expected to decrease in all but the Broad Loading Approach. In addition, Bronze enrollment would be expected to decrease substantially in all approaches.

These changes in enrollment result in the higher estimated average Actuarial Values for the market that were provided previously in Table 3. Again, the primary driver is the reduced cost of Gold premium rates relative to Bronze and Silver premium rates (see Charts 23 and 24).

Projected Enrollment by Household Income Level

Chart 29 provides the estimated enrollment by income level under each of the alternative rate setting approaches that were explored.

Chart 29



For both the New Mexico and Pennsylvania-like approaches, projected enrollment increases would be expected to be concentrated among households with income levels between 201% to 400% FPL. The households at the lowest income levels (100% to 200% FPL) are primarily enrolled in 87% CSR and 94% CSR Silver plans; therefore, changes in Bronze and Gold plan premiums relative to Silver premiums have little impact. Changes in enrollment for households at the highest income levels (401%+ FPL) are also estimated to remain mostly unchanged as this population is generally less price sensitive and, in many cases, may not be eligible for premium subsidies.

Projected Enrollment by Age, ACA Rating Region, and Race

Charts 30, 31, and 32 provide the projected enrollment by age, region, and ethnicity. Notably, the distribution of enrollees for each of these demographic categories would not be expected to change significantly under any of the four alternative rate setting approaches relative to current pricing levels. That is, our modeling projects proportional changes to the enrollment under each of these categories.

Chart 30

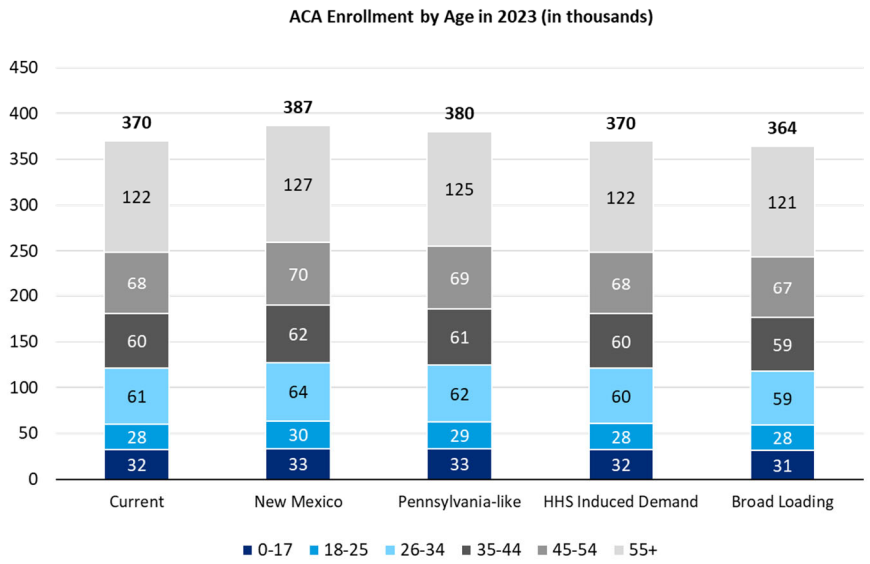


Chart 31

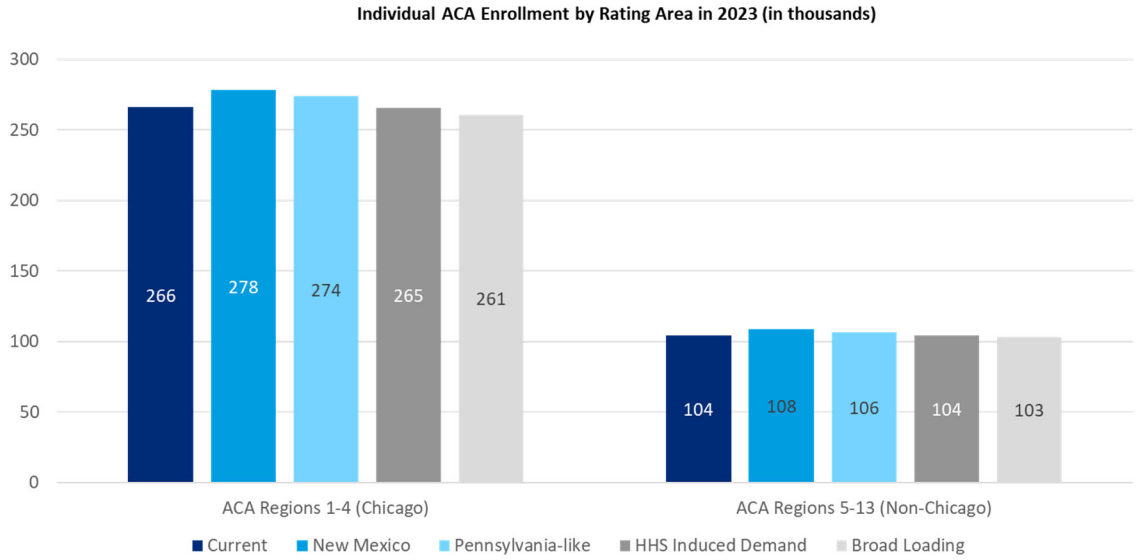
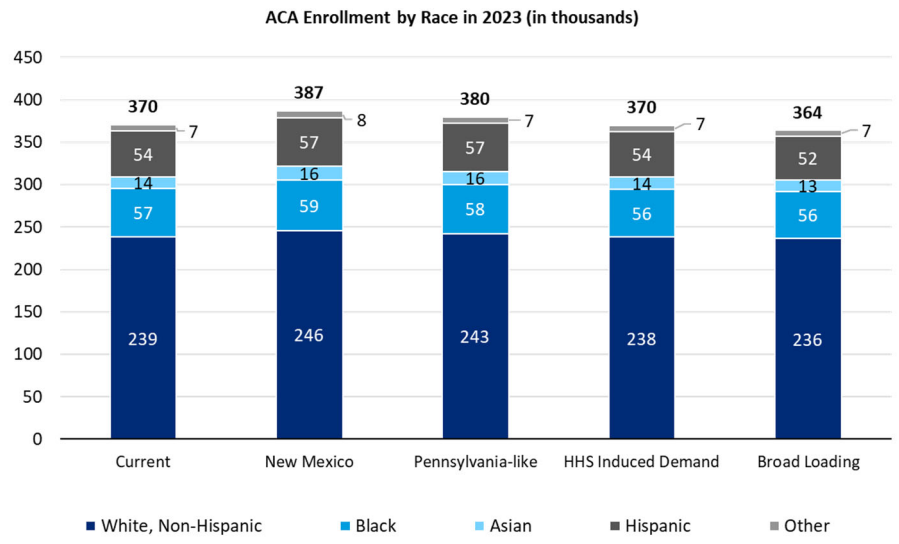


Chart 32

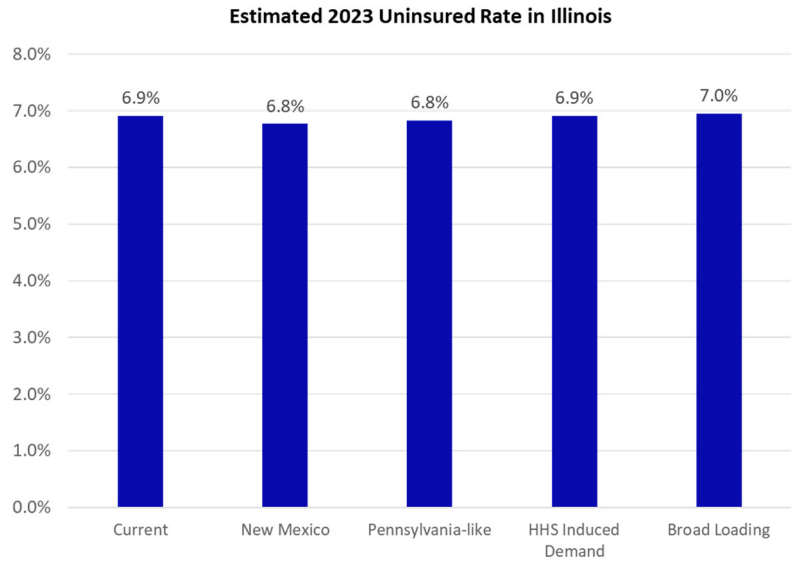


Impact on Uninsured Rates

One of the goals of this study is to estimate how uninsured rates would change for Illinois residents under the alternative rate setting approaches that are being explored. Chart 33 shows the estimated total uninsured rate[26] in 2023 for each of the alternative approaches as well as at current pricing levels. The New Mexico Approach and Pennsylvania-like Approach would be expected to drive a slight decrease in the uninsured rate while the Broad Loading Approach would be expected to drive a slight increase in the uninsured rate.

