

SPECIAL ENROLLMENT PERIODS AND THE NON-GROUP, ACA-COMPLIANT MARKET

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Executive Summary

Oliver Wyman reviewed data from health insurance issuers to understand the impact that special enrollment periods (SEP) are having on the non-group, ACA-compliant market. We found that individuals enrolling during an SEP represent a significant and growing share of exchange enrollment. Moreover, we found that SEP enrollees have higher morbidity than those who enrolled during the open enrollment period (OEP) and were much more likely, on average, to lapse coverage than those that enrolled during the OEP. Specifically, we found:

- SEP enrollment represented 17% of total exchange enrollment during 2014, and represented almost 20% of active enrollees at December 31, 2014.
- The per member per month (PMPM) claim costs during 2014 for individuals that enrolled during an SEP were 10% higher than those that enrolled during the OEP.
- PMPM claim costs for SEP enrollees during 2014 were 24% higher on average during the first three months of enrollment than for OEP enrollees.
- In 2015, the difference in PMPM claims costs increased to 41% for the first three months of enrollment.
- SEP enrollees are more than 40% more likely, on average, to lapse coverage than those that enroll during the OEP (lapse rates were 3.5% per month for OEP enrollees as compared to 5.0% per month for SEP enrollees).
- SEP enrollees that chose plans with the highest actuarial values showed especially high costs during the first month of enrollment.
- Newborns who are born to a mother who enrolled during the OEP are considered SEP enrollees in our analysis, but we estimate that they contributed only 2.5% of the increased cost for all SEP enrollees during 2014.

Introduction

The Affordable Care Act (ACA) allows all individuals to enroll in a health plan on a guaranteed basis regardless of pre-existing conditions. To help manage selection, the ACA allows individuals to enroll only during a time-limited OEP, so individuals cannot wait until they become ill or require medical care before enrolling in a health plan. However, recognizing that a person's circumstances may change, the ACA makes allowances for an individual to enroll in non-group coverage outside of the OEP. Periods during which this is allowed are referred to as SEPs and are triggered when an individual meets certain criteria, such as when an individual loses their

employer-sponsored health coverage. Through regulation and guidance, the eligibility categories allowing an individual to qualify for an SEP have expanded to include over 30 different criteria and there is considerable concern among issuers that individuals are using SEPs to delay purchasing health insurance until a need arises. The resulting adverse selection results in individuals enrolling through SEPs costing far more than those enrolling during the OEP. This, in turn, increases the cost to provide health care for all enrollees. Eventually, this higher cost will be passed down to consumers in the form of higher premiums.

We were engaged by America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA) to collect and analyze data from issuers to quantify the impact of SEPs on the non-group market. This report provides the results of our analysis and compares the cost of individuals enrolling through an SEP to individuals enrolling during the OEP.

Data and Methodology

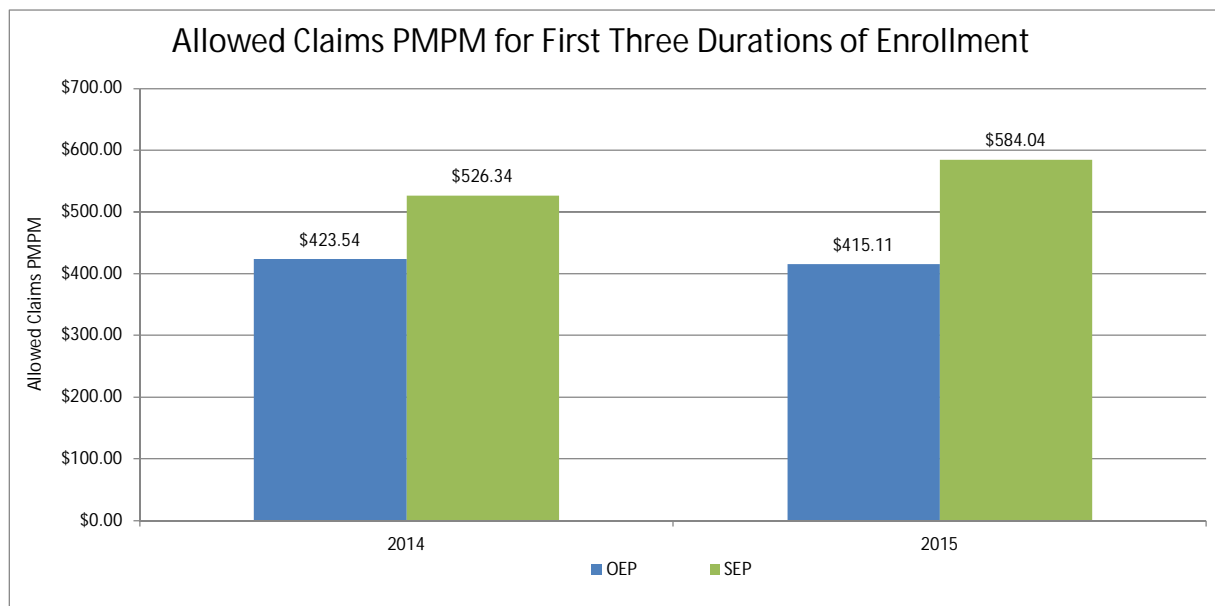
AHIP and BCBSA solicited their member plans to provide data to Oliver Wyman to support our work. Thirteen health insurance issuers responded to the data request and the results provided in this report reflect the collective data for these health plans. In total, the data represent 82 million member months, \$27 billion of premium from January 2014 through June 2015, and over \$26 billion in allowed claims (using claims incurred from January 2014 through June 2015 and paid through October 2015). We have \$15 billion of the premium in 2014, which we estimate represents more than 40% of the total premium for the non-group, ACA-compliant market.

