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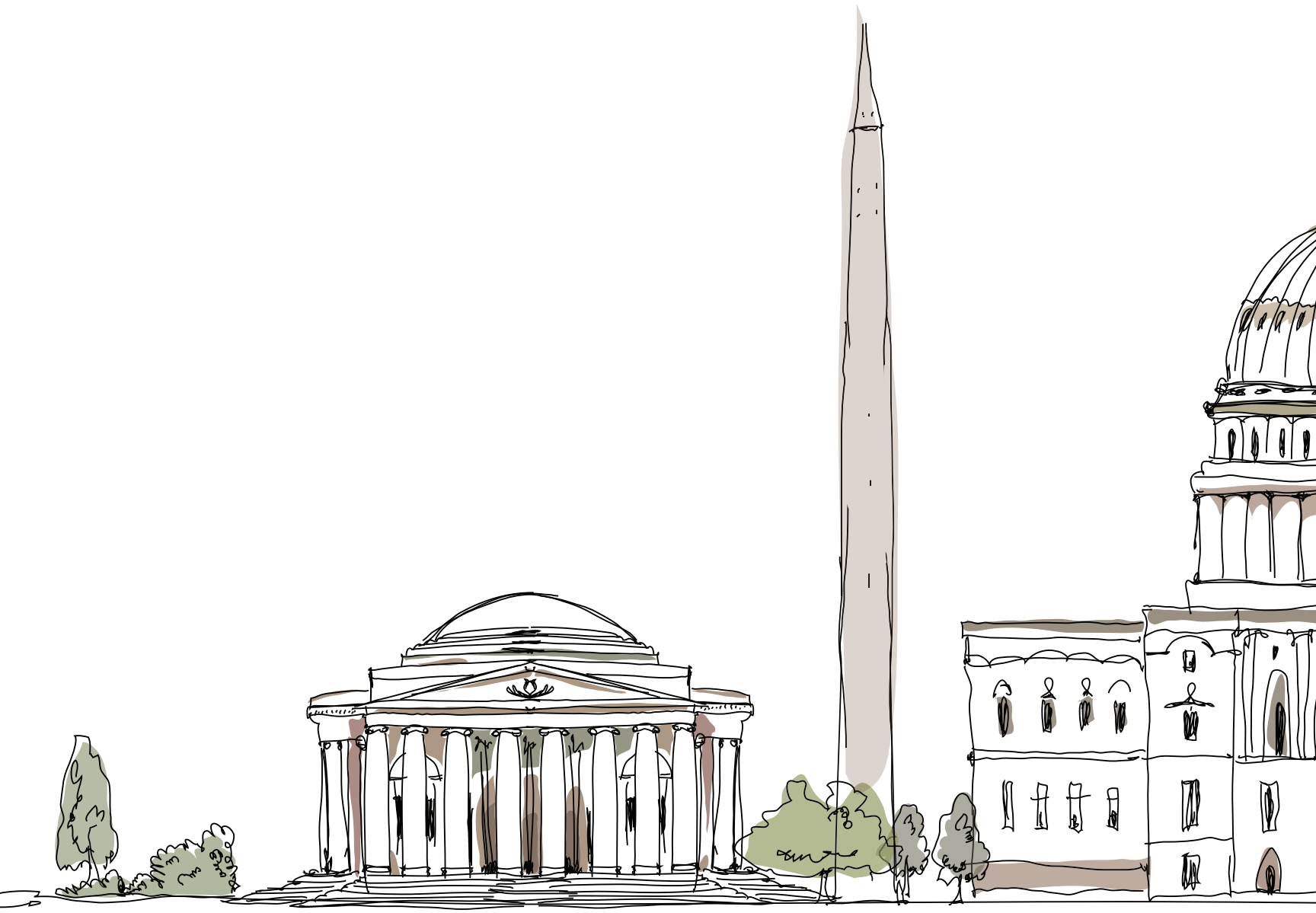