[26] Estimated based on 2021 uninsured rates, adjusted for enrollment changes in the Individual market from 2021 to 2023.

Chart 33



Charts that compare the expected uninsured rates by FPL, age, region, and ethnicity for each of the alternative rate setting approaches that were explored can be found in the Appendix D. As with the overall uninsured rates, we estimate that there would not be expected to be significant variation in the expected impact on the uninsured rates amongst the segments within the different demographic categories.

Additional Important Considerations

The results provided in this report are reflective of best estimates based on assumed premium rate changes under each of the approaches that were explored, as detailed in Table 2. Some additional important items that should be considered before finalizing any policy decisions include the following:

- Over the long run, compared to the current approach, all of the alternative rate setting approaches that have been explored would be expected to create greater consistency in the market with respect to metal pricing relativities across carriers. However, in the short term, each of the alternative rate setting approaches that were modeled would create varying degrees of disruption to carriers' current premium rates (see Appendix A). The disruption to current rates that is created under these approaches could result in near-term changes to the market that are undesirable, including but not limited to: decisions by some carriers to exit the market, decisions by some carriers to no longer offer certain plans or Metal levels, consumers experiencing significant swings in their premium rates (from year-to-year), and increased uncertainty for carriers in projecting future costs if there are material changes in enrollment between carriers due to premium rate swings.
- Both the New Mexico and Pennsylvania-like approaches assume only 87% and 94% CSR eligible members enroll in on-Exchange Silver plans. Currently, approximately 31% of on-Exchange Silver enrollees in Illinois are in base Silver or 73% Silver CSR plans. Based on CMS' Open Enrollment Public Use files, for 2023, we estimate that approximately 14% of on-Exchange Silver enrollees in New Mexico are still in base Silver or 73% Silver CSR plans and approximately 29% of on-Exchange Silver enrollees in Pennsylvania are still in base Silver or 73% Silver CSR plans. If all of the current Silver on-Exchange enrollees in Illinois who are in base Silver or 73% Silver CSR plans don't move to Bronze or Gold plans, the Actuarial Value used for Silver on-Exchange plans may be too high relative to the

anticipated paid-to-allowed ratio for on-Exchange Silver plans by approximately 3% to 5%. This "overpricing" could manifest itself in a couple of different ways: 1) the profit margin that the carrier anticipated and planned for would be greater than expected for on-Exchange Silver plans or 2) the carriers could adjust the rates of other metal plans down (essentially underpricing the plans) so that the profit across the entire book of business meets their target expectations.

- The New Mexico Approach utilizes standard Metal Actuarial Values (i.e., 0.70 for base Silver, 0.73 for 73% CSR, 0.87 for 87% CSR, and 0.94 for 94% CSR plans) from the federal Actuarial Value Calculator in the development of the CSR load. Base Silver paid-to-allowed ratios have historically been higher than a 0.70 Metal Actuarial Value and carriers have generally reflected the higher observed Actuarial Values for base Silver plans in their pricing. Therefore, if the CSR load under the New Mexico Approach were applied directly to the Actuarial Values used currently by carriers for their base Silver plans, we would anticipate that, even if only 87% and 94% CSR eligible members enroll in on-Exchange plans, the resulting Actuarial Values of Silver on-Exchange plans may be too high relative to the anticipated paid-to-allowed ratio for on-Exchange Silver plans by as much as 4%.

- A uniform CSR load is prescribed across all carriers under the New Mexico and Pennsylvania-like approaches. To the extent the distribution of enrollees among Silver plans (i.e., base Silver, 73% CSR, 87% CSR, and 94% CSR plans) is not the same across all carriers, then the Actuarial Values of on-Exchange Silver plans will be either too high or too low for certain carriers.

- The modeling results included in this report assume an ACA environment consistent with that which is in place in Illinois for 2023, including the following: no differences in the make-up or volume of carriers offering Individual ACA coverage, the availability of enhanced federal premium subsidies that are consistent with those made available under ARPA and extended via the Inflation Reduction Act (IRA), no Basic Health Program, and no funding of CSR subsidies by the federal government. To the extent material changes were to occur, we would expect that actual results would vary, potentially significantly, from those being projected in this analysis.

- The level of authority that a state has to approve or disapprove rates may play an important role in the ability to prescribe a market-wide rating approach, particularly if that approach includes state-prescribed factors that differ from carriers' actuarially supported pricing assumptions. Both New Mexico[27] and Pennsylvania[28] appear to have rate approval authority, which is something we understand that the Illinois Department of Insurance does not currently have.

- The Broad Loading Approach would be expected to produce Actuarial Values for on-Exchange Silver plans that are too low relative to actual anticipated paid-to-allowed ratios and Actuarial Values for other metal levels that are too high relative to actual anticipated paid-to-allowed ratios.

- While the New Mexico and Pennsylvania-like approaches would be expected to have a favorable impact on the average net premium rates of consumers, each approach would be projected to result in higher average increases to gross premium rates (i.e., impacts of +8.9% and +4.8% due solely to changes to the CSR loads and induced demand factors, respectively) than the other approaches would.

[27] https://www.truehealthnewmexico.com/aca-rate-increase-justification/#:~:text=True%20Health%20New%20Mexico%20submits,are%20posted%20on%20its%20website.

[28] https://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Pages/ACA-Health-Rate-Filings.aspx

Changes in gross premium rates are typically what get communicated to the public and could result a negative public reaction if the overall pricing impacts are not fully understood.

8. Distribution and Use

Usage and Responsibility of Client – Oliver Wyman prepared this report for the sole use of the client named herein for the stated purpose. This report includes important considerations, assumptions, and limitations and, as a result, is intended to be read and used only as a whole. This report may not be separated into, or distributed, in parts other than by the client to whom this report was issued, as needed, in the case of distribution to such client's directors, officers, or employees. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client named herein.

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9. Considerations and Limitations

Data Verification – For our analysis, we relied on publicly available data and information provided by the client named herein without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. Our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions might therefore be unreliable.

Unanticipated Changes – We based our conclusions on the estimation of the outcome of many contingent events. We developed our estimates from historical experience, with adjustments for anticipated changes. Unless otherwise stated, our estimates make no provision for the emergence of new types of risks not sufficiently represented in the historical data on which we relied or which are not yet quantifiable.

Internal / External Changes – The sources of uncertainty affecting our estimates are numerous and include factors internal and external to the client named herein. Internal factors include items such as changes in provider reimbursement and claims adjudication practices. The most significant external influences include, but are not limited to, changes in the legal, social, or regulatory environment, and the potential for emerging diseases. Uncontrollable factors such as general economic conditions also contribute to the variability.

Uncertainty Inherent in Projections – While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events and are subject to economic and statistical variations from expected values. We have not anticipated any extraordinary changes to the regulatory, legal, social, or economic environment or the emergence of new diseases or catastrophes that might affect our results. For these reasons, we provide no assurance that the emergence of actual experience will correspond to the projections in this analysis.