The data provided by each issuer is aggregated data (earned premium, members, allowed claims, etc.) for each month and is split by the original effective date of the enrollee. For the purposes of this analysis, we have defined individuals that have an effective date from June through December 2014, and April through June 2015 as having enrolled through an SEP. In the event of a newborn, the data associated with the mother and other family members is identified based on their initial effective date, typically during the OEP. However, the newborn is assigned a new effective date which would be considered an SEP if enrolled during the months described above. We show below the impact that newborns have on the results of our analysis.

For lapse and durational studies, we excluded any lapses that occurred at calendar year-end to avoid counting members who changed plans during open enrollment as having lapsed. The data represent a cross-section of issuers that cover many states. The results we provide represent a weighted average for all of the issuers and are not necessarily representative of any specific issuer or market. Our analysis of claim costs focuses on allowed claims before the application of any cost-sharing.

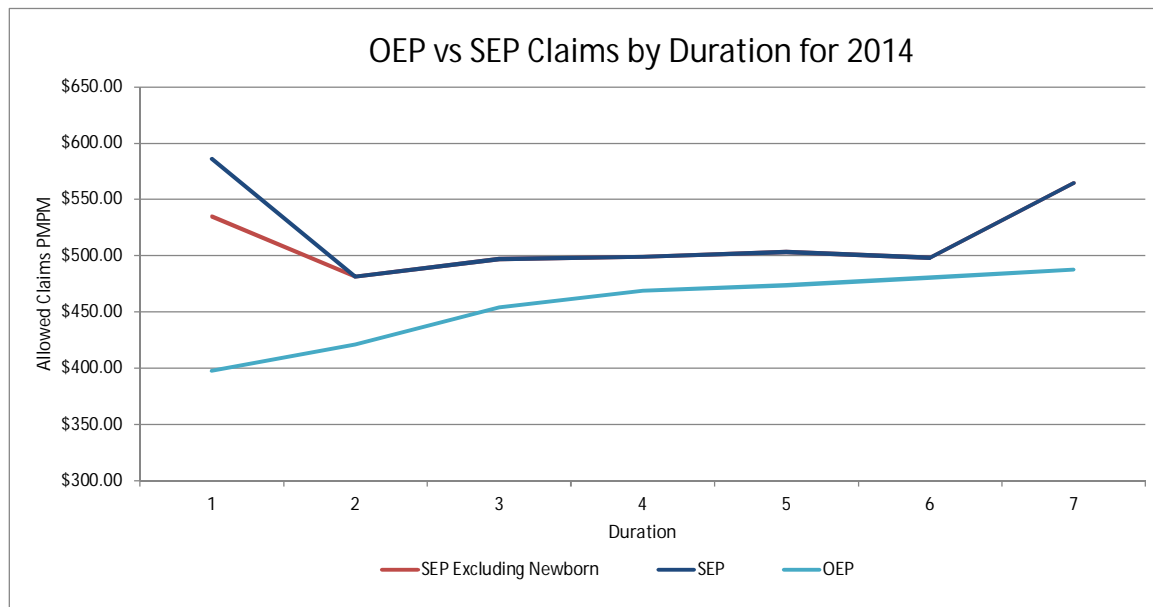
Detailed Results

Issuers' primary concern is that a portion of individuals who are enrolling through an SEP are doing so because of an immediate or imminent need for health care. Therefore, we compared PMPM claim costs for SEP and OEP enrollees during the first three months of coverage. In total, the average cost PMPM for the SEP enrollees was 24% higher over this period in 2014, and 41% higher in 2015. The chart below shows the average allowed claims PMPM during the first three months of enrollment.



