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THE INDIVIDUAL ACA MARKET

WHAT'S NEXT?

BEFORE THE ACA WAS PASSED, INSURERS HAD AN INCENTIVE STRUCTURE THAT INCLUDED THE POTENTIAL FOR PROFIT AND LOSS; IN THE TRANSITIONAL ACA PHASE, THE RISK PROTECTIONS AND THE PROFIT CONSTRAINTS DRAMATICALLY LIMIT THE VARIATION IN FINANCIAL RESULTS FOR AN INSURER. BY KURT WROBEL

With most observers focusing on emerging demographic data and rate increases to define the ultimate outcome of the Affordable Care Act (ACA), at this point, we simply do not have enough data to make a conclusive assessment. In the absence of more quantitative evidence, we can make more definitive assessments regarding the changing risk profile between the transitional ACA period (2014-16) and under the final ACA period (beyond 2017) for the individual market.

As highlighted below, these periods are separately delineated because the policy differences in each period have a dramatically different impact on the degree of risk accepted by health plans. While in the initial transition period, the risk protections and profit limitations inherent in the legislation will ensure that the ultimate financial results will likely not deviate significantly from the original margin assumptions, the final phase will require health plans to accept the full risk associated with this program. As a result, the policy risk in the short term will be the financial costs associated with the risk protection program, while the longer-term result could be lower participation by health plans.

TRANSITIONAL ACA PERIOD IMPACT

Before the ACA was passed, insurers had an incentive structure that included the potential for profit and loss; in the transitional ACA phase, the risk protections and the profit constraints dramatically limit the variation in

financial results for an insurer. These ACA risk protections include reinsurance, risk adjustment and the risk corridor. These provisions provide financial protection if claims exceed a defined threshold (reinsurance), payment or cost to an insurer if the risk is higher or lower than the market level risk (risk adjustment), and additional financial protection or cost if the ultimate claims are different from expectations (risk corridor). In addition to the risk protections, this period also includes the application of a minimum medical loss ratio floor that requires an insurer to pay out a fixed percentage in claims relative to its premium rate.

Because the upside is limited by the minimum medical loss ratio floor and the downside limited by the risk protections, the payment structure more closely resembles a "cost plus" type arrangement where a contractor submits its cost and expected profit to receive an agreed-upon payment—similar to arrangements with a regulated utility or a defense contractor. Consistent with the ACA policy goals, health plans are effectively trading the benefits of greater risk and reward for an arrangement where the financial outcome is much less variable. In return, health plans are allowed a period to better understand the risk and buying behavior of consumers so that this population can be more accurately priced once the risk protections are removed. In addition to allowing a period to collect data and better analyze the ACA population, this funding approach also increases the downside risk associated with overpricing the exchange population—particularly relative to the period before passage of the ACA. Because the potential cost of underpricing the block is limited by the financial protections, the chief risk becomes the loss of market share by overpricing the exchange population relative to other competitors. With this loss in market share, a health plan would have a much smaller membership base to spread its fixed costs and investments associated with its exchange membership and miss an opportunity to better understand the risk profile of this population before 2017. In contrast, in the period before the ACA was in effect, a health plan would have to bear the entire cost of financial losses associated with underpricing along with the potential loss of market share if the block was overpriced.

CONSISTENT WITH THE ACA POLICY GOALS, HEALTH PLANS ARE EFFECTIVELY TRADING THE BENEFITS OF GREATER RISK AND REWARD FOR AN ARRANGEMENT WHERE THE FINANCIAL OUTCOME IS MUCH LESS VARIABLE.

THE RATIONALE FOR THE RISK PROTECTIONS

This risk protection is critical because the structure of the program requires health plans to make assumptions regarding a completely new and potentially volatile population that will no longer be required to undergo the medical underwriting process that health plans have used to ensure the expected costs were appropriate for the premium charged to each individual. As a result, without this historical information and the ability to develop a unique rate for each individual, health actuaries must now develop a rate structure that represents the risk composition for the entire ACA pool. The new rates must now be adequate in total—even if some individuals will have rates that will result in an expected subsidy or an additional cost to the broader pool. In addition to estimating the costs for the entire risk pool, actuaries must also ensure the program provides adequate funding through the ACA's risk protections at the individual health plan level to meet the financial goals outlined in its rate filing. As outlined below, the challenges with rating this population require the additional financial risk protections to ensure broad insurer participation.