10. Acknowledgement of Qualifications

The authors Ryan Schultz, Gabe Rivera, and Peter Kaczmarek are Fellows in the Society of Actuaries and John Rienstra is an Associate in the Society of Actuaries; all four authors are members of the American Academy of Actuaries and meet that body's qualification standards to perform the work herein. This work conforms with the Actuarial Standards of Practice.

Appendix A. Overview of Oliver Wyman's Healthcare Reform Microsimulation Model

The Healthcare Reform Microsimulation (HRM) Model is an economic utility model that captures the flow of individuals across various markets and coverage options based on their economic purchasing decisions and is integrated with actuarial modeling designed to assess the impact various reforms are expected to have on the health insurance markets. This model is a leading-edge tool for analyzing the impact of various healthcare reforms or proposed legislation.

The HRM Model projects the number of individuals expected to seek coverage under each health insurance coverage type using economic utility functions. The decision-making process for determining which health insurance coverage type is selected is made at the health insurance unit (HIU) level, where an HIU is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. One exception to this is that individuals who are identified as being eligible for Medicare, Medicaid, CHIP, and other government sponsored coverage (e.g., government workers) are assumed to retain their government sponsored coverage, and the economic utility associated with employer-based coverage, individual market coverage or being uninsured is only evaluated by the HRM Model for the remaining individuals within an HIU.

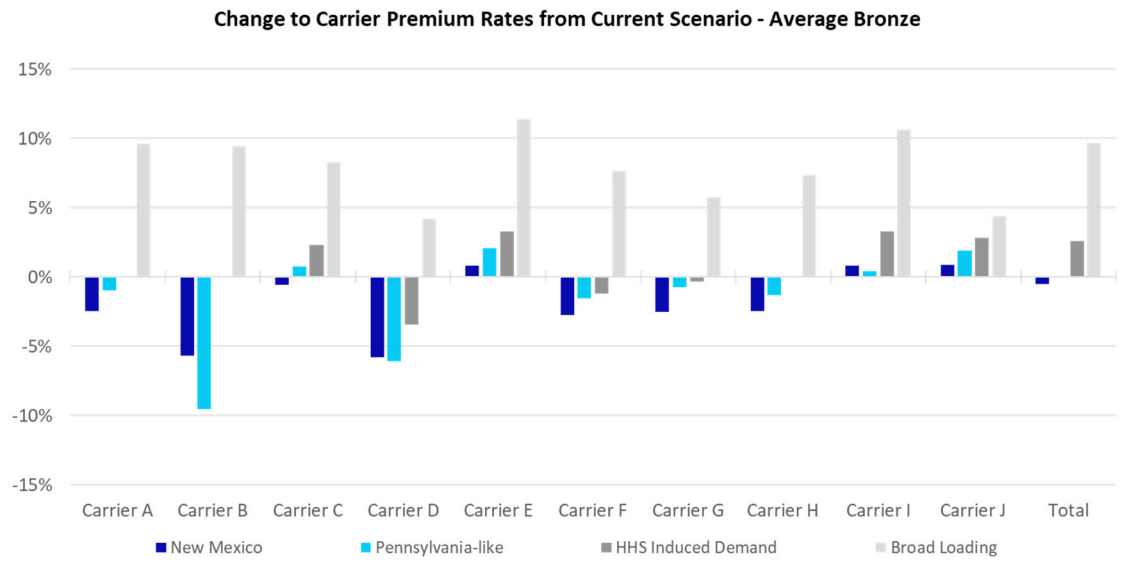
HIUs are generally assumed to make economically rational decisions in selecting the health insurance option that maximizes the economic utility for the HIU. The HRM Model allows for some irrational behavior, including the principle of "inertia" in HIU decision making (i.e., people are unlikely to make significant changes in their situation for relatively small changes in utility) and the assumption that not all uninsured individuals will actually shop for health insurance coverage each year.

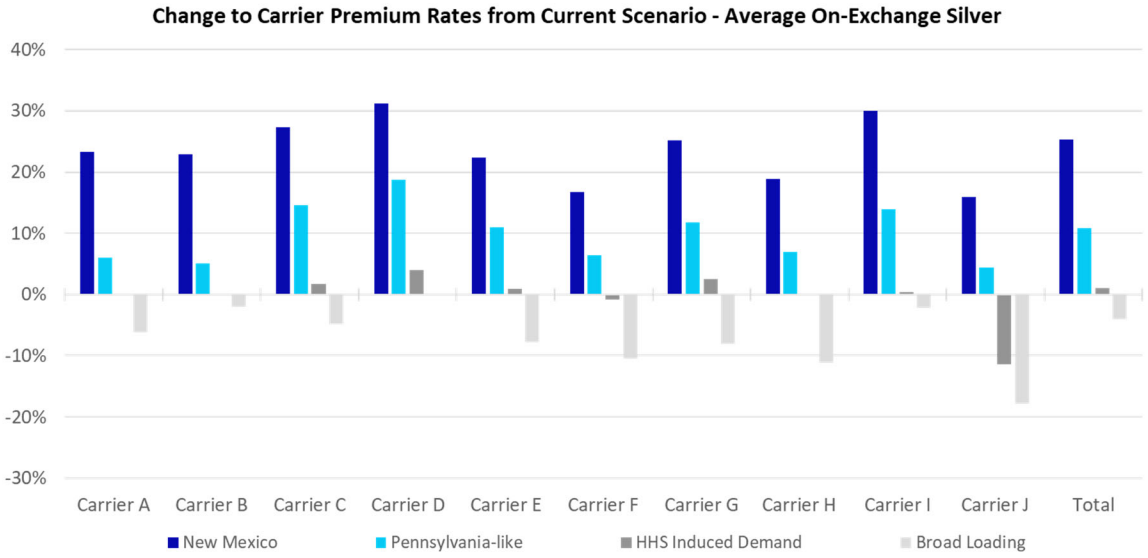
An HIU's decision to enroll in ACA coverage is based on the lowest cost Bronze, Silver, or Gold plan available in each rating area which provides the greatest economic value. Both on-Exchange and off-Exchange plans are made available to each HIU, with PTCs applied to eligible HIUs. The economic utilities for all members of the HIU are aggregated to develop the corresponding utility for the HIU under each health insurance option.

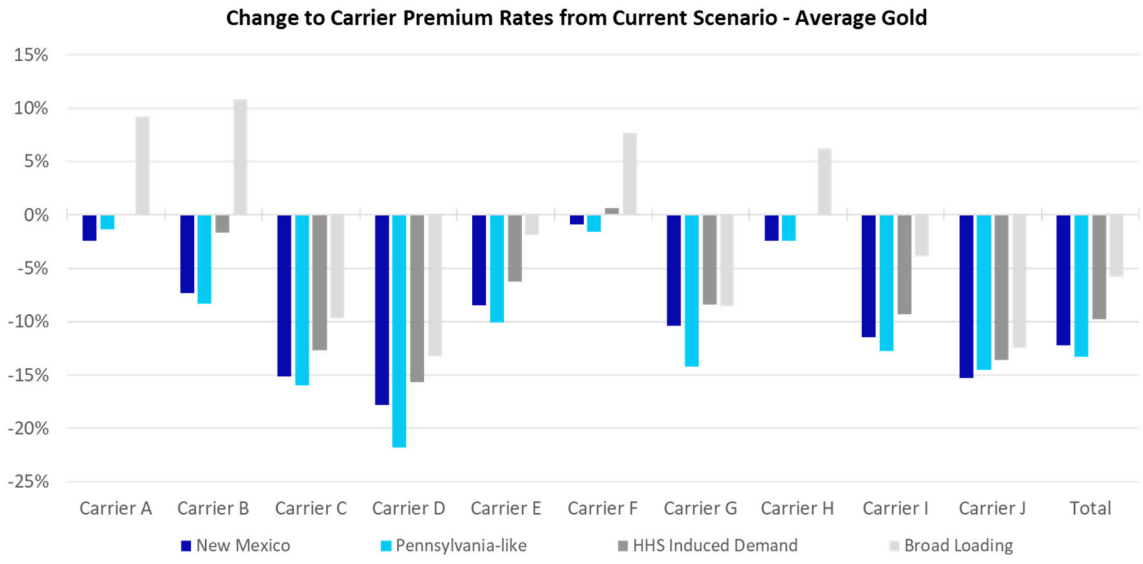
Individuals identified as working for private employers are randomly categorized into synthetic employer groups of varying group sizes based on the distribution of group size from the Medical Expenditure Panel Survey (MEPS). An employer-based economic utility function, which takes into account items such as the expected costs which would be incurred as a result of not offering coverage (e.g., the penalty for not offering coverage) and the benefits that would be available to an employer's employees if they were to purchase coverage in the individual market (e.g., PTCs), determines whether a given employer will offer health insurance coverage to its employees and their dependents. If an employer offers coverage, all eligible employees and their dependents within each HIU (i.e., individuals who are not eligible for health insurance coverage through a government sponsored program) are assumed to evaluate the health insurance coverage options offered by the employer.