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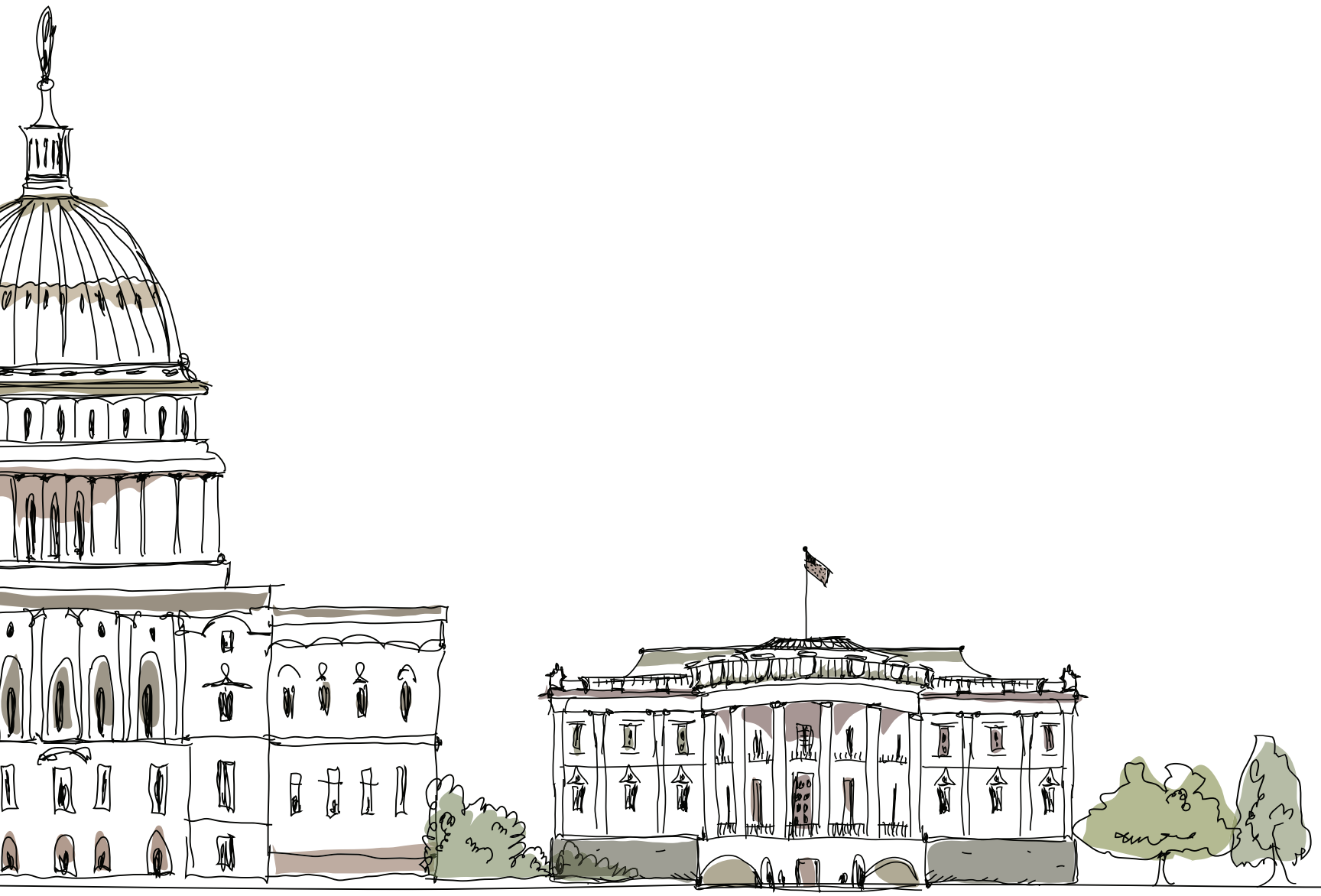
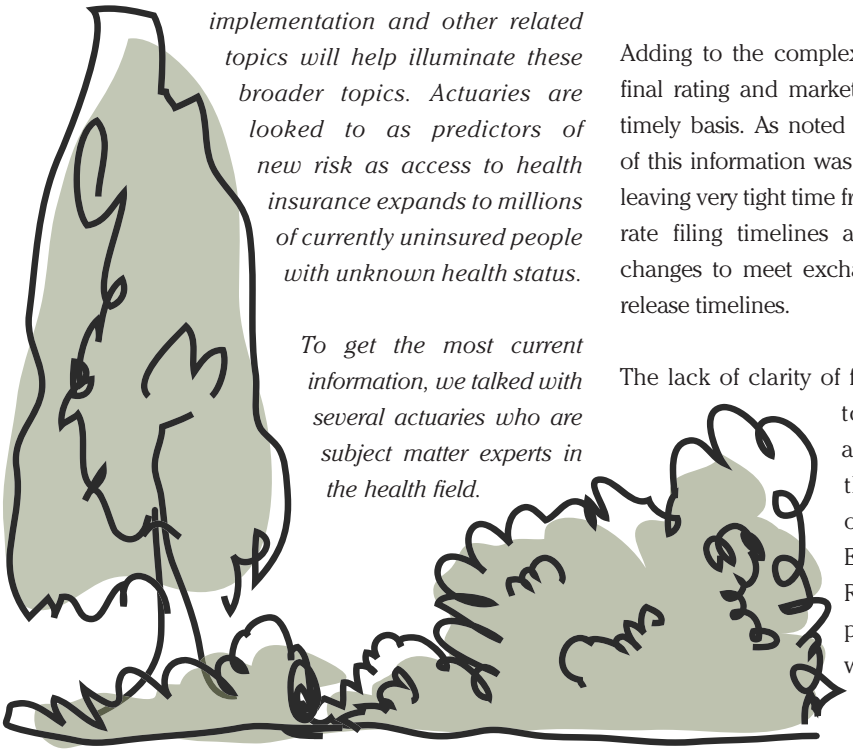