- **Estimating the expected health expenses for the ACA exchange risk pool.** In developing the expected expenses for the entire risk pool, along with estimating traditional actuarial variables such as utilization and unit cost trend, actuaries must also estimate who is expected to participate in the ACA pool. Without historical information in the first year of the program and only a limited amount of emerging data in the second year, actuaries must make a determination of how several factors will impact ACA participation, including the health status and age of the individual, the net premium level (premium cost less the subsidy) of the individual, the availability of other insurance options—including the extension plans available in several states where individuals can continue

with their existing plans, and the consumer response to the tax penalty. As one would expect, actuaries can reasonably disagree on the interaction of these various assumptions and the extent individuals will react to the economic incentives to purchase insurance in the most cost-effective insurance pool. Ultimately, this uncertainty has manifested itself in widely varying rates in the exchanges for the initial calendar year with the likelihood of continued volatility in the second year as health plans make decisions with a limited amount of emerging information. In addition to ensuring that some health plans would have either over- or underpriced their exchange business, this rate divergence has the potential to magnify the financial impact of any underpricing as members are disproportionately attracted to the lower-priced plans.

- **Estimating the impact of the risk protections.** After estimating the costs for the entire risk pool, actuaries must then ensure that the total revenue from the program is sufficient to meet the financial requirements identified in their rate filing for their particular organization. While the emerging data will include premium information and initial reinsurance recoveries, actuaries will not be in a position to completely measure the total financial impact of the other risk protections—the risk adjustment and the risk corridor—for their health plan until the middle of the following year. As structured in the legislation, the risk adjustment program requires a final accounting in the middle of the year following the rating period where the relative risk among the health plans is compared and payments are made to the health plans that attracted a population with greater health needs than other health plans. Similar to the challenges in estimating the broader risk pools, this additional uncertainty could increase the potential volatility in estimating the expenses for this population.

In addition to the delay in receiving the risk payment, the ACA subsidy structure could lead to substantial net premium (premium less subsidy) differences among plans in a given year and significant changes in net premium from one year to the next. (See "The Implications of the ACA Subsidy Program on Net Premium Levels" on page 18). This volatility is created by the development of the subsidy, which is dependent on the second-lowest silver plan. To the extent the second-lowest silver plan changes relative to a member's existing plan, a member could see substantial changes from one year to the next. The net effect of this volatility could be substantial migration among the plans and increased difficulty in estimating a health plan's specific risk adjustment as the population changes. This potential volatility also further increases the risk associated with overpricing the exchange population relative to other competitors.

Overall, consistent with the expectations inherent in the risk adjustment program, we can expect to see substantial rate volatility as actuaries make their initial assumptions regarding participation in the ACA exchanges. This volatility will likely continue into 2015 as actuaries continue to estimate the expected ACA participation rate with limited information and without complete visibility to the value of the risk protections at the health plan level. While these costs have the potential to be volatile, if unfavorable results occur, health plans will have sufficient protection from the federal government to continue their participation in the initial transitional phase. This remains the key to the short-

THE IMPLICATIONS OF THE ACA SUBSIDY PROGRAM ON NET PREMIUM LEVELS

The following example from the 2014 Milliman briefing paper "The Proposed Federal Exchange Auto-Enrollment Process: Implications for Consumers and Insurers" by Susan Pantely and Paul Houchens highlights the potential for consumer switching. In the chart below, the authors highlighted the premium and subsidy level offered to an exchange participant at 150 percent of the federal poverty limit. Consistent with ACA policy, the subsidy level in this example is based on the second-lowest silver plan premium—in this case, the maximum expenditure individual is 4 percent of a household's income or $57. The resulting subsidy amount ($268) can then be applied to all the plans to produce a higher or lower net premium.

ACA COMPONENT	PLAN 1	PLAN 2	PLAN 3
Full premium	$300	$325	$350
Subsidy amount (based on the second-lowest silver plan)	$268	$268	$268
Monthly net premium	$32	$57	$82
% of income	2.2%	4.0%	5.7%

As highlighted above, a significant percentage differential in actual net premium levels—$32 compared to $57 and $82—could prompt an individual with an income level slightly above the federal poverty limit to choose the lowest-cost plan.