The decision as to whether an HIU will take up coverage in either the employer-based market, the individual market, or choose to be uninsured is based on the result from comparing two economic utility functions. The first economic utility function calculates the utility associated with taking up coverage in either the employer-based market or the individual market (depending on whether the employer of the primary or spouse within an HIU is modeled to offer coverage) and is a function of the premium the HIU would be expected to pay (net of employer subsidies or federal premium subsidies, respectively), any cost-sharing the HIU would be expected to pay out-of-pocket (net of any CSRs for applicable individual market coverage), and the risk aversion of the HIU. If multiple coverage options are available (e.g., employer coverage, individual market bronze-level coverage, individual market silver-level coverage), the utility of each coverage option is evaluated and the best option is selected. The second economic utility function calculates the utility associated with not taking coverage and remaining uninsured and is a function of any tax penalty the HIU would be assessed, total allowed claim costs for the HIU (assuming a reduced level of utilization due to the lack of insurance coverage), and the risk aversion of the HIU. If the utility of being uninsured is greater than the utility associated with taking up health insurance coverage, the HIU is assumed to be uninsured. Otherwise, the HIU is assumed to take up coverage in either the employer-based market or the individual market for the coverage option that provides the maximum utility for the HIU.

Appendix B. Projected Rate Impacts of Alternative Approaches by Carrier

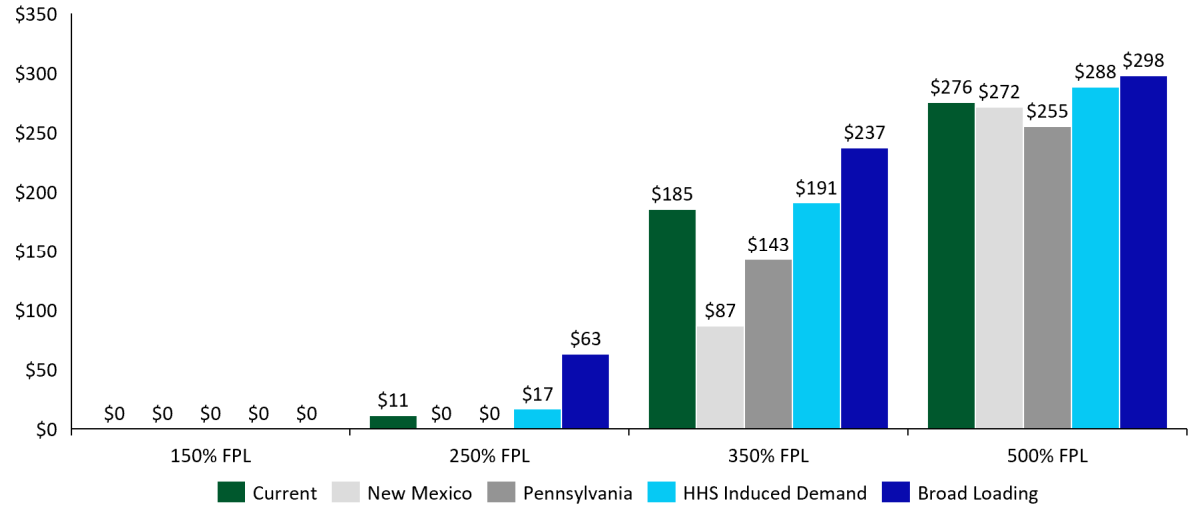




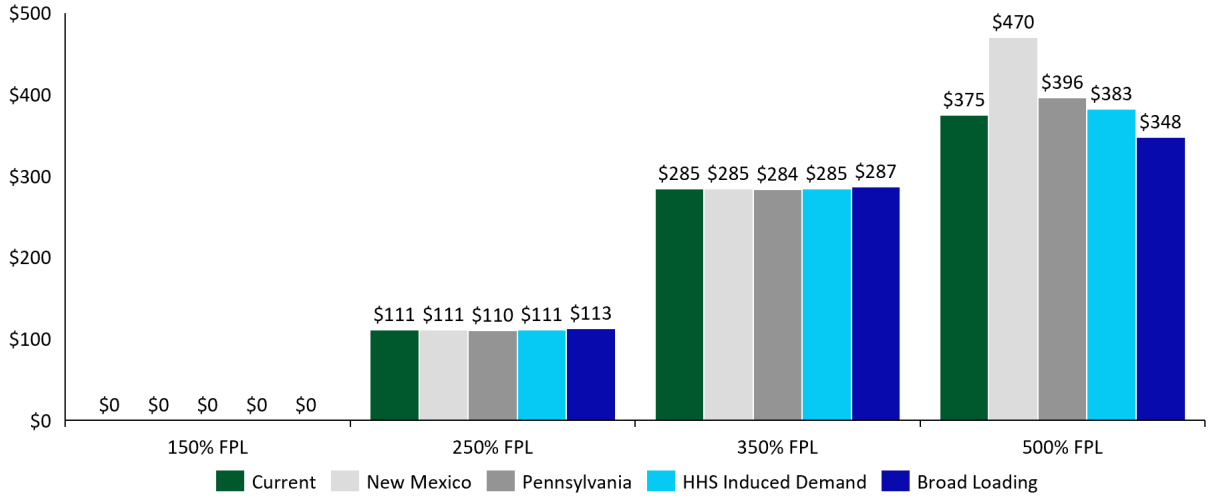

Change to Carrier Premium Rates from Current Scenario - Average Gold
15%
10%
5%
0%
-5%
-10%
-15%
-20%
-25%
Carrier A
Carrier B
Carrier C
Carrier D
Carrier E
Carrier F
Carrier G
Carrier H
Carrier I
Carrier J
Total
New Mexico
Pennsylvania-like
HHS Induced Demand
Broad Loading