ACTUARIES ARE LOOKED TO AS PREDICTORS OF NEW RISK AS ACCESS TO HEALTH INSURANCE EXPANDS TO MILLIONS OF CURRENTLY UNINSURED PEOPLE WITH UNKNOWN HEALTH STATUS. HERE'S SOME INFORMATION FROM AN ACTUARIAL PERSPECTIVE. COMPILED BY KARIN SWENSON-MOORE AND THE EDITORIAL STAFF

EDITOR'S NOTE: The following insights were collected in September 2013, which is prior to knowledge of the exchanges' operational struggles during the first weeks after their Oct. 1 launch, and also prior to the president's announcement on Nov. 14, 2013, alluding to the possible extension of pre-ACA health plans. This latter announcement is causing additional uncertainty among many health actuaries than was contemplated in September 2013.

The implementation of the Affordable Care Act (ACA) has had a tremendous impact on the health care industry in general. Exploring lessons learned from the perspective of product development, rate filing process and review, exchange implementation and other related topics will help illuminate these broader topics. Actuaries are looked to as predictors of new risk as access to health insurance expands to millions of currently uninsured people with unknown health status.

To get the most current information, we talked with several actuaries who are subject matter experts in the health field.



Our thanks to Dan Bailey, FSA; Hobson Carroll, FSA; Laure Goldberg, FSA; Paul Harmon, FSA; Brett Heineman, ASA; Erik Poppe, FSA; Sam Vorderstrasse, FSA; and others who contributed their thoughts, knowledge and insights.

AFFORDABLE CARE ACT IMPLEMENTATION

The greatest concern raised by the actuarial contributors about the ACA—related to implementation and decisions made to date—is the uncertainty, inconsistency and lack of timely rules, guidance and decisions at both the federal and state level. Even in states where some level of reform was already in place, the ACA requirements are far more material and significant than initially expected.

Adding to the complexity was not receiving final rating and market guidance rules on a timely basis. As noted by one source, much of this information was received during 2013, leaving very tight time frames to meet required rate filing timelines and necessary system changes to meet exchange and market rate release timelines.