This switching could be magnified over time as some health plans change premium rates to increase market share. The authors highlighted the following example where Plan 3 purposely reduced its premium and Plan 2 maintained its initial rate in an effort to increase market share.

ACA COMPONENT	PLAN 1	PLAN 2	PLAN 3
Full premium	$320	$325	$350
Percentage change from 2014	7%	0%	−16%
Subsidy amount (based on the second-lowest silver plan)	$263	$263	$263
2015 net premium	$57	$62	$32
2014 monthly net premium	$32	$57	$82
% net premium change from 2014	78%	9.0%	−61%

In this case, a member in Plan 1 where the health plan proposed a modest 7 percent increase would still see a large net premium change caused by two factors—an increase in the premium by 7 percent and a reduction in the subsidy caused by a reduction in the second-lowest silver plan ($325 to $320). Because the member would see the entire burden of the rate increase and the reduced subsidy, the incentive to switch to a lower-cost plan would increase significantly.

term results in the legislation for health plans—any potential mispricing will have financial protection from the federal government.

FINAL ACA PHASE

Beginning in 2017, the ACA market will no longer offer two of the three risk protections—reinsurance and the risk corridor. The risk adjustment program and the existing reconciliation process will continue along with the minimum medical loss ratio floor.

Although one could debate the absolute level of the risk, health plans are clearly taking on more risk relative to the period before the ACA and the current transitional period. The additional risk factors include:

- *Unlimited downside risk combined with limited upside potential.* While before the ACA, health plans bore all the risks and rewards of better- or worse-than-expected results, health plans in the current transitional phase have risk protections that dramatically limit the potential volatility in financial results. Under full implementation of the ACA where two of the three risk protections are eliminated, health plans will face unlimited downside with a financial upside limited by the minimum medical loss ratio floor. With this change, health plans now have a much less attractive arrangement than under both the transitional and pre-ACA periods.

- *Difficulty estimating the total risk pool.* In addition to the challenges already discussed, because the extension policies allowed a number of policyholders to remain outside of the ACA risk pool in some states, insurers would not have gained any information on these members prior to the final ACA period. This lack of information will make the ultimate expense estimate of the risk pool subject to additional variance.

In addition to the above changes, the challenges with having full visibility to the risk adjustment payments and the potential for significant consumer switching among the health plans will continue. These factors will make managing the exchange population more challenging and could reduce participation in 2017.

CONCLUSION

Taken in total, the ACA has introduced new incentives that will have a profound impact in the insurance market for both consumers and health plans. In the short term, the lack of historical information, the selection that could occur as individuals choose the most advantageous risk pool, and the migration among the plans make the potential for inaccurate pricing more likely. The potential downside for health plans, however, will be limited by the financial protections in place through the reinsurance, risk adjustment and risk corridor programs. Any potential profit would also be limited by the minimum medical loss ratio floor.

From a health plan perspective, the real challenge will occur in the longer term as the final ACA rule provisions are put in place. Because the final period increases the risk to insurers and limits any potential upside associated with better-than-expected performance, health plans will need to be able to estimate the expected cost for this population with a greater degree of accuracy than other historical periods. As outlined above, however, this will not be easy. Although the extension plans will presumably be phased out, health plans will still face the potential prospect of attracting a much different population from one year to the next as consumers with dramatically different net premium rates respond by switching from one plan to another. If this migration occurs, the rating process will be made much more volatile because the rated population could change significantly from one year to the next for a given health plan. This challenge is further magnified by the delay in estimating the true financial performance in a year caused by the risk adjustment settlement process. This will ultimately make the consumer participation rate and migration behavior critical in determining a health plan's willingness to participate.

As we make this transition into 2017, our profession is in a unique position to help facilitate the change from the current period to the final ACA period where health plans will have to take on substantially more risk. Relative to most policymakers and observers, we have been on the ground floor managing the technical details associated with the legislation. As a profession, we also have a deep understanding of risk and the financial implications associated with uncertainty. In short, the ball is in our court to help provide policy recommendations and advice as we enter into the most impactful phase of the ACA legislation. A

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