Appendix C. Premium Case Studies under the Alternative Rate Setting Approaches

40 Year-Old Single – Rating Area 1 – Lowest Cost Bronze – 2023 Monthly Net Premium by Income

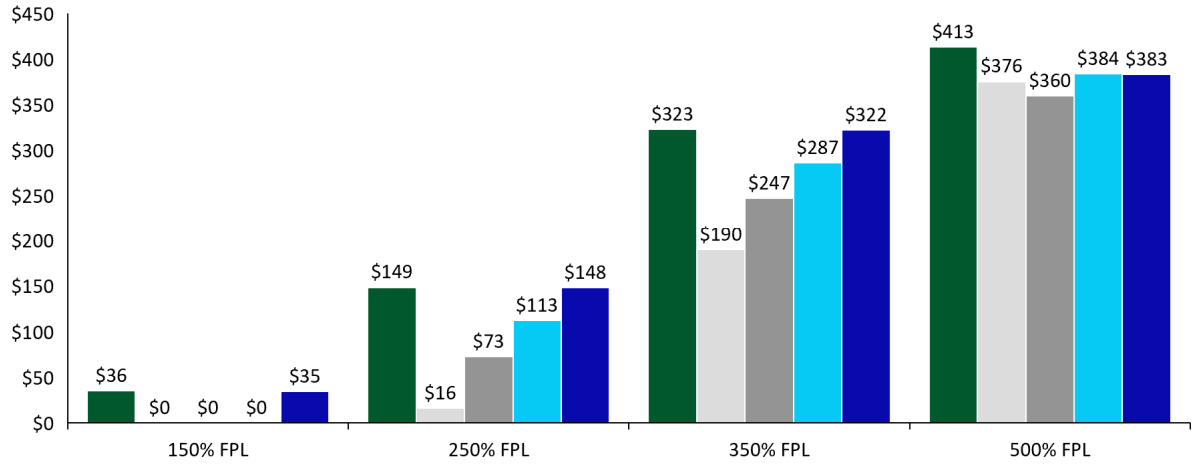


40 Year-Old Single – Rating Area 1 – Lowest Cost On-Exchange Silver – 2023 Monthly Net Premium by Income

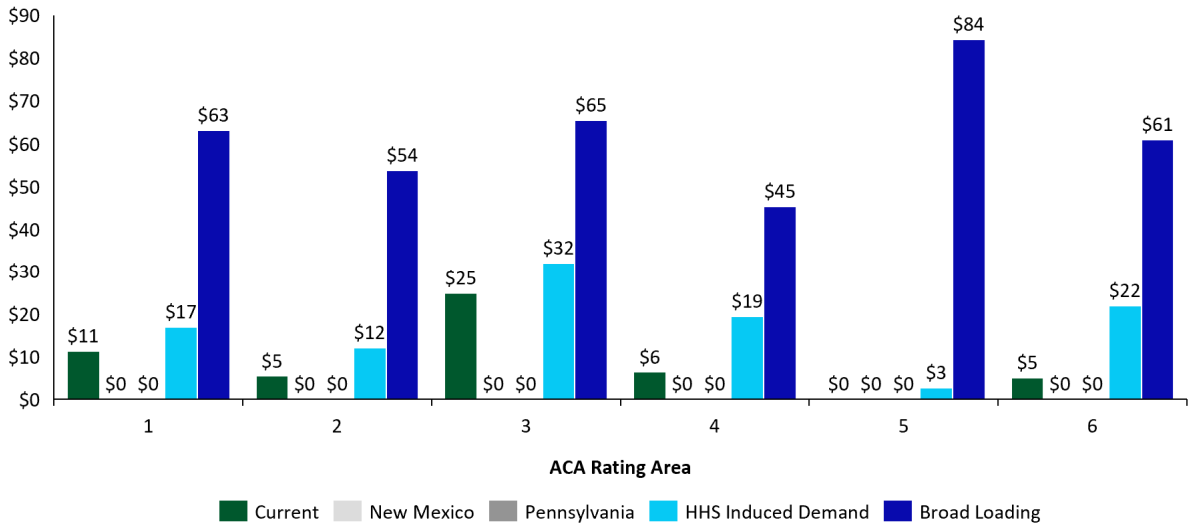


© Oliver Wyman

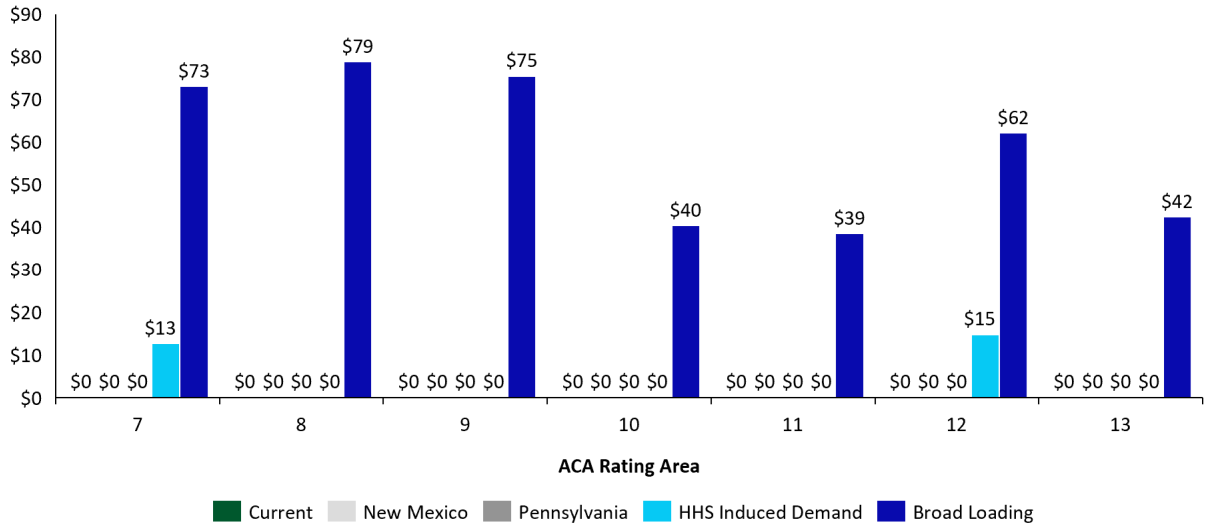
40 Year-Old Single – Rating Area 1 – Lowest Cost Gold – 2023 Monthly Net Premium by Income



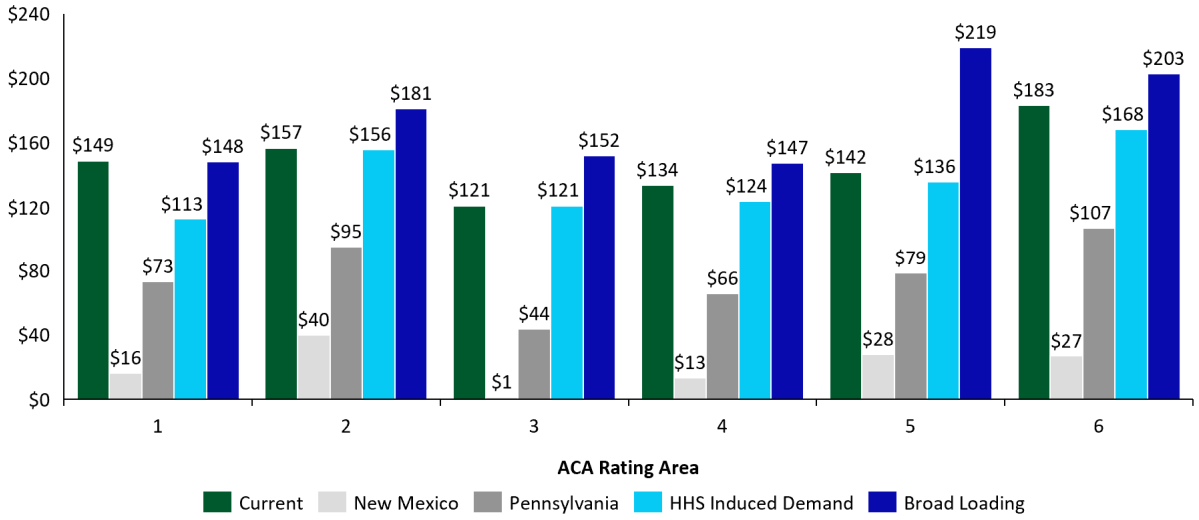
40 Year-Old Single – Rating Areas 1-6 – Lowest Cost Bronze – 2023 Monthly Net Premium at 250% FPL