The lack of clarity of federal rules applying to large employers and concerns about the revenue impact of delaying the Employer Shared Responsibility (ESR) penalties to 2015 also were significant.

Further, responders were surprised that most states chose to implement the federal age curve, rather than adjusting to market-specific curves. Massachusetts, New Jersey, Minnesota, Utah and the District of Columbia created their own specific factors.[1]

IMPLEMENTATION CHALLENGES

Organizations have been challenged to implement the ACA, especially in the arenas of defining products, rating assumptions, 3Rs, preparing filings, regulatory requirements and working with the exchanges.

Complexity and uncertainty around the ACA regulations, as well as delayed release of federal and state guidance, created implementation challenges not only for exchange business, but also for large employers.

Paul Harmon, FSA, shared his thoughts about exchange products.

"We were prepared for a certain level of uncertainty but we were not prepared for states to make detailed benefit level decisions on products after rates and contracts were filed," he said. "This resulted in needing to revise the contract and rate filings on multiple occasions."

Hobson Carroll, FSA, who consults in the self-insured arena, said the confusion caused by the delay in the employer mandate created a great deal of stress after a lot of effort and resources were already spent adjusting benefit designs, administrative capabilities and other related issues.

Contributors were also concerned about communicating the impact of ACA internally to corporate leaders, and with effectively managing the many system and process changes under aggressive and fluid requirements and timelines.

"On the actuarial side in particular, we were challenged by the volume of rate filing, rating formula and assumption changes occurring simultaneously," said Laure Goldberg, FSA. "There were several work streams that required actuarial expertise and leadership ranging from understanding the "3Rs" (the federal risk mitigation programs), to the phase-out of certain rating factors, to drafting a new federal filing that hardly resembled past state filings. The actuarial team had the additional challenge of helping the organization, up to the CEO level, understand all of these rating changes and how they would affect our customers."

MARKET CHANGES

The actuarial contributors expect to see significant change across many aspects of the health care market. With the new subsidies and focus on the individual market, several actuaries commented on the potential for movement of members from the small group market to the individual market. This movement will be driven by several factors, including the potential rate increases that could occur for some small groups who experience dramatic changes due to the new rating formula, combined with the temporary reduction in individual market rates emanating from the reinsurance subsidization.

The potential for rate changes in the small group market could also impact funding approaches and how small groups organize to purchase health insurance. The contributors suggested that small groups might be more likely to use self-funding or the Professional Employer Organization umbrellas as a mechanism to purchase health insurance. In both cases, the small employer would have the opportunity to avoid the general small group rating pool and rating rules.

Contributors predict that we will continue to see more participants in the individual market—particularly from Medicaid providers and community-based plans and providers. Over time, however, they expect to see consolidation as the market becomes mature. This trend will also be driven by the continued consolidation in the provider community and the further development of integrated provider groups.

GLOSSARY OF TERMS

3Rs—Includes the federal reinsurance program, risk adjustment payments and risk corridor payments outlined in the ACA.

ACA—The Patient Protection and Affordable Care Act, passed by the U.S. Congress in early 2010.

Accountable Care Organization (ACO)—A health care delivery system that assumes risk for patient utilization, total cost of care and outcomes.

Coordinated Care Organization (CCO)—Similar to an ACO. Also known as Coordinated Care Plans (CCPs).

Employer Shared Responsibility (ESR)—This provision requires large employers offering health insurance to modify eligibility requirements for coverage, as well as the level of premium support from the employer, or pay a financial penalty (as defined in ACA).

Health Maintenance Organization (HMO)—Typically provides a more tightly managed care system with more limited access to providers, often in exchange for a higher level of benefits.

Patient Centered Medical Homes (PCMH)—Health care delivery focused on improving quality of life and outcomes for individuals with multiple conditions and high medical needs.

Primary Care Physician (PCP)—Primary care physician, most often found in an HMO model.

Reinsurance—Three-year federal transitional program designed to reduce premiums for the individual risk pool, and redistribute the costs to groups.

Risk Adjustment—Federally administered program to redistribute premiums among individual and small group health insurance carriers within each state based on the health status of the individuals enrolled in each carrier.