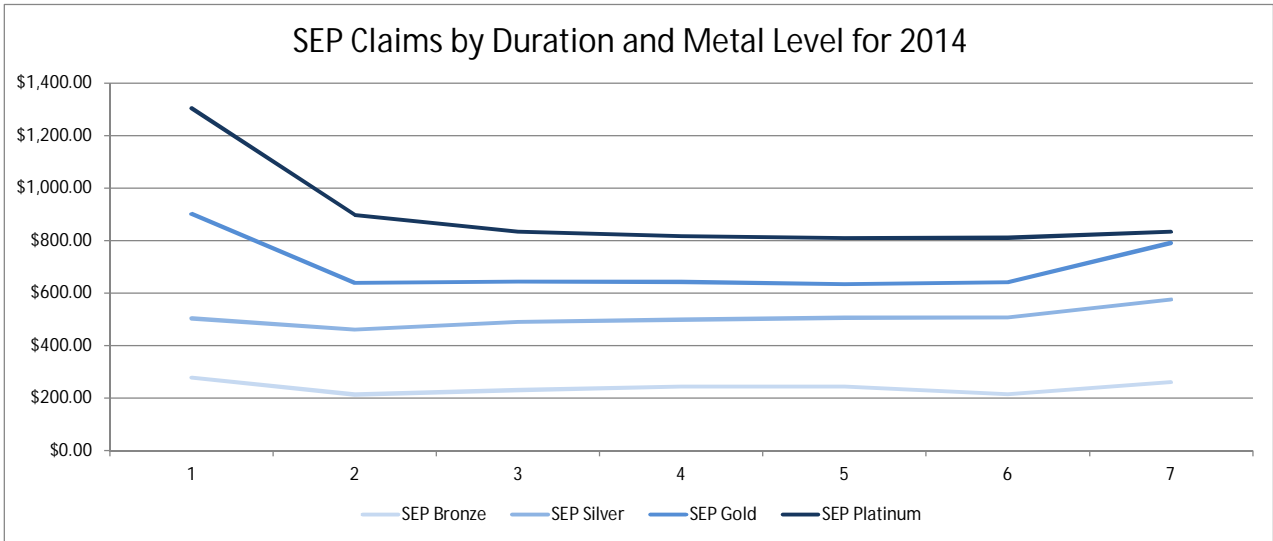
Beyond the first three months of enrollment, the claim costs for those that enrolled through an SEP remained higher than for OEP enrollees. As discussed previously, newborns that are born to mothers who enrolled during the OEP are identified as SEP in our data, even though their family unit previously was covered. While these newborns enrolled because of an SEP, it is more appropriate to include their costs as OEP for this analysis, since their parents were previously enrolled during the OEP. However, data limitations prevent us from using the issuer-provided data to remove the cost of these newborns from our analysis. Therefore, we reviewed a different claims database that accumulated data from a group of nationally representative issuers to assess the impact of the newborns. We found that the allowed claim costs for the newborns that are born to mothers who enrolled during the OEP represented 2.5% of the total allowed claim costs during 2014 for the individuals enrolling through an SEP.

The chart below shows claim costs by duration throughout 2014. Note that the duration only goes to seven months, which is the maximum duration for an individual that enrolled through an SEP in 2014. To understand how the newborn SEP issue affects our analysis, we reallocated 2.5% of the 2014 SEP claim costs to OEP to reflect the newborn costs. Note that in this chart we assumed that all of the newborn costs are incurred during the first month of enrollment.