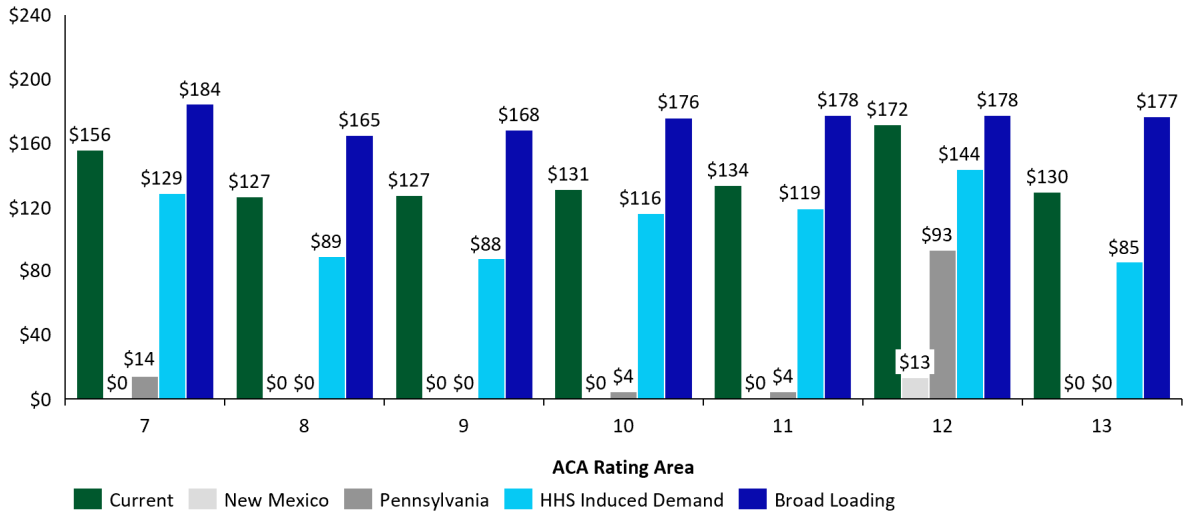
40 Year-Old Single – Rating Areas 7-13 – Lowest Cost Bronze – 2023 Monthly Net Premium at 250% FPL



40 Year-Old Single – Rating Areas 1-6 – Lowest Cost Gold – 2023 Monthly Net Premium at 250% FPL

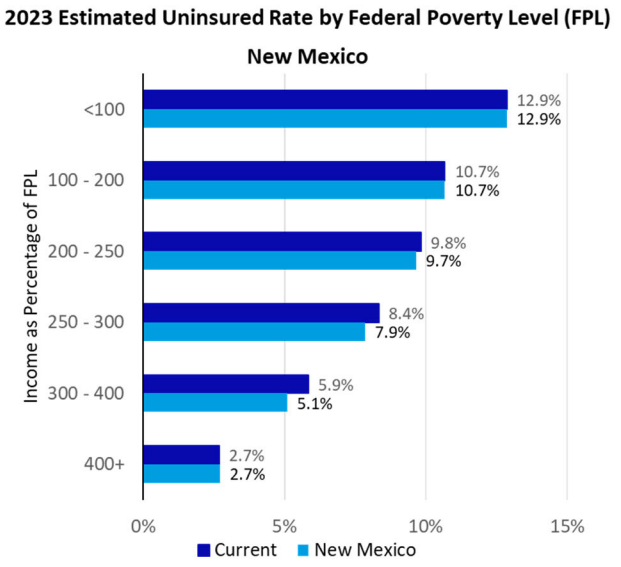


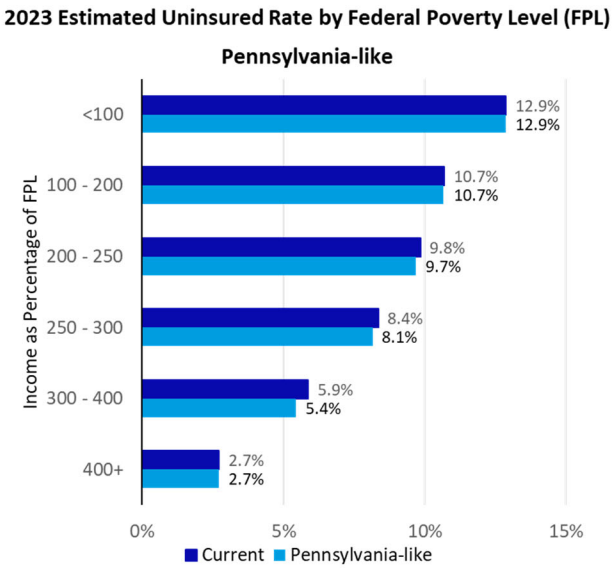
40 Year-Old Single – Rating Areas 7-13 – Lowest Cost Gold – 2023 Monthly Net Premium at 250% FPL

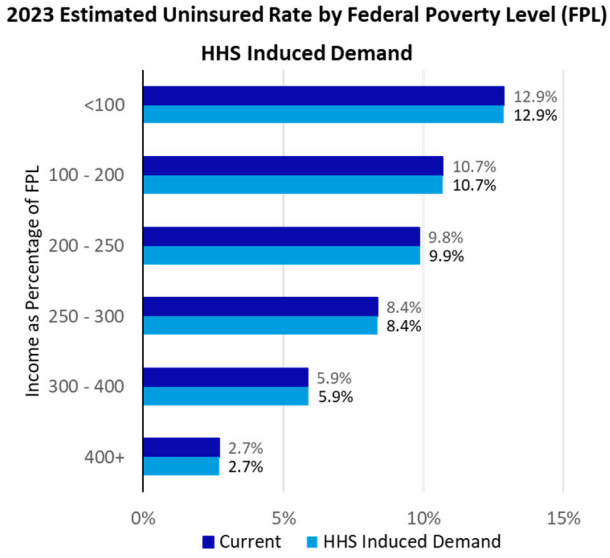


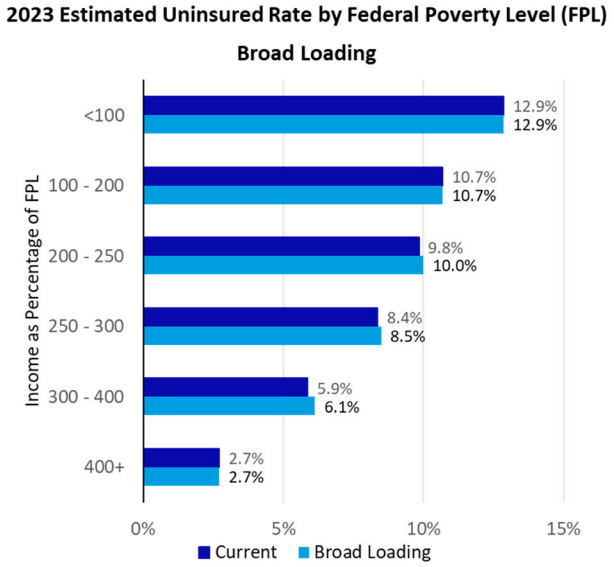
Appendix D. Uninsured Rate Impact under the Alternative Rate Setting Approaches