Risk Corridor—Federally administered program to protect health insurance carriers against severe financial losses in the individual and small group risk pools, and to charge carriers with significant financial gains.

Brett Heineman, ASA, highlighted the consolidation dynamic.

"In general, I expect health plans to consolidate in response to the consolidation trend in the provider community," he said. "In addition, the movement toward care integration models will also create incentives for provider networks to develop their own health plans to provide coverage in addition to care. These will be marketed as ACO or PCMH plans, but will really operate like HMOs of yesteryear—hopefully with better acceptance from the community, and better technology to drive quality outcomes."

EFFECT ON NATIONAL HEALTH UTILIZATION

Contributors generally believe that short-term utilization in 2014 will remain steady, or increase, as newly insured seek long-delayed services, and as benefit richness increases, with potential cost offsets coming from more aggressive provider contracting that could drive the cost per service down. There could be a backlash from aggressive contracting tactics though.

"We are concerned that the trend in large-dollar claims will accelerate as providers face reduced base rates and also know that a large fraction of the population doesn't have lifetime limits but has a strong annual out-of-pocket maximum," said Sam Vorderstrasse, FSA.

There also is concern about spikes in small group costs in late 2013, as insureds seek services prior to changes in coverage.

Longer term, the contributors did not expect that the ACA will significantly affect national health care cost trends. Some raised concerns about inadequate provider capacity.

Prior to the ACA, many large employers were already seeking innovative approaches to managing trends.

IMPACT OF THE CHANGING ENVIRONMENT

Several contributors commented on the changing environment and how it will impact the rating process in 2015.

Harmon summarized the sentiment of the group regarding the uncertainty and the potential strategic response of the carriers.

"I think 2015 implementation will be very similar to 2014 in that we'll still face a high level of uncertainty regarding state and federal decisions until later in the filing preparation process, and there will only be limited enrollment and cost information to adapt assumptions for, particularly the 3Rs," he said. "I think 2015 strategy will be very interesting as carriers adapt to the new marketplace and try to better target their price and benefits to the competition."

Vorderstrasse also commented on the potential uncertainty.

"Sometime during 2015, I would expect carrier cash flow concerns to start arising in small carriers in small markets," he said. "Not having enough information for rate filings will require extending the unknown claims cost question into the 2015 contract year. With the extended open enrollment period for 2014, we will also not know final enrollment numbers by the time rate filings for 2015 are due."

In addition to the rating impact, the contributors also expect employers to more seriously consider dropping coverage and make further benefit design changes. These benefit designs will be more likely to account for cost-sharing provisions that emphasize favorable provider-payer partnerships and ensure a more efficient provision of care.

IMPACT OF 3R PROTECTIONS

As a group, the contributors had varying views toward the 3Rs policy in the ACA (federal reinsurance, risk adjustment and risk corridors). Goldberg, for example, identified the possibility for the policy to reduce conservatism for selection concerns:

THE IDEA BEHIND THE 3RS IS TO MITIGATE THE CONCEPT OF 'GOOD RISKS' AND 'BAD RISKS.'

"The idea behind the 3Rs is to mitigate the concept of 'good risks' and 'bad risks' as the individual mandate is implemented," she said. "Nationally, this should help reduce padding for selection concerns."

Another contributor highlighted the potential for the reinsurance program to reduce individual rates in the shorter term, but this effect will wear off over time as the reinsurance program is phased out. This source added that hopefully this wear-off will be offset by additional members entering the individual market from the uninsured ranks that are better risk overall than observed 2014 market risk levels.

HEALTH WATCH

The October 2013 edition of *Health Watch,* the newsletter of SOA's Health Section, is dedicated to ACA implementation. Read articles such as "Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details," "Diary of a Health Care Reform Actuary," "The ACA—Two Policy Experts' Perspectives," and more. Visit ***www.soa.org/Health-Watch-2013.pdf.***

In contrast, Heineman pointed out the potential incentive for some carriers to underprice, given the additional financial backing afforded by the 3Rs protection.