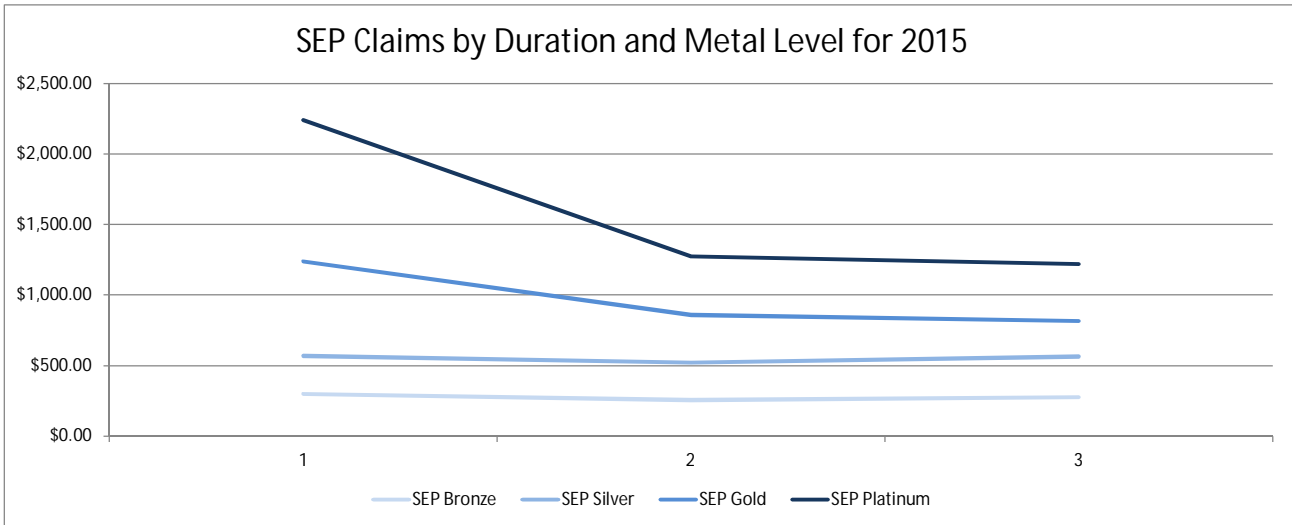


This chart illustrates that even after adjusting for the newborn costs, the data indicate that individuals with other health care needs are enrolling through SEPs and using health care services at higher rates shortly after enrollment.

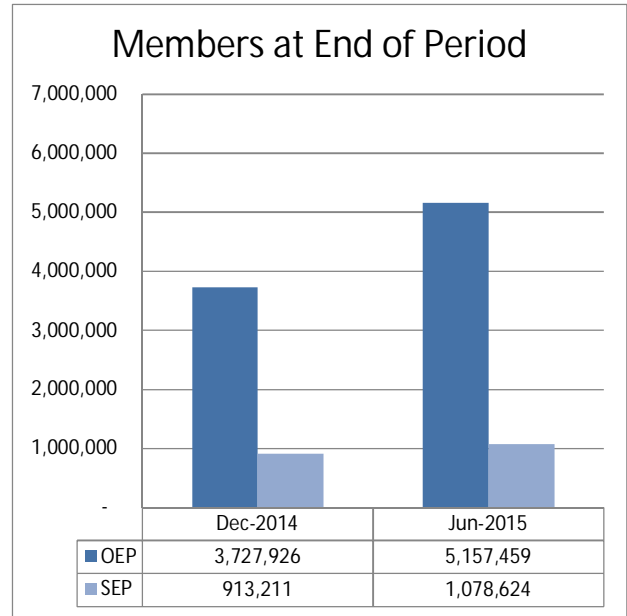
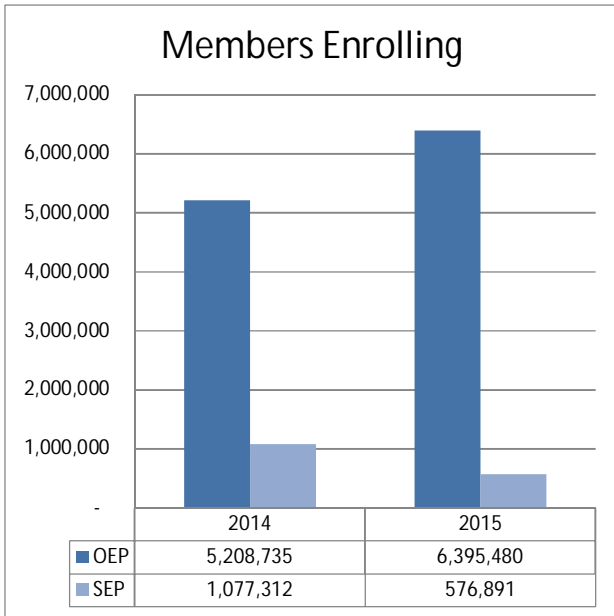
Individuals enrolling through an SEP have no limitations on the plans that they may choose to enroll in. Therefore, it is likely that enrollees that anticipate a greater need for health care services will enroll in a richer benefit plan. To illustrate this point, we split the SEP data from the prior chart based on the metal level of the health plan that was selected. As shown in the chart below, SEP enrollees choosing the richest benefit plans are also those with the highest costs during the first month of enrollment. Specifically, the claim costs for platinum enrollees in the first month are 56% higher than the average of all other months, but for gold and bronze enrollees, the first month is only 35% and 18% higher, respectively. There is almost no spike for silver plan enrollees.