Uninsured Impact by FPL

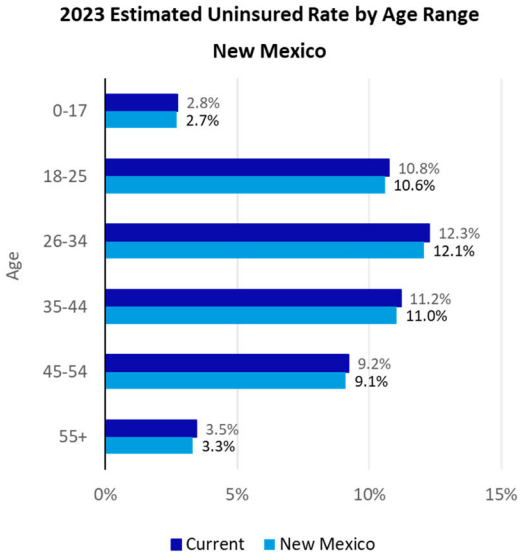


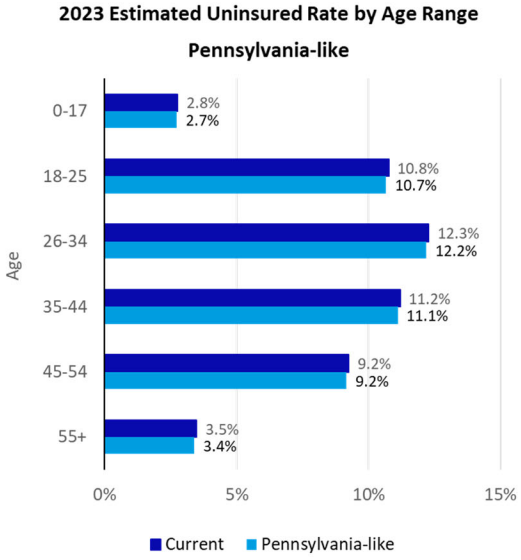


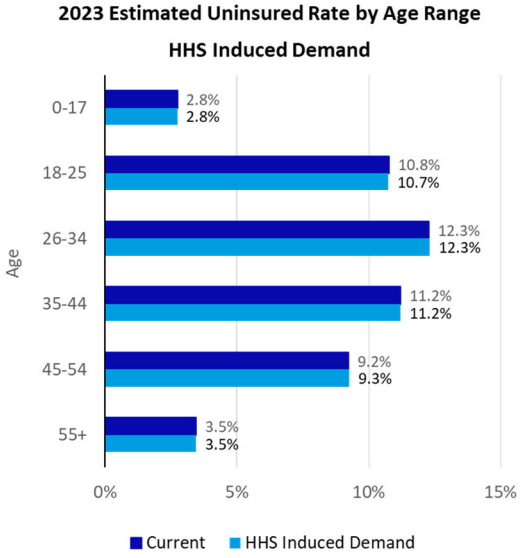


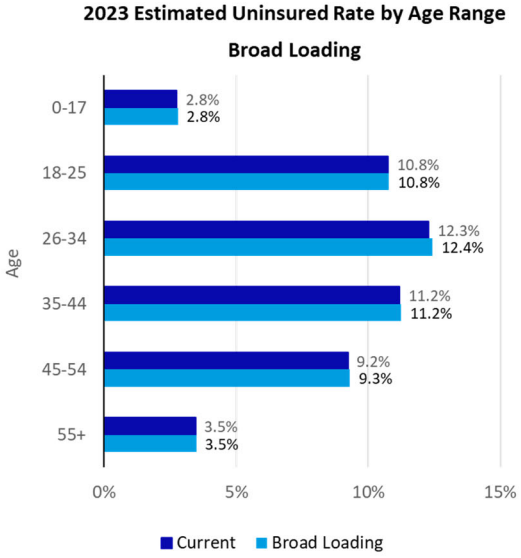


Uninsured Impact by Age

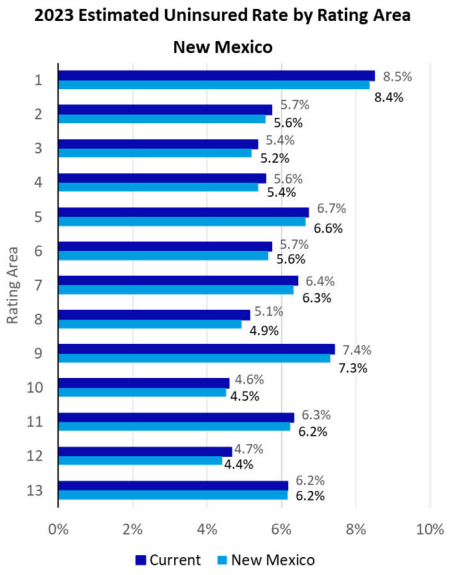


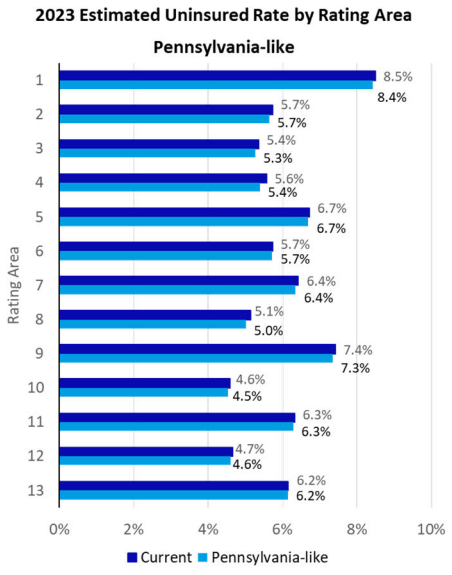


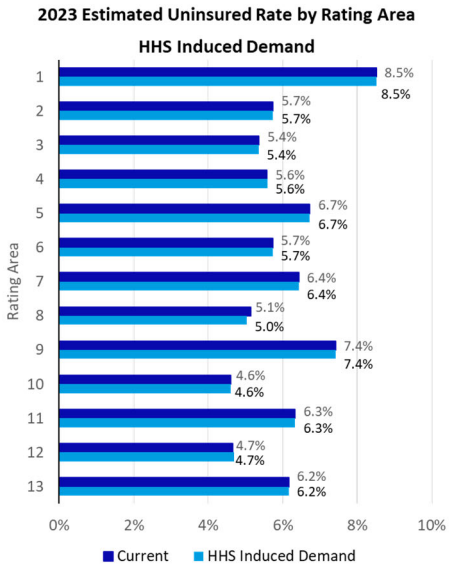


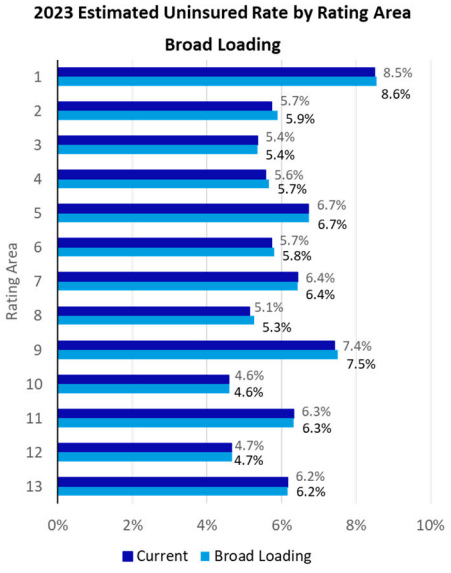


Uninsured Impact by Region

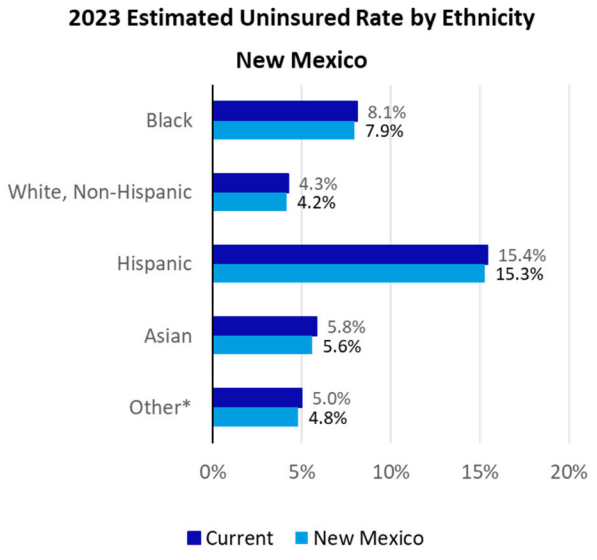


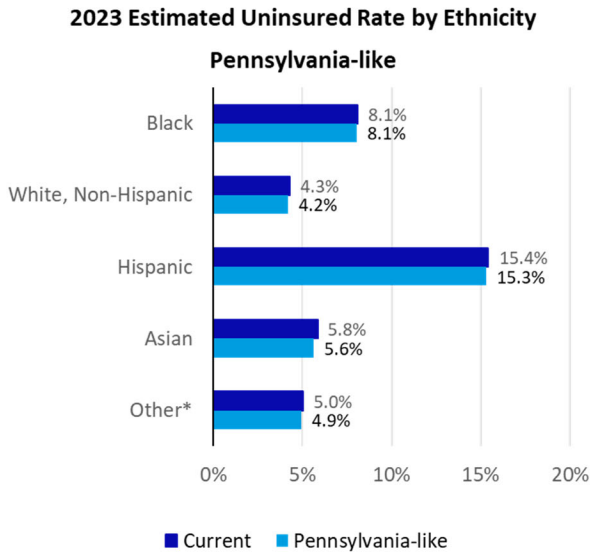


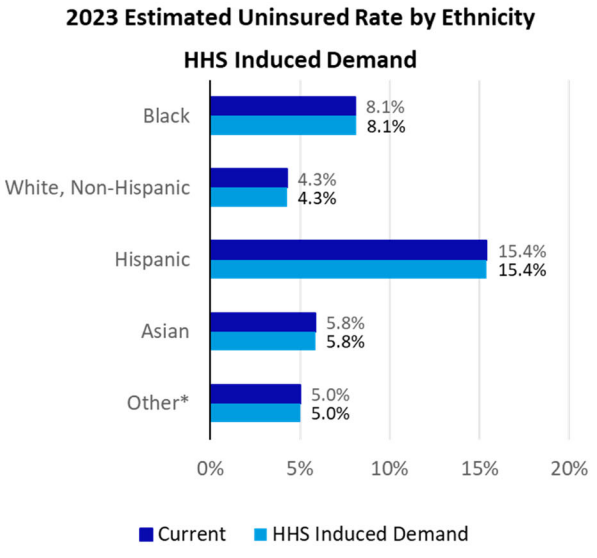


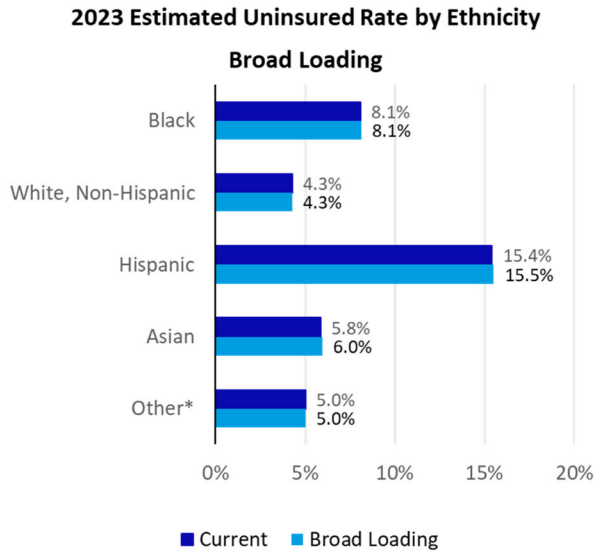


Uninsured Impact by Ethnicity









Appendix E. Glossary Table

Terms	Definitions
ACA Marketplace	The Affordable Care Act (ACA) Marketplace is a platform created for carriers to compete and offer health plans to the Individual and Small Group markets.
ACA Rating Area	These are registered geographic regions within the state that allow carriers to vary their rates to account for specific regional differences in healthcare costs. Illinois has 13 distinct ACA Rating Areas.
Actuarial Value	The percentage of total cost for covered benefits that a plan will cover on average. For example, if a plan has an actuarial value of 80%, on average, the plan would be expected to pay 80% of the costs with the enrollee paying the other 20%.
Actuarial Value Calculator	The Actuarial Value Calculator (AV Calculator) is a tool provided by the Federal government to estimate the Actuarial Value of a plan.
American Rescue Plan Act (ARPA)	The American Rescue Plan Act (ARPA) is a federal stimulus bill implemented in March of 2021 to aid public health and economic recovery from the COVID-19 pandemic. Specific to the ACA Market, ARPA increased both the percent of people eligible to receive subsidies and the amount of the subsidies.
APTC (aka., Premium Subsidy)	The Advanced Premium Tax Credit (APTC) is a subsidy provided to enrollees who purchase an ACA plan via the Exchange. The amount of the subsidy will vary depending on the enrollee's income as compared to the Federal Poverty Limit (FPL).
The Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides health coverage to eligible children whose family may not qualify for Medicaid but do not earn enough to afford private insurance.
Cost Sharing	The share of insurance costs that enrollees pay out of pocket. These include Copays, Deductibles and Coinsurance.
Cost-Sharing Reduction Subsidies (CSRs)	Subsidies available to lower-income enrollees (between 100% and 250% of FPL) who sign up for a Silver plan through the ACA Marketplace that reduces the enrollee's cost sharing (deductibles, copays, coinsurance). Initially, these subsidies were paid by the federal government. Currently, these subsidies are required to be paid for by the insurance carriers.
CSR Load (aka., Silver Loading)	The factor that carriers develop to estimate the amount of the CSR Subsidy they are currently responsible for, which then gets added to plan rates during pricing as a 'Load'.
Data Call	A data request by the Illinois Department of Insurance (developed by Oliver Wyman) to carriers with Individual ACA business to submit the data needed to support this Premium Misalignment study.