"I think carriers, particularly small carriers, have the incentive to underprice in hopes of growing membership in the short term, and getting paid on the back end by the 3Rs," he said. "I doubt many carriers will deliberately take this kind of risky strategy. However, an overly optimistic carrier may be bailed out in a way they never would have been without the ACA, and it will be interesting to see how states will react to under-priced carriers."

On the other hand, Vorderstrasse thought that the impact would be more modest.

"I don't think that the risk adjustment program presents much protection in the immediate term, since the biggest risk factor is the overall morbidity of each statewide market," he said. "Beginning in 2015, the transitional reinsurance program will begin to be scaled back, which will increase premiums in the individual market."

COST OF CARE AND ACCOUNTABLE CARE ORGANIZATIONS

One of the major concerns is how Accountable Care Organizations (ACOs) or Coordinated Care Organizations (CCOs) are likely to affect availability and cost of care, and related concerns about these entities. In most cases, the contributors believe that these organizations hold real promise, but savings are not likely to occur immediately.

Heineman highlighted some challenges.

"I am a firm believer in the power of care coordination, but I don't think CCOs will succeed in lowering the cost of care for the majority of instances during the first year of implementation," he said. "I think it will take some time for the industry to work the kinks out of the system. Specific challenges for this space include:

- Motivating patients to participate and do their fair share
- Integrating mental and behavioral health information into care coordination efforts (this is currently very difficult due to privacy concerns and laws)
- Synchronizing care coordination efforts with providers
- Providing outcome-based incentives for care coordinators to drive increased quality.

"My biggest concern about CCOs is that they represent a new paradigm in providing care. Current providers have fundamental barriers to fully embracing this new paradigm including information technology infrastructure and training, education on how to use a CCO effectively, reimbursement incentives to use CCO, and old-fashioned 'that's not the way they were trained' sentiments. These barriers are not insignificant, and pose the biggest threat to the success of CCOs. I think enough organizations will get it right that there will be an increase in adoption of care coordination over the next several years, with best practices and operating models becoming established."

Erik Poppe, FSA, identified some of the potential advantages.

"The goal is for ACOs to become efficient at delivering care at

multiple settings without the overlapping of costs that had existed in the past," he said. "For example, transition of care from an inpatient setting to a home setting will be more efficient with linked electronic medical records when all the patients' providers belong to the same ACO."

Dan Bailey, FSA, further highlighted the potential of these programs with specific examples of their effectiveness.

"The concept of coordinated care, in general, works well in actual practice—it has been working well for some time," he said. "For elderly and non-elderly populations, coordinated care has long been an inextricable part of Staff Model and Group Model HMOs—it is inherent in their delivery model. These organizations pre-date the use of the term 'Coordinated Care.' Co-location of services (primary, specialty, allied and ancillary) in these types of delivery structures also enhances their ability to coordinate care and uses resources more efficiently while improving patient health and quality of care. PCP buy-in and an emphasis on better primary care is common to these models and to effective CCOs in general. These delivery concepts seem to be more practical and prevalent in urban locations, supported by robust networks with adequate geo-access. In these types of delivery systems, which tend to be more local, coordinated care arises more naturally. It is an effective way of improving efficiency. Coordinated care works in terms of lowering per capita health care cost, all else being equal. It is not, however, the silver bullet or panacea for all that ails our system. In a broader sense of the term 'coordinated care,' we even have examples of its effectiveness as provided through Medicare Advantage (MA) Coordinated Care Plans (CCPs), which are HMOs, HMO-POS and PPO plans, including HMO Special Needs Plans. Over 90 percent of the 15 million people in MA Part C medical plans are enrolled in CCPs. MedPAC conducted analysis showing that MA CCP plans, especially HMOs, provide more benefits for less medical cost at lower total cost. This translates into lower cost to the MA member in terms of monthly member premium and member cost-sharing.