Although we have only three months of data for the SEP enrollees during 2015, the claim costs by metal level follow a similar pattern, as shown below.

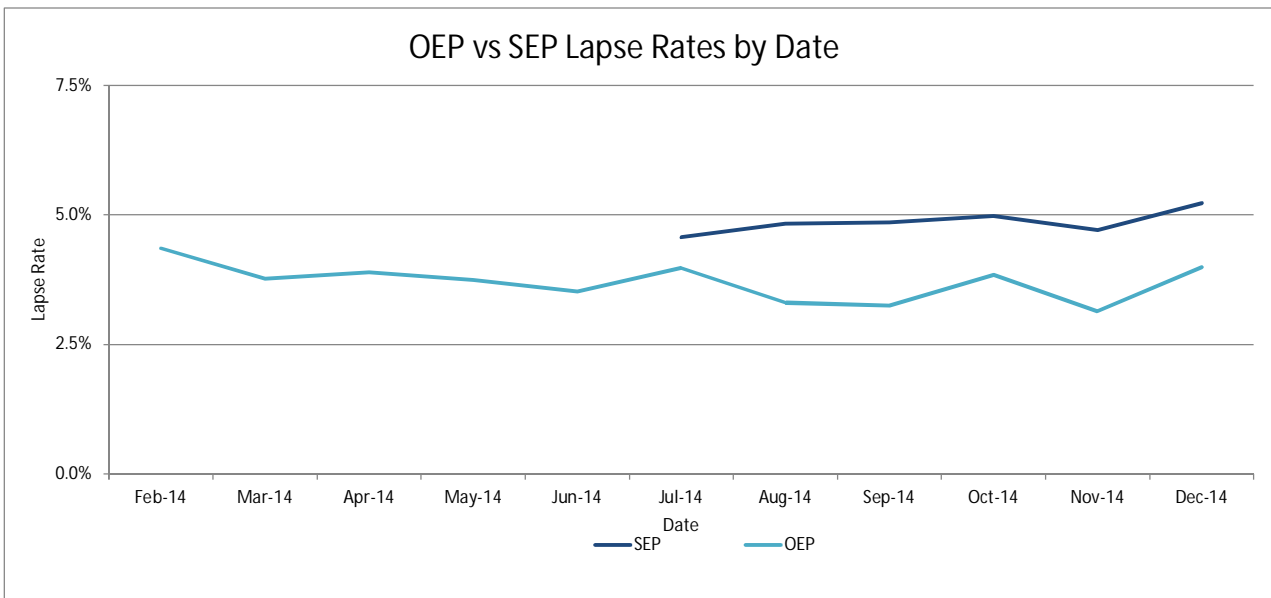


SEP enrollment represents a significant and growing portion of the total membership. In the chart below we show the total enrollees during 2014 and 2015 based on whether they enrolled in the OEP or through an SEP. We also show the membership at the end of the period.



During 2014, 17% of enrollment was through an SEP. With only three months of SEP enrollees during 2015, this amount already exceeded 8% of total enrollment. Furthermore, at the end of 2014, SEP enrollees represented almost 20% of total enrollees. As of June 2015, the SEP enrollees represent 17% but this amount will grow throughout the year.

Finally, in addition to higher claim costs, SEP enrollees lapse at a higher rate than the OEP enrollees. The table below shows the monthly lapse rates during 2014.



Limitations

This report does not constitute advice by Oliver Wyman to any third parties and is solely for informational purposes and not for purposes of reliance by any third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any third party.

For our analysis, we relied on data and information provided by health insurance issuers without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that 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 may need to be revised.