Federal Poverty Level (FPL)	The Federal Poverty Level (FPL) is a measurement factor used to determine subsidy amounts in the ACA Marketplace. For example, someone who earns twice the pre-determined FPL amount would be eligible for the subsidy amounts designated for someone who is at the 200% of FPL level.
Gross Premium	The total premium developed by carriers for a plan inclusive of administrative loads but is NOT reduced to account for enrollee subsidies.
Healthcare Reform Microsimulation (HRM) Model	The Healthcare Reform Microsimulation (HRM) Model is a proprietary Oliver Wyman model used to estimate impacts of regulatory or healthcare landscape changes.
Individual ACA Market	The Individual ACA Market primarily represents individuals and families who are not covered by Medicare, Medicaid or Employer plans who purchase ACA-compliant plans.
Induced Demand Factors (IDF)	Factors intended to represent the anticipated increase in utilization for plans with richer benefits. These factors EXCLUDE health status in their estimates and calculations.

Metal Actuarial Values	Represents the Actuarial Value associated with different Metal Levels as determined by the Actuarial Value Calculator. Gold plans hold an actuarial value between 78%-82%, Silver between 70%-72% and Bronze a 58%-65%.
Net Premium	The gross premium rate less federal premium subsidies.
Off-Exchange	ACA Health insurance plans that are not purchased through the Health Insurance marketplace and are instead purchased directly from an insurance provider or through a broker.
On-Exchange	Health insurance plans that are purchased directly from the Health Insurance Marketplace. Enrollees eligible for health care subsidies must enroll on-exchange to receive benefits.
Open Enrollment	The period of time in which all enrollees are able to make ACA Marketplace plan selections. Occurs annually between November 1st and January 15th. Outside of this period, only those who experience qualifying life events may make a plan selection.
Paid-to-Allowed Ratio	The ratio of actual claims paid to health care providers by the carrier (paid claims) over the total value of claims both the insurer and enrollee are responsible for (allowed claims).
Plan-Level Adjustment	An adjustment that can be applied at the plan-level and that is allowed under the ACA to produce varying rates by plan.
PMPM	Per Member Per Month
Qualified Health Plans	An insurance plan that's certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act.
Risk Adjustment	A federal program through which carriers who enroll members with higher than average health risks are compensated by the carriers that enrolled members with lower than average health risks.
Silver Level Plan Type	On-Exchange Silver CSR variant plans have different actuarial values (AVs) based on income. For enrollees with income at or below 150% FPL the AV is 94% (94% CSR), between 151% and 200% the AV is 87% (87% CSR), and between 201% and 250% the AV is 73% (73% CSR).
Subsidized Market	Subset of Individual ACA Market that includes enrollees receiving subsidies.
Unified Rate Review Template	Unified Rate Review Template (URRT) is the standardized federal template that all carriers offering ACA Marketplace plans must complete. This template summarizes the historical experience, provides the adjustments made to project future experience and ultimately provides the premium rates that will be charged by plan.

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