"Medicare beneficiaries benefit both from the coordinated care practiced in MA plans (to varying degrees) as well as in the newer accountable care programs made available to the 35 million beneficiaries in Original A/B Medicare (not MA). These ACOs recently brought about under the ACA are an extension of the MA experience and a concerted effort to stimulate better care delivery more broadly in the largely fee-for-service space. The jury is still out on the effectiveness of these new ACOs. But these are not the only CCO examples. Many states are experimenting with coordinated care for their residents covered by Medicaid, and they are assembling the data and analytics to prove or disprove its value."

BENEFICIAL OR NOT?

Actuarial contributors commented on the aspects of the ACA that will have the greatest benefit to the United States, and what aspects will not, both in the short and long term.

Many contributors cited improved access to comprehensive health insurance with lower member cost sharing for more individuals as a significant benefit. They also cited increased consumer awareness of health care costs and benefits due to transparency requirements.

"Another benefit of the ACA is the education and transparency of the actual health care costs to the average U.S. citizen," said Poppe. "Most employees are not aware of the total cost of health care provided by their employer; after ACA is fully implemented, these costs will be very apparent. Ideally, this will lead to consumer pressure that results in reduced health care costs across the board in the coming years."

Several contributors noted the lack of focus on health care cost reform and control as a major missed opportunity.

Goldberg noted that there needs to be a parallel effort to control health care costs. "Without more focus on the cost aspect, it will be challenging for the ACA to succeed in making health care both more accessible and more affordable," she said.

"The ACA did little to limit the cost increases providers, drug companies and durable medical equipment vendors pass through," said Heineman. "This will come to a head sometime between 2015 and 2017, as many carriers will face costs rising faster than premiums."

Other contributors noted the complex rules and responsibilities for employers, the lack of catastrophic low-cost coverage, inadequate penalties causing healthy, currently uninsured individuals who do not qualify for premium subsidies to remain uninsured, and significant rating factor changes resulting in substantial premium rate changes for younger, lower-risk individuals.

One source added that by limiting the catastrophic level of benefits (plans with less than 60 percent actuarial value will be subject to penalties), along with low penalty consequences, some Americans who do not have coverage and perceive themselves to be healthy risks will choose not to enter the market in the early years of the ACA, keeping costs higher for those who select coverage.

WHAT WOULD YOU CHANGE ABOUT THE ACA?

Our responding contributors offered many suggestions for change. Some of the opinions included:

- Increase clarity and timeliness of ACA rules and regulations, and better coordinate decisions needed at both the federal and state level.
- Change the Employer Shared Responsibility affordability test to reflect family coverage. Also, provide more guidance on family design benefit richness evaluation.
- Allow exchange plans with less than 60 percent actuarial value to provide lower-cost premium options and thus attract additional lower-risk individuals to the exchange marketplaces.
- Include standardized provider reimbursement in the exchanges.
- Address existing continuation of coverage requirements such as COBRA and group conversion laws that may be inconsistent with ACA.
- Address the continuum of health insurance reform to include Medicare.

Harmon commented on the work and re-work required as carriers and regulators attempted to achieve clarification concerning the regulatory guidance.

"Decisions were revisited multiple times, causing compressed timelines for filings, updates and implementation," he said. "Uncertainty places large risks on the new marketplace on either side of the pricing spectrum through carrier conservatism or simplified pricing approaches."

IN CLOSING

2013 has been an action-packed year for health actuaries as we implement ACA for 2014. Health plans already are moving into the next cycle of product development, rating and implementation. Actuaries will be challenged to manage expectations around enrollment and risk with little data. Hang on for another wild ride!

Karin Swenson-Moore, FSA, MAAA, is director, Actuarial, at Cambia Health Solutions. She can be reached at *karin.swenson-moore@cambiahealth.com*.

END NOTE

[1] *http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-08-09-2013.pdf.*

RELATED READS

Read the SOA's research report, "Cost of the Newly Insured Under the Affordable Care Act." The research predicts ACA-driven changes in individual market composition of the individual health care market could drive up underlying claims costs by an average of 32 percent nationally by 2017. Visit the SOA website. Click on the Research tab, then Completed Research Projects. Click on Health and scroll down to access